

# CAIPE

## Interprofessional Education Guidelines 2016

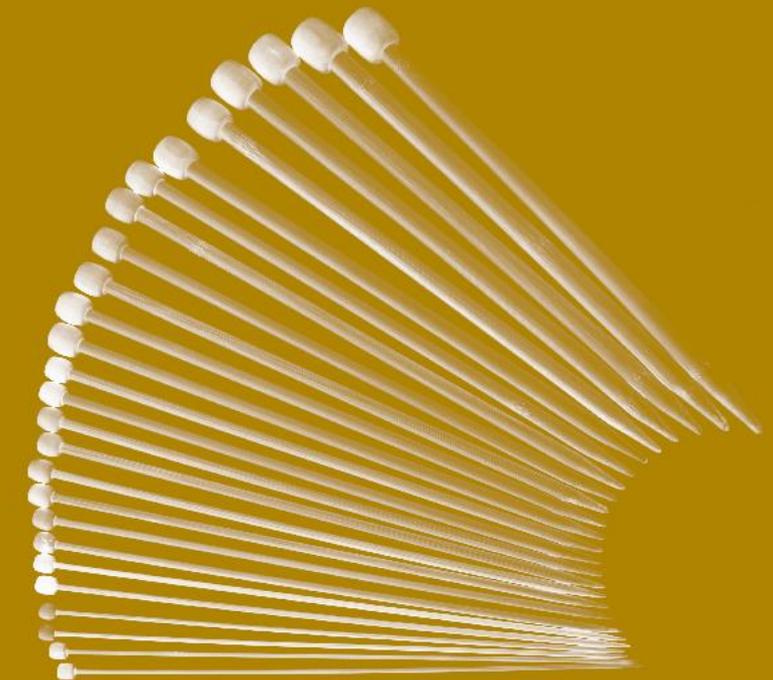
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# CAIPE

## Centre for the Advancement of Interprofessional Education

Founded in 1987 CAIPE is a UK-based charity and company limited by guarantee which is a global leader in promoting and developing interprofessional education and learning.

CAIPE is a community of committed individuals and organisations dedicated to a collaborative future, working with like-minded organisations in the UK and overseas to improve collaborative practice, patient safety and quality of care by professions learning and working together. We offer expertise and experience and an independent perspective to facilitate collaboration across the boundaries between education and health, health and social care, and beyond. We support students, academics, practitioners, researchers and people who use health and social care services through sharing information and enabling networking opportunities.

Our contributions include publications, development workshops, consultancy, commissioned studies and international partnerships, projects and networks. Membership of CAIPE is open to individuals, students, service users and organisations including academic institutions, independent and public service providers in the UK and overseas.

Benefits of membership include access to:

- The global interprofessional community of practice
- A programme of events
- Developmental workshops
- On-line resources
- Individual and group expertise
- Funding opportunities and bursaries
- Research and opportunities for research collaborations
- The Journal of Interprofessional of Care

For further information about CAIPE including the benefits of membership for organisations, individuals, students and service users and how to join go to [www.caipe.org.uk](http://www.caipe.org.uk) or email: [admin@caipe.org.uk](mailto:admin@caipe.org.uk)

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## PREFACE

These guidelines are addressed to organisations responsible for commissioning, developing, delivering, evaluating, regulating and overseeing interprofessional education (IPE) during prequalifying and continuing professional education for health, social care and related fields in the United Kingdom (UK) and beyond. CAIPE commends them to inform consistent policies, practices and procedures within and between those organisations to ensure efficient, effective, economic and expeditious planning and implementation of IPE interventions and strategies.

Grounded in CAIPE's Statement of Principles (see Appendix A), they build on:

- the experience of CAIPE's members and the interprofessional movement nationally and internationally;
- findings from the UK IPE review (Barr, Helme & D'Avray, 2011 & 2014a&b);
- evidence from systematic and scoping reviews;
- consultations with UK commissioning, regulatory and other standard setting organisations.

Publication of the UK IPE Review prompted two additional studies. Health Education Thames Valley followed up responses by universities and service agencies (unpublished) to recommendations in the Review addressed to Health Education England probing further selected policies and practices. Discussions followed with CAIPE regarding ongoing work to promote collaboration in Thames Valley and throughout England. The Health and Care Professions Council (HCPC) commissioned an unpublished review of IPE from Keele University.

CAIPE has lodged on its website a summary of its consultations throughout the UK following the Review (CAIPE, 2016).

We draw attention to findings from systematic and scoping reviews recording evidence regarding the effects of IPE on collaborative practice. They include the updated Best Evidence Medical Education review (Reeves, Fletcher, Barr et al., 2016) as well as other publications which have synthesised the evidence for IPE (e.g. Abu-Rish, Kim, Choe et al., 2012; Brandt, Lutfiyyer, King et al., 2014; O'Carroll, McSwiggan & Campbell, 2016; Reeves, Pataganis & Zeirler, in press). We urge universities and others to delve into that literature when planning their IPE. Securing the foundations must not, however, inhibit innovation which, by definition, reaches beyond the tried and tested. It is here that evaluation needs to be most rigorous to add robust findings to the growing evidence base as the boundaries for IPE extend wider.

Consistent with national and international usage, we employ the term interprofessional education (IPE) to embrace a repertoire of learning methods within a rationale comprising values, objectives and theory grounded in evidence. We employ interprofessional learning (IPL) when one or more of those methods is embedded within professional education whilst respecting alternative usage by others. We distinguish between IPL interventions, i.e. discrete elements of such learning, and IPL strategies, i.e. planned progressions of such elements. Other terms employed accord with the Journal of Interprofessional Care glossary reprinted selectively as Appendix B.

