

**Exploring the professional identity of
health and social care staff via
experiences of interprofessional
education and collaborative practice**

Viktorija Cheryl Taz Joynes

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The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

The study of professional identities in health and social care (H&SC) was last prominent in the 1980s, with social theorists and policymakers taking an interest the way in which identities and roles were formed. This thesis proposes that the study of professional identity in H&SC requires renewed attention, especially in the context of expectations that students will both train and work across professional boundaries. Specifically, the thesis questions whether experiences of interprofessional education (IPE) and collaborative practice have any impact on perceptions of professional identity for those working in H&SC, and examines how socialisation processes influence the development of 'professional identities' as well as considering the implications for patient care. A case study of a large-scale interprofessional programme – the ALPS CETL – is also drawn upon to examine the long-term impact of IPE initiatives on the identities and roles of staff involved in interprofessional initiatives.

The empirical elements of this study consisted of surveys of practicing (n=288) and academic (n=31) staff, and interviews with participants drawn from the same groups (n=33). Drawing upon both thematic and narrative analysis of the data, the thesis argues that previous conceptualisations of professional identity aligned to a 'whole' profession do not relate to the way in which H&SC professionals actually perceive their identities. As respondents were far more likely to identify as being part of a branch or sub-group of a profession, it is proposed here that the concept of an 'intra-professional identity' is a more useful way to conceptualise the identity of H&SC professionals. More 'senior' professionals appeared to be more comfortable with their own professional identity, and with working across professional boundaries, than junior colleagues. This has implications for the way in which IPE is 'taught'. Finally, in order to address identified tensions between professional identities and cross-professional working, it is proposed that the concept of 'interprofessional responsibility' can and should be incorporated into the professional identities of all H&SC staff.

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Chapter One

The implications of interprofessional education for uni-professional identity

1.1 Introduction

When thinking about health care provision in England in the twenty-first century, it is impossible not to consider the myriad health and social care (H&SC) professions involved in providing care and supporting service users in both hospital and community settings. When systems of H&SC fail, or fall below the expected standards of modern times, large inquiries often ascribe the blame for such failings onto breakdowns in communication between professionals or across professional boundaries (Kennedy 2001; Laming 2003; Laming 2009; Francis 2013). The recommendations in such reports often reiterate the need for effective communication and team-working to achieve high quality and efficient care, and to ‘avoid tragedies’ (Cooper *et al.* 2004).

A brief study of the history of H&SC shows that placing an emphasis on team-centred healthcare provision to ensure that service users receive the best possible care has not always been the dominant model. The purpose of ‘caring’ for patients did not exist until the eighteenth and nineteenth centuries when hospitals moved away from being ‘instruments of repression’ and started to focus on becoming ‘important institutions in the delivery of healthcare’ (Waddington 2011, p145). The point at which those involved in all H&SC occupations and professions started to co-operate, that is to work collaboratively and *interprofessionally*, in order to provide and improve service user care, is harder to locate. Many histories of the various H&SC roles do exist, but are written with a focus less on professional co-operation than on exploring and understanding their own journey to ‘professionalisation’ (see for example Dingwall *et al.* 1988; Lane 2001). Leathard (1994) suggests that the background developments for interprofessional working were laid in Britain in the 1970s, with the

'pressure to go inter-professional' increasing considerably as a result of government policy from the mid-1980s, and 'noticeably in the 1990s' (p9). Both the Local Government and Housing Act 1989 and the NHS and Community Care Act 1990, for example, placed a great deal of emphasis on inter-agency co-operation and information sharing between local authority social services and healthcare providers. Consequently, successful H&SC delivery in the modern health care system is now seen to depend upon the effectiveness of a professional team made up of members from many different professions. Subsequently there has been (and still is) much debate about how to best educate and prepare health and social care students so that when they graduate they are ready to work in teams involving two or more professions. The primary aim of this thesis is to explore the way in which H&SC professionals perceive their professional identity and consider what interrelationship this has with their interpretations and experiences of interprofessional education and working.

The concept of 'interprofessional education' (IPE) emerged in the late 1980s. In the UK the concept developed alongside the formation of CAIPE (Centre for the Advancement of Interprofessional Education), who were responsible for the definition of IPE as it is now most commonly recognised; where two or more professions 'learn with, from and about each other to improve collaboration and the quality of care' (CAIPE 2002 from CAIPE website; Hammick 2007). Thus, 'interprofessional education' was considered a step further on than 'shared-learning' models, with the focus of IPE being on collaborative practice and 'on interactive learning between [the] different professional groups involved' (Leathard 1994, p29). While questions remain over whether educating H&SC students together using IPE results in graduates who are better able to work in multi-professional teams than those receiving other forms of education (Thistlethwaite 2012; Craddock *et al.* 2006; Pirrie *et al.* 1999), it is accurate to claim that by the 2000s IPE had become the dominant discourse – 'the way forward' – for improving H&SC provision. In the UK, this approach

was particularly prevalent, as can be seen in the developing policy framework of the Health Act 1999 and Health and Social Care Act 2001 which, as Cooper *et al.* argue, paved the way for 'requisite structural and organisational change' (2004, p179).

Such a change in emphasis toward IPE is also evident in '*Tomorrow's Doctors*', the General Medical Council's (GMC) 'standards for knowledge skills and behaviours that medical students should learn at UK medical schools' (GMC Website), first published in 1993. The 2003 version stipulated that graduates needed be aware of both current developments and the guiding principles in the NHS, including understanding 'the importance of working as a team within a multi-professional unit' (GMC 2003, p15). The 2009 version of the same document was much more explicit concerning the standard of interprofessional behaviour expected from graduate doctors, highlighting that they need to be able to both learn and work in multi-professional teams, understand and respect the expertise and roles of other H&SC professionals as well as understand:

...the contribution that effective interdisciplinary teamworking makes to the delivery of safe and high-quality care.

(GMC 2009, p27)

IPE is also a significant issue on the international policy agenda. In 1988 the World Health Organisation (WHO) published *Learning Together to Work Together for Health*, an influential report which reviewed multi-professional education initiatives throughout the world, and which recommended that such educational initiatives should be promoted as a complementary aspect to the education of health professionals (and offered suggestions as to how such initiatives may be instigated). By 2010 the WHO had published a '*Framework for Action on Interprofessional Education and Collaborative Practice*', in which it is stated:

The WHO and its partners recognize interprofessional collaboration in education and practice as an innovative strategy

that will play an important part in mitigating the global health workforce crisis. (WHO 2010, p7)

However, while answering this call to 'interprofessional arms', it is recognised that H&SC professionals must still be trained to their own regulatory body's professional standards, and be able to perform their own roles, carrying out profession-specific tasks that they are in the healthcare organisations to provide; they must work in an interprofessional way (that is, collaboratively, with other professions) while in essence 'maintaining' their own 'discrete' professional identity (Pirrie *et al.* 1999; Hornby and Atkins 2000). In order to understand 'hindrances' to collaborative, interprofessional working it is therefore important to understand the concepts of 'identity, role and boundaries' (Hornby and Atkins 2000, p97).

The notion that professional identity partly develops through a 'socialisation' process in the health and social care professions has become a popular theory, explored in various ethnographic studies of the professions since the 1960s, and perhaps most famously in health and social care in Becker *et al.*'s 1961 study '*Boys in White: student culture in medical school*', although it is a concept that can be applied to all H&SC professions. Socialisation into a profession is understood to be a complex process, but one of the key parts is exposure to professional behaviour and interaction in the 'real world', through what Thompson and Ryan (1996) refer to as 'fieldwork' experiences, but what in the UK are more commonly referred to as 'placements'. Nevertheless, while socialisation is a recognised part of professional identity formation, the concept of professional identity (explored in detail in Chapter Two) is contested and debated, with no single, agreed definition.

Olckers *et al.* (2007 p2) argue that professional identity is widely accepted to be associated with the way professions perform their roles and that developing such an identity is often associated with the 'internalising' of 'professionalism'. Notably, conceptualisations of professional identity are commonly linked to single-professions, so that people performing those

roles have such identities as, for example, 'doctors', 'nurses', 'midwives' or 'social workers'. As such, professional identities have been depicted as a 'barrier' to interprofessional education and working (see Elston and Holloway 2001). However, more latterly an emerging tension in the academic debate surrounding IPE and professional identity stems from IPE being portrayed as something that strengthens individual professional identities (see Jakobsen *et al.* 2011). Chapter Three explores in depth the evidence in the literature that supports both sides of this argument.

In this thesis, I suggest that in order to enable H&SC professionals to better work together, it is fundamentally important to understand what relationship exists between IPE and professional identity, because of the impact that professional roles and (inter)professional working have on service user care. The need to understand this relationship is recognised by Cameron (2011, p53), who suggests there is a:

...need to move beyond the current focus on the role of education, training and regulation which structure professional boundaries to appreciate the 'human and social aspects'...in order to understand how individual professionals perceive and experiences the boundaries between professional groups.

To reiterate, exploring the interrelationship between perceptions of professional identity and the way in which H&SC professionals interpret and experience interprofessional education and working is therefore the primary objective of this thesis.

1.2 Background to the study

I first became aware of the concept of 'interprofessional education' when I started working for the Assessment and Learning in Practice Settings (ALPS) Centre for Excellence in Teaching and Learning (CETL). ALPS was initially funded as a five year programme by the Higher Education Funding Council for England (HEFCE) as one of 74 CETLs in the country. ALPS

involved sixteen H&SC professions across five Higher Education Institutions (HEIs) in West Yorkshire, as well as partnering with professional bodies, the (then) West Yorkshire and the Humber Strategic Health Authority (WYHSHA) and practice networks. The ALPS mission was:

to explore ways which ensured that students from courses in Health and Social Care graduate fully equipped to perform confidently and competently at the start of their professional careers. (ALPS Website)

There were many strands to the ALPS programme of work, but one of the main aspects was to develop a series of 'Common Competency' maps that were relevant to all sixteen H&SC professions involved. From these maps, a series of assessment tools was developed for students to use while out on practice placement, with one of the key features of the tools being that they involved an element of interprofessional feedback – i.e. the student would receive feedback from either staff or students in professions other than the one they were training to join.

While already aware of a body of literature on the sociology of the professions, it was during the development phase of the ALPS maps and tools that I became conscious of academic debates on the 'tribalistic' nature of H&SC professions and the way in which allegiances to professions were sometimes depicted as a barrier to people from different professions working successfully together (Carlisle *et al.* 2004; Smith and Roberts 2005). As a result, I questioned what impact, if any, a long-term large-scale interprofessional project such as ALPS would have on the professionals who were involved in it. In particular I was interested on the impact of such a project on staff involved in developing and delivering it, rather than on students taking part in the programme. This was because I considered that some of the opinions expressed by staff involved in ALPS were indicative that their opinions could be one of the barriers to an interprofessional programme of work being implemented successfully.

Resultantly, I wanted to further explore what IPE qualified staff had themselves experienced, in order to consider the impact of these experiences on IPE programmes they were subsequently involved in facilitating.

As is discussed in Chapter Three, most of the existing literature on IPE focuses on students, including a large body of work on their 'readiness' or willingness to engage with interprofessional material (see for example the works of Parsell and Bligh 1999; McFadyen *et al.* 2006). The literature that does concentrate on staff perceptions of IPE most commonly focuses on the organisational structures that restrict interprofessional initiatives and on ways to address this (Deutschlander *et al.* 2012; Salfi *et al.* 2012; Reeves *et al.* 2007). However, there is a growing recognition of the need for staff to be 'signed up' to the idea of IPE and to be well-trained for it to 'work' (Williamson *et al.* 2011; Anderson *et al.* 2011). As socialisation is such an important part of developing professional role and identity (see Chapter 2), for IPE to achieve its aims of improving service user care by preparing students to communicate and work more effectively in interprofessional teams, part of the success of this process will rest with those *doing* the 'socialisation'.

