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A list of topics in this exciting new series is listed on the back inside cover.
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Abstract
This Guide is for health and social care professionals who teach or guide others’ learning before and after qualification, in formal courses or the workplace. It clarifies the understanding of interprofessional learning and explores the concept of teams and team working. Illustrated by examples from practice, the practicalities of effective interprofessional learning are described, and the underlying concepts of patient-centred care, excellent communication, development of capacity and clarity of roles that underpin this explored.

TAKE HOME MESSAGES
- Interprofessional working and learning involves staff from different professional and working backgrounds learning and working together.
- Interprofessional working and learning should be service user/patient focused with service users/patients and their carers participating in the interprofessional team.
- Learning in interprofessional teams enables practitioners to work better together and improves services.
- The interprofessional team achieves its purpose through the collaborative learning and working and the collective knowledge and skills of all team members.
- Interprofessional teams need skilled leadership and members who respect and value each other.
Introduction

Aims and objectives of this Guide
The aim of this Guide is to introduce and elaborate on the meaning and application of learning in interprofessional teams. More specifically we have written with some objectives in mind for you, our reader.

We hope that this guide will improve your understanding of the:
- types of learning that are effective for interprofessional teams;
- characteristics and challenges of interprofessional team learning;
- practical ways to enhance interprofessional learning in teams;
- means by which interprofessional learning in teams can lead to more effective practice.

Why this Guide was written
Learning in interprofessional teams is increasingly an important part of the learning experience for health and social care sciences students during their initial education and training and in their post registration programmes and continuing professional development (CPD). For more than a decade now co-operation between professions has been advocated as a way of rationalising educational resources, lessening duplication of training and ultimately and more importantly, providing a more effective, efficient and integrated service for both users and providers (Leathard, 1994). As Hammick and her colleagues (Hammick et al., 2007 and Barr et al., 2005) have shown, there is now evidence to indicate that this type of learning is an effective means of enabling practitioners to better understand each other, to work more collaboratively and thus to enhance patient and client care and service delivery. A recent study of graduates from one UK university found that:

“Participants who had experienced pre-qualifying IPE demonstrated a more sophisticated understanding of relevant issues and contributing factors, and appeared to be more aware of the impact of poor interprofessional working on care delivery, than participants without such experience”. (Pollard et al., 2008)

Evaluations and the systematic review evidence cited above have led to increasing opportunities for students and practitioners to be part of an interprofessional team and to learn from that experience. Despite these initiatives, the potential for this type of learning is not always fully realised and where it is part of the curriculum it does not always achieve its objectives for the learners who participate. Hence our interest in writing on a topic that we believe has growing significance in international health and social care sciences education. This Guide, with its focus on explaining key concepts and their practical application, is an important part of the burgeoning literature on the topic.
Who is our reader?

This Guide is written for an international audience, primarily staff who work in any one of the numerous health and social care science professions, as practitioners, educators or both. We acknowledge, of course, that everyone is a learner. Our readers may include on-campus and clinical teachers, service managers and many who may not regard themselves as having a profession but who are as essential to the delivery of effective human and health services as those practitioners more normally regarded as professionals. In other words, the professional part of interprofessional relates to conduct, rather than to the traditional view of who is and who is not a professional. Students on formal courses that include the opportunity to learn in an interprofessional team will also find this Guide a useful addition to their reading list.

How to use this Guide

If you are unfamiliar with or want to check that you share our understanding of what learning in an interprofessional team is then you will want to read section one first. After that, and once familiar with the contents list, you may wish to dip in and out of the Guide as and when necessary in your current work and studies. Please remember that this is a Guide: each section only touches lightly on the aspects of the topic it addresses. We have drawn on the work of key authors in the field in several Comment Boxes within the text. There are also suggestions for other literature to draw on for a fuller discussion and other viewpoints. The Bibliography Boxes have some key texts for this purpose. The references list also provides a rich resource for your own reading.

What you will find in this Guide

The Guide has three main sections:

• In Section One we explore the meaning of the three major concepts in the title: interprofessional, team and learning. All three are complex terms that exist alongside similar words with similar meanings. Experience has taught us the wisdom of establishing meaning of key words in a discourse before elaborating on its characteristics and the issues it raises.

• The middle section of the Guide looks at who is involved in interprofessional learning teams and the settings in which these teams operate.

• Finally, we discuss ways to ensure that interprofessional learning is effective as the means towards the delivery of care services that are perceived as effective by the service user and their carers.

Reading about concepts and their meanings and application can lead to the assumption of an approach that is theoretical and lacks utility for the everyday practice of staff in contemporary health and social care services. It is our contention that learning in interprofessional teams is one of the most practical and effective means to enhance service delivery. This Guide has a practice based case study and uses examples from practice to illustrate what we say and to show how the models we write about work in practice.
Learning in interprofessional teams happens internationally. It takes place in colleges and universities as part of on-campus and in-practice learning, and now frequently happens in the simulation classroom. It occurs in many service delivery units, for pre-registration students and for staff as part of post-graduate studies and continuing professional development (CPD). To be comprehensive and democratic in selecting examples in this brief Guide was impossible. Some readers, we hope very few, may not recognise their particular practice setting in these pages. Our choices were dependant on our experiences and limited by the word count. Throughout the Guide we ask you to Stop & Think and to consider the application of what we discuss in relation to your practice. Each Stop & Think place allows some space for your own notes. Of course, as this Guide is about matters interprofessional, we recommend that whenever possible you do this with members of the interprofessional team you are learning and working with.

We were mindful as we wrote that this Guide was commissioned and is published by the Association for Medical Education in Europe (AMEE). Their constituency is mainly educators associated with the medical profession but clearly, the topic being interprofessional learning, this precluded a focus simply on this one profession. However, any publication must be in tune with its potential audience. We know that AMEE Guides are mostly read by on-campus and clinical teachers of medical students and doctors in training. This is in part an explanation for perhaps the slight emphasis in the illustrative material on these practitioners. That said, along with their nursing colleagues, medical doctors are the most frequent participants in interprofessional education (Hammick et al., 2007).

We hope you enjoy reading this Guide and that your interprofessional practice is enhanced by what we have written.
Learning in interprofessional teams

Whilst learning in interprofessional teams is increasingly part of the normal experience for many health science and social care students and staff, a common understanding of what this really means is a goal yet to be achieved. To this end for the readers of this Guide, this section looks closely at its title. We discuss meanings and models for each key word, firstly, interprofessional, then team and finally learning. Our aim is to establish a shared understanding of these words to anchor our commentary on the characteristics and challenges of, and ways of enhancing, learning in interprofessional teams.