These guidelines replace those published previously by CAIPE for prequalifying IPE (Barr & Low, 2012).

## PART 1: Understanding Interprofessional Education

### Improving collaboration

IPE enables two or more professions to learn with, from and about each other to improve collaborative practice and quality of care (CAIPE, 2002). Well planned and conducted, it can promote flexible, coordinated, complementary, patient centred and cost effective collaboration in interprofessional teams within a policy-aware understanding of organisational relationships. IPE recognises and respects profession-specific requirements and safeguards the identity of each profession. Dealing in difference, it works towards meeting competency-based outcomes within a common framework.

CAIPE's (2011) statement of principles for IPE enshrines and extends those for adult learning. Responsibility for managing the learning rests not only on the individual but also on the group - a peer group from different professions with discrete and differing roles, perceptions and expectations. Within a given set of learning outcomes, members explore how each of them can contribute to a process of cooperative, cyclical, iterative, reflective and socially constructed learning, towards the resolution of conflicts, and the development of insight, understanding and skills. The learners become a community of practice. They negotiate the meaning of phenomena and problems engaged in a process which relies for its success upon their willingness and ability to enter into new experiences, to reflect on them from different perspectives, to align their values, to create concepts that integrate their observations into logical theories and to use them to make decisions and solve problems. Interprofessional students call on a shared repertoire of communal learning resources, facilitating change where the meaning of the activities that occur is a constantly negotiated and renegotiated interpretation of those held by all the participants (Kolb, 1984; Lave & Wenger, 1991; Wenger, 1998; Barr & Gray, 2013).

Prequalifying IPE can heighten students' appreciation of safe and good practice. It can create opportunities for them to explore ways in which their professions can work more closely together to respond more fully, more effectively and more economically to multiple and complex needs associated, amongst other factors, with ageing populations, urbanisation, migration and multiculturalism. It may respond, inter alia, to public and political concern to engage more effectively together in care, including end of life care, for people coping with chronic illnesses and disabilities, not least dementia, beyond the capacity of any one profession or service alone.

Learning together can cultivate mutual awareness, trust and respect, countering ignorance, prejudice and rivalry in readiness for collaborative practice. Interdependence in learning may pave the way for interdependence in practice helping workers to withstand occupational stress and mitigating defensive behaviour impeding innovation and collaboration (Hinshelwood & Skogstad, 2000; Menzies, 1970; Obholzer, 1994).

Educators structure opportunities in the classroom, on placement and in virtual learning environments where students can compare and contrast their professions' roles, responsibilities and relationships. University based educators usually approach such learning from psychological, social psychological or sociological perspectives to explore relationships within and between groups (Barr, 2013), challenging 'groupthink', i.e. allegiance to one group at the price of invidious, prejudiced and stereotypical perceptions of others (Janis, 1972 & 1982). Practice based educators enable students to apply that learning as they observe and evaluate good and not so good relationships between agencies and between professions.

In developed countries, prequalifying IPE typically prioritises work with disabled and older adults, less often with children and their families, still less in public health; priorities that may well be reordered in developing countries. Accommodating all three within the same IPE strategy can be over complex. IPE may more effectively be organised separately for each within a unifying rationale.

Ideally, pre-qualifying IPE is the first step from induction and orientation into advanced or specialist practice, and educational, managerial or research roles along a continuum of interprofessional development (CIPD) woven into the continuum of professional development (CPD). Realistically, much remains to be done to achieve that goal. Educators can and do help students to acquire the habit of self and group-directed learning anticipating how each may apply and progress that learning as career preferences take shape. Workers on first appointment need encouragement, support and guidance to recognise, exploit and access work-based IPL opportunities helped by designated line managers, mentors and training personnel supported in their learning by more experienced team members. They may be steered towards courses and study programmes that complement their work-based learning and promise to further their interprofessional

development (Kitto, Goldman, Schmitt et al., 2014). CAIPE is preparing CIPD guides for workers and their mentors.

### Improving care

The collaboration for which IPE prepares is more than cooperation. It is planned, purposeful, concerted and sustained endeavour within a defined legal and policy context to ensure comprehensive provision of quality care which transcends demarcations between professions, between practice settings, and between organisations. Teamwork can drive collaborative practice. Students can learn how members empower each other in a nurturing and mutually supportive environment to collaborate flexibly, economically, expeditiously and effectively across predetermined professional demarcations; not only teamwork but also more diffuse, more ephemeral and less structured ways of working together such as networking.

Appraising policy and practice critically from interprofessional perspectives can alert students to the need for closer collaboration to improve care and services as they explore how each professional group complements the others. Projects and assignments on placement and in the classroom enable learners to explore roles, responsibilities and relationships between their respective professions.

Learners may discover that integrating services is not enough to ensure collaborative practice and deliver better care unless and until the professions are actively, positively and collectively engaged, mediating the application of policies to practice, countering unintended consequences, resolving rivalries and conflicts, pulling together for the good of those whom together they serve. They can embed that learning within a working knowledge of relevant health and social care policies; policies that may redraw boundaries, reassign responsibilities or redistribute power facilitating or frustrating collaboration as they learn how to hold the tension between competition and collaboration.

The interprofessional movement is one of several driving change in health and healthcare delivery.

Others include:

- integrated care;
- quality improvement;
- health education;
- health improvement;
- patient safety;
- clinical communications;
- workforce planning.

Each relies for its success on professions joining in common purpose which IPE promotes.