Meerabeau (1998, p83) identifies two broad analytical approaches to occupational socialisation:

1. the induction approach, which derives from functionalism, focuses on the acquisition of professional roles, but takes motivation for granted and neglects the expectations which individuals bring with them...
2. the reaction approach, which analyses how students react to their educational experiences, explores their motivation, and regards the training institution as an independent social unit.

However, neither of these approaches encompasses the entire approach of this thesis. While the acquisition of professional roles through both formal and informal learning is a concern of this research, the impact of pre-

existing ideas concerning professional identities is viewed as an important part of identity formation (Chapters Two and Six). The reaction of students to educational experiences of students are also understood here as key to the socialisation experience, but this thesis is additionally concerned with exploring the opinions of those responsible (in part at least) for 'doing' the socialisation, the practicing and academic staff who influence the experiences of students.

The influence of staff as professionals, both in an academic and practice environment is potentially very great, as they will likely be the first role models for students in their chosen profession. I therefore argue that the focus of this thesis, which involves understanding the attitudes of (some) qualified H&SC staff towards professional identity and IPE, that may have arisen as a result of experiences of IPE, is an extremely important area of research, because it may yield knowledge about the successful implementation of initiatives that could lead to more effective collaborative practice.

Another advantage to focusing the research on qualified H&SC staff is that these groups already possess a 'professional identity' – that is, an identity as a 'practicing professional'. Focusing the research on students would be complicated and far more questionable in terms of its results, as students are likely to be still developing their 'professional identity[ies]' and, at the very least, would have a dual identity associated with being a 'student' of a 'profession'. As such, to explore potential relationships between perceptions of professional identity and IPE, it was more appropriate to focus the research on qualified staff, and offers a different approach to the study of socialisation than the two previously identified by Meerabeau (1998).

1.3 Terminology

At this juncture it is important to define some of the terminology that will be used throughout this thesis. The terms 'interprofessional', 'multi-

professional' and 'multi-disciplinary' are sometimes used interchangeably, as if they describe the same phenomenon (Craddock *et al.* 2006, p221). However, as already discussed, the term 'interprofessional' does have a specific meaning *when applied to education* and is now commonly understood and accepted to refer to occasions where two or more professions 'learn with, from and about each other to improve collaboration and the quality of care' (CAIPE 2002). It is the emphasis on learning *with* and *from* one another to which I refer whenever the term 'interprofessional' is used in this thesis. The concept of 'multiprofessional' I define as when more than one profession contributes to an educational initiative or work practice, but where there is little or no interaction or learning between the professions. Nevertheless, as Leathard (1994, 2003) indicates with a long list of alternative terminology, contrasting definitions of 'multiprofessional' and 'interprofessional' have been described as a 'semantic quagmire' (Craddock *et al.* 2006, p221, citing Leathard 1991 and McPherson *et al.* 2001). As such, even though I am using 'interprofessional' and 'multiprofessional' to mean separate things, unless it is explicitly stated, it cannot be assumed that other authors make the same distinction.

Applying the term 'interprofessional' to working is not so clear cut, with there being no suggestion that 'interprofessional working' is in any way different or distinct from 'multiprofessional working'. However, the concept of interprofessional 'collaborative practice' could be argued to describe more usefully the intended outcome of IPE, with the interactional nature of IPE more likely to enhance 'collaborative practice' than either multiprofessional or uniprofessional education (Reeves *et al.* 2008, p3). It is the term 'collaborative practice' that I shall therefore use throughout this thesis to describe meaningful interprofessional working.

Lastly, I have throughout this chapter referred to all health and social care occupations as 'professions'. As will be discussed in Chapter Two, this label can be somewhat problematic, with a long history of debate over which occupations are entitled to such a label (and accompanying status). Nevertheless, for ease of discussion I shall continue to use 'professions' and

'professionals' as the collective label for those working in health and social care, while the detail of how accurate this is discussed in the following chapter.

1.4 Research questions

The overarching aim of this study is to understand how practicing H&SC professionals perceive their own professional identities and how this relates to what they consider their professional roles and boundaries, which will be addressed by answering the following inter-related research questions:

1. How do practicing H&SC staff conceptualise their professional identity, and the professional identity of other professions with whom they work or learn?
2. Do practicing H&SC staff perceive that 'professional identities' are reinforced, challenged or changed by interprofessional education and / or collaborative practice?
3. What implications do conceptualisations of professional identities and IPE have for the implementation of educational initiatives aimed at improving teamwork between professions for the ultimate aim of improving service user care?

Using a case study approach, one further research question is addressed to help answer the three main research questions cited above:

4. What impact does the implementation of a large-scale interprofessional programme have on staff involved in delivering the programme?

The study is also concerned with understanding how health and social care staff regard IPE; this is based not only upon their experiences but also upon their perceptions (which may not be based on any experience of IPE). In the analysis, attention is given to whether there is a link between perceptions of interprofessional experiences and perceptions of

professional identity. The study was started under the premise that it is possible that there is no 'link' between professional identity perception and IPE / collaborative practice, but that this itself would have implications for the way that IPE is conceptualised and consequently how it is taught. The study was not therefore designed to look explicitly for a 'link'; rather, it is concerned with exploring whether it is possible to establish such a link. As such, the research is exploratory in nature and the methods adopted (discussed in Chapter Four) reflect this. The nature of undertaking 'identity' as a research topic also means that the study makes no claims that the findings could be generalised to the entire H&SC staff population. Instead, individual perspectives are explored that, if contributing to a 'cohesive picture' of interpretations of professional identity, may have implications for the way IPE is developed and delivered.

1.5 Context: IPE and understandings of 'learning' and 'practice'

The premise of interprofessional education – IPE, the theories and evidence underlying approaches to it, are covered in detail in Chapter Three. However there are also associated concepts that will benefit from discussion at this juncture, as their definition impacts upon understandings and interpretations of any form of educational initiative, but in this instance IPE. In particular, the terms 'learning' and 'practice' require definition, although the task of defining each of these could, and indeed has in the past, taken entire chapters and books. The definitions given here are therefore necessarily brief, and are not intended as a complete summary of the much wider academic debates which surround their use, but are presented here only to outline the context in which the terms are understood and used in this thesis.

Following a sociocultural perspective, professional learning is understood here through the 'participational' metaphor of learning, where 'knowing is...situated in activity and therefore is particular to settings and communities' (Fenwick and Nerland 2014, p3). This is in contrast to the

conceptualisation of learning as ‘acquisitional’, that is as an individual experience that involves ‘the acquisition of disciplinary and problem-solving competencies in knowing what to do, how and why’ (Fenwick and Nerland 2014, p2). Simultaneously, and from the same sociocultural perspective, ‘practice’ is understood to involve ‘practitioners knowing and learning in everyday activity’ (Fenwick and Nerland 2014, p3). Thus it is possible to understand that ‘learning’ cannot be separated from ‘practice’ because from this perspective one necessarily involves the other.

The purpose in this thesis of using this approach to ‘learning’ and ‘practice’ is that they highlight the importance of understanding ‘situatedness’; that is, they are based on the premise that the social situation and the material setting must be considered as the context for ‘knowing, working, learning and innovating’ (Gherardi 2014, p12). Such methods highlight the extremely complex and challenging nature of understanding an educational innovation such as IPE, which is intended to result in organisational change. While, as has been acknowledged, the sociocultural understandings used here are only one of a number of interpretations of ‘learning’ and ‘practice’, they do raise questions about the extent to which IPE is based upon an ‘over-simplified understanding of work, learning and change’ (Kilminster and Zukas 2007). Using such a lens is thus particularly useful in a project concerned with exploring the impact of IPE on professional identities, which must be understood to involve a web of enmeshed activity and not a straightforward, linear relationship. It is in this context which IPE and professional identity are discussed throughout this thesis.

1.6 Approach to ‘identity’

The approach taken to identity in this thesis is a sociological one. While there is much work grounded in psychology on the topic of identity, such approaches tend to focus on the individual conceptualisations of ‘the self’, where sociological perspectives are concentrated around the notion that

identity is 'fundamentally social and collective' (Lawler 2008, p1). The focus of this thesis concerns 'professional identity', that is an identity that can only be earned through membership of a group (as one of many, simultaneous 'identities' that an individual may possess at any given time). As such it was important for the theoretical approach to identity to be able to provide explanation for the significance of an individual being labelled as a member of a professional group, and simultaneously, as *not* being labelled as something else. This discussion is elaborated in detail in Chapter Two.

1.7 'Interprofessional Responsibility'

The notion of 'interprofessional responsibility' is an emerging theme of the work of the entire thesis. The results of the literature review, case study and interview data all raise questions about the extent to which professions – either individually or collectively depending on the context, have a responsibility to engage with, share best practice concerning, or educate their own members about, interprofessional education and collaborative practice. In the final chapter, the thesis also questions the extent to which individual H&SC professionals should view 'interprofessional responsibility' as part of their own professional identity, and the extent to which this may be achievable. The term is defined here, then, as any instance where an individual professional or profession as a whole could be perceived to have a responsibility concerning interprofessional behaviour.

1.8 Structure of the thesis

The arguments of this thesis are presented in the following order:

Chapter Two outlines dominant theories concerning professional identity. It is argued that to understand concepts of professional identity, it is first essential to understand how 'professions' have been conceptualised and

how, through earning the status of a profession, occupations adopt and present a professional identity. Attention is given to various theories of identity, and how it is possible for professional identities to be viewed as tribalistic or even as 'subcultures', resulting in the need for students to be socialised into their profession by 'good' role models. The extent to which members of health and social care professions have been able to lay claim to a professional identity is also discussed.

Chapter Three presents an extensive review of the literature on IPE, and critically evaluates previous research and theories concerning IPE. It argues that a large amount of attention has been given to work on student 'readiness' for interprofessional learning and staff and student perspectives about IPE, at the expense of developing evidence-based practice for IPE interventions. The chapter then explores existing research on staff perspectives on IPE, and discusses the outcomes, relevance and implications of existing studies linking professional identity to IPE. Finally it questions whether there is a need for 'interprofessional responsibility' to be incorporated into individual professional identities, and discusses the potential implications of this for introducing IPE into curricula.

Chapter Four discusses in detail the methodologies used to complete the empirical elements of the research – namely, surveys, semi-structured interviews, and a case study, and outlines the methods used to analyse the collected data.

Chapter Five presents a case study of the ALPS CETL. It describes the aims and objectives of the CETL and goes on to explore the evidence for how successful ALPS was at achieving its aims relating to the introduction of interprofessional teaching and assessment. Using interview data collected for this study, it then examines what impact staff involved in the CETL perceived that being involved in a large-scale interprofessional programme had on them as individuals, their departments and the institutions which they work for. In this chapter, the question of 'interprofessional responsibility' is raised regarding whether larger professions should invite

and include smaller professions to take part in interprofessional initiatives, in order to ensure that best-practice is shared as widely as possible.

Chapter Six presents further findings from the empirical research carried out specifically for this thesis. After outlining some of the key findings from the survey, it outlines several recurring narratives which emerged from the interviews, and relates these to the literature discussed in earlier chapters. In particular, attention is paid to the notions of 'intra-professional' and 'academic / teaching' identities, as well as to the suggestion that professional identity can be a hindrance to patient care. It also returns to one of the key themes of this thesis, the notion of the need to incorporate 'interprofessional responsibility' into individual professional identities.