Firstly we look at some semantic issues to clarify two commonly used terms associated with learning in interprofessional teams: interprofessional education and interprofessional learning.

Interprofessional Education and Interprofessional Learning

The AMEE Medical Education Guide 12 (1999) was entitled “Multiprofessional Education” and this begs the question of why this Guide refers to interprofessional education and learning. Is it a matter of semantics, or is there a difference? The answer is that it is both.

There is a great deal of confusion in the literature and within key organisations and a general but benign use and abuse of the terms interprofessional, multiprofessional, interdisciplinary and multidisciplinary, and all these sometimes with and sometimes without a hyphen! Harden (1998) described multiprofessional education along a continuum of eleven stages from isolation, where healthcare professionals are taught separately from one-another to transprofessional where learning is based in practice.

The World Health Organisation (WHO, 1988) defined multi-professional education as:

“the process by which a group of students (or workers) from the health-related occupations with different educational backgrounds learn together during certain periods of their education, with interaction as an important goal, to collaborate in providing promotive, preventive, curative, rehabilitative and other health-related services”.

It should be noted that the 2008 WHO Study Group on Interprofessional Education and Collaborative Practice has in its terms of reference to review the 1988 document and throughout its work refers to interprofessional education.

More recently, the UK Centre for the Advancement of Interprofessional Education re-issued its definition, which is as follows:

“Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 1997 & 2006)
This definition has been adopted by The International Association for Interprofessional Education and Collaborative Practice (InterED) and The Canadian Interprofessional Health Collaborative (CICH). It is the one we recommend to readers of this Guide.

It is clearly important for anyone discussing the topic to make plain their understanding of any terms they use; in this way, assumptions and misunderstandings can be avoided. Following our own advice we set out below our understanding of a number of the terms used in the interprofessional discourse and within this Guide. We start by defining in Box 1 what is meant by discipline and profession and continue with terms that add prefixes to these roots.

**BOX 1**
Definitions of terms related to learning in interprofessional teams

- **Discipline** means an academic discipline, such as sociology or physics, and subspecialties or branches of knowledge within professions, for example, the disciplines of paediatrics and obstetrics within the health care sciences professions.

- A **Profession** is a self-regulating group of people who have a common body of knowledge, entitled by law to call themselves a specific professional name, for example, Law, Dentistry, Nursing, and Occupational Therapy.

- **Multiprofessional education** is when students from two or more professions learn alongside one another. It is parallel rather than interactive learning and often also referred to as shared or common learning.

- **Multidisciplinary education** is those occasions when members (or students) of two or more disciplines learn together.

- **Uniprofessional education** is members (or students) of a single profession learning together.

We now want to focus more sharply on the meaning of learning in interprofessional teams. The roots of the meaning of interprofessional lie in its two parts: inter and professional. Inter denotes a between-ness, as it does in the word international or internet. In this simplistic way interprofessional comes to mean between the professionals; a phrase that is rather meaningless! So we need to look elsewhere for its real meaning and where better than to what practice shows us.

**BOX 2**
Further reading about interprofessional education, learning and team working


Examples from practice of interprofessional working and interprofessional education clearly indicate that the interprofessional part of this is about how staff from different professional and working backgrounds behave with each other. This behaviour is one that means the service delivered or learning achieved is a shared enterprise between staff from two or more different professions or work settings and that everyone involved in this behaves in a way that we have come to know as professional. In other words, behaviour that is respectful of others regardless of their role and traditional place in the ‘system’; recognises individual scopes of practice and where there is overlap in these; and perhaps most importantly, maintains a focus on the needs of the recipient of the service that is to be delivered. This list is not exhaustive and you might like to Stop & Think here and add other indicators of this type of working from your experiences.

Thus, interprofessional takes on the meaning of a way of learning and working with others that is respectful of them and, by implication, of what they know. This way of working then requires knowing about those others and about their contribution to the service recipient’s needs. Because of its focus on the recipient of the care, it also demands that we select the most appropriate form of care from what is known by all involved. This may mean tailoring what one practitioner knows and would therefore do, according to what is known and done by others.

It can also identify what is not known and in this way with others’, new knowledge and novel ways of delivering care and services may be found. All these propositions imply that students and staff working together interprofessionaly are almost certainly going to be learning about, from and with each other. This leads us neatly to our assertion that interprofessional learning is an integral part of interprofessional working.

In other words, interprofessional describes behaviour that involves being with colleagues from different professional and practice backgrounds to deliver care or services and taking the optimal way of doing this from the experience and expertise of all staff involved as the result of time spent learning about each other. It is an additional component of, and complimentary to, the characteristics that hallmark professional behaviour. We have listed some key texts on professional behaviour and the professions in Box 3.

**Stop & Think (i)**
- Interprofessional means having:
- Respect for all others
- An awareness of shared and unique scopes of practice
- A patient, client, and/or carer focus to your work
- ...

**BOX 3**

Further reading about professional behaviour

Our discussion about the meaning of interprofessional clearly implies that this word can only be used to describe something done with others. In the next section we look at this type of activity – most usually called team working and at the characteristics of teams.

**Teams and team working**

Much is written on this subject and we do not plan to rehearse the work of many others here. For example, Miller (1999) described a variety of models of teamwork and pointed out that an effective team is more than just a group of people working alongside each other. Box 4 has a list of characteristics of a team that shows integrated working adapted from Miller (1999).

**BOX 4**

**Characteristics of an integrated team**

- A highly developed shared vision of team-working and philosophy of patient care.
- Team members contribute to the decision making processes.
- Shared responsibility for team actions.
- Information and knowledge sharing are recognised as important.
- Team members know about their role and the roles of others.
- Role boundaries are flexible.
- A pool of team skills and knowledge is developed.

In Box 2 we included texts that discuss some of the key general theories about teams and team working. Our task now is to identify definitions and processes that have strong conceptual links with what we have already said about what it is to behave in an interprofessional way. Our aim is to build a picture of what defines an interprofessional team as the basis for what the processes of interprofessional team working and learning might look like.

The scene is set in Box 5 where we quote Mickan and Rodgers (2000) on what a team is and what its important features are.