## PART 2: Implementing An Interprofessional Learning Strategy

### Planning together

IPL is best planned jointly at every level closely involving educators from all the relevant professions with representatives of practice and employing agencies, professional associations, trade unions, students, service users, carers and other stakeholders. Some will have interprofessional experience on which to call. Others may be hoping to learn from those already travelling the interprofessional road. Much can be learnt by comparing and contrasting IPL interventions and strategies, but no two situations are the same. One size does not fit all. Each group has to devise its own strategy allowing time and opportunity to reconcile differing expectations.

### Devising a strategy

Agreeing when, where and how to introduce IPL between two or more professional courses is a complex process. Courses differ in length, structure and timetabling. Educators differ in their practice backgrounds, their theoretical orientation and their preferred learning methods. Introducing IPL interventions ad hoc may seem the realistic way to begin, but can make it difficult later to knit them together into coherent and progressive sequences. Formulating and agreeing an IPL strategy at the outset saves time in the long run.

### Underpinning with theory

IPL is more coherently planned, consistently delivered, rigorously evaluated and effectively reported when it is explicitly underpinned with theory. Educators need to reconcile and harmonise theoretical perspectives from education and practice from their respective professions. Psychodynamic perspectives informed some early IPL initiatives, giving way to psycho-social and, more recently, sociological perspectives (Barr, Koppel, Reeves et al., 2005). The onus rests on the planners to construct their own, synthesising anthropological, educational, organisational, psychological and/or sociological perspectives into a coherent and theoretical rational underpinning the IPE programme (Barr, 2013; Hean & Reeves, 2011; Hutchings, Scammell & Quinney, 2013).

### Formulating outcomes

Composite benchmarks, as agreed between UK associations for the health professions (QAA, 2006), set overall standards before formulating competency-based outcomes. The most authoritative frameworks come from Canada (Canadian Interprofessional Health Collaborative, 2010) and the United States (Interprofessional Education Collaborative Expert Panel, 2011). Both refer to a UK framework (CUILU, 2010) in which educators formulated capabilities rather than competencies to convey an ongoing learning process. Outcome led curricula encourage educators and students to develop teaching and learning responsively and flexibly (Barr, 1998; Reeves, 2012).

## Adapting teaching and learning methods

A range of learning methods have been adopted and adapted from professional for interprofessional education from which educators choose including: case-based learning; problem based learning; collaborative inquiry; appreciative inquiry; observation-based learning; experiential learning; reflective learning; simulated learning; continuous quality improvement; and others (Barr, 2002; Barr, Koppel, Reeves et al., 2005).

Experienced educators may well change the learning methods as students' needs evolve and to hold their interest. No one method suffices. Whichever are selected they should be active, interactive, reflective and patient centred creating opportunities to compare and contrast roles and responsibilities, power and authority, ethics and codes of practice, knowledge and skills in order to build effective relationships between the professions and to develop and reinforce skills for collaborative practice.

## Strengthening interprofessional practice learning

Interprofessional practice learning is more robust when universities and practice agencies enter into mutually beneficial agreements ensuring, on the one hand, that IPE placement experiences are available in the necessary numbers to the required standard and, on the other hand, that practice educators are prepared, supported and valued. Teaching and learning in the classroom and on placements can then be two sides of the same coin.

Relying on students to identify the IPL opportunities for themselves falls short. Practice based educators may assemble those opportunities with university-based educators. Together, they can generate collaborative and team-based opportunities for co-located students (Barr & Brewer, 2012).

A well planned sequence of placements progresses from observation to hands-on, team-based practice. There is a compelling case for every student to have at least one placement in an interprofessional team during their course, for example, on a training ward or in a community setting (Brewer & Stewart-Wynne, 2013; Jakobsen, 2016; Thomas & Reeves, 2015). It is there that they have opportunities to reflect on their working relationships and respective performance as they sharpen their awareness of conditions favourable to effective teamwork.

## Enhancing learning with technology

Technologically enhanced learning has been widely adopted in IPE. Many UK universities have developed reusable 'learning objects' accessible on-line (Gordon, Booth & Bywater, 2010; Bromage, Clouder, Thistlethwaite et al., 2010), others 'virtual communities' which support and strengthen an authentic patient centred approach (e.g. Quinney et al., 2008).

### Simulating learning

Simulation is also being widely adopted as patient safety comes to the fore, including opportunity for students comprising an interprofessional team to practice their respective interventions together around a manikin (Boet, Bould, Burnset al., 2014; Thomas & Reeves 2015). More investment in the technology and provision of clinical skills laboratories is critical before every IPE student will have that opportunity. But simulation must not replace practice-based learning, however hard it may be to find enough suitable placements. It is more effective when 'blended' with face-to-face learning. Each complements the other (Reeves & van Schaik, 2012).

### Assessing learning

Assessment of students' IPL should be based on demonstrated competencies for collaborative practice. It may be formative, but students and educators are more likely to value assessment that is summative towards professional qualifications. Reflective diaries, learning logs, portfolios and objective structured clinical examinations (OSCEs) are some of the assessment methods used. Some students may be required to demonstrate interprofessional outcomes when completing profession-specific assessments. Procedures, criteria and credits should be consistent across professions and across courses (Wagner & Reeves, 2015).

## PART 3: Engaging the Parties

### Involving students

There is growing evidence for providing IPE for all health and social care students during their pre-qualifying courses (Hammick, Freeth, Koppel et al., 2007; Abu-Rish, Kim, Choe et al., 2012; Reeves, Fletcher, Barr et al., in press). Pressure can build to include an open-ended list of professions as IPE gains popularity. Depending upon the configuration of professions engaged in collaborative practice, some universities are extending IPE beyond health and social care to include, for example, students from sports and leisure, school teaching, law, probation and police. Choices may, however, be constrained by the range of professions studying in the same location, eased sometimes by assembling the preferred mix across sites, schools or universities.