Chapter Seven is the concluding chapter which summarises the key findings and central arguments of the thesis, and discusses the possibilities and directions for future research. While recognising that the narratives told around professional identities and experiences of IPE were unique to the participants of this research, it also proposes that there are broader implications for the findings of this work, for both the introduction of IPE into curricula and also for the further study of professional identities in H&SC.

Chapter Two

'Professions', Professional Status and Professional Identity

...all professionals are laymen to the other professions...

-Harold Perkin (2002)

This chapter explores all aspects of 'professional identity', by first explaining why professional identity and status are so important, and still worthy of study. It then discusses in detail how 'identity' and 'professional identities' have been theoretically conceptualised, before going on to explore how the specific professional identities of a number of different H&SC professions have developed by looking briefly at their history and claims to a 'professional identity'. Finally, the chapter explores some notable points for consideration arising in the study of identity such as the concepts of 'occupational ideology and vocation' and the issues of tribalism and silos working.

2.1 Why defining 'professional identity' is important

Exploring and explaining identity has been a key concern of social theorists for many years. Nevertheless, as will be made evident in this discussion, there is no consensus around what identity 'is', and no agreed, simple definition that encapsulates 'an' identity. However, despite differences in interpretations of the *reasons* behind it (such as individual, social and cultural transformations), much work exploring the subject recognises that 'identities' change over time and context, and are dependent upon interpretations made by the self and others. These ideas play a key role in trying to understand how people define, and interpret, their own 'professional identity'.

As made clear in this chapter, and previously, 'identity' is very much associated with situation – that is, with the time and space in which it is being viewed or experienced. The 'professional identity' of a doctor, nurse

or any other H&SC professional is likely to vary greatly from country to country, as it will be associated with the educational systems and expected role that each profession fulfils in each location. As such, unless otherwise specified, the majority of the following discussion on professions and their history refers specifically to the UK, where this research was undertaken, and is therefore most relevant to later analysis and discussion of empirical data collected specifically for this project.

Why then is understanding 'professional identity' so important? As Woodward (2002) suggests, being able to 'lay claim to an identity' distinguishes us from others; it not only 'marks us out as sharing culture [or] experience with those whom we identify' but also results in the ability to exclude or 'exile' those who do not share the same identity (p156). McDonald (2004) also notes that sharing a common, stable identity can advance practice for H&SC professionals and that conversely unmanaged, unstable identities can lead to feelings of disempowerment. Being able to 'lay claim' to a 'professional identity' is therefore important because of what such an identity means to both individuals and professional practice; and so to understand why professional identity is so important, it is firstly necessary to understand what it means to be a member of a 'profession'.

2.2 The 'place' of professions in society

To be considered 'professional' has, historically at least, been considered desirable for occupations and individuals, because of both the status and the privileged position in society which professionals are afforded (Hughes 1971). However the concept of the profession/al is itself is historically specific and has long-been criticised as uncritical reproduction of the knowledge of those attempting to define it, usually 'professionals' themselves (Witz 1992; Brante 1988). These critiques, stemming from both sociological and feminist literature provide for some interesting academic debate, but do not detract from the 'desirability' of a professional status for occupations. Perkin suggests that the notion of a 'professional

society' is more complicated than being about a society dominated by professionals, with professional hierarchies transcending traditional class boundaries and allowing many occupations to aspire to professional status, with the consequence that many jobs have 'become subject to specialized training', allowing them to 'claim expertise beyond the common sense of the layman' (2002, p3). It is argued that being able to claim such a status brings rewards – a claim examined here – which itself makes professional status and identity as a 'professional' desirable. Macdonald suggests that:

The professional project is intended to secure for its members economic and social advantage, thus achieving upward social mobility. (1995, p63)

While Becker *et al.* also propose:

In our society, among the most desired and admired statuses is to be a member of a profession. Such status is attained not by going into the woods for intense, but brief, ordeals of initiation into adult mysteries, but by a long course of professional instruction and supervised practice. (1961, p4)

To achieve a professional status is therefore seen as desirable for individuals; but to do this they must first earn membership of an occupation which *itself* is regarded as a 'profession'. The achievement of 'professional status' by occupations has in itself been the topic of sociological study and debate for a number of years, and is worthy of some attention at this juncture.

Many academic works have attempted to define 'professions' by the 'traits' they possess, with the consequence that 'professional status' is seen as being achieved once an occupation can lay claim to possessing such attributes. This body of work, often referred to as the 'trait approach', defines professions as possessing 'systematic theory, authority, community sanction, ethical codes and a culture' (Greenwood 1957, and similarly Horobin 1983 and Atkinson 1983). The trait approach is, however, widely regarded as problematic due to the way in which it delineates professions

with an 'idealized conception of the characteristics of the archetypal professions – medicine and law' (Abbott & Meerabeau 1998, p4). Wilding suggests that a key problem in defining 'professional' using the trait approach is that there seems to be an 'endless search for one true profession, an archetypal, ideal type...exuding the very *esse* of professionalism' (1982, p3), whilst Freidson argues that one cannot define a 'profession' by 'struggling to formulate a single definition which is hoped to win the day' (1983, p35). In a later in-depth discussion on 'identifying professions' Freidson also suggests that the problem of definition is created by:

...attempting to treat profession as if it were a generic concept rather than a changing historic concept with particularistic roots in those industrial nations that are strongly influenced by Anglo-American institutions. (1986, p32)

Ultimately, using a trait approach has been dismissed as unhelpful because it focuses on what professionals claim to do (Abbott and Meerabeau 1998, p4). Abbott and Meerabeau propose that alternative conceptualisations are considered, such as Becker's (1971) proposal that the concept of 'profession' is a symbol attached to some occupations but not others, or Freidson's (1986) suggestion that it is more helpful to use the notion of 'professionalism' as used in practice. However, whilst *using* a trait approach may now be considered an inappropriate and misleading way to define the professions, it remains important and must be referred to because of the considerable contribution it has made to academic debate around the subject. It also highlights how professions have been viewed historically, which is important when trying to understand the attributes to which occupations may have been expected to aspire in order to become professions.

Whether one accepts that a set of 'traits' can define a profession as a full or partial list, there is nonetheless one attribute referred to as defining access to a professional status above all others: *knowledge*. However, as already

discussed, it is not just access to facts and figures that turn a layman into a professional; it is the training in how to use and apply them, what Freidson (1986) defines as 'formal knowledge'. Today, it could be argued that the notion of the 'all-knowing professional' is far less stable than in the past, because of the way in which the internet can be used to acquire information, something previously only in the domain of professionals. The 'systematic theory' owned only by professionals in the past is now often available for all to access, but it is the training received by professionals that still provides the distinction for what can be done with such information, turning it in to usable skills and knowledge. Eve and Hodgkin (1997) add to this by highlighting that 'professionalism' is about using this knowledge in the 'affairs of others':

A professional task is one which requires the exercise of discretion or initiative on behalf of another in a situation of complexity. (p70)

However, they suggest that, ideally, the definition of a professional task would be:

...where one person exercises discretion *with* another in a situation of complexity *ensuring so far as possible that all necessary information, together with any financial incentives and constraints which the professional may be under, are transparent to the patient or client.*

(Eve and Hodgkin 1997, p84, original emphasis)

Although they recognise that such a feat is not likely to be achieved easily, and would be reliant upon 'sophisticated information technology'. But this, they suggest, is the way that professionalism will adapt and survive in a 'rapidly changing world' (Eve and Hodgkin 1997, p84). While it is clear that this is an 'ideal type' description of the role performed by professionals, it does highlight the significance of other characteristics that arise when professional knowledge is used: *trust* and *power*.

Giddens proposes that trust is *necessarily* involved in a relationship where one member of that relationship has much less access to knowledge than the other:

Trust is only demanded where there is ignorance – either of the knowledge claims of technical experts of the thoughts and intentions of intimates upon whom a person relies...Thus trust is much less a leap to commitment than a tacit acceptance of circumstances in which other alternatives are largely foreclosed.
(1990, pp89-90)

The necessity for a trust relationship between professionals and their clients (or patients) can be seen as an example of what Weber (and subsequently Parsons) refer to as a 'legitimation' of power (Dingwall 1983, p2). Foucault interprets the process by which professionals achieve power and dominance. He describes that 'discipline' has a double meaning, being both a result of formal knowledge and a 'consequence of its application to the affairs of others', and results in power being gained through the 'normalization' of such 'disciplines' as health care (amongst others) (Freidson 1986, p6). In terms of financial reward for such knowledge, Perkin (2002) argues that members of professions are no different from any other members of society (from the 'richest capitalist' to the 'most unskilled labourer') when it comes to the 'economic battle' for their services, but that the difference for professionals is that:

...beyond the layman's knowledge or judgement, impossible to pin down or fault even when it fails, and which therefore must be taken on trust...[the professional] is dependent on persuading the client to accept his valuation of the service rather than allowing it to find its own value in the marketplace. (p117)

The consequence of doing this successfully, Perkin argues, is what leads to professionals rising above the 'economic battle', with the result that it is in the interest of those afforded this status to:

play down class conflict...[and] play up mutual service and responsibility and the efficient use of human resources.

(2002, p117)

Trust and power, it could therefore be argued, are a desirable part of being a professional, allowing freedom and control over their own work. On the other hand, it could be suggested that the consequence of being afforded trust and power are the responsibilities of holding such status, of being seen always to do the 'right' thing and to take the blame when things go wrong. Freidson also argues that the relationship between professional status and power represents two diametrically opposed views; the first, following Foucault and others, that it is the professions who are rewarded by dominance and as such have a great deal of influence on state policy and on the affairs of individuals; the second, that professions are 'passive instruments of capital, the state or their individual clients' and that as such they have little or no control over policy or their own affairs (Freidson 1994, p31).

For the purposes of this thesis, I would suggest that the first of these theories is still the most relevant to the health and social care professions in the UK today. Whilst it may be true that today people are more inclined to question professionals (and those in positions of power), it is still the case that health and social care occupations are regulated by professional and regulatory bodies made up of their own members (albeit often with representation from other professions). This gives those in H&SC the ability to define their own 'systematic theory' and 'ethical codes', and suggests that they are not entirely passive instruments of the state. On an individual level, H&SC professionals can also be seen to hold power in the sense that clients / patients who need expert advice and opinion must consult professionals when they perceive there is no alternative, and also must accept their diagnosis or judgement without knowing if they are being given the 'right' information. The nature of this type of contact with clients is what leads to the need for a code of ethics (Millerson 1964, p153).

Whilst association with certain attributes (such as having a 'code of ethics' or 'systematic theory') may define (or be a result of) the 'professionalisation' of an occupation, there is a further distinction to be drawn between the occupation as a 'profession', and the individual as a 'professional' who displays 'professionalism'. As Johnson (1972) suggests:

It is not at all clear then that professionalisation refers to the same process as occurs when claims for professional status are made. However, *professionalism is a successful ideology* and as such has entered the political vocabulary of a wide range of occupational groups who compete for status and income. (p32, emphasis added)

As an individual, being a member of a profession dictates the need for a certain standard of conduct to be met, and by adhering to and displaying that standard through one's 'professionalism', an identity as a professional can be gained and reinforced (or, in cases where the standards are not met, denied). Nevertheless, understanding the various interpretations and nuances of the terms 'professional' and 'professionalism' still only represents half the story of why 'professional identity' remains both difficult to describe and define and, the key to understanding professional roles. The following section explores some theories of identity in order to complete this task.

