# Inter-professional education, working and learning

What do you understand by the terms inter professional education (IPE), inter professional working (IPW) and enquiry based learning (EBL)? Discuss the potential benefits and difficulties associated with them

The modern NHS is constantly evolving and arguably has done so since its inception. This evolution has been on many different levels. In this essay we shall consider some of the changes in the professional working and learning practices of the nurse with consideration of the topics of inter professional education (IPE), inter professional working (IPW) and enquiry based learning (EBL). We shall consider each in turn and then examine its relevance to modern day practice.

Interprofessional education (IPE),

IPE has been defined in a number of ways. One of the most complete is:

The application of principles of adult learning to interactive, group-based learning, which relates collaborative learning to collaborative practice within a coherent rationale which is informed by understanding of interpersonal, group, inter-group, organisational and inter-organisational relations and processes of professionalisation. (Gough D. A et al. 2003)

When reading the literature on the subject, one quickly becomes aware that there are a number of commonly used terms that are virtually synonymous with IPE, and contribute to the “ semantic quagmire” referred to in the McPhearson paper (discussed later) that surrounds terms such as multi-disciplinary learning and multi-professional education. (Scottish Office 1998). In broad terms they describe the process whereby two (or more) professions

or disciplines come together for the purposes of learning (Jackson, N et al. 2004). The important functional features of such a system are not that the individuals concerned learn the same material together but that there is a learning both about and from each other to improve collaboration and the overall quality of care provided and it is this latter feature which distinguishes the term IPE from the rest of the group mentioned earlier. (NCIHE 1997)

The emergence of multidisciplinary teamwork and the seamless interface concepts (Yura H et al. 1998) have highlighted the need for smoother integration of both processes and knowledge (as well as other less tangible concepts such as mutual respect and understanding) between the caring professions. (CAIPE 1997)

Quite apart from the ideological requirement for such processes to be adopted, we note that there is an increased pressure of guidances coming from central sources, primarily the Dept. of Health, that specify IPE as essential to the task of healthcare professionals and also a number of enquiry reports (such as the Kennedy report and other in the field of child abuse and mental health such as the Laming inquiry (2003)) that have highlighted the need for strengthening both IPE and interprofessional working

Interprofessional Working (IPW)

IPW is, to a large extent, a direct and natural consequence from the adoption of the concepts of IPE. (Molyneux J 2001). In essence, it describes the process of healthcare professionals collaborating in working together more

effectively to improve the quality of patient care thereby allowing for both flexible and coordinated services and a skilled and responsive workforce. (McNair R et al. 2001).

We should note that the adoption of IPW is seen as a key element in the optimum working of multidisciplinary team working which allows healthcare professionals to work competently and confidently across previously defined professional boundaries and it enables effective role substitution (Finch J et al. 2000)

Enquiry based learning (EBL)

This is essentially a description of a process of learning that is driven by a process of enquiry. It is complementary to the process of project based learning (PBL) which is determined by the end point of the solution of a problem and usually requires the creation of a finished product such as a project report or a dissertation. EBL is characterised by deep involvement and engagement with a complex problem and incorporates structures and forms of support which can help the student carry out their enquiries and can cover a broad spectrum of different approaches.

The characteristic feature of this type of structured learning is that the tutor establishes the topic and the student then pursues their own lines of enquiry, both seeking evidence to support their views and also taking responsibility to present this evidence appropriately.