**BOX 5**

**Defining features of a team (Mickan S & Rodger S 2000)**

There is broad consensus in the literature about the defining features of teams. Katzenbach and Smith (1993) stated that “a team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable” (p. 45). In addition, regular communication, coordination, distinctive roles, interdependent tasks and shared norms are important features (Ducanis & Golin 1979; Brannick & Prince 1997).

Behaviour by its members and team function are significant in ensuring that the team achieves its purpose. Boxes 6 & 7 set out some good team working skills and in Box 8 is a list of some of the things that teams need in order to work well and be effective.
Like everything involving relationships between people, building a team that works well takes time. Getting to the stage when the team is working well can be challenging and it is helpful to know the different steps in the development of a team. It is useful to draw on Tuckman’s (1965) work, which divided the phases of group development into four stages. These are listed below with some notes about how it might feel and what might happen during each stage.

- **Forming** – testing, guarded, impersonal, no conflicts, concern for structure, hidden agenda stay hidden, group identity is low.
- **Storming** – confusion, some conflicts and confrontation, hidden agenda may emerge, may be a leadership struggle, may feel stuck, some may opt out, lack of listening.
- **Norming** – getting organised, procedures developed, issues confronted, more open exchange of views and ideas, more listening, cooperation and feedback, leadership may be shared, preconceived ideas are let go, creativity is high.
- **Performing** – flexibility, creativity, open, effective, mature closeness, supportive, settled interdependence, high morale, empathy, high level of problem solving behaviour.
- In 1977 Tuckman added a fifth stage Adjourning: the ending or termination phase of the group.

**What is an interprofessional team?**

There are clearly differences between an interprofessional team and the many other teams that exist in order to deliver health and social care and services to individuals and the public. Box 9 sets out the definition of an interprofessional team being used for the work in progress of The 2008 WHO Study Group on Interprofessional Education and Practice.
Within any team, members typically assume different roles – whether consciously or unconsciously. We look at team roles and types below. Now we turn to leadership and its counter balance in any team, that of followership.
Skilled leadership of interprofessional teams involves adaptation: different styles of leadership for the different situations a practitioner finds him or herself in. For example, leading an established team that has recognised the value of being a learning team to improve the delivery of a service as the case study below describes, is different to leading a newly formed interprofessional team perhaps with members who have not worked and learnt in this way before. In this case one role of the leader is to signal the need for reflection about the different professional roles and the interactions between team members.

Space prevents us fully discussing leadership. It is however worthwhile noting that styles of leadership include distributed leadership (Senge 1990), servant leadership (Greenleaf 1977) and primal leadership and emotional intelligence (Goleman 1996, 2002). Another important concept is the origins of a leader’s power which may come through position, past experience, knowledge or expertise, culture and hierarchy or style and charisma.

One role hardly ever mentioned is that of being a follower in the team. If a team appoints a leader, and this is generally considered a good idea, then all the other members need to accept that appointment and behave accordingly. We would argue that this can be challenging in interprofessional teams which often consist of staff who at other times work within a traditional hierarchy. The leader by tradition may not be the appropriate leader of the interprofessional team. More often in health and social care settings leaders come from the high status professions. Recognising the need to relinquish a traditional role for the good of the team and its objectives can be challenging. Knowing when and how to be a follower in these situations is one of those interprofessional attributes we referred to earlier. Another one to add to the list in Stop & Think (i), if it’s not there already.

One of the hallmarks of a successful team is that each of the members takes one of the roles deemed necessary for the team to function well. Much of the work on team roles was done by Meredith Belbin at Henley Management College in the 1970’s and you can find full details of this at http://www.belbin.com/ (accessed 17 Jan 2008). It’s fun to read this and useful to find out your team type: the website has full details.

Learning

Now to the third key word in this Guide’s title: learning. We showed in our discussion about the meaning of interprofessional that working in this way involved learning. That is why this Guide is called learning in interprofessional teams. In Box 10 you will see evidence on mechanisms related to learning that have been shown to be influence effective interprofessional learning. These are taken from a recent systematic review of the interprofessional education for Best Evidence Medical Education (BEME) by Hammick et al. (2007). You can read the full review at http://www.bemecollaboration.org.
The focus for effective learning in interprofessional teams needs to be on creating learning situations that maximise the potential for adult learning. We have summarised key features of adults as learners in Box 12 drawing on some seminal texts which still have much to recommend them. We also bring to your attention two other learning theories: situated learning and communities of practice. These link adult learning with professional practice and with praxis or the translation of our ideas into ethical actions. See Box 11 for more on praxis and use Stop & Think (iii) space to note your experiences of these ways of learning for your practice.

**BOX 12**

**Key features of adults learners**

**Adult Learners:**
*Are not beginners but are in a continuing process of growth*

- Bring a wealth of experiences and values
- Come to education with intentions
- Already have set patterns of learning
- Need to know why they need to learn something
- Need to learn experientially
- Approach learning as problem-solving
- Learn best when the topic is of immediate value
- Have competing interests - the realities of their lives

Summarised from Knowles 1970 & Brookfield 1996

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**Related Boxes**

**BOX 10**

**Effective interprofessional learning from Hammick et al. (2007)**

The value of using principles of adult learning for IPE emerged as a key mechanism for well received IPE in this review. Additionally, the unique nature of IPE demands authenticity from the learning experience, a characteristic that arises when the development and delivery process are customised to the particular learning group and their professional practice. Increasingly this is being recognised as part of good IPE practice in, for example, the use of simulated patients and learning in practice or simulated practice settings as a way to realise this. We suggest that authenticity is a mechanism that enhances the effectiveness of IPE through the diverse ways of delivering the curriculum mentioned above. Similarly, the customisation of IPE so that it reflects the reality of practice for specific groups of interprofessional learners acts as a mechanism for positive outcomes.

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**BOX 11**

**More on praxis**

According to Kant, praxis is the application of a theory to cases encountered in experience, but is also ethically significant thought, or practical reason, that is, reasoning about what there should be as opposed to what there is. (http://www.answers.com/topic/praxis accessed 16 Jan 2008)
**Stop & Think (iii)**

*Situated learning* (Lave & Wenger 1991) happens as learners are immersed in practice, and participate and collaborate in action. Participation includes problem solving, discussing ethical dilemmas, using critical thinking skills and making difficult judgements as a team grapples with the challenges of real life situations. Traditionally seen as an apprenticeship model with learning largely derived from observation of a master's everyday work, now the relationship with the wider community replaces the single master.