2.3 Identity and Identities

Identity and identities have long been considered to be 'socially produced', with a variety of interpretations focusing on the 'mechanisms' by which identity can be 'achieved' (Lawler 2008, p1). For George Mead, whose approach came to be known as symbolic interactionism, the self is something that develops: 'it is not initially there, at birth, but arises in the process of social experience and activity' (1934, p135). For Mead, the 'self' could only be understood and given meaning in relation to other people, based upon the interactions with others and the meanings given to those (inter)actions. Indeed, for Mead, the 'self' did not exist without

communication, and he proposed that the self develops as part of the communicative process, suggesting that: 'it is impossible to conceive of a self arising outside of social experience' (1934, p140). Developing the arguments of Cooley and James, Mead proposed there was a distinction between the 'I' and the 'me', with the process that links the two and develops the 'self' being the interactions between the internal 'inner dramatization, by the individual' and the external 'conversation of significant gestures' with 'individuals belonging to the same society' (1934, p173):

Thus 'I' understand myself through imagining how I am understood by others – as 'me'. (Woodward 2002, p9)

Consequently any meaning given to the 'self' (our 'self-consciousness' – and therefore our identity, and our interpretation of the identity of others) comes through a shared understanding of language.

Mead's interpretation of the 'self' also allows for the possibility that the 'self' can have multiple identities, so that in different social contexts we can, or are required to, 'present different selves' (Woodward 2002, p9), a theme also developed by Goffman. Goffman (1959) contributed to discussions on the interpretation of identity by suggesting that the 'self' can be both presented and interpreted through a series of signs. Using the metaphor of the stage to explain how people 'perform' or 'act' their 'roles' in a variety of 'settings', Goffman suggested that:

A setting tends to stay put, geographically speaking, so that those who would use a particular setting as part of their performance cannot begin their act until they have brought themselves to the appropriate place and must terminate their performance when they leave it. (1959, p33)

Using this interpretation, one can understand how it is possible to have, or to be seen to have, different identities in different places; thus one can have a different identity at work than in one's personal life. As with Mead, Goffman's work also has implications for the notion that identity is open to

interpretation, and that the 'self' that one hopes to present is not necessarily interpreted correctly by the 'audience'. Goffman talks about the subsequent need for 'impression management' to enable a 'performer' to successfully 'stage a character' (Goffman 1959, p203), but he also acknowledges that under certain circumstances, 'misrepresentation' may be desired by the 'performer[s]' (Goffman 1959, p65 - 73) – for example, by acting as if everything is fine when there is a problem the 'performer' wishes to conceal from the 'audience'. The theories that both Mead and Goffman offer also suggest that identity is not static; it can be situation and context specific, and as such individuals can have multiple, simultaneous identities.

Garfinkel's ethnomethodological approach also has relevance to theories of identity. Garfinkel proposed that the self is produced through social interaction, and as such, the 'self' can change from moment to moment, dependent upon whom the person is interacting with, the context of that interaction, and the (meaningful production of) interpretation placed upon that interaction by the social actors involved. However, in attempting to define 'the factual world', Garfinkel was concerned to use only the 'observable-and-reportable' to describe how people organize and make sense of their lives and produce and present their identities (Garfinkel 1967). Garfinkel's work has been criticised because of its tendency to describe what we already know, and its failure to take a firm theoretical position (Woodward 2002, p12), but it does further support the notion that one person (or self) can have multiple and simultaneous identities.

More recently, academic narrative on identity has turned its attention to the extent to which people are able to shape, and actively participate in constructing their own identities (Woodward 2002; Calhoun 1994). Michel Foucault's (1988) work on the 'technologies of the self', explored how subjects 'actively constitute themselves, through engaging in the cultural practices of everyday life' (Woodward 2002, p30). Giddens (1991) discusses the reflexive nature of the self in an age of modernity, suggesting that coherent but continuously revised biographical narratives take place

in the 'context of multiple-choice filtered through abstract systems' (p5). He goes on to suggest that the question "how shall I live?" has to be answered in day-to-day decisions about how to behave' (p14). Similarly, Bauman states:

One becomes aware that 'belonging' and 'identity' are not cut in rock...that they are eminently negotiable and revocable; and that one's own decisions, the steps one takes, the way one acts...are crucial factors of both. (2004, p11)

It is therefore possible to argue at a theoretical extreme that identity is not only constructed but self-constructed, that we can appear as we desire to appear in different places and at different times, and that we can, to some extent, control this through the choices that we make and through our behaviour. This point needs to be considered alongside the 'structural' influences on behaviour such as culture, which are particularly important when considering those aspects of identity related to professional behaviour. However, Calhoun indicates that the strength of using theories grounded in social constructionism (that is theories with an emphasis on the socially created nature of social life - such as those presented here) is that 'they challenge...the idea that identity is given naturally and the idea that it is produced *purely* by acts of individual will' (1994 p13, emphasis added). Such theories provide useful lenses through which to examine perceptions of professional identity and identities.

A further important contribution to exploring and explaining identity focuses on the extent to which identity should be understood as, and through, narrative. Somers and Gibson suggest that theories of identity should focus on the substantive nature of the narrative, and acknowledge that 'social life is *storied*':

... people construct identities (however multiple and changing) locating themselves or being located within a repertoire of emplotted stories. (1994, p38)

Lawler, following Ricoeur (1991), highlights how 'emplotment' (that is, the process by which a plot *becomes* a plot 'through action or transformation and characters') is central to the understanding of 'narratives' (Lawler 2008, pp14-15). She suggests that [through this perspective]:

The self is understood as unfolding through episodes which both express and constitute that self...So identity is not something foundational and essential, but something *produced* through the narratives people use to explain and understand their lives.

(Lawler 2008, pp16-17)

However, Somers and Gibson suggest that people act only within the limited range of narratives available to them:

...people make sense of what is happening to them by attempting to assemble or in some way integrate these happenings within one or more narratives; and...are guided to act in certain ways, and not others, on the basis of projections, expectations, and memories derived from multiplicity but ultimately limited repertoire of available social, public, and cultural narratives. (1994, pp38-39)

Lawler also warns that using narratives to explore identity can be misleading, where people 'borrow' from the stories of others by not being who or what they claim to be (often interpreted as 'a breach of fundamental social rules') (2008, p30). I would suggest, however, that this is a danger for all work on identities and not just those focusing on narrative; the extent to which one accepts the 'performance' of the 'identity' presented must surely be an occupational hazard of those studying identity, resulting in a need for a degree of critical reflection during analysis. Additionally, it has been recognised that narratives are representative only of the time at which they are gathered: they express current views 'rather than being actually representative of the future or past' (Beech and Sims 2007, p300). Nevertheless, as narratives 'can highlight the ways in which lived experiences and identities are *embedded in relationships*' (Lawler 2008, p30, emphasis added), interpreting

narratives is a particularly useful tool for a study exploring identities which can only be achieved through membership of a group – an occupation which is itself perceived to be a profession.

The theories examined so far have shown how the identity of an individual may be described as one of multiple, simultaneous identities, how it may be ‘acted’ and ‘interpreted’, shaped by selves and others, and understood, at least in part, through exploring the narratives which people use to explain their lives. Nevertheless, another important feature of ‘professional identity’ is the notion of a *group identity* – that is to say, while an individual earns the right to call themselves a ‘professional’, they do so by becoming a member of a profession, composed of a group of individuals who have also earned the right to be viewed and described as professional. Wenger (1998) suggests that professional identity is mutually constituted between individuals and groups, and develops through the learning by participation in practice, while Kalet *et al.* (2002) propose that the key to developing a meaningful understanding of professional values and skills is the purposeful mentorship of students. These proposals relate to the view that one of the significant factors in professional identity development is how students are *socialised* into their profession – that is, how they are influenced by those with whom they come into contact and who share the same or similar identities: peers and tutors, practicing members of their profession and members of other professions. It is possible to see how the notions of ‘performance’ proposed by Goffman are particularly relevant to the process of socialisation, which can be described as a process of making a professional identity ‘believable’:

...the highly socialized member of a profession so plays his role that they appear inseparable from him...The development of a professional self-conception involves a complicated chain of perceptions, skills, values, and interactions. In this process, a professional identity is forged which *is believable both to the individual and to others.* (Lortie 1966, p98, emphasis added)

'Socialisation' is a concept that can be applied to all H&SC professions (see Adams *et al.* 2006) and has implications for IPE and collaborative practice because of the way in which negative experiences of, or negative discussions about, working with other professionals may reinforce undesirable behaviour towards - or stereotypes of - other professions. The implications are that there is a need for all practicing health and social care staff (including academic staff) to be good role models, regardless of whether IPE is delivered formally or not, to ensure that students are not exposed to negative attitudes or behaviour towards other professionals or to the concept of IPE. The topic of 'role-modelling' has itself been widely discussed in medical education literature, and is considered to be part of 'the hidden curriculum' (Pollard 2008). The process by which individuals absorb and acquire information in both formal learning settings but also in less-conscious ways through observation and non-formal learning has been noted to occur regardless or not of whether behaviours are desirable (Cheetham and Chivers 2005). Thus while the concept of socialisation is important to the understanding of the forming of professional identities, it is also associated with the forming of opinions and attitudes towards other professions and collaborative practice. Consequently this thesis aims to explore how perceptions of professional identities might be influenced by experiences of interprofessional education and working.

To a certain extent one could argue that a person does not choose to have a 'professional identity' and that, while for some it may become a welcome part of their personal identity, for others it may be a necessary but unwanted consequence of choosing a certain occupation. In health and social care this might arise from or reflect a desire to not have people revealing their health problems in social / recreational situations, but may also be because of the expected standards of upholding a professional identity and status, even while 'off-duty' and in personal spaces (such as social media sites). Nevertheless, it must be acknowledged that a professional identity indicates someone who upholds it as a member of a

group, and as a result, the 'social identity theory' (SIT) first developed by Henri Tajfel in the 1970s (Hogg 2006) is of some relevance.