Students often respond more positively, and more readily see relevance, when they are learning with professions with whom they anticipate working after qualifying. That can be difficult to arrange where those professions are taught in different universities or at different levels, i.e. pre-qualifying and post-qualifying. The absence of one or more professions whose role is pivotal in collaborative practice, e.g. management, medicine or social work, may make the IPL seem less relevant, however carefully educators may try to compensate. The participating professions may be drawn closer together neglecting the

absent one at its expense.

Limits must be set operationally taking into account not only local needs, priorities and opportunities, but also how operational boundaries are drawn around occupations deemed to be 'professions'. A narrowly elitist definition, restricted to the established professions, excludes many whose engagement in collaborative practice is essential, with much to give and gain during IPE. Conversely, an egalitarian definition which blurs the boundary between professions and other occupational groups may optimise student mix for collaborative practice, but detract from the search for shared professional values, dissuade more established professions from participating and limit learning opportunities.

Educators engage students as adult learners. That may run counter to students' prior experience at school or university. They may need help in letting go of deferential and hierarchical styles of learning where the teacher was the unchallenged authority, before being ready to embrace egalitarian, democratic and socially constructed learning. They may need help also in relinquishing assumptions about professional relationships and hierarchies colouring reciprocal perceptions in the student group. Preparation is essential for students to understand the IPL process and their educators' expectations.

Confidence in self-directed and peer-group learning builds up over time. Some final year students, prepared and supported by their educators, facilitate groups and mentor first year students. Others contribute to IPE promotion, planning, development and evaluation.

Prospective students may well expect to find information about IPE in course prospectuses tracking one or more interprofessional pathway that they might follow to the outcome competencies.

### **Involving service users and their carers**

Consistent with its definition, service users and carers should invariably be at the centre of IPE. There are several models, frameworks and taxonomies which inform and explain the ways in which patients can contribute to healthcare education (Spencer, Godolphin, Karpenko et al., 2011). In the UK, the most frequently cited framework is the ladder of involvement from mental health (Tew, Gell & Foster, 2004). At the lower levels of involvement, service users may simply be the person with whom a group of students work. At the higher levels, service users and carers may work alongside educators to design learning and may support other service users and lead teaching (McKeown, Malihi-Shoja & Downe, 2010). Service users and carers can also be involved in student selection, mentoring and assessment, as well as the planning and reviewing of IPL interventions and strategies (e.g. Cooper & Spencer-Dawe, 2006; Anderson & Lennox, 2009; Furness, Armitage & Pitt, 2011).

Considerations that need to be born in mind include: the relevance of service users'

and carers' experience to students' learning needs; their readiness to share personal matters; and their vulnerability. Service users are more effective in their teaching roles, more confident and more at ease when they have preparation and ongoing support from the educators. Planning their induction, preparation and support is essential. Some have high dependency needs calling for additional support and sensitivity from students, educators and each other as part of the mutual learning. The nature of their involvement will determine their relationship with the university. Where, as in many instances, this is an employment relationship, universities carry an obligation as good employers to support, sustain and remunerate the service users and carers whom they engage. Some retain panels who contribute to teaching and learning across a range of professional and interprofessional programmes (McKeown, Malihi-Shoja & Downe, 2010).

### **Learning how to facilitate**

Teaching has its place in IPE, but the role of the educator is essentially to facilitate student learning rather than to deliver information didactically. Facilitating professional learning is challenging; facilitating interprofessional learning more so. Educators enable students from different professions to enrich and enhance each other's learning in supportive small group settings; sensitive to the perspectives, perceptions and particular needs of each individual and profession; able to turn conflict into constructive learning; and aware of ways in which their own attitudes and behaviour can impact positively or negatively on students' experience. They need to be able to discern and address with sensitivity, diversity and differences between the student groups in educational, professional and cultural background, power, status and hierarchy, language and practice perspectives across professional and organisational barriers to effect group development equitably and effectively. Mindful that students will perceive them as interprofessional role models, they must maintain their professional neutrality, listen actively, understand and respond to the dynamics of the group diplomatically and flexibly as they motivate, encourage and support the IPL process (Anderson, Cox & Thorpe, 2009; Barr & Coyle, 2012; Egan-Lee, Baker, Tobin et al., 2011; Freeman, Wright & Lindqvist, 2010).

### **Preparing for the interprofessional teaching role**

Even the most experienced educators find it challenging to be confronted with students from diverse backgrounds with different perspectives, expectations, assumptions and styles of learning (Egan-Lee, Baker, Tobin et al., 2011; Evans, Knight, Søndelund et al., 2014). Preparation is essential. It differs depending on the roles to which they are assigned. All educators engaged in IPE need preparation to understand its ethos, principles and methods and to be aware of its implications for their habitual styles of teaching. Those who are already well versed in the application of principles of adult learning in professional education may need less help than those accustomed to more didactic methods, but will nevertheless still have much to learn. Workshops for educators enable them to enter into

an interprofessional experience learning from positive and negative interprofessional encounters in the group. Team teaching, or working with a 'buddy', can help them gain confidence in teaching outside their 'comfort zone' (Hanna, Soren, Telner et al., 2013).

Hall and Zierler (2015) advise on interprofessional faculty development in the first of a series of practice guides in the Journal of Interprofessional Care based on the experience of pilot programmes in US universities and academic health centres comprising a combination of didactic presentations, small group activities and immersion experiences including direct involvement in IPE facilitation with coaching and peer support. The faculty development needs to fit the context, focus on problems learning from failures as well as successes, compare experience between institutions, measure and monitor outcomes relating education and training robustly.