Much of this is informal as learners learn about the history and current practices, values and tacit knowledge and underpinning values and beliefs - often by observing established workers demonstrating mastery in their work. Immersion of learners in the team also means that they may become aware of the hidden curriculum. In particular, attitudes to and beliefs about service users and fellow practitioners may be conveyed implicitly and both excellent and poor practice can be modelled. Within interprofessional learning teams we need to be conscious of the beliefs and values we communicate and the impact of this on the personal and professional values of novices in the team.

*Informal learning* or implicit, unintended, opportunistic and unstructured learning, often in the absence of a teacher that takes place in the course of work (Eraut, 2000).

*Implicit learning* described as ‘the acquisition of knowledge independent of conscious attempts to learn and in the absence of knowledge of what was learned’ (Reber 1995).

*Tacit knowledge*: ‘that which we know but cannot tell’ (Polyani 1958).

It may be self evident but where excellent interprofessional team working is evident these are the ways in which everyone, including students, will learn how to be an interprofessional practitioner. With prompted reflection the learner can be made aware of this and thus their learning becomes explicit. (From Kaufman D & Mann K, 2007).

Communities of practice (Wenger 1998) are real groups who exist to do real work. They have mutual engagement, shared tasks, participation and a joint enterprise. By discussion within a community of practice key components of learning become evident:

- Meaning – learning as experience;
- Practice – learning as doing;
- Community – learning as belonging;
- Identity – learning as becoming.

There is active exchange of knowledge and information and application to the problem under consideration. Learning in this way can be especially rich and effective for an interprofessional team.
The case study that follows (Box 13) illustrates how the key attributes of learning in interprofessional teams we discussed above are mirrored by examples of this type of working in two different practice settings. In each we have bolded the key words of this Guide’s title and some of the key aspects of interprofessional, team working and learning we have discussed. As you read them you might like to identify some of the other attributes you added in your list in Stop & Think (ii). We also suggest that you evaluate an interprofessional team you are part of using the bolded words and attributes. This could be an interprofessional learning exercise for the team: do the evaluation individually and then discuss the results and what these can teach you about the practice of being in an interprofessional team.

A Dorset General Practice found they were having difficulty in responding to incoming telephone clinical inquiries. There was great dissatisfaction with the current system. Patients were having to call repeatedly to get an answer to their inquiry, consultations were interrupted and those responding often did not have the information to hand.

1. They wanted to improve the service their patients received.
2. They brought together an interprofessional team.
3. They agreed ground rules (see below) to help them work together successfully.
4. They agreed their high level aims, which were to:
   • Improve services for the patients
   • Appreciate team work
   • Make effective use of resources
   • Offer an additional and different service
   • Help patients access the most appropriate of the Practice’s services
1. They worked together to learn about the processes of the current situation and decided on some simple measures that would increase their understanding of the current situation. They logged all incoming telephone inquiries over a period noting what the caller wanted, how many times patients recalled, who the patient believed could answer their inquiry and who in fact had the information they required.
2. With this information they were ready to generate ideas for improvement and choose one with which to begin. Interestingly this entailed letting go of their initial idea of creating a nurse telephone clinic. As one participant said “That would have just shifted the problem, not solved it”.
3. They were able to answer the question “what are we trying to accomplish by this change?” in very specific terms. They hoped for fewer interrupted consultations and a high proportion of enquiries to be answered within the agreed time by the most appropriate team member. They designed measures to check the outcomes of their change.
4. They designed a system whereby the receptionist gathered information about the nature of the inquiry on a purpose-designed form and the appropriate member of the clinical team responded at a mutually convenient time with all the relevant information to hand. They ran a pilot for a limited time, collecting all the forms as an audit. They met to study the effect of the change and found it had fulfilled their hopes. It was agreed to adopt this as the usual way the Practice would respond to telephone inquiries and two years later the scheme remains in place.
5. They rechecked the new system against the “high level” aim agreed earlier and found that the improvement was consistent with this.

The Ground Rules for the Project
• Say what you think – no matter what
• Listen – let people finish
• Value everyone’s contribution – and their right to silence
• Timekeeping
• Confidentiality
• Not knowing / asking for clarification is OK!
• Disagreement is alright – it may be creative
• Keep to subject (perhaps?)
• Ownership of statements
This Section has demonstrated the meaningfulness of learning in interprofessional teams, showing links with some longstanding and substantial theories about teams and learning and explaining what describing a learning team as interprofessional means. Having established this, we turn, in Section Three, to look in more detail at the practice of this sort of team. We consider the value, importance and integrated nature of learning and working interprofessionally.

The interprofessional learning team examined

In this section we look at what it means, in practice, to participate in interprofessional learning. In turn we examine two of the most common ways this is experienced.

Firstly, we look at students on courses that include formal interprofessional education initiatives i.e. those that are planned to promote opportunities to learn and change through interprofessional interaction (Freeth et al. 2005).

Secondly, we consider those occasions when practitioners from two or more professions learn with, from and about each other to improve collaboration and the quality of care and where this is integrated into their work. In many places both are becoming part of what is considered to be normal practice and we anticipate that the future workforce will increasingly see both as part of their learning and working lives. Other ways of sharing learning are also popular, for example, multiprofessional learning and these initiatives often create opportunities for informal or serendipitous interprofessional learning.

An example of shared or multiprofessional learning is the two first year courses— “Becoming a Professional” and “Becoming a Health Professional—offered at the University of Cape Town. Students from medicine, occupational therapy, audiology, speech therapy and physiotherapy come together to learn about professionalism and more specifically the broad themes of interpersonal skills and the primary healthcare approach. The methodology is largely experiential with focus on gaining knowledge as well as developing skills of reflection and empathy within what is called the “The Integrated Health Professional” (Olckers et al. 2006).

Stop & Think (iv) 

Use this space to note your experiences of multiprofessional education

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1 This case study originally appeared in Interprofessional learning to improve patient care (2001 Institute of Health & Community Studies, Bournemouth University and is reproduced here with the permission of the authors, Charles Campion-Smith, Eloise Carr, and Peter Wilcock.

2 This draws on the CAIPE definition of interprofessional education and that used by Freeth et al. in 2005. For a discussion of this see Chapter one in Freeth et al. 2005.
Formal planned interprofessional education most usually takes place on-campus or in work settings as part of initial health care sciences programmes and for postgraduate programmes. Many different examples exist of such programmes and in Appendix 2 you will find a brief description and full reference for the 21 interprofessional programmes that were reviewed by Hammick et al. in 2007. This shows the diversity of learners involved and the range of ways the education was organised. Many more such programmes exist and are available to read about in the literature and on university websites.