According to SIT, the self-concept is comprised of personal identity encompassing idiosyncratic characteristics (e.g. bodily attributes, abilities, psychological traits, interests) and a social identity encompassing salient group classifications. Social identification, therefore, is the perception of oneness with or belongingness to some human aggregate. (Ashforth and Mael 2004, p125)

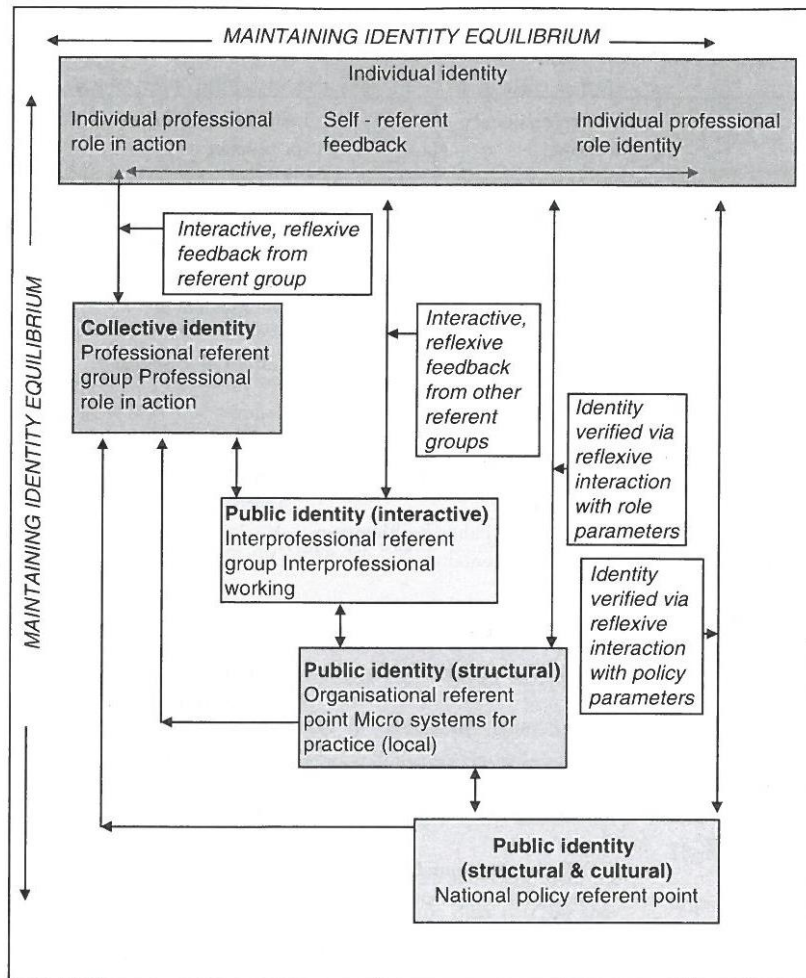
Tajfel suggested that social identity is, in part, about the emotional significance of belonging to certain social groups (Hogg 2006). Psychological studies based on SIT have implied that merely categorising an individual as a member of a group by apportioning a label (for example, being in 'group x') results in people discriminating in favour of their own group (Ashforth and Mael 2004 based on Brewer 1979 and Tajfel 1982). However, despite offering a way to interpret an identity arising from group membership, this thesis will not use SIT to 'universalise work identities' (Mendelson 2011, p167). Indeed, a study by Machin *et al.* (2011) exploring the role identities of health visitors notes that even where there are shared reference points for identity such as a profession, 'collective identity cannot be assumed' (p1532). While understanding the social aspect of identities which arises through membership of a professional group is important for the implications it may have - for organisations, for intergroup conflict and for individuals, if they face conflicting demands - it is not my intention to suggest that there is such a thing as a 'universal work identity' held by those who share a profession, nor should the allusions to SIT here be interpreted as such. Returning to Mead's suggestion that *the self* is something that arises out of social experience, I would reiterate that identity needs to be seen as something that is personal and non-generalisable, arising as it does from our own experiences and interpretations of them. O'Connell Davidson was writing about prostitution when she suggested that there is a:

[c]ontinuum in terms of earnings, working and conditions and the degree of control that individuals exercise...the experience of those at the top of the hierarchy is vastly different from, some would say incomparable to, that of individuals of the lowest rungs.
(2005, p34)

I would suggest that this is an equally relevant description for most if not all professions. I therefore propose that identity and professional identity need to be viewed as uniquely personal; experienced by individuals through the social nature of interactions both in and out of work. However, where a 'professional identity' becomes meaningful for an individual, it is possible to understand how anything interpreted as a 'threat' to this identity could be interpreted as problematic; in particular, this could be exacerbated where individuals or individuals who share an element of their identity (and are therefore seen as a group) become defensive and / or competitive over their distinctiveness, or their 'consensual status and prestige' (Hogg 2006, p113). This negotiation over managing identity and the way in which perceived variations in role may reflect role autonomy is described by Machin *et al.* (2011) as being part of the Role Identity Equilibrium Process (RIEP) (Figure 2.1). Drawing upon Collier (2001) and Foley (2005), Machin *et al.* (2011) describe how personal identity roles are stabilised through 'self-referent, verifying feedback', while also acknowledging that identity is influenced by interactions over time in professional practice settings. While Machin *et al.*'s (2011) model was developed after a study involving just one profession (health visitors), it helps to demonstrate the extremely complex nature of 'maintaining' an identity for all professions, from just one interpretation of the many influences upon it.

This section has examined how identity is understood by social theorists to be constructed by both the self and other's interpretations of it, so that while each individual has their own unique identity, it cannot be defined as one thing; identities change according to scenarios and audiences, and individuals can have many, simultaneous 'identities'. Using the concept of

Figure 2.1: Machin *et al.*'s (2011) Role identity equilibrium process



Source: Machin *et al.* 2011, p1530.

narrative as a tool is helpful in understanding identities, as it allows people to explain who they feel they are and how they got to that point, for any given moment. The concept of 'professional identity' has also been explored, and how its portrayal by an individual identifies them as belonging to an exclusive group. For H&SC staff, this leads to certain responsibilities over how they are seen to act both in and outside of work where they still represent their profession. This also raises questions for how H&SC professionals gain their identities through the process of socialisation, as they learn to 'perform' their roles in order to meet the expectations of their peers, other professionals and patients / service-users. The next section will examine in more detail the claims made about

the professional status and identity of various different health and social care professions in order to understand where the differences between the different professional identities come from.

2.4 The professional identities of the health and social care professions

This study involves exploring the perspectives of a variety of different H&SC professionals. While the history of some professions is summarised (where pertinent), this section is not intended to provide a detailed history of each profession (the entirety of each of which would be worthy of a thesis in its own right). Rather, the main debates around professional identity of the H&SC professions are explored in general, using as many examples from different professions as is appropriate, with brief descriptions of the history of various professions where relevant. Additionally, this section is based on existing works concerning only some of the sixteen H&SC professions involved in the ALPS CETL programme.¹ A number of these professions were not represented in the fieldwork (see Chapter Four) and the discussion of different professional identities presented is based upon those professions who represented the largest proportion of respondents in the study (doctors, nurses, midwives, physiotherapists, occupational therapists, social workers, audiologists, and diagnostic radiographers). Attempts were also made to identify work concerning the professional identity of dieticians and speech / language therapists, but a series of searches revealed no suitable material.

2.4.1 The role of regulators and professional bodies

Before discussion of individual professional identities, it will be useful to acknowledge the part that the regulatory bodies play with reference to

¹ Audiology; Clinical Physiology; Dentistry; Diagnostic Radiography; Dietetics; Medicine; Midwifery; Nursing; Occupational Therapy; Operating Department Practice; Optometry; Pharmacy; Physiotherapy; Podiatry; Social Work; Speech and Language Therapy.

their influence on the roles (and subsequently identities) of professions and professionals for which they are responsible. All H&SC professionals are required to register with a professional (regulatory) body tasked with ensuring that individuals adhere to required standards. These are different from professional associations (such as the British Medical Association (BMA) and the British Association of Social Workers (BASW)) which are the trade unions of various professions but to whom individual membership is voluntary. Regulators can establish rules, ensure conformity with them and 'manipulate sanctions...in an attempt to influence future behaviour' (Scott 2001, p52). The professional bodies for H&SC are therefore expected to maintain an up-to-date register of professionals; set and maintain standard for education, training and conduct; and investigate when these standards are perceived not to be met (HSE website). Professional bodies are both regulators and advocates of the professions they represent.

As a result of being responsible for education, training and professional standards, it could be argued that the professional bodies are the most influential actors in defining what is considered 'professional behaviour' and, therefore to a certain extent, identity (although there may be gaps between the two). As Hugman (1991) points out, through membership of such bodies, there is a 'tendency to create new power structures, which enhance the position of professionals at the expense of others' (p222). The result is that professional bodies – in theory – hold much power over individuals and subsequently the professions they represent, and can also exert a powerful influence in policy making concerning H&SC services through the 'external pressure' they are able to apply as a regulative element (Currie and Suhomlinova 2006). However, it should also be noted that while it is widely accepted that professional bodies are powerful, there is little academic literature exploring the extent to which they *currently* are powerful or how this power manifests itself.

Table 2.1 maps out the professional bodies and the professions they represented in England in 2013. Of particular note is that social workers are now registered by the Health and Care Professions Council (HCPC).

Table 2.1: Professional Bodies in England, 2013

Professional Body	Responsible for
General Medical Council (GMC)	Doctors
Nursing and Midwifery Council (NMC)	Nurses; Midwives
Health and Care Professions Council (HCPC)	Arts therapists; Biomedical scientists; Chiropodists / Podiatrists; Clinical Scientists; Dieticians; Hearing aid dispensers; Occupational therapists; Operating department practitioners; Orthoptists; Paramedics; Physiotherapists; Practitioner psychologists; Prosthetists / Orthotists; Radiographers; Social workers and Speech and language therapists
General Dental Council (GDC)	Dentists; Dental nurses; Dental technicians; Clinical dental technicians; Dental hygienists; Dental therapists; Orthodontic therapists
General Optical Council (GOC)	Optometrists; Dispensing opticians; Student opticians; Optical businesses
General Chiropractic Council (GCC)	Chiropractors
General Osteopathic Council (GOsC)	Osteopaths
General Pharmaceutical Council (GPhC)	Pharmacists; Pharmacy technicians; Pharmacy premises

Source: HSE Website

This has only been the case since August 2012, with social workers formerly registered with the (now defunct) General Social Care Council (GSCC). The GSCC was abolished after a review by the Department of

Health (DH) into 'arms-length bodies' concluded that there was 'no compelling reason' to retain it and suggested that there were 'potentially significant benefits' from combining regulation of social workers with other healthcare professions (Dunning 2010). The impact on the profession of moving social work regulation to the HCPC, which has previously only had a healthcare as opposed to a social care focus, is as yet unknown.

2.42 All professions are equal, but some are more equal than others?

When talking about professions in general, Greenwood wrote that occupations in a society should be considered along a 'continuum' (1957, p510), which implies that some professions are *more professional* than others. In discussing the professional identity of those employed in H&SC it is tempting to conflate – misleadingly – the notion of a continuum of professions with the traditional hierarchical nature of a healthcare team, which has someone (often a doctor) at the top as decision maker and ultimate team leader, forming a necessary organisational structure for effective teamworking. Freidson (1970), for example, notes that the hierarchy of institutional expertise renders medicine the dominant profession in terms of the division of labour in health and social care. This is also not to deny Abbott's (1988) claim that there is a 'system' of professions, which involves a 'currency of competition' in the form of knowledge systems and their degree of abstraction, resulting in interprofessional contestation and the potential for subordination of some occupational groups by others. However, for a 'continuum' to be relevant, with some occupations deemed 'more professional' than others, each occupation would have to be judged on the same set of criteria, such as those defined by the 'trait approach' to defining professions. But, as already discussed, such an approach, while useful for identifying general characteristics associated with professions, is not considered particularly helpful because it assumes there exists an 'ideal type' of profession (often characterised by medicine or law). This is evidently not the case, with consideration given to the different functions of different roles carried out

by different professions, so that instead of a continuum, one could make the case that they are 'differently professional'. In other words, where occupations demonstrate a unique body of knowledge, and consequently, role which requires the fulfilment of tasks in complex situations to help others (a 'professional task' as defined by Eve and Hodgkin 1997), the attribution of the label 'profession' can easily be argued to be applicable without objection. However, as each profession performs different roles, the extent to which they have certain traits will necessarily differ, and it therefore seems incongruous to suggest that one could rate one profession as being 'more professional' than another. Rather, each profession can be seen to perform the professional role as specific to their profession, and, as such, each profession could be said to be 'differently professional' to another. The rest of this section will therefore examine how the professional status and identity of a variety of H&SC occupations has been described, but will not claim that one profession is 'more professional' than others, as this thesis's argues that such a conceptualisation is inaccurate.