### Leading the way

IPE coordinators need industry and ingenuity to create interprofessional learning opportunities that complement requirements for each of the constituent professional programmes. Prior teaching experience, however substantial, is less than sufficient to prepare them to work within and between institutional and professional traditions and cultures; systems and structures; expectations and requirements; policies and priorities; and budgets and resources.

## PART 4: Minding Resources

### Accommodating teaching and learning

Small group teaching, on which effective IPE relies, needs an ample supply of comfortably appointed syndicate rooms ensuring privacy to discuss confidences including those in case based material. A large lecture theatre may also be needed for interprofessional groups to come together for shared didactic teaching. Access to clinical skills laboratories is critical to enable all the students to engage in simulated IPL with particular reference to patient safety. Libraries need to stock interprofessional texts, journals and learning materials for the benefit of students and teachers (Nordquist, Kitto & Reeves, 2013).

### Being cost effective

Investment needed to plan an IPE strategy is repaid when cost effective educational systems result and returned with interest when it drives collaborative practice leading to more efficient and more economic delivery of care (Berwick, Nolan & Whittington, 2008; Barr & Beunza, 2014; Brandt et al., 2014; Walsh, Reeves & Maloney, 2014). Small group learning, on which IPE relies, carries a price tag offset where agreement is reached and logistics resolved to combine lectures for core subjects across professional programmes. Technologically enhanced learning can also result in savings once the initial outlay has

been met. IPE strategies that reinforce community-based care result in savings where they reduce or delay hospital admissions and expedite discharge planning.

## PART 5: Aligning Learning

Misalignment between the professional courses can frustrate best made plans to weave the interprofessional teaching and learning sequentially, logically and progressively into each. Coordination and commitment is needed within and sometimes between universities to synchronise systems and structures to accommodate not only timetabling and placement patterns but also assessment procedures and criteria.

Misalignment between classroom, placement and virtual environments can result in disjointed learning leaving the students to make connections with difficulty; compounded when more than one university sends students to more than one practice agency. Universities and agencies need to agree plans that reconcile requirements and structures for placements (Anderson, Cox & Thorpe, 2009; Long, Dann, Wolff et al., 2014).

## PART 6: Aligning Regulation

Misalignment between regulatory systems can result in costly duplication of effort in the preparation of review material in response to different requirements at different times resulting in conflicting advice and decisions, and missed opportunities for comparative critique.

IPE is typically subject to internal and external validation, modification and review within the professional courses in which it is embedded. Requirements and procedures differ between universities internally and between regulatory bodies externally rendering it difficult to ensure that procedures and criteria are consistent, coherent and comparable. Efforts have been made between regulatory bodies to conduct reviews concurrently for those professional courses including the same IPE strategy thereby facilitating comparative critique of process and outcomes. The dividends outweigh the difficulties.

Comparison can be further assisted by explicit, consistent and systematic recording of IPL found during reviews in each course in a common template carried forward into periodic subject reports. That practice is assisted where visiting panels include at least one member with first-hand IPE experience and all members have had an interprofessional orientation. Transparently and consistently conducted reviews generate data meriting inclusion in the IPE evidence base.

## PART 7: Evaluating Interprofessional Interventions and Strategies

Universities expect educators to monitor and report IPE interventions. Some educators go further, engaging in systematic investigation sometimes included in research leading to higher degrees. A Journal of Interprofessional Care Practice Guide (Reeves, Boet, Zierler et al., 2015) helps by formulating the evaluation questions. Consider, the authors advise, evaluation as early as possible; involve as many stakeholders as practicable; be clear about the purpose of the evaluation; consider learning outcomes; think about theoretical perspectives; employ an evaluation model; select an evaluation design; think about ethical approval; understand that there is an evaluation effect; manage the evaluation; and diversify dissemination methods. Relatively few IPE interventions are subject to independent and external research. Available funds may best be protected to evaluate innovative pilot approaches that may merit wider adoption (Freeth, Reeves, Koppel et al., 2005).

## PART 8: Transforming Professional Education from Within

From the outset, the World Health Organization (WHO, 1973 & 1978) invoked IPE as the means to reform professional education to become more responsive to population healthcare needs and community based developments. Returning to that theme in its first education and training guidelines, the WHO (2013) envisaged that a transformative and interdependent professional educational system for health professionals could be achieved by activating the case championed by the Lancet Commission (Frenk, Chen & Bhutta et al., 2010) for the reform of health professionals' education through IPE.

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## REFERENCES

Abu-Rish, E., Kim, S., Choe, L., Varpio, L., Malik, E., White, A.A., Craddock, K., Blondon, K., Robins, L., Nagasawa, P., Thigpen, A., Chen, L.L., Rich, J. & Zierler, B. (2012) Current trends in interprofessional education of health sciences students: A literature review. *Journal of Interprofessional Care* 26, 444-451.

Anderson, E., Cox, D. & Thorpe, L. (2009) Preparation of educators involved in interprofessional education. *Journal of Interprofessional Care* 23, 81-94.

Anderson, E. & Lennox, A. (2009) The Leicester model of interprofessional education: Developing, delivering and learning from student voices for 10 years. *Journal of Interprofessional Care* 23: 557-573.

Barr, H. (1998) Competent to collaborate: towards a competency-based model for interprofessional education. *Journal of Interprofessional Care* 12, 181-188.

Barr, H. (2002) Interprofessional education: Today, yesterday and tomorrow. Higher Education Academy Health Sciences and Practice. Occasional Paper No 1. [www.health.heacademy.ac.uk](http://www.health.heacademy.ac.uk).

