

**Education Committee Discussion Document**  
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**Undergraduate Interprofessional Education**

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CAIPE defined interprofessional education as:

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

(CAIPE, 1997)

‘Common learning’ has been commended more recently by Government to facilitate substitution and to ease progression between professions to develop a more flexible and more responsive workforce as part of the modernisation agenda (Department of Health, 2000). Interprofessional education can make an indispensable contribution to common learning by cultivating collaboration without which workforce reforms may falter for lack of give and take between the professions, and counter resistance when change is threatening.

Common learning programmes are being launched nationwide where as many as a dozen health and social care professions, including medicine, often share parts of their undergraduate studies<sup>1</sup>. Many base common curricula on a common core of benchmark statements derived from those prepared for medicine<sup>2</sup>, allied health professions and nursing (QAA, 2001) and social work (QAA, 2000).

Valuable though common curricula may well be, comparative curricula are also needed. This is where interprofessional education comes in. Comparative curricula enable the professions to compare perspectives on practice and respective values, roles and skills as they explore how each can call intelligently on the expertise of the others as co-workers and fellow team members.

Interprofessional education employs a range of interactive learning methods to facilitate comparative learning and to sustain student interest. Of these, problem based learning is perhaps the most popular (drawing on its application in medical education), but there are others, e.g. experiential, observational, virtual and, critically important, practice learning. Shared placements are hard to arrange. Linked studies during concurrent placements in neighbouring work settings may be more feasible.

All these methods apply principles of adult learning, which draw upon participants’ experience and value the diversity of the group in a spirit of co-operation. The ground is well prepared for interprofessional education where these principles already characterise undergraduate programmes for the participant professions.

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<sup>1</sup> With special funding for four pilot sites based on King’s College London with Greenwich and South Bank universities, Sheffield and Sheffield Hallam universities, Southampton and Portsmouth universities, and Newcastle and Northumbria universities, with neighbouring employing agencies.

<sup>2</sup> See [www.ltsn-1.ac.uk/resources/news/display\\_single?newsindex=204](http://www.ltsn-1.ac.uk/resources/news/display_single?newsindex=204)

Interprofessional education is strengthening its theoretical bases as it wins friends in higher education. The “contact hypothesis” merits special attention. Formulated by social psychologists in the US to improve race relations, it has been applied in the UK to improve interprofessional learning and working (Hewstone and Brown, 1986). It specifies seven conditions to be satisfied before interprofessional education may succeed in modifying attitudes positively between professions:

- positive expectations by participants
- equal status of participants
- positive institutional support
- a co-operative learning environment
- successful joint working between participants
- exploration of differences as well as commonalities
- perceptions of fellow participants as typical of their professions

Progress is being made painstakingly in establishing the evidence base for interprofessional education (Freeth et al, 2002; Zwarenstein et al, 2000). Findings, so far, suggest that undergraduate interprofessional education can, under favourable conditions, enhance mutual understanding between professions, modify reciprocal attitudes and teach teamwork. Work-based interprofessional education can build on this to improve services and patient care.

The challenge lies in developing the current wave of undergraduate interprofessional education initiatives in the UK not simply to match past outcomes as reported in the literature, but to exceed them, for example, by introducing competency based models. Expectations of undergraduate interprofessional education must nevertheless be realistic, given the demands of profession-specific objectives and the inexperience of the students. This points to the need for such education to lead into a planned and progressive career-long continuum of professional and interprofessional learning.

Many programmes build in evaluation (Barr, 2003), but often limited to feedback on student satisfaction or simple before and after measures. More longitudinal studies are needed which follow students through and beyond their undergraduate studies complemented by critical observation of the learning process.

Adopting hard and fast principles of interprofessional education may be premature. Framing questions may be more productive at this stage - questions about interprofessional education, in general, and about its introduction into common learning programmes, in particular, within which medical students are being included.

Does the interprofessional education:

- respond to the demands of policy and practice?
- build on evidence?
- incorporate theory?

- apply principles of adult learning?
- include common and comparative curricula?
- employ a repertoire of interactive learning methods?
- enhance mutual understanding?
- cultivate collaborative competence?
- complement common learning?
- complement profession-specific learning?
- balance numbers from the professions participating?
- include teachers from each of the professions participating?
- involve patients in planning, teaching and evaluation?
- help to improve practice and patient care?
- evaluate experience and disseminate findings?

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(CAIPE)

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## References:

Barr, H. (2003) Assuring the Quality of Interprofessional Education for Health and Social Care. *CAIPE Bulletin No 22*.