2.43 Medicine

Doctors have often been used as a paradigmatic example of a profession, and as such there is little debate as to their right to claim professional status. Eve and Hodgkin (1997) suggest that medicine has always occupied a 'singular and interesting position amongst the professions' because it is the only one of the 'traditional "learned professions"' that is based on science and technology (p69).

In Britain, the medical profession was officially founded via royal charter in the early sixteenth century (Macdonald 1995). The publication of medical registers in 1779 has been argued to be:

[a]n important step in the professionalization of medicine...
enabling patients to choose practitioners and practitioners to
contact each other. (Lane 2001, p15)

Whilst regulation of the profession came later in the form of the 1815 Apothecaries Act, the state left the initiative to unify the profession, and to set up regulative mechanisms, to reformers and *the professionals themselves* (Macdonald 1995, p77 emphasis added). Thus, a great deal of theory and research on the medical profession has focused on the power and influence of doctors, over both their own profession (including education) and other paramedical occupations (Macdonald 1995; Larkin 1983; Wilding 1982). The introduction of the National Health Service (NHS) in 1948 changed medicine from a consumer product to a state service, with Lane suggesting that:

...changes within medicine itself, bringing enhanced status and prosperity to practitioners, in turn gave consultants and GPs a place in society by the twentieth century that their predecessors could not have envisaged, except for the few grand physicians and 'surgeon princes' of earlier periods. (2001, p202)

Eve and Hodgkin (1997, p72), however, suggest that within the healthcare system at least, the status of doctors had been 'downgraded' since the 1950s and 1960s, when they had much more influence on the services and policy developments that guided the NHS than they did by 1997, when an erosion of some 'power', brought about by increases in accountability to the government, professional bodies and patients had occurred (p76). Whilst this is not necessarily a bad thing from the perspective of patients, it still says little about the actual role and identity of doctors in the modern era. Eve and Hodgkin suggest that (to 1997) 'the role and form of professional education has changed little for practising doctors' (1997, p77), resulting in professionals who had no means of keeping up with an exponentially growing knowledge base. The recognition of the need for this to change, and the need to focus on the responsibilities of holding the role of doctor led to a large amount of attention being paid to the teaching of medical 'professionalism' (Goldie *et al.* 2007; Hilton and Slotnick 2005). This included a recommendation in the 2003 version of *Tomorrow's Doctors* that 'professionalism be included as a curricular theme in

undergraduate medical education' (Goldie *et al.* 2007, p610). However, there is little consensus on the most effective methods to either teach or assess professionalism (one review, Lynch *et al.* 2009, suggested that at least 88 different assessments of professionalism have been used in medical education since 1982). Noted tensions exist within medical education between the discourses of 'diversity' and 'standardisation', where diversity emphasises respect for individual students and life experiences, and standardisation concerns 'uniformity and consistency' and a drive to define what is 'core or essential' to being a physician (Frost and Regehr 2012, p2). Student doctors are thus expected to embrace both, with the consequence of this being that medical educators are concerned that students' professional identities do not align with expectations. In order to ensure that the transformative process of student to doctor is not complicated by these competing discourses, this tension must be recognised and acknowledged for future generations of physicians (Frost and Regehr 2012).

Hilton and Slotnick (2005) suggest that in medicine, identity develops during learning that takes place before 'mature professionalism' is reached, an extended phase which occurs over years of medical training which the authors refer to as 'proto-professionalism'. They propose that 'the professional's development of identity is a product of two simultaneous processes: *attainment* and *attrition*' (Hilton and Slotnick 2005, p62). The process of *attainment* they describe as being about 'positive influences' that include curriculum design and clinical environment. Applying Lave and Wenger's concept of 'legitimate peripheral participation', they describe how medical students start at the periphery of activity of the profession, mimicking practicing clinicians (performing physical examinations, for example) but without treating patients; then, as they mature and learn more skills, they eventually find themselves at the 'centre' as independent clinicians (Hilton and Slotnick 2005, pp62-63). Moving from the periphery to the centre involves moving through different 'identities', as, at different stages, how they relate to others and their role will differ, and while these

experiences and opportunities in themselves do not constitute professionalism, 'they are necessary for professionalism in the future' (Hilton and Slotnick 2005, p63).

In contrast, Hilton and Slotnick draw attention to the role of *attrition*, which highlights that identity formation does not always occur as a result of positive encounters and experiences. Attrition results from adverse effects of the environment including 'negative role models, unsupportive work conditions and pressures of overwork' (Hilton and Slotnick 2005, p63). Similarly, work by Kilminster *et al.* (2010) on 'transitions' of qualified medics (where a 'transition' is defined as a change in seniority, geographical location, specialty or clinical team) shows how the performance of doctors, their practice and their learning are 'mutually constitutive'; however, the performance levels of doctors does not:

...increase incrementally across transitions or even remain stable within each transition... (p566)

as performance was seen to rely upon a multitude of demands placed on doctors, and factors including but not limited to 'time, specialty, hospital rotas and trust policies' (p566).

These works provide particularly significant context for this thesis, as they recognise that professional identity arising from professionalism and performance for medics arises from both long-term experiences, and reflections upon those experiences. Recognition is also given to the fact that the culture of the workplace is extremely important to understanding effective performance (and therefore role). Hilton and Slotnick conclude that the consequence of their findings for those yet to qualify is a need to 'provide stage-appropriate experiences', maximise 'opportunities for attainment' and minimise 'inappropriate attrition' (2005, p63), although these are equally applicable recommendations to assist qualified staff. For this to be achieved, consideration must be given to how doctors learn from peers and role-models through socialisation into their profession.

Much of the discourse surrounding the professional identity of doctors considers the process by which they 'become' doctors and are *socialised* into the world of medicine. Indeed, some recent literature on the professional identity of doctors focuses on how those who train in medicine identify with the role of a doctor – both before and after studying - to become one (see Pratt *et al.* 2006 and Gude *et al.* 2005). Such studies are not new. Becker *et al.*'s (1961) highly influential study *Boys in White* followed and described the process of 'becoming' a doctor in great detail after studying students from every year group at the University of Kansas Medical School in 1956-57. Whilst they do not talk about the concept of 'socialisation' explicitly, they discuss how students entering medical school are idealistic about the way in which they will practice medicine in a patient-oriented way, but ultimately they act as all other medical students do and often just do what they 'have to', in accordance with expectations and pressures upon them. Hilton and Slotnick (2005, p63) describe this as part of the 'attrition' process, where self-interest or self-preservation 'takes precedence over altruism'. Similarly, Becker *et al.* (1961) examine the way in which the medical students end up focusing on 'what the faculty wants' from them (which enables them to gain both clinical experience and more responsibility). More recently, Apker and Eggly (2004) have discussed the way in which formal teaching on wards through a morning report socialises the medical residents (in the US) into the accepted way of thinking about patient cases – i.e. about the medical issues involved and not about the more personal and humanistic characteristics of students. Hamstra *et al.* (2007) also examine socialisation into medicine, and propose that in the past residents worked long hours in order to impress their supervising doctors 'and in the process develop their professional identity' (p8) (although the article assumes that this occurs, it does not explore this process in any detail).

One of the difficulties of ensuring that socialisation into one's own profession is a positive experience is that all professions can be described by a series of pre-conceptions and stereotypes. We all 'know' what a

doctor is and therefore their identity should be obvious to us; and those who become doctors should know how to identify themselves as such (in line with Goffman's theories on performances and role management). Nevertheless, very little of the preceding discussion on 'identity' described the actual role of doctors. The primary reason is illustrated by Eve and Hodgkin who highlight that the huge variations in the practice of medicine can lead to individual patients with identical conditions being treated in 'radically different ways by highly qualified professionals', whose corpus of knowledge is (theoretically) the same, but where importance is given to 'clinical freedom' (1997, p71). Thus there is no 'single professional identity' that describes a doctor, nor indeed any other profession. As we have seen, there are merely ways to make claims to 'professionalism', a process that will now be explored and discussed with reference to other professions from health and social care.

2.44 Nursing

Nursing has not traditionally been afforded the same status as medicine and has been described variously as a 'semi-profession' (Etzioni 1969), a 'personal service profession' (Halmos 1973), and a 'caring profession' (Abbott and Wallace 1998). Until the 1860s:

...nursing was regarded as a superior form of domestic service relying mainly on respectable working class women...these women would have no background or identity as nurses and the supervision of nursing care was a marginal part of their work.

(Dingwall *et al.* 1988, p69)

It has been claimed that the transformation of nursing into a 'career' for young middle-class women was led by reforms introduced by Florence Nightingale, although feminist historians have suggested that the purpose of mobilising the Nightingale 'myth' was to 'serve colonial and nationalistic aspirations' (Hallam 2000, p10). However, when new ways of practicing medicine were developed in the 1830s, it was recognised that there was a

need for a new role: 'a new type of assistant who could monitor the patients' (Abbott and Wallace 1998, p41). Nightingale recognised the need to develop nursing into an occupation, and the need for training, yet initially training was provided only in 'obedience' to ensure that nurses realised they were subordinate to doctors, with emphasis given to the notion that nursing was a *vocation* rather than a profession (Abbott and Wallace 1998). For those professions typically understood to be 'female professional projects' (Macdonald 1995, p133), (including health visiting, midwifery and social work) it has been suggested that:

...the conditions under which these female occupations were allowed to develop meant that women entered the public sphere on terms defined by men and exchanged private patriarchy for public patriarchy. (Walby 1990 in Abbott & Wallace 1998, p48)

Thus the history of the nursing profession and the identity of nurses have long been associated with a female identity, in opposition to, and undermining of, the power held by medical men (Hallam 2000; Poovey 1989).

Additionally, the treatment of nurses as a 'disposable workforce', because they are seen as 'young, female and easily replaced', also needs to be considered (Mackay 1998, p59). In England, one could substantiate this by looking at the ever-changing nature of the health care system, which, based upon the funding restraints and organisational models imposed by successive governments, mean that the publically funded H&SC system is an uncertain place to work. Whilst doctors also work in the same system, nurses have historically taken less time to train, which does seem to substantiate at least some of the argument that nurses may be seen or treated as more 'disposable' and therefore the system in which they work is more uncertain and unstable. (Nevertheless, from September 2013, all new entrants to the nursing profession will have to study for a degree, which itself may have some implications for the nursing 'identity'.)

In 1969, Etzioni suggested that nursing (amongst other roles) should not be considered a 'true' profession because they have less of a specialised body of knowledge, less autonomy and control and less training in comparison with what he defines as the professions. But this implies that all professions can be defined by the same set of traits, a notion that is argued in this chapter to be misleading. This history of having claims to their professional status questioned has (perhaps unsurprisingly) led to a situation where nurses are quite often perceived to be defensive about their professional status, and consequently the identity that accompanies it (Hallam 2000; Tschudin 1999); indeed some explorations of the nursing profession focus purely on a 'loss' or 'crisis' of identity. Deppoliti (2008), for example, suggests that in part, loss of identity for nurses in the United States relates to how financial reimbursement for nurses connects to decreases in patient stay, and that nurses – who gain some of their identities from positive feedback from patients – are in danger of losing this, as they no longer have the opportunity to get to know their patients in any depth (p261). In the UK, the 'identity crisis' in nursing has also been associated with one of the biggest reforms to nursing and nursing education in recent history: Project 2000.