Barr, H. (2009) An anatomy of continuing interprofessional education. *Journal Continuing Education in the Health Professions* 29, 147-151.

Barr, H. (2013) Toward a theoretical framework for interprofessional education. *Journal of Interprofessional Care* 27, 4-9.

Barr, H. & Beunza, J-J. (2014) The Economics of interprofessional education: costs and benefits (English, Spanish and Portuguese) In: *La educación interprofesional: una visión económica*, Papeles de Economía Española, 142.

Barr, H. & Brewer, M. (2012) Interprofessional practice based education In: J. Higgs, J., R. Barnett, S. Billett, M. Hutchings & F. Trede (eds) Rotterdam: Sense Publishers.

Billett, M. Hutchings & F. Trede (eds). *Practice-based education: Perspectives and strategies*. Rotterdam: Sense Publishers, 199-212.

Barr, H. & Coyle, J. (2012) Facilitating interprofessional learning. In: S. Loftus, T. Gerzina, J. Higgs, M. Smith and E. Duffy (eds). *Educating health professionals: Becoming a University teacher*. Rotterdam: Sense Publishers, 185-198.

Barr, H. & Gray, R. (2013) *Interprofessional Education: learning together in health and*

social care. In K. Walsh (ed), *A handbook of medical education*. Oxford: OUP. 38-49.

Barr, H., Helme, M. & D'Avray, L. (2011) *Developing interprofessional education in health and social care courses in the United Kingdom*. Paper 12. The Higher Education Academy: Health Sciences and Practice [www.health.heacademy.ac.uk](http://www.health.heacademy.ac.uk)

Barr, H., Helme, M. & D'Avray, L. (2014) *Review of interprofessional education in the United Kingdom, 1997-2013*. London: CAIPE. *Review of Interprofessional Education in the United*

Barr, H., Koppel, I., Reeves, S., Hammick, M. & Freeth, D. (2005) *Effective interprofessional education: argument, assumption & evidence*. Oxford: Blackwell.

Barr, H. & Low, H. (2012) *Interprofessional learning in pre-registration education courses: A CAIPE guide for commissioners and regulators of education*. London: CAIPE.

Berwick, D.M., Nolan, T.W. & Whittington, J. (2008) *The Triple Aim: Care, Health, and Cost*. *Health Aff (Millwood)*.27, 759-769.

Boet, S., Bould, M.D., Burn, C. L. & Reeves, S. (2014) *Twelve tips for a successful interprofessional team-based high-fidelity simulation education session*. *Medical Teacher* 36, 853-857

Brandt, B., Luftiyya, M.N., King, J.A. & Chioreso, C. (2014) *A scoping exercise of interprofessional collaborative practice and education using the lens of the Triple Aim*. *Journal of Interprofessional Care* 28, 393-399.

Brewer, M.L. & Stewart-Wynne, E.G. (2013) *An Australian hospital-based student training ward delivering safe, client-centred care while developing students' interprofessional practice capabilities*. *Journal of Interprofessional Care* 27, 482-488.

Bromage, A., Clouder, L., Thistlethwaite, J. & Gordon, F. (2010) *Interprofessional e-learning and collaborative work: Practices and technologies*. Hershey PA: Information Science Reference

CAIPE (2002) *Interprofessional education – a definition*. [www.caipe.org.uk](http://www.caipe.org.uk)

CAIPE (2011) *Principles of interprofessional education* [www.caipe.org.uk](http://www.caipe.org.uk)

CAIPE (2016) *Report on consultations following the publication of the UK review of interprofessional education 1997-2013*.

Canadian Interprofessional Health Collaborative. (2010) A national competency framework for interprofessional collaboration. [www.cihc.ca/files/CIHC\\_IPCompetencies\\_Feb2010.pdf](http://www.cihc.ca/files/CIHC_IPCompetencies_Feb2010.pdf)

Combined Universities Interprofessional Learning Unit (2010) Interprofessional capability framework 2010 mini-guide. London: Higher Education Academy Subject Centre for Health Sciences and Practice.

Cooper, H. & Spencer-Dawe, E. (2006) Involving service users in interprofessional education narrowing the gap between theory and practice. *Journal of Interprofessional Care* 20, 603-617.

Egan-Lee, E., Baker, L., Tobin, S., Hollenberg, E., Dematteo, D. & Reeves, S. (2011) Neophyte facilitator experiences of interprofessional education: Implications for faculty development. *Journal of Interprofessional Care* 25, 333-338.

Evans, S; Knight, T; Sønderlund, A; & Tooley, G (2014) Facilitators' experience of delivering asynchronous and synchronous online interprofessional education. *Medical Teacher* 36, 1051-1056.

Freeman, S., Wright, A. & Lindqvist, S. (2010) Facilitator training for educators involved in interprofessional learning. *Journal of Interprofessional Care* 24, 375-385.

Freeth, D., Reeves, S., Koppel, I., Hammick, M. & Barr, H. (2005) Evaluating interprofessional education: A self-help guide. Higher Education Academy: Health Sciences and Practice [www.health.heacademy.ac.uk](http://www.health.heacademy.ac.uk)

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, E., Fineberg, H., Garcia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Medez, A., Reddy, S., Scrimshaw, S., Sepulveda, J., Sewadda, D. & Zurayk, H. (2010) Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. A Global Independent Commission. ([www.thelancet.com](http://www.thelancet.com))

Furness, P., Armitage, H. & Pitt, R. (2011) An evaluation of practice-based interprofessional education initiatives involving service users. *Journal of Interprofessional Care* 25: 46-52.