In the words of Barrett:

It promotes personal research… the student becomes familiar with the multifarious resources at their disposal such as e-journals and databases. There is the opportunity to support one another in research and explore different avenues of information. The whole experience becomes one of interchange where students can share opinions, research and experience to achieve an end result. (Barrett et al. 2005)

Collaborative working

In essence, the forgoing paragraphs all come under the over-reaching concept of collaborative working. This is not an isolated academic concept, it is a very practical one. The literature on the subject is very informative. If we consider a number of specific examples from recent journals, we can cite the paper by Rogowski (J A et al. 2001) which produced an ingenious design of study to assess the degree to which a number of neonatal intensive care units (NICUs) could make improvements in both the quality of care and also the economic functioning of their departments by embracing the concept of collaborative multidisciplinary working. Ten NICUs adopted the collaborative multidisciplinary working model and their outcomes were compared with nine “ controls” who did not. The paper is both long and complex and the analysis is exhaustive but, in essence, the authors concluded that such collaborative working practices could certainly achieve cost savings (which were comparatively easy to quantify). They noted that these were certainly obtainable in the short term and most were sustainable in the long term. They also commented on the improvements in the quality of care parameters (which were much harder to quantify). There was an improvement in a number of indices of quality of care including patient

(parent) satisfaction levels, staff satisfaction levels and this was not accompanied by any reduction in clinical outcome.

On a wider consideration, one can turn to the paper by Anderson (P et al. 2003)

Which describes the WHO’s collaborative survey on the management of alcohol problems in a primary health care setting. The paper starts with the premise that the handling of alcohol-related problems in primary healthcare is poor (and cites many reasons for this). (Aalto, M et al. 2001) . The relevance to our discussions here is that the paper considers the outcomes in this area when such problems are treated by the GP alone and when they are treated by a multidisciplinary primary healthcare team (IPW) and it is clear that the later group has a generally better outcome.

These two papers are presented to support the hypotheses that IPW and collaborative working are not simply new mechanisms without foundation or substance, they are a demonstration of their ability to work in a practical field.

If we now consider the benefits and shortcomings of IPE and IPW within the context of the modern NHS, we note that there is not only a consideration of the benefits of IPW between the various healthcare professional’s specialties but some authors also call for IPW between those healthcare professionals who work in primary healthcare teams and those who work in a hospital setting. The current structure of the NHS is such that hospital based practitioners tend to train, work, and have their horizons limited by the confines of the hospital environment. When the patient leaves this

environment they become “ someone else’s problem” and the care is then taken over by another team of healthcare professionals. Parsell ( G, et al. 1998) calls for both IPE and IPW to accommodate this rather artificial divide and to educate healthcare professionals into the consideration that it is the patient who is the constant factor and that considerable levels of collaborative working are required to provide optimum levels of patient care.

A more recent paper by McPherson (K et al. 2001) takes this argument a stage further. It is both analytical and well written and the authors have an impressive pedigree (two professors of medicine and a lecturer in health administration). The paper puts education at the centre of the modernisation debate

They make the very pertinent observation:

Most health needs require the collaboration of a group of health professionals. The professionals involved may work together in the same space or be scattered throughout several hospital departments or sectors of care. Whether or not the caregivers see themselves as part of a team, each patient depends on the performance of the whole.

The paper then makes a number of analyses form both practical experience of the authors and the current literature. They suggest that, in order to work well a work group or team should have the following characteristics:

Clear aim: shared understanding of goals.

Clear processes: knowledge of (and respect for) others' contributions, good communication, conflict management, matching of roles and training to the task. (Headrick L A et al. 1998)

Flexible structures that support such processes: skilled staff, appropriate staffing mix, responsive and proactive leadership that emphasises excellence, effective team meetings, documentation that facilitates sharing of knowledge, access to needed resources, and appropriate rewards. (Firth-Cozens J 2000)

The authors cite an impressive and persuasive evidence base that IPW and collaborative working have been demonstrated to produce patient benefit in a number of specific areas including reduced mortality for the elderly. (Rubenstein L Z et al. 1991), morbidity after CVA (Langhorne P et al. 2001) and mortality after CABG (O'Connor G T et al. 1996) to mention just three.