Department of Health (2000) *A Health Service for All the Talents: Developing the NHS Workforce*. London: Department of Health

Freeth, D., Hammick, M., Koppel, I., Reeves, S. and Barr, H. (2002) *A Critical Review of Evaluations of Interprofessional Education*. London: Learning and Teaching Support Network for Health Sciences and Practice.

Hewstone, M. and Brown, R.J. (1986) Contact is not enough: An intergroup perspective on the 'contact hypothesis'. In: M. Hewstone and R.J. Brown, *Contact and Conflict in Intergroup Encounters*. Oxford: Blackwell

Quality Assurance Agency (2000) *Social Policy and Social Work: Subject Benchmarking Statements*. Bristol: Quality Assurance Agency for Higher Education

Quality Assurance Agency (2001) *Benchmarking Academic and Practitioner Standards in Health Care Subjects*. Bristol: Quality Assurance Agency for Higher Education

Zwarenstein, M., Reeves, S., Barr, H., Hammick, M., Koppel, I. and Atkins, J. (2000) *Interprofessional Education: Effects on Professional Practice and Health*. Oxford: The Cochrane Library

## **A Selected Bibliography with Annotations**

**Areskog, N-H. (1995) *Multiprofessional Education at the Undergraduate Level*. In: Keith Soothill, Lesley Mackay and Christine Webb, *Interprofessional Relations in Health Care*. London: Edward Arnold 125-139**

This is one of several papers in which Areskog describes his ground-breaking work at the University of Linköping in Sweden to develop a ten-week block of shared studies for six professions including medicine before they entered their respective courses. The programme followed closely the blueprint commended by the WHO and employed problem based learning throughout.

**Barrett, G., Greenwood, R. and Ross, K. (2003) *Integrating Interprofessional Education into Ten Health and Social Care Programmes*. *Journal of Interprofessional Care* 17 (3) 293-302**

Teachers at the University of the West of England share lessons learned in resolving challenges - logistical, numerical and operational – involved in introducing interprofessional learning into undergraduate professional education. They emphasise the need for such learning to permeate the whole of the student's experience and for mutual support between teachers across professions to sustain commitment.

**Barr, H. (1996) *Ends and Means in Interprofessional Education: Towards a Typology*. *Education for Health* 9 (3) 341-353**

This paper classifies objectives, content and learning methods in interprofessional education, and variables affecting realistic expectations of outcomes, as a basis for formulating hypotheses to test claims made for particular types of interprofessional education.

**Barr, H. (1998) *Competent to Collaborate: Towards a Competency-based Model for Interprofessional Education*. *Journal of Interprofessional Care* 12 (2) 181-188.**

This is the first reported attempt to define outcomes from undergraduate interprofessional education as competencies rather than knowledge, skills and attitudes.

**Barr, H. (2002) *Interprofessional Education Today, Yesterday and Tomorrow*. London: Learning and Teaching Support Network for Health Sciences and Practice. See [www.health.ltsn.ac.uk](http://www.health.ltsn.ac.uk) or [www.caipe.org.uk](http://www.caipe.org.uk)**

This is a critical review of current health and social care policies in the UK generating calls for interprofessional education set in the context of developments over the past thirty years and marking up issues for future attention. It introduces theoretical perspectives and summarises findings from earlier surveys, reviews and evaluations.

**Barr, H. (2003) *Unpacking Interprofessional Education*. In: Audrey Leathard (ed) *Interprofessional Education: from Policy to Practice in Health and Social Care*. Hove: Brummer: Routledge 265-279**

This chapter comprises a critical review of expectations of interprofessional education found in two WHO reports, with examples of programmes embracing each of them. Of these, five are at undergraduate level.

**Barr, H. and Waterton, S. (1996) *Interprofessional Education in Health and Social Care in the UK*. London: CAIPE**

Albeit dated this is still the most recent survey of the incidence of interprofessional education throughout the UK. Nursing groups made up the largest number of participants followed by medicine. An eighth of the 'initiatives' reported at that time were at the undergraduate level.

**Barr, H., Freeth, D., Hammick, M., Koppel, I. and Reeves, S. (2000) *Evaluations of Interprofessional Education: A United Kingdom Review of Health and Social Care*. London: CAIPE and the British Educational Research Association (BERA) See [www.caipe.org.uk](http://www.caipe.org.uk)**

The Interprofessional Education Joint Evaluation Team (JET) was commissioned by BERA in association with CAIPE to conduct a qualitative review of evaluations of interprofessional education. Nineteen are analysed and summarised. Only six were at undergraduate level.