As Appendix 2 shows, formal learning in an interprofessional team often combines classroom and practice based interprofessional learning and includes simulation as part of the interprofessional curriculum. There are also increasing examples of blended learning making the most of e-learning formats and enabling large numbers of students to experience interprofessional learning. This also means that students on distance placements for their practice learning can continue to learn with their peers. The essential element in all these teaching approaches is that the learners interact with each other to enable learning about, from and with to take place. Table 1 gives you examples of four different types of interactive learning.

**TABLE 1**

Types of interactive learning (modified from Barr, 1996 by Freeth et al. 2005)

<table>
<thead>
<tr>
<th>Type of learning</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exchange-based</td>
<td>Debates, seminar or workshop discussions, case and problem-solving study sessions.</td>
</tr>
<tr>
<td>2. Observation-based</td>
<td>Work shadowing, joint client/patient consultations.</td>
</tr>
<tr>
<td>3. Action-based</td>
<td>Collaborative enquiry, problem based learning, joint research, quality improvement initiatives, practice or community development projects, work-related practice placements for students.</td>
</tr>
<tr>
<td>4. Simulation-based</td>
<td>Role play, experiential group work, the use of clinical skills centres and integrating drama groups within teaching sessions.</td>
</tr>
</tbody>
</table>

So far in this section we have described formal interprofessional education that is developed and delivered by educational institutions and has a known curriculum. This often provides the first experience of interprofessional learning for new entrants into the health and social care workforce. It is increasingly accepted as part of most programmes that lead to a professional qualification in the health and social care sciences. However, we stressed earlier that learning in interprofessional teams is also often embedded in daily work, or reflection on it, by many practitioners.

The following paragraphs examine this informal but increasingly common form of interprofessional education. In these situations interprofessional learning has the potential to not only enhance individuals knowledge and understanding of the role, skills, training, knowledge and professional ethos of other professions but to promote reflection on and clarify their own sense.
of professional identity. To further develop their sense of what it means to be a nurse, social worker or doctor, the strengths and limitations of their professional role, what it brings to the care of patients and clients and what is lacking that needs to be complimented by other professional colleagues. Box 14 demonstrates the integration of continued professional development with interprofessional learning for general practitioners in the UK.

This brief review of interprofessional education has shown interprofessional learning is part of lifelong learning. Formal undergraduate or pre-registration interprofessional education prepares students for their practitioner-role in interprofessional teams where, although less explicit and certainly less formal, their interprofessional learning continues.

BOX 14
Experiences of learning in interprofessional teams by UK general practitioners

Vocational training for general practice trainees means an apprenticeship and immersion in the interprofessional team. The year long attachment provides many opportunities for involvement in team meetings for information exchange and interprofessional learning events, often combined as care review meetings. Interprofessional learning also takes place at clinically focussed meetings, learning not only about knowing-how but also about and from the capabilities and strengths of other team members.

Postgraduate situated interprofessional learning occurs in clinical settings and at specific interprofessional courses e.g. child protection, alcohol & drug misuse, palliative care master-classes.

Many GPs now gain much of their CPD and CME at interprofessional practice meetings. The content of these meetings is often guided by a Practice Professional Development Plan where practice wide and individual learning needs to enable the practice to meet the challenges and opportunities presented may be met. As the care of many conditions become increasingly interprofessional, clinical updates are aimed at the interprofessional learning team.

One aspect of interprofessional education we have not discussed is those organisational and professional challenges that present themselves during the development of formal courses of interprofessional learning. Informal interprofessional learning also presents challenges and although they are more usually of a local nature, they are none the less significant. We recommend the second part of Freeth et al. (2005) to those readers interested in these and in ways to manage them during the development and delivery of interprofessional education. Our experience has been that, despite these challenges, it is worthwhile and important that opportunities for learning in interprofessional teams are available to the health and social care workforce and to an increasingly wide number of practitioners in for example, education, housing and welfare services. We develop this argument further in the following paragraphs.

Reasons for learning in interprofessional teams

Learning in interprofessional teams is increasingly seen as the way to enable practitioners to work better together, and for service users to then experience improved collaborative services. For this reason we see learning in interprofessional teams as (one of) the means of achieving this improvement. The delivery of health and social care services to individuals and communities is highly complex. Good health is dependent upon more than these services
can provide: housing conditions, educational opportunities and access to employment are amongst numerous factors influencing our physical and mental well-being. Outcomes are not related to inputs in a linear way and relationships, values, communication and flexibility can have as great an effect on these outcomes as facts and technical aspects of care. Most of you work in a world where much is uncertain and not all decisions can be based solely on clinical evidence.

One of the aims of the interprofessional learning team should be to improve capacity to deliver as well as competence (Fraser & Greenhalgh 2001). This often relates to how the team as a whole functions, though capacity still needs to be underpinned by individuals having the appropriate skills, competence and training.

Fraser & Greenhalgh (2001) remind us that, while traditional education and training is largely focused on the acquisition of factual knowledge and skills in today’s complex world, there is a need for more than just competence. These authors suggest the need for capability as the ability to adapt to changes, generate new knowledge and continuously monitor and improve performance that is essential for success in the fast changing world of health and social care where neither the external environment nor the systems within it are constant. The challenge of working in unfamiliar situations and feedback on performance as well as small group and problem-based learning and the sharing of narratives all enhance capability. It is important to acknowledge and develop individuals’ creativity so progress can be made even where problems cannot be solved. The lack of linear relationship between inputs and outputs needs to be highlighted – small changes can have great effects.

Education, and that includes interprofessional education, that accepts and encompasses this complex world prepares learners for the reality in which they will be working. This education must focus on an understanding of the process of care and the contribution of different professional groups to this and learners should be encouraged to identify their own learning needs and set their own goals. The only certainty they face is that there will be more change and increasingly new and different ways of delivering health and social care.
Without doubt the future workforce will at some time be part of an interprofessional learning team: many such teams are part of the present landscape of public services for health and well being. You will have been part of, or met, some contemporary interprofessional working and learning teams. They operate in almost all areas of public services and many are part of quality improvement initiatives with the means to enhance service provision. The list below gives but a few examples and you will notice the specific nature of some and that others have more general headings. Use this list to help you complete Stop & Think (v) for the teams that you meet in your work.