Despite these clear and demonstrable benefits, the authors make the point that IPW is not just something that happens when professional training is completed, it should ideally be considered as part of a continuum of learning starting with the pre-qualification experience, continuing into postgraduate education, and extending into continuing professional development. They make a call (which has been echoed by many others – viz. CGME 2000) for learning in the field of healthcare to be about healthcare as a whole, rather than a series of disjointed " chapters" in order to help the developing healthcare professionals to acquire a deeper understanding of the processes of care and also to prepare the professionals to be in a better position to contribute to the development of a better system in the fullness of time

One of the impediments to a wholehearted embracing of these concepts is perhaps a clinging onto the older concepts of trying to blur boundaries between what a nurse and a doctor might do or perhaps how an occupational therapist or a psychologist might approach management issues. It seems to be a fundamental issue that need to collectively understand the different ways of thinking and problem solving that the different specialties require so that the different skills and knowledge bases can be combined in a way that benefits patients. (Koppel I et al. 2001)

Part of the requirement of the writing of this essay is to reflect on the experiences gained in the EBL group work and the learning derived from the research for this essay.

Gibbs reflective model is ideal for this purpose.

The descriptive elements are largely contained within this essay and, in addition, my experiences within the various groups. It has to be said that the groups that I was involved with were largely harmonious and entered into the various learning exercises in a spirit of self-help. I am aware however, that a number of the other groups did not share this experience and I have been told about a number of heated discussions that apparently tool place within these other groups. My feelings are that instinctively I find the former more conducive to a positive learning experience. Although it can be useful to enter into a heated debate on a subject, it rarely helps to persuade you to a different point of view. (Taylor, E. 2000). The evaluation of the episode was that it gave me a personal insight into how other healthcare professionals consider and manage problems in their own sphere and, as such, I feel that I

have learned a great deal and formed a deeper understanding of their perceptions and knowledge of certain issues.

In terms of what I might have done differently, I believe that I was able to assimilate a great deal of useful information from these groups which will almost certainly help me in my professional career. On reflection, I think that I was not as vociferous as I might have been in putting my own viewpoint forward, and it occurred to me that the other healthcare professionals in the group may therefore not have had the same opportunity to assimilate my particular viewpoints and opinions and may therefore have been disadvantaged by this. (Palmer 2005). It is certainly clear to me that there is considerable benefit to be obtained in both IPE and IPW and the mechanism of EBL is a valuable tool to obtaining that benefit.

In terms of a discrete action plan, I have every intention of engaging as fully as I can in any further measures in this regard and will try to make my own viewpoint available for others to assess and assimilate as actively as I have tried to assess and assimilate theirs. (Van Manen, M. 1997). I feel that this is a positive step in making all of us more fully professional and able to contribute more fully to the healthcare systems that we will eventually work in.

## References

Aalto, M., Pekuri, P. and Seppa K. (2001) Primary health care nurses' and physicians' attitudes, knowledge and beliefs regarding brief intervention for heavy drinkers. Addiction 96 : 305–311

Anderson P, Eileen Kaner, Sonia Wutzke, Michel Wensing, Richard Grol, Nick Heather, and John Saunders 2003 ATTITUDES AND MANAGEMENT OF ALCOHOL PROBLEMS IN GENERAL PRACTICE: DESCRIPTIVE ANALYSIS BASED ON FINDINGS OF A WORLD HEALTH ORGANIZATION INTERNATIONAL COLLABORATIVE SURVEY Alcohol Alcohol., November/December 2003 ; 38 : 597 – 601.

Barrett T, MacIbrahim I, Fallon H (eds) 2005 Handbook of enquiry and problem based learning Galaway : CELT 2005

CAIPE (1997) Interprofessional Education – A Definition. CAIPE Bulletin. No. 13, 19.

CGME 2000 Council on Graduate Medical Education & National Advisory Council on Nurse Education and Practice. Collaborative education to ensure patient safety: report to US Department of Health and Human Services and Congress. A Report on a Joint COGME-NACNEP meeting and implications of the IOM Report. Washington, DC: Health Resources and Services Administration, 2000 : 9–18.

Finch J, May C & Mair F et al 2000 Interprofessional education and teamworking: a view from the education providers. British Medical Journal 321 : 1138-40.