**Carpenter, J. (1995) *Interprofessional Education for Medical and Nursing Students: Evaluation of a Programme*. *Medical Education* 29 (4) 265-272**

This is classic early example of an evaluation of undergraduate interprofessional education employing before and after instruments to measure changes in reciprocal attitudes and the application of the contact hypothesis.

**Crow, J. and Smith, L. (2003) *Using Co-teaching as Means of Facilitating Interprofessional Collaboration in Health and Social Care*. *Journal of Interprofessional Care* 17 (1) 45-55**

Two tutors from different professions share their experience of co-teaching an undergraduate interprofessional module and their students' reactions.

**Freeth, D., Hammick, M., Koppel, I., Reeves, S. and Barr, H. (2002) *A Critical Review of Evaluations of Interprofessional Education*. London: Learning and Teaching Support Network for Health Sciences and Practice.**

See [www.health.ltsn.ac.uk](http://www.health.ltsn.ac.uk) or [www.caipe.org.uk](http://www.caipe.org.uk)

Freeth and her fellow members of the Interprofessional Education Joint Evaluation Team (JET) report on systematic searches of Medline, CINAHL and the British Education Index and analyses in progress. They pay particular attention at this stage to the quality of the studies reported and methodologies employed.

**Gilbert, J. and Bainbridge, L. (2003) *Canada - Interprofessional Education and Collaboration: Theoretical Challenges, Practical Solutions*. In: Audrey Leathard (ed), *Interprofessional Collaboration: from Policy to practice in Health and Social Care*. Hove. Brummer-Routledge. 280-296**

This overview includes ambitious plans to integrated undergraduate education for students from fifteen professions in different schools in the University of British Columbia to form the College of Health Disciplines. It explores the organisational process leading to structural reform.

**Gilbert, J., Camp, R., Cole, C., Bruce, C., Fielding, D. and Stanton, S. (2000) Preparing Students for Interprofessional Teamwork in Health Care. *Journal of Interprofessional Education* 14 (3) 223-235**

Gilbert and his colleagues describe a two-day team-building workshop for undergraduates from nine professions including medicine calling on methods used in business education. Different groups were given instructions to build a 'lego' model using different theoretical approaches to organisational learning. Feedback from students was positive.

**Harden, R.M., (1999) *Effective Multiprofessional Education: a Three Dimensional Perspective*. In AMEE Guide No. 12**

For Harden the question is not whether "multiprofessional education" is effective, but how it can be made effective. He explores the context in which such education is applied, goals and approaches presented as eleven steps from "isolated" to "transprofessional" learning.

**Harris, D.L., Henry, R.C., Bland, C.J., Starnman, S.M. and Voytek, K.L. (2003) Lessons Learned from Implementing Multidisciplinary Health Professions Education Models in Community Settings. *Journal of Interprofessional Care* 17 (1) 7-20**

The paper describes barriers and facilitators affecting the sustainability of community-based undergraduate interprofessional education drawing on the experience of five programs for seven professions in the United States. It includes insights into the workings of the community-campus collaborative movement.

**Hind, M., Norman, I., Cooper, S. Gill, E., Hilton, R., Judd, P. and Jones, C. (2003) Interprofessional Perceptions of Health Care Students. *Journal of Interprofessional Care* 17 (1) 21-34**

This is a study of students' attitudes towards their own and other professions on entering undergraduate interprofessional education. Hypothesised relationships are tested between stereotypes, professional identity and readiness for interprofessional learning.

**Hughes, L. and Lucas, J. (1997) An Evaluation of Problem Based Learning in the Multiprofessional Education Curriculum for Health Professions. *Journal of Interprofessional Care* 11 (1) 77-88**

This paper is one of the few reports of problem based learning in undergraduate interprofessional education in the UK. It evaluates three modules for four professions (not including medicine). The vast majority of the students reported that their interprofessional and PBL objectives had been met.

**Miller, C., Freeman, M. and Ross, N. (2001) *Interprofessional Practice in Health and Social Care: Challenging the Shared Learning Agenda*. London: Arnold**

Findings are reported from a mapping exercise regarding the extent of shared learning within and between health and social care professions linked with an analysis of factors influencing nursing practice in multidisciplinary teams. The authors conclude that very little multiprofessional education in universities addresses interprofessional issues for which it was never designed. Common learning failed to value professional differences. Undergraduates, according to their teachers, saw learning teamwork as unimportant compared with clinical knowledge and skills.

**Parsell, G. and Bligh, J. (1999) *Educational Principles Underpinning Successful Shared Learning*. In AMEE Guide No.12**

Grounded in personal experience, Parsell and Bligh offer a step by step approach to student-centred “shared learning” - planning, surmounting obstacles and designing the course - with a checklist.