Gordon, F. Booth, K. & Bywater, H. (2010) Developing an e-pedagogy for interprofessional learning: lecturers' thinking on curriculum design. *Journal of Interprofessional Care* 24, 536-548.

Hall, L.W. & Zierler, B.K. (2015) Interprofessional education and practice guide No. 1: Developing faculty to effectively facilitate interprofessional education. *Journal of Interprofessional Care* 29, 3-7.

Hammick, M., Freeth, D., Koppel, I., Reeves, S. & Barr, H. (2007) A best evidence systematic review of interprofessional education. *Medical Teacher* 29, 735-751.

Hanna, E., Soren, B., Telner, D., MacNeill, H., Lowe, M. & Reeves, S. (2013) Flying blind: the experience of online interprofessional facilitation. *Journal of Interprofessional Care* 27, 298-304.

Hinshelwood, R.D. & Skogstad, W. (eds) (2000) *Observing organisations: anxiety, defence and culture in health care*. London: Routledge

Hutchings, M., Scammell, J. & Quinney, A. (2013) Praxis and reflexivity for interprofessional education: Towards an inclusive theoretical framework for learning. *Journal of Interprofessional Care* 27, 358-366.

Jacobsen, F. B. (2016) An overview of pedagogy and organization in Clinical Interprofessional Training Units in Sweden and Denmark. *Journal of Interprofessional Care*.

Janis, I. L. (1972). *Victims of Groupthink*. New York: Houghton Mifflin.

Janis, I. L. (1982). *Groupthink: Psychological Studies of Policy Decisions and Fiascoes*. Second Edition. New York: Houghton Mifflin.

Kirkpatrick, D. L. (1967) Evaluation of training. In: R. Craig & L. Bittel (eds). *Training and Development Handbook*. 87-112 New York: McGraw-Hill.

Kitto, S., Goldman, J., Schmitt, M.H. & Olson, C.A. (2014) Examining the intersection between continuing education, interprofessional education and workplace learning. *Journal of Interprofessional Care* 28, 183-185.

Kolb, D.A. (1984) *Experiential learning: Experience as the source of learning and development*. New Jersey: Prentice Hall.

Lave, J. & Wenger, E. (1991) *Situated Learning: Legitimate peripheral participation*. Cambridge. Cambridge University Press.

Long, T., Dann, S., Wolff, M. & Brienzabc, R. (2014) Moving from silos to teamwork: integration of interprofessional trainees into a medical home model. *Journal of Interprofessional Care* 28, 473-474.

Menzies, I. (1970) *The functioning of social systems against anxiety*. London: Tavistock

McKeown, M., Malihi-Shoja, L. & Downe, S. (2010) Service user and carer involvement in

education for health and social care. Oxford: Wiley-Blackwell.

Nordquist, J., Kitto, S. & Reeves, S. (2013) "Living museums": Is it time to reconsider the learning landscape for professional and interprofessional education? *Journal of Interprofessional Care* 27, 2-4.

Obholzer, A. (1994) Managing social anxieties in public sector organisations. In: A. Obholzer & V. Zagier Roberts, *The unconscious at work: Individual and organisational stress in human services*. London: Routledge, 169-78.

O'Carroll, V., McSwiggan, L., & Campbell M. (2016) Health and social care professionals' attitudes to interprofessional working and interprofessional education: A literature review. *Journal of Interprofessional Care*; 30: 42-49.

QAA (2006) Statement of common purpose for subject benchmarks for health and social care. Bristol: the Quality Assurance Agency for Higher Education in England.

Quinney, A., Hutchings, M. & Scammell, J. (2008) Student and staff experiences of using a virtual community, Wessex Bay, to support interprofessional learning: Messages for collaborative practice. *Social Work Education* 27, 658-664.

Interprofessional Education Collaborative Expert Panel (2011) Core competencies for interprofessional collaborative practice: report of an expert panel. Washington D.C.: Interprofessional collaborative

Reeves, S. (2012) The rise and rise of interprofessional competence. *Journal of Interprofessional Care* 26, 253-255.

Reeves S, Palaganas J. & Zierler B (in press) An updated synthesis of review evidence of interprofessional education. *Journal of Allied Health*

Reeves, S., Boet, S., Zierler, B. & Kitto, S. (2015) Interprofessional education and practice guide No. 3: Evaluating interprofessional education. *Journal of Interprofessional Care* 29, 305-312.

Reeves, S, Fletcher, S., Barr, H., Birch I, Boet S, Davies N, McFadyen A, Rivera J, & Kitto S. (2016) A BEME systematic review of the effects of interprofessional education: BEME Guide No. 39. *Medical Teacher*.

Reeves, S. & Hean, S. (2013) Why we need theory to help us better understand the nature of interprofessional education, practice and care. *Journal of Interprofessional Care*, 27, 1-3

Reeves, S. & van Schaik, S. (2012) Simulation: A panacea for interprofessional learning? *Journal of Interprofessional Care* 26, 167-169.

Thomas, L. & Reeves, S. (2015) Sociological fidelity: keeping the patient at the heart of interprofessional learning. *Journal of Interprofessional Care* 29, 177-178.

Spencer, J., Godolphin, W., Karpenko, N. & Towle, A. (2011) Can patients be teachers? Involving patients and service users in health care professionals' education. London: The Health Foundation.

Tew, J, Gell, C., & Foster, F. (2004) A good practice guide. Learning from experience. Involving service users and carers in mental health education and training. Nottingham: Mental Health in Higher Education. National Institute for Mental Health in England/Trent Workforce Development Confederation.