Introduced in the late 1990s, Project 2000 moved responsibility for nurse education away from hospitals and into Universities and higher education establishments. Where previously some diploma and degree courses had been available, Project 2000 made such a route into nursing compulsory, and phased out apprenticeships where nurses were attached to hospital schools or trained 'on the job'. The overarching aim of Project 2000 was to enhance educational standards, the key to which was seen as being achieved through the introduction of supernumerary status for students (that is, being seen as additional members of a clinical team who learn on placement rather than being paid members of the team who 'learn on the job') (Elkan and Robinson 2000). Meerabeau suggests that one of the key themes in work on the socialisation of nurses pre-Project 2000 focused on a 'theory-practice gap', which indicated a disjuncture between what was

taught and what was practised on wards (and specifically that 'care on the wards was routinized and not patient-centered') (1998, p83). However, discussion of these issues is still evident post-Project 2000 implementation, and, of interest to this project, is linked with concerns over the identity of the profession. Indeed, it is noticeable that concerns raised about the socialisation processes of nurses are similar to the issues raised relating to doctors. A number of small-scale studies identify transition points through different stages of learning as key points of uncertainty, necessitating the adjustment of expectations about role (Gray and Smith 1999; Maben and Macleod Clark 1998; O'Neill *et al.* 1993). Similar to Hilton and Slotnick's research, Gray and Smith conclude that the key factors in the socialisation of nurses are 'the mentor and the learning environment' (1999, p646), although they acknowledge that one of the limitations of their study was that it followed students only through the common foundation unit of their programme (that is, before they began training in the specific branch of nursing in which they were going to qualify). Freshwater (2000) also raised concerns over whether the teachers of nurses (who in the UK are nurses themselves) feel able to use their own positions of power, and subsequently questioned whether nurses have been socialised 'into having no voice by the teachers who may themselves feel oppressed' (p484). She proposed that the current system of nurse education (which nurses argued should be nurse-led) was in 'danger of reinforcing the submissive position of nurses' (Freshwater 2000, p484).

Scholes (2008) also provides a brief editorial on the 'identity crisis' in nursing, suggesting it is caused by the challenges found in the contemporary healthcare context, which implies that the theory of nursing does not match up to the realities of clinical practice. However, one could question whether nursing is alone in facing such a 'crisis'. As previously discussed, the situation in which the medical undergraduates found themselves in Becker *et al.*'s (1961) study was not all that they had hoped it would be when the realities of working in a pressurised health care environment became apparent; nevertheless, education and training have

obviously moved on considerably since this study was undertaken in the 1950s.

In addition to concerns raised over whether nurses are being socialised appropriately to prepare them for their role, and work with other professionals, Abbott and Meerabeau (1998) highlight that some critics still suggest that the work of the caring professionals (including nursing, health visiting, midwifery and social work) is not specialised enough to require training, and that instead it should be seen as an extension of work that women are expected to carry out 'naturally' in the domestic sphere. This demonstrates Abbott and Wallace's suggestion that 'gender ideologies are an important factor in all the caring professions' (1998, p47). The fact that 'care' is seen as an extension of female role means that all those occupations focused around its provision are afforded a less privileged status. It has also been argued that providing such 'care' is a form of 'emotional labour' (Hochschild 1979; 1983) which itself requires complex emotion management, and that as a role it can be as challenging and productive as physical and technical work (Bolton 2000). Furthermore, some propose that it would be dangerous for nursing to lose its focus on authentic caring behaviour by over-emphasizing a need to develop technical skill (Bolton 2000; Downe 1990) and that 'something intrinsic to nursing practice would be lost if the vocational element were extinguished' (Mackay 1998, p69).

The claim of a 'professional identity' in nursing is therefore complicated because, historically, notions of 'caring' and 'professional' have been interpreted as contradictory. As medicine has previously been treated as the 'ideal type' of profession, the desire to combine 'caring' and 'professional' has consequently been interpreted as a dilemma for nursing. Simultaneously, the key element that arguably *defines* the nursing profession - the notion of 'caring', that makes it 'differently professional' to medicine - has been used to critique and detract from its status, rather than be seen as a defining professional feature.

Whilst there has been a relative paucity of later work concerning the professional identity of nurses, one recent piece of research published in Portugal suggests that nurses in one hospital still feel that, while they have a recognisable identity, they also realise that their work still lacks socio-professional recognition, which hinders relationships and effectiveness of multi-disciplinary teams (Franco and Tavares 2013, p118). Whether there is indeed a lack of recognition of status, or merely a perception by nurses that this is the case (perhaps from being socialised into a profession which believes it has such identity concerns), the implication is that while the role and education of nurses has greatly developed and changed over the last century and a half, some of the concerns around the identity and status of the profession of nursing have moved on very little during this time.

2.45 Midwifery

Kirkham (1998) suggests that 'midwifery has clearly aimed to be a profession since the foundation of the Midwives Institute gave midwifery a leadership voice' (p123). Much like nursing, before the early nineteenth century midwifery was practised by a variety of people (both men and women), although only very few would have been 'full-time practitioners' (Dingwall *et al.* 1988, p153). However, unlike nursing, and despite initial public opposition, it was male midwifery that started to dominate; by the late nineteenth century, medical doctors agreed that 'midwifery should be undertaken and controlled by men' such that by 1866 proficiency in midwifery was 'necessary for qualification as a medical practitioner' (Abbott and Wallace 1998, p46). However, a distinction remained between '*assistance at childbirth* and *intervention at childbirth*' (Abbott and Wallace 1998, p47), and while men controlled both the intervention side (only men were allowed to use forceps and intervene surgically) and registration / education (through the Midwifery Registration Act of 1902), women midwives remained in control of the 'assistance' side (although Abbott and Wallace (1998) suggest that this is only because there was no way in which the trained male practitioners would be able to meet the demand for

assistance). This 'deskilling and deprofessionalisation' of midwives is argued by Abbott and Wallace to have continued into the late twentieth century where the ultimate control of births remained 'in the hands of the (generally male) obstetrician' (1998, p47).

Recent studies have found that midwives in the UK perceive themselves to have an inconsistent professional identity (Pollard 2011; Porter *et al.* 2007) and that in Sweden midwives encounter challenges to their identity from technology, other professionals and parents who make high demands of them (Larsson *et al.* 2009). Both Larsson *et al.* 2009 and Pollard 2011 noted that there are still challenges for midwives in juggling midwifery perspectives with medical perspectives on childbirth, which have implications for power relationships, hierarchies and for notions of professionalism. Pollard suggested that, in the UK, it was not surprising that midwives held inconsistent positions and practices:

...given that the UK midwifery system demands that midwives simultaneously adhere to a medicalised approach to childbirth, act as advocates for women, practice according to the midwifery approach, promote the professionalization of midwifery and observe their contractual obligations as employees. (2011, p618)

To claim that they are an autonomous profession, it is suggested that midwives need not only to be able to challenge medical supervision of their work, but also to establish that their work is distinct from medical work, with a unique knowledge and practice (Abbott and Wallace 1998). However, this argument once again privileges the notion that traits consisting of technical skill and unique knowledge would result in the definition of midwifery as 'more' professional. This does not acknowledge the professionalism that is demonstrated in the already unique skill and role undertaken by the midwives during pregnancy and birth. The discussion of professions in history has thus done little for the construction of perceptions of some occupations as professionals, even when they are carrying out unique roles in a professional way. For midwifery, this has led

to confusion not only about whether it is seen as a 'profession' by others, but has also resulted in questions about the 'professional identity' of midwifery by midwives themselves.

2.46 Physiotherapy

The history of physiotherapy is linked to the employment of Swedish remedial gymnasts in the 1880s by 'progressive members of the medical profession for "medical rubbing"' (Jones 1991, p12; Wickstead 1948). As a result, many women in Britain started undertaking this work as an alternative or an addition to nursing and midwifery, with the setting up of the Society of Trained Masseuses in 1894, which in turn led to medical recognition of the role (through medical assistance in qualifying students, and certificates of competence presented to those who reached a satisfactory standard) (Jones 1991). By 1905, male nursing orderlies from the Royal Medical Corps were allowed to take the examinations but were not permitted to be members of the Society (by that time the Incorporated Society of Trained Masseuses) as this included a right to membership of the Trained Nurses Club, which did not permit male members (Jones 1991). The development of physiotherapy as a profession is seen as having increased with the skills of orthopaedic surgeons during the 1914–1918 war, with large numbers of patients surviving disabling injuries and the surgeons needing assistance with the rehabilitation work (Jones 1991). In 1920, the need for the role was symbolically recognised with the granting of a Royal Charter, but it was the founding of the NHS in 1948 that enabled the Chartered Society of Physiotherapy (as it had been called since 1942) 'to become the dominant occupational group in the remedial therapy services' (Jones 1991, p14). Nevertheless, the profession remained under the control of doctors for many years, to the extent that the profession's ethical code stated that patients could only be treated after direct referral from a doctor (Jones 1991).

The move towards an advanced level of clinical autonomy has been argued to be the most significant change in the profession in the last 50 years (Robertson *et al.* 2003), with Jones suggesting that this autonomy has moved physiotherapists further along the 'professional continuum' than nursing, because nurses' work is still much more dependent on doctors (1991, p16). The extent to which interprofessional comparison exists can be seen in the way in which literature simply outlining the formation of one profession is pervaded by such comparisons and positioning.

While some recent literature on the professional identity of physiotherapists has focused on the role overlap between physiotherapy and occupational therapy (Booth and Hewitson 2002; Brown and Greenwood 1999) (whilst maintaining that the roles are indeed similar but separate), a study undertaken between Sweden and the UK suggested that there is a 'diversity of professional identities in graduating physiotherapists' (Lindquist *et al.* 2006, p270). The authors identify three distinct identities: 'Empowerers, Educators or Treaters'; however, they classified some of their participants in two of the three categories (Lindquist *et al.* 2001, p274) (although it should be noted that this work was conducted with students about to graduate and as such it could be suggested that these may not be the identities of physiotherapists once they are working and have lost their 'student' identity). Nevertheless, there are still implications for educators and the socialisation process, including the necessity of educators being aware of the 'range of professional identities that students may develop and the processes through which that may occur' (Lindquist *et al.* 2006, p275) to ensure that students are not too far grounded in one philosophy to the detriment of others.

2.47 Occupational Therapy

Occupational therapy emerged in the years before the Second World War, developing not to exploit new technologies, but as a therapy that was promising once 'it became possible to save the lives of those who would in

earlier times have died' (Blom-Cooper 1990, p13). The origins of occupational therapy came from a group of psychiatrists who, challenging traditional medical treatments, 'advocated a link between occupation and health as a treatment or therapy' (Clouston and Whitcombe 2008, p315). While originally carried out by nurses under medical direction, the specific role of 'occupational therapy' has emerged over time, although notably in the (relatively small) body of work concerning occupational therapy and its history, a lot is made of the 'successive identity crises in name, focus and purpose' (Clouston and Whitcombe 2008, p315; Wilcock 2002) and the 'struggle to establish [itself as] a self-governing profession with control over recruitment and education' (Blom-Cooper 1990, p18).