Firth-Cozens J. 2001 Multidisciplinary teamwork: the good, bad, and everything in between. Quality in Health Care 2001 ; 10 : 65–6.

Gibbs, G 1988 Learning by doing: A guide to Teaching and Learning methods EMU Oxford Brookes University, Oxford. 1988

Gough D. A., Kiwan D., Sutcliffe K., Simpson D. & Houghton N. (2003). A systematic map and synthesis review of the effectiveness of personal development planning for improvement student learning London : EPPICentre, Social Science Research Unit. 2003

Headrick L A, Wilcock O M, Batalden P B. 1998 Interprofessional working and continuing medical education. British Medical Journal 1998 ; 316 : 771–4

Jackson, N. & Ward, R. 2004 A fresh perspective on progress files. A way of representing complex learning and achievement in higher education Assessment & Evaluation in Higher Education Vol. 29 : No. 4, August 2004.

Koppel I, Barr H, Reeves S, et al. 2001 Establishing a systematic approach to evaluating the effectiveness of interprofessional education. Issues in Interdisciplinary Care 2001 ; 3 : 41–9.

Laming, Lord. 2003 The Victoria Climbie inquiry: report of an inquiry by Lord Laming. London: The Stationery Office. 2003

Langhorne P, Duncan P. 2001 Does the organization of postacute stroke care really matter? Stroke 2001 ; 32 : 268–74.

McNair R, Brown R & Stone N et al (2001) Rural interprofessional education: promoting teamwork in primary health care education and practice. Australian Journal of Rural Health 9 : s19-s26.

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

Molyneux, J. (2001) Interprofessional teamworking: what makes teams work well? Journal of interprofessional care. vol. 15. (1) p29-35.

NCIHE 1997 The National Committee of Inquiry into Higher Education (1997)

Higher education in the learning society : Report of the National Committee of Inquiry into higher Education London : HMSO. 1997

O’Connor G T, Plume S K, Olmstead E M, et al. 1996 A regional intervention to improve the hospital mortality associated with coronary artery bypass graft surgery.

JAMA 1996 ; 275 : 841–6 Palmer 2005 In – Learning about reflection from the student Bulpitt and Martin

Active Learning in Higher Education. 2005 ; 6 : 207-217. Parsell G and J Bligh 1998 Interprofessional learning Postgrad. Med. J., Feb 1998 ; 74 : 89 – 95.

Rogowski J A, Jeffrey D. Horbar, Paul E. Plsek, Linda Schuurmann Baker, Julie Deterding, William H. Edwards, James Hocker, Anand D. Kantak, Patrick Lewallen, William Lewis, Eugene Lewit, Connie J. McCarroll, Dennis Mujsce, Nathaniel R. Payne, Patricia Shiono, Roger F. Soll, and Kathy Leahy 2001 Economic Implications of Neonatal Intensive Care Unit Collaborative Quality Improvement Pediatrics, Jan 2001 ; 107 : 23 – 29.

Rubenstein L Z, Stuck A E, Siu A L, et al. 1991 Impacts of geriatric evaluation and management programs on defined outcomes: overview of the evidence. J Am Geriatr Soc 1991 ; 39 : 8–16S ; discussion 17–18S.

Scottish Office (1998) Higher Education for the 21st Century: Response to the Garrick Report. London: HMSO. 1998

Taylor, E. (2000). Building upon the theoretical debate: A critical review of the empirical studies of Mezirow’s transformative learning theory. Adult Education Quarterly, 48 (1) , 34-59.

Van Manen, M. (1997) Linking Ways of Knowing with Ways of being Practical. Curriculum Inquiry 6 (3) , 205-228.

Yura H, Walsh M. 1998 The nursing process. Assessing, planning, implementing, evaluating. 5th edition. Norwalk, CT: Appleton & Lange, 1998.

##########################################################################

19. 11. 06 Word count 3, 069 PDG.