Wagner, S.J. & Reeves, S. (2015) Milestones and entrustable professional activities: The key to practically translating competencies for interprofessional education? *Journal of Interprofessional Care on-line*

Walsh, K., Reeves, S. & Maloney, S. (2014) Exploring issues of cost and value in professional and interprofessional education. *Journal of Interprofessional Care* 28, 493-94.

Wenger, E. (1998) *Communities of practice: learning, meaning and identity*. Cambridge MA: Cambridge University Press.

WHO (1973) Continuing education for physicians. Technical Report Series 534. Geneva: World Health Organization.

WHO (1978) Declaration of Alma Ata. Geneva: World Health Organization.

WHO (2010) Framework for action on interprofessional education & collaborative practice. Geneva: World Health Organization. [http://www.who.int/hrh/resources/framework\\_action/en/index.html](http://www.who.int/hrh/resources/framework_action/en/index.html).

WHO (2013) Transforming and scaling up health professionals' education and training. Geneva: World Health Organization

## APPENDICES

### APPENDIX A

#### CAIPE Statement of Principles of Interprofessional Education

CAIPE commends the following principles, drawn from the experience of its members and the interprofessional literature, for the consideration of all who are engaged in commissioning, designing, delivering and evaluating interprofessional education.

#### Values

Interprofessional education:

- Focuses on the needs of individuals, families and communities to improve their quality of care, health outcomes and wellbeing;
- Applies equal opportunities within and between the professions and all with whom they learn and work;
- Respects individuality, difference and diversity within and between the professions and all with whom they learn and work;
- Sustains the identity and expertise of each profession;
- Promotes parity between professions in the learning environment;
- Instils interprofessional values and perspectives throughout uniprofessional and multiprofessional learning.

#### Process

Interprofessional education:

- Comprises a continuum of learning for education, health, managerial, medical, social care and other professions;
- Encourages student participation in planning, progressing and evaluating their learning;
- Reviewing policy and practice critically from different perspectives;
- Enables the professions to learn with, from and about each other to optimise exchange of experience and expertise;
- Deals in difference as it searches for common ground;
- Integrates learning in college and the work place;
- Synthesises theory and practice;
- Grounds teaching and learning in evidence;

- Includes discrete and dedicated interprofessional sequences and placements;
- Applies consistent assessment criteria and processes for all the participant professions;
- Carries credit towards professional qualifications;
- Involves service users and carers in teaching and learning;

## Outcomes

Interprofessional education:

- Engenders interprofessional capability;
- Enhances practice within each profession;
- Informs joint action to improve services and instigate change;
- Improves outcomes for individuals, families and communities;
- Disseminates its experience;
- Subjects developments to systematic evaluation and research.

Hugh Barr, Helena Low

January 2011

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## APPENDIX B

### Glossary

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**Accountability:** Active acceptance for the responsibility for the diverse roles, obligations, actions, including self-regulations, and other behaviours that positively influence patient and client outcomes, the profession, and the health needs of society.

**Altruism:** Overt behaviour that reflects concern for the welfare and well-being of others and assumes the responsibility of placing the needs of the patients or clients ahead of the professionals' interest.

**Care/Caring:** Behaviour that reflects concern, empathy and consideration for the needs and values of others and a level of responsibility for someone's well being.

**Collaboration:** The act of working together cooperatively, especially in the case management of a patient or client; including sharing responsibilities for solving problems and making decisions to formulate and carry out plans for patient care.

**Communication:** Imparting or interchange of thoughts, opinions or information by speech, writing or signs which are the means through which professional behaviour is enacted.

**Ethical Behaviour:** Reflects the values and guidelines governing decisions in health care practice.

**Excellence:** Behaviour that adheres to, exceeds, or adapts best practices to provide the highest quality care; including engagement in continuous professional development.

**Respect:** Behaviour that shows regard for another person with esteem, deference and dignity. It is a personal commitment to honour other peoples' choices and rights regarding themselves and includes a sensitivity and responsiveness to a person's culture, gender, age and disabilities.

**Teamwork:** Cooperative effort by the members of a group to achieve a common goal.

**Interdisciplinary Health Care** occurs when health care professionals representing expertise from various health care disciplines participate in the support of clients and their families in health care delivery.

**Interprofessional Health Care** occurs when various professions learn from and about each other to improve collaboration and the quality of care. Their interactions are characterised by integration and modification reflecting participants understanding of the core principles and concepts of each contributing discipline and familiarity with the basic language and mindsets of the various disciplines.

**Interprofessional Education** occurs when students from various professions learn from and about each other to improve collaboration and the quality of care. Their interactions are characterized by integration and modification reflecting participants understanding of the core principles and concepts of each contributing discipline and familiarity with the basic language and mindsets of the various disciplines.

**Interprofessional Practice** occurs when practitioners from two or more professional work together with a common purpose, commitment and mutual respect.

**Interprofessional Professionalism** is the consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of, altruism, excellence, caring, ethics, respect, communication, accountability to achieve optimal health

and wellness in individuals and communities.

Multidisciplinary is an adjective used to describe, for example, types of teams or education and indicates that people from different disciplines are involved in the given activity. In other words, individuals from two or more disciplines working in parallel, coming together only for specific issues and problems.

Profession refers to a vocation with a body of knowledge and skills put into service for the good of others which has led to an autonomous, self-regulated health care profession.

Professionalism includes a distinct set of professional responsibilities and actions composed of seven basic elements: excellence, humanism, accountability, altruism, duty, honour and integrity, and respect of others.

Transdisciplinary is used to describe teams in which members' share roles and systematically cross discipline boundaries to pool and integrate their expertise so that more efficient and comprehensive assessment and intervention services may be provided.

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