**Parsell, G., Spalding, R. and Bligh, J. (1998) Shared Goals, Shared Learning: Evaluation of a Multiprofessional Course. *Medical Education* 32 (3) 304-311**

Parsell and her colleagues evaluated the experience of 28 student from eight professions participating in a two-day pilot course to identify issue surrounding multiprofessional teamwork. Findings showed that the course increased knowledge and understanding of other health professions, developed more positive attitudes and demonstrated the importance of multiprofessional teamwork and communication.

**Reeves, S. and Freeth, D. (2002) The London Training Ward: An Innovative Interprofessional Learning Initiative. *Journal of Interprofessional Care* 16 (1) 41-52**

Findings are reported from a multi-method evaluation of an interprofessional training ward in a London teaching hospital for undergraduate medical, nursing, occupational therapy and physiotherapy students. Data were collected from students, teachers and institutions. Students were followed up a year later. They felt generally that learning and working together on the ward had enhanced their teamwork skills, but medical, physiotherapy and radiography students said that that the ward was too nursing oriented. Particular attention is paid to the experience of the medical students.

**Tope, R. (1996) *Integrated Interdisciplinary Learning between the Health and Social Care Professions: A Feasibility Study*. Aldershot: Avebury**

Based upon her PhD thesis, Tope presents findings from a content analysis designed to identify common themes from 14 undergraduate programmes in health and social care (including medicine) in south east Wales. The views of teachers and students about the merits of integrated learning are reported.

**Tucker, S., Strange, C., Cordeaux, C., Moules, T. and Torrance, N. (1999) Developing an Interdisciplinary Framework for the Education and Training of those Working with Children and Young People. *Journal of Interprofessional Care* 13 (3) 261-270**

This exercise in integrated curriculum development acquires renewed significance in view of impending reforms in services for children. It distinguishes between child development, environmental factors and the range of available services with reference to practice.

**Tunstall-Pedoe, S., Rink, E. and Hilton, S. (2003) Student Attitudes to Undergraduate Interprofessional Education. *Journal of Interprofessional Care* 17 (2) 161-172**

St George's Hospital Medical School and Kingston University report findings from a "Common Foundation Programme" for medical, radiography, physiotherapy and nursing students comparing reciprocal stereotypes reported by questionnaire before and after the learning together. Contrary to expectation, stereotypes were reinforced. Students nevertheless thought that their interprofessional learning would enhance interprofessional working, although some complained that they were forced to learn irrelevant things. Further work, said the researchers, was needed to determine how best to break down stereotypes.

**Turner, P., Sheldon, F., Coles, C., Mountford, B., Hillier, R., Radway, P. and Wee, B. (2000) Listening to and learning from the family carer's story: an innovative approach in interprofessional education. *Journal of Interprofessional Care* 14 (4) 387-395**

Undergraduates, including medical students, interviewed family members caring for a terminally ill patient or had been recently bereaved. Meeting these carers reportedly had a profound impact on the students. Some said that they were "changed" by the experience and felt that it would significantly influence their professional behaviour.

**World Health Organization (1988) *Learning Together to Work Together for Health*. Geneva: WHO**

For many, this is the seminal report on interprofessional education credited with its promotion in many developing countries and some smaller European states. It advocated shared undergraduate learning to complement professional programmes. Emphasis was put on interactive learning, community orientation and team competence.

## **Bulletins and Journals**

### ***The CAIPE Bulletin***

Published periodically, the CAIPE Bulletin reports its activities and those of its members in interprofessional education throughout the UK. It is circulated free to subscribing members. See [www.caipe.org.uk](http://www.caipe.org.uk)

### ***The Journal of Interprofessional Care***

Published quarterly by Taylor & Francis, this peer reviewed Journal comprises papers, abstracts, book reviews and research reports about collaboration in education, practice and research worldwide. Individual members of CAIPE can subscribe at a substantial discount. See [www.tandf.co.uk](http://www.tandf.co.uk) or [www.caipe.org.uk](http://www.caipe.org.uk)

Journals occasionally carrying papers about interprofessional education include *Education for Health, Learning for Health and Social Care, Medical Teacher and Medical Education*.

### **Relevant Websites**

The CAIPE website – [www.caipe.org.uk](http://www.caipe.org.uk) – includes national and international reviews of interprofessional education as well as a complete list of evaluations included by the Interprofessional Education Joint Evaluation Team (JET) in its latest review.

The three Learning and Teaching Support Networks covering medical, health and social care professions has an interactive website – [www.triple-ltsn@kcl.ac.uk](http://www.triple-ltsn@kcl.ac.uk) – for their Triple project which supports teachers in higher education developing interprofessional education.

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