- Teenage pregnancy
- Mentally ill elderly people
- Chronic ill health management
- Transitional care for learning disabled adolescents

These teams can include any who can contribute to the best care of the patient and might include the patient or carer – or at least seek their views and preferences. For example, general practice based teams reviewing the palliative care of patients nearing the end of their life includes

- the patient
- their carer(s)
- family doctor
- district nurses
- specialist cancer care nurses
- administrator
- pharmacist
- palliative care specialist doctor and social worker.
- complementary healthcare practitioners
- hospice support staff.

Even if a patient is unable to attend the team meeting in person, his or her preferences about the place of care and views on further interventions including cardiopulmonary resuscitation should be considered as their care is planned. Carers are essential members of the team – they are an unpaid part of the workforce in many areas of health and social care and have unique insights about the patient and their care needs. We look in more detail at learning about, from and with service users and carers in the following section.

Stop & Think (v)

The interprofessional learning and working teams I am part of are...

Interprofessional learning and working teams I meet or know about are...

Interprofessional learning and working teams should be in place for...

Carers are essential members of the team – they are an unpaid part of the workforce in many areas of health and social care and have unique insights about the patient and their care needs.

**Learning with service users and carers**

Changes in health and social care are moving to more equitable sharing of information and power with service users/patients and their families and friends who often act as informal and unpaid carers. There is recognition that a health care system where the patient or client or service user is the passive recipient of care is neither morally acceptable, financially sustainable nor particularly effective. This has lead to a fundamental shift in relationships, with professionals providing information on which patients can
base rational choices and focusing on maximising self efficacy. This different role for professionals is ideally provided by small interprofessional teams with complimentary though sometimes overlapping skills. Hence the value of learning interprofessionally and reaching mutual agreement about each other’s scopes of practice.

The need to continuously monitor and improve the service we give to patients is an accepted part of professional practice. The guiding principle is that the better a service matches the need of those who rely upon it, the higher the quality of the service. However understanding the needs of service users is not easy and it is the responsibility of the practitioners to enable their clients/patients to feel comfortable making their contribution to care planning.

Techniques such as flow charting patients’ journeys through the system often identify bottlenecks and places where errors are more likely to occur. Such systematic examination of the process of care can only be done by an interprofessional team that includes the service user and their carers. No one individual will have knowledge of the whole process: when all come together there is great depth of knowledge and understanding.

**Planning and facilitating interprofessional learning**

In this section we briefly look at two important aspects of interprofessional learning: planning what to teach and facilitating the learning in teams.

**Curriculum planning for interprofessional learning**

There is evidence that interprofessional education which reflects the authenticity of practice is more effective (Hammick et al. 2007). The reality is that course planners have to start with what they have. This means working with the courses taught in their institutions, contracts with service providers for CPD and often within geographical and teaching space constraints. Take another look at the studies listed in Appendix 2 and you will see examples of curriculum development that was tailored to the context of particular institutions or developed in response to a specific service need in a particular place. Often these initiatives started small as pilot initiatives and importantly they were evaluated as a way of developing and improving for the next stage. Pollard et al. (2008) highlight some suggestions for enhancing pre-qualifying interprofessional education as shown in Box 15.

**BOX 15**

*Improving interprofessional education from Pollard et al. (2008)*

Suggestions for enhancing pre-qualifying IPE included broadening the professional mix of IPE groups and soliciting input from professionals, service users and carers in the academic environment; and learning with students from different professions, engaging in interprofessional activities, shadowing practitioners from other professions and including specific interprofessional competencies in learning outcomes while on placement.
One important issue is the sustainability of these initial courses. You can listen to the views of staff from three UK universities about how to ensure that interprofessional learning in teams is developed and taken forward by going to http://www.health.heacademy.ac.uk/ where the resources section has a podcast (or healthcast) recorded on 20 May 2007. One important point to note is that funding for interprofessional education was not seen as essential. We've left some space for you to Stop & Think about the reasons for this. After you have listened to the podcast, make a note of what is important for sustaining interprofessional learning in teams.

Staff development
Finally, we turn our attention to some aspects of facilitating interprofessional learning. This is a case of last but by no means of little importance as the quotes in Boxes 16 & 17 confirm. These highlight the role of all staff (teacher and clinical practitioners alike) and the importance of staff development for them in enabling the interprofessional learning undertaken by students to be enjoyable and effective.

**BOX 16**
The role of staff and staff development in effective interprofessional learning from Hammick et al. (2007)

"The capability of staff with the responsibility to facilitate interprofessional learning is a key factor in students' experience … of the IPE. Staff development to ensure the competence and confidence of interprofessional facilitators is a key mechanism in the delivery of well received IPE."

**BOX 17**
The role of mentorship in effective interprofessional learning from Pollard et al. (2008)

"Mentors' support and encouragement for students' engagement in interprofessional working was considered invaluable."

To facilitate the process of interprofessional learning, educators need to understand how groups function and the know-how to skilfully put their knowledge about this into their teaching practice. We remarked earlier that much of what we said about the skills of team working applies to facilitating a learning group. So now would be a good time to return to the section above that looks at this and to remember that what Barnes, Ernst and Hyde (1992, p2) say about a group applies to interprofessional learning teams, namely that:
“A group is more than people who happen to be doing the same thing at the same time in the same place; to be a group, the people must have some connection……with a common aim, purpose or function”.

Research suggests that personal qualities of a facilitator of a learning group are often more central to their success than subject expertise (Moust and Schmidt, 1995 in Makoni, 2000). Qualities described by psychologist Carl Rogers such as empathy, openness, support, interest and unconditional positive regard (Cowan, 1998) have to be demonstrated by the group facilitator and it is important to adopt a “student-centred approach” (Gibbs, 1992). Learning groups are examples of formed groups (Toseland and Rivas, 2001) and are typically either treatment or task-orientated in their focus. Whatever the focus, all groups go through clear and predictable stages that typically involve a beginning, middle and end.

With interprofessional learning teams in particular, the facilitator may need to draw out preconceptions and stereotypes held by the members by exploring the foundations on which they are based. Exercises that ask learners to see themselves, or their opinions and behaviours through the eyes of others can be fruitful at the beginning of interprofessional learning sessions. Ground rules or group agreements – possibly based on reflection on successful or less positive interprofessional work – or an appreciative enquiry visioning exercise of how the learning would be if successful – can be very valuable. It can also be helpful to elicit:

- specific statements about the value of each participant’s contribution,
- the acknowledgement that people will bring different and complimentary knowledge and understanding to the learning team,
- an agreement about the use of jargon as this can be particularly excluding,
- permission that it’s OK to ask for clarification of uncertain points and to express disagreement.

Recognition that disagreement (properly managed by a skilled group facilitator) can be creative and lead to important learning may need to be made explicit. With the involvement of service users and their carers in both initial education courses and service development aspects listed above have an added importance. The facilitator and practitioner team members have a responsibility to remember that these members may be in a group of learners for the very first time. Being empathetic to their feelings about the learning team processes brings its own set of challenges.

Before we conclude this section on planning and facilitating learning in interprofessional teams we have a comment to direct to those who manage classroom and practice based teaching staff and mentors. One of your responsibilities is to ensure your staff are capable of these roles and to recognise that facilitating learning in interprofessional teams is not simply a case of just transferring skills needed to do this for learners from your own profession or work setting.
Working with an interprofessional learning team has its particular challenges and when done well is rewarding and satisfying.

Workshops and courses to enable skilled facilitation and mentorship of interprofessional learning teams are available. For example, the UK Centre for the Advancement of Interprofessional Education runs a series of workshops tailored to different staff, for more details see www.caipe.org.uk and InterEd has a bi-annual conference where experiences and expertise is shared amongst international colleagues (www.health-disciplines.ubc.ca/intered).

**Conclusion**

We leave you with a reminder of the importance of interprofessional learning for the future, and the necessity of continuing to provide an interprofessional curriculum for undergraduates and staff CPD that equips practitioners for the 21st Century world of work. This is not part of our education and training that can stand still but as Pollard et al. (2008) found:

“there is a need for IPE to go further, in that it should also make students explicitly aware of how organisational factors can affect interprofessional working (and) it is necessary to get students to start thinking about how interprofessional working happens within different organisational contexts; and, in particular, to encourage a habit of thinking creatively about strategies for change within all situations”.

Our best wishes to you as a learner in your interprofessional team.
For your information

This section gives details of some of the organisations mentioned in the Guide and others relevant to interprofessional learning. Where possible we give their websites where you can read much more about them and, for some, find details of how you or your institution can become a member. Please bear in mind that website content can change; details given here are correct at the time of going to press.

AIPPEN  The Australasian Interprofessional Practice and Education Network founded at the All Together Better Health 3 Conference in London in 2006. www.aippen.net

AMEE  The Association for Medical Education in Europe is a worldwide organisation with members in 90 countries on five continents. Members include educators, researchers, administrators, curriculum developers, assessors and students in medicine and the healthcare professions. www.amee.org

BEME  The BEME Collaboration is a group of individuals or institutions who are committed to the promotion of Best Evidence Medical Education through the dissemination of information from the production of appropriate systematic reviews of medical education and the creation of a culture of best evidence medical education amongst individual teachers, institutions and national bodies. www.bemecollaboration.org

CAIPE  The UK Centre for the Advancement of Interprofessional Education is a charity and company limited by guarantee whose claim to special expertise is founded on its members, publications and development activities. Its members form a network of mutual support and interest that facilitates intellectual engagement with, and the development of, individual and organisational, interprofessionalism. www.caipe.org.uk

CICH  The Canadian Interprofessional Health Collaborative is a 2-year initiative funded by Health Canada. It aims to promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice and to stimulate networking and the sharing of the best approaches to interprofessional education for collaborative patient-centred practice. www.cihc.ca

EIPEN  European Interprofessional Education Network was a European Union funded project from 2004-8 which aimed to establish a sustainable inclusive network of people and organisations in six partner countries to share and develop effective interprofessional learning and teaching for improving collaborative practice and multi-agency working in health and social care. www.eipen.org

InterEd  The International Association for Interprofessional Education and Collaborative Practice is a collective voice and a forum for mutual exchange. InterEd’s aim is to promote and advance scholarship and inform policy in interprofessional education and collaborative practice worldwide, but in partnership with others. www.health-disciplinesubc.ca/intered

NaHSSA  The National Health Sciences Students’ Association of Canada & L’Association des Étudiants des Sciences de la Santé du Canada is a diverse network of 18 university-based student chapters and seeks to address the unmet need of actively involving Canada’s health and human service students in interprofessional education while promoting the attitudes, skills, and behaviours necessary to provide collaborative patient-centred care. www.nahssa.ca

The Network, TUFH  The Network: Towards Unity for Health is a global association of individuals, groups, institutions and organisations committed to improving and maintaining health in the communities they have a mandate to serve. It includes an IPE task force that has produced a position paper on IPE. www.the-networktufh.org
NIPNET

The Nordic Interprofessional Network, is a learning network to foster interprofessional collaboration in education, practice and research, primarily for Nordic educators, practitioners and researchers in the fields of health. It aims to explore theories and evidence bases of interprofessional collaboration, develop approaches, methods and evaluations of interprofessional learning and practice, stimulate exchange of ideas and experiences between countries and to link with other similar networks. www.nipnet.org

UKISN

The United Kingdom Interprofessional Students Network supported by CAIPE and Birmingham City University, inaugurated in 2007 it seeks to support the collaboration of learners, students' interprofessional learning and their transition to practice. They can be contacted at: caipestudents@googlemail.com
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Abbreviations used

AMEE: Association for Medical Education in Europe*
BEME: Best Evidence Medical Education*
CAIPE: UK Centre for the Advancement of Interprofessional Education*
CICH: Canadian Interprofessional Health Collaborative*
CME: Continuing medical education
CPD: Continuing professional development
GP: General Practitioners (or Family Physicians)
InterED: International Association for Interprofessional Education and Collaborative Practice*
The Network / TUFH: Towards Unity for Health*
Appendix 1: Building ground rules for successful learning in a group

A. Working on your own
1. Think of the best learning times you have had: what happened that made them so? Make a few notes.
2. Think of the worst (or one of the worst) learning times: what happened that made it so? Make a few notes.

B. Working with the other members of your team
3. Take turns in talking sharing what made learning work so well for people. Listen for common themes, shared experiences, and features of good learning times. Move around the group quickly getting these ideas out and searching for dominant shared ideas.
4. Take turns in sharing what made learning work so badly for people. Listen for common themes, shared experiences, and features of poor learning times. Move around the group quickly getting these ideas out and searching for dominant shared ideas.

C. Together identify 2-5 working rules for your team
5. For each of the most popular characteristics of good learning that you agree on, suggest three things the group could do to see that these characteristics are present. Be as specific and as concrete as you can.
6. For each of the most popular characteristics of bad learning that you agree on, suggest three things the group could do to see that these characteristics are avoided. Be as specific and as concrete as you can.
7. Finalise this by agreeing 2-5 specific rules the whole group would benefit from.

(Modified after Stephen Brookfield (1995)
Becoming a critically reflective teacher, San Francisco: Jossey-Bass pp. 143ff)
### Appendix 2: Different examples of interprofessional education

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Country</th>
<th>Practice context for IPE</th>
<th>Level &amp; educational context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barber et al</td>
<td>1997</td>
<td>USA</td>
<td>Care for older people</td>
<td>Pre-qualification, classroom &amp; practice-based</td>
</tr>
<tr>
<td>Carpenter</td>
<td>1995</td>
<td>UK</td>
<td>Mental health</td>
<td>Pre-qualification, university-based</td>
</tr>
<tr>
<td>Carpenter &amp; Hewstone</td>
<td>1996</td>
<td>UK</td>
<td>Mental health</td>
<td>Pre-qualification, university-based</td>
</tr>
<tr>
<td>Cooke et al</td>
<td>2003</td>
<td>UK</td>
<td>Breaking bad news</td>
<td>Pre-qualification, university-based, simulation</td>
</tr>
<tr>
<td>Crutcher et al</td>
<td>2004</td>
<td>Canada</td>
<td>Diabetes care</td>
<td>Mixed (final year students &amp; residents), classroom</td>
</tr>
<tr>
<td>Dienst &amp; Byl</td>
<td>1981</td>
<td>USA</td>
<td>Ambulatory care</td>
<td>Pre-qualification, classroom &amp; practice-based</td>
</tr>
<tr>
<td>Horbar et al</td>
<td>2001</td>
<td>USA</td>
<td>Neonatal intensive care</td>
<td>CPD, practice-based quality improvement</td>
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<tr>
<td>Ketola et al</td>
<td>2000</td>
<td>Finland</td>
<td>Primary care: cardiovascular disease</td>
<td>CPD, practice-based quality improvement</td>
</tr>
<tr>
<td>Kilminster et al</td>
<td>2004</td>
<td>UK</td>
<td>Communication skills, team roles</td>
<td>Pre-qualification, university-based, simulation</td>
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<tr>
<td>Morison et al</td>
<td>2003</td>
<td>UK</td>
<td>Paediatrics</td>
<td>Pre-qualification, classroom &amp; practice-based</td>
</tr>
<tr>
<td>Moray et al</td>
<td>2002</td>
<td>USA</td>
<td>Emergency departments</td>
<td>CPD, practice-based quality improvement</td>
</tr>
<tr>
<td>Mu et al</td>
<td>2004</td>
<td>USA</td>
<td>Rural &amp; underserved populations</td>
<td>Pre-qualification, practice-based</td>
</tr>
<tr>
<td>Nash &amp; Hoy</td>
<td>1993</td>
<td>UK</td>
<td>Palliative care</td>
<td>CPD, residential workshops</td>
</tr>
<tr>
<td>Pollard et al</td>
<td>2005</td>
<td>UK</td>
<td>Communication and teamwork skills</td>
<td>Pre-qualification, classroom &amp; practice-based</td>
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<tr>
<td>Ponzer et al</td>
<td>2004</td>
<td>Sweden</td>
<td>Orthopaedics</td>
<td>Pre-qualification, practice-based</td>
</tr>
<tr>
<td>Reeves &amp; Freeth</td>
<td>2002</td>
<td>UK</td>
<td>Orthopaedics &amp; rheumatology</td>
<td>Pre-qualification, practice-based</td>
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<td>Reeves</td>
<td>2000</td>
<td>UK</td>
<td>Community care / general practice</td>
<td>Pre-qualification, practice-based</td>
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<td>Shefer et al</td>
<td>2002</td>
<td>USA</td>
<td>Chlamydial screening</td>
<td>CPD, practice-based quality improvement</td>
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<td>Solberg et al</td>
<td>1998</td>
<td>USA</td>
<td>Primary care: preventive services</td>
<td>CPD, practice-based quality improvement</td>
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<td>Tucker et al</td>
<td>2003</td>
<td>UK</td>
<td>Clinical skills</td>
<td>Pre-qualification, university-based, simulation</td>
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<tr>
<td>Tunstall-Pedoe et al</td>
<td>2003</td>
<td>UK</td>
<td>Common foundation programme</td>
<td>Pre-qualification, university-based, some practice visits</td>
</tr>
</tbody>
</table>

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3 This table and its references originally appeared in Hammick M, Freeth D, Koppel I, Reeves S & Barr H (2007) A Best Evidence Systematic Review of Interprofessional Education BEME Guide no. 9 Medical Teacher 29 (8): pp. 735-51 and appears here with the kind permission of the authors.
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About AMEE

What is AMEE?
AMEE is an association for all with an interest in medical and healthcare professions education, with members throughout the world. AMEE’s interests span the continuum of education from undergraduate/basic training, through postgraduate/specialist training, to continuing professional development/continuing medical education.

- **Conferences**: Since 1973 AMEE has been organising an annual conference, held in a European city. The conference now attracts over 2300 participants from 80 countries.
- **Courses**: AMEE offers a series of courses at AMEE and other major medical education conferences relating to teaching, assessment, research and technology in medical education.
- **MedEdWorld**: AMEE’s exciting new initiative has been established to help all concerned with medical education to keep up to date with developments in the field, to promote networking and sharing of ideas and resources between members and to promote collaborative learning between students and teachers internationally.
- **Medical Teacher**: AMEE produces a leading international journal, Medical Teacher, published 12 times a year, included in the membership fee for individual and student members.
- **Education Guides**: AMEE also produces a series of education guides on a range of topics, including Best Evidence Medical Education Guides reporting results of BEME Systematic Reviews in medical education.
- **Best Evidence Medical Education (BEME)**: AMEE is a leading player in the BEME initiative which aims to create a culture of the use of best evidence in making decisions about teaching in medical and healthcare professions education.

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See the website (www.amee.org) for more information.

If you would like more information about AMEE and its activities, please contact the AMEE Office:
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