Occupational Therapy appears to be seen from both inside and outside of the profession as one that struggles with its own professional status and identity. In 1990, Blom-Cooper suggested that there were multiple reasons for this:

- the dominant position of medics in the health service and social workers in care services;
- the dependence of occupational therapists on doctors and social workers for access to clients;
- a stereotypical view of occupational therapists as 'do-gooders';
- the female composition of the profession;
- the difficulties of providing outcome measures of the efficacy of the profession. (pp18-20)

In comparing occupational therapy to other health care professions, Blom-Cooper suggests that occupational therapists are seen as performing 'unskilled and common-sense tasks', which do not earn the same respect or prestige of the doctors whose skills come from 'high intelligence and long training' (1990, pp19–20). He notably continues:

Even nursing, which is popularly regarded as requiring angelic dedication in carrying out distasteful work, is given an enhanced status. (Blom-Cooper 1990, p20, emphasis added)

Since Blom-Cooper's report was published, there has been a paucity of empirical research on the impact of changes to the health and social care systems on the role and identity of occupational therapy (Clouston and Whitcombe 2008), although Thompson and Ryan published a small scale study involving looking at the influence of 600 hours of 'fieldwork' (placement experience) on four occupational therapy students in Canada in 1996. Their findings suggested that: there was a process of professional socialisation by 'osmosis', and that while interactions between student and therapist focused on the 'technicalities of therapeutic interventions', the underlying beliefs and values of the profession were not explicitly addressed, with students expected to absorb these 'unconsciously and interpret without questioning' (Thompson and Ryan 1996, p69). However this brings into question the extent to which it would be possible to 'teach' the 'underlying beliefs and values' of the profession, as well whether this would be wholly expected to occur in a placement setting.

Finally, Thompson and Ryan note that:

The students in this study were aware of their natural lowly position as neophyte professionals, but this position was compounded by their awareness of the low profile of the profession and its apparent invisibility. (1996, p69)

This was exacerbated, the authors claim, by the necessity for the students to deal with the traditional 'embedded hierarchy' of healthcare where doctors are the 'key-decision makers' (Thompson and Ryan 1996, p69). While it might be argued that interprofessional education may be useful for exploring these issues with students (a claim explored in Chapter Three), it also brings into question the extent to which socialisation into a profession involving being told (or having it reinforced) that this profession has a weak – or strong – professional identity becomes a self-fulfilling prophecy. The notion / mantra of 'we are a weak profession' (and which could be as equally problematic as 'we are a strong profession') appears to be learned

and performed by the next generation of professionals, but this does not appear to have been identified as potentially problematic in this case.

2.48 Social Work

While The Charity Organisation Society was credited with having developed the 'social work method of individualized casework', social work, like health visiting, was seen to provide not just a role but a career opportunity for middle class women in the nineteenth century, after developing out of a variety of voluntary, charitable and philanthropic Victorian projects (Abbott and Wallace 1998, pp31-32). However, the role and definition of social work's boundaries have long been debated. Gibelman identifies that as far back as 1915, the question of whether social work was a profession was being raised by Flexner, and that later, in 1917, Richmond sought to 'identify the skill base for work with individuals and families' (Gibelman 1999, p299). Hugman (1991, p88) highlights that in the UK, until 1970, there was little attempt made to campaign for a 'unified professional body' in social work. As there was no single body to advocate for social work as a single profession, this could explain some of the lack of definition over identity. However, Gibelman argues that, despite variations in the depth and scope, and being developed at different times, there is a 'remarkable consistency' to the definitions ascribed to social work over the years (1999, p299). Horner reflects that one of the key questions relating to social workers is whether all societies need them:

We take it for granted, perhaps erroneously, that other professions – teachers, doctors, architects, lawyers – are social necessities, yet concede that social workers are not automatic members of the list.

(2009, p14)

The answer to this question, Horner argues, lies in the extent to which one believes it is the responsibility of the state to respond and intervene on behalf of vulnerable and dependent people (2009, p15). It is not the place of this thesis to debate whether there is a 'need' for social work, nor to

interpret the hugely complex and vast debate on the 'sanction' for its existence, but the existence of the question is significant for this discussion, as it places the role and identity of social workers in a different position from that of the other health professions explored so far (for instance, there is no long-running debate about the need for doctors, nurses, midwives, physiotherapists or occupational therapists). Additionally, Abbott and Wallace (1998) highlight how successive scandals relating to child protection have resulted in social workers being 'vilified' in the press, leading to a 'further crisis of confidence for a fragile profession' which led some to challenge the 'whole basis of social work's professional practice' (p38). This is a theme which can be seen to have culminated in the 'hostile reactions to social workers following the conviction of the killers of Baby P in November 2008' (Warner 2013). The ability of social workers to fulfil their role of moral regulators is often questioned by the media on the basis of real or imagined class-divides between the social workers and their clients. Both Warner (2013) and Clapton *et al.* (2013) apply the lens of 'moral panic' to describe the reaction of the press to social worker engagement in child protection cases, noting that social workers are usually portrayed as the 'folk devils' (see Cohen 1972).

It is also important to remember that social workers operate in a different part of the health and social care system to many of the other professions discussed in this thesis, and those who work in the public sector are mainly employed by Local Authorities rather than the National Health Service. (The Health and Social Care Act 2012 may have some impact on the way that social care is commissioned, but the impacts of this are yet unknown; Samuel 2013). In addition, social workers have unique legal powers that allow them to intervene in the lives of others (by, for example, 'safeguarding' a child or vulnerable adult, by removing them from their home). These interventions can often result in situations where decisions are disliked by the public; being seen as interfering and over-bearing in cases where they successfully safeguard someone by removing them from a home environment, or as having failed the moral system if they do not

remove someone from potential harm and something detrimental ultimately happens to them. Gibelman concludes that:

The potential failures [of the profession] lie not in what directions we choose but in not having the debate *and allowing our profession to be defined by the forces and decisions of others.*

(1999, p308, emphasis added)

Unlike occupational therapy and midwifery, who have concerns over their professions' identity and justify their professional status by contrasting themselves to other health roles, social workers are more concerned with justifying the existence of their profession *at all*, despite the fact that social work clearly occupies a unique role within the H&SC system. The subsequent impact of this insecurity is that there are concerns over the directions in which others (policy makers and other professional groups) wish to push social work.

2.49 The 'younger' professions and 'assistants'

While only representing a small portion of available literature, and a small number of professions, the preceding discussion indicates how the struggle for professional status and role is a recurring theme across all H&SC professions for a variety of different perceived reasons. The use of phrases such as 'the professions allied to medicine' and then later 'allied health professionals' which have been typically used to describe any H&SC profession outside of medicine, dentistry and nursing can also be seen to have contributed to difficulties for individual professions seeking to develop and control their own identities.

The identities discussed here still probably only represent those of the largest and more established professions, and inevitably there is more research available on them. Whilst there are some discussions of professional identity of 'younger' professions, there are far fewer empirical studies (and studies, generally) available. Lubinski and Golper's (2007)

chapter on audiology and speech pathology, for example, provides a discussion of the history of these professions in America, and suggest that 'a certain noble motivation pervades our professional identity' (p3), but this appears to be only their opinion and is not evidenced in any way.

Niemi and Paasivaara (2007) explored the professional identity of radiographers by using a discourse analytical approach to explore the content of professional journal articles. They conclude that radiographers have a dual identity, the first based on a command of scientific-mechanic technology and a technical working environment, and the second based on the humanistic element of nursing work. However, Bolderston *et al.* (2010) (who interviewed radiation therapists), and Ekmekci and Turley (2008), suggest that the 'caring' element of the role is different for those who work in radiation therapy from other 'radiologic science disciplines'. This is due to radiation therapists' prolonged and or / repeated patient contact, and because of an expectation of patients receiving radiation therapy that staff would have time to listen, and be both caring and sympathetic. This implies that there are slightly different identifying features and therefore identities for staff carrying out different roles under the same professional label, which is interesting but not surprising given the individual nature of experiences that result in different perceptions of group boundaries.

There are also those occupations that are not considered to be 'professional' because they have developed to fulfil very specific, individual-task based roles which are not easily defined into one profession. Gibbs (2013), for example, notes that sonography encompasses a 'broad spectrum' of functions, the skills of which are covered by a number of different professional bodies. However, while sonographers have often undergone 'rigorous training' to achieve competence, and regulation of sonography practice has been recommended by the HCPC, because their role duplicates skills held by other professions, they are yet to achieve recognition as a profession in their own right, a situation which Gibbs (2013) suggests is unlikely to change any time in the near future.

One final category to note is that of 'auxiliaries / assistants', 'technicians' and 'support workers', and in particular Health Care Assistants (HCAs) who are non-registered care-givers but who often perceive themselves as 'substituting' for registered staff (Thornley 2001). The role of the HCA has been much reviewed in literature, and particularly from the perspective of registered nurses, where discussions focus on the impact of the changing role of nurses resulting in HCAs being expected to carry out more 'nursing work', and whether this is appropriate given the level of competence of the (usually untrained) HCAs (Spilsbury and Meyer 2004; McKenna *et al.* 2004). The untrained, unregistered assistants who work only under the direct supervision of qualified staff are perhaps the most easily identifiable group who are *not* afforded a 'professional identity' and yet they are still expected to display elements of 'professionalism' in their work and physically identify themselves as staff by the wearing of uniforms. To distinguish the 'professional' from the mere 'staff-member' in H&SC is therefore arguably not as straightforward as it would first appear, and particularly if the meanings of different uniforms are not apparent.

In addition to those whose claim to a 'professional identity' is less clear, there are also those in job roles whose professional role boundaries blur or cross over other more traditionally distinct roles. In particular, 'nurse consultants' and 'assistant physicians' both perform elements or tasks more typically undertaken by doctors such as making clinical decisions or re-writing drug charts. The changing of existing professions and emergence of new roles raises questions about a subsequent need to reassess perceptions of identity to ensure they reflect the modern profession (Gough 2001). However, this needs to be done without 'dissolving' existing identities, which can be seen as a threat and demoralizing to all those concerned (Howkins 2002). One of the challenges for nurse consultants and assistant physicians is that there is a lack of progression opportunities within these roles. Based upon an earlier study she completed, Ewens (2003) noted that while nurses were keen to embrace new roles and the accompanying identities, the realities of the

workplace opportunities were that organisations were unsure what to do with such practitioners, and that their opportunities to expand or innovate within their new roles were limited, leading to those in these roles feeling very frustrated and discontented. It is thus apparent that the creation of roles which extend professional responsibilities has many implications for healthcare organisations, who need to be able to support (and develop) those who undertake the roles, and for individual professionals, who may no longer feel part of, or be identified as, a member of a specific profession (differentiated as they are from the rest of their colleagues through additional responsibilities).

2.5 Uniforms and signifiers

The wearing of a uniform, or certain role-related clothing, is perhaps the most obvious indication that one belongs to a certain group. However, although uniforms play a key role in delineating occupational boundaries, there has been comparatively little empirical analysis into their function (Timmons and East 2011). In 2004, Douse *et al.* conducted a study which found that while 56% (of 276) patients preferred doctors to wear white coats for ease of identification and because it looked 'more professional', only 24% (of 86) doctors preferred to wear them, with the primary reason for not doing so being concern about risk of infection. In fact wearing white coats was banned in 2007 precisely because of the infection risk they were found to carry (BBC News Website 17.09.07).

The majority of other existing work into wearing uniforms in H&SC focuses on nurses. Spragley and Francis (2006) suggest that nursing uniforms are 'nonverbal conscious statements' that indicate that those wearing them have the 'skills and knowledge to care for others', a point which could be argued to apply to any H&SC professional who wears a uniform. The same could be said of Newton and Chaney's (1996) assertion that wearing a uniform does not automatically denote that a nurse is 'good' or acts professionally. While Douse *et al.*'s study into white coats for doctors

highlighted the symbolic significance of uniforms for patients, both Hallam (2000) and Pearson *et al.* (2001) talk about the significance of the wearing of a uniform for nurses, for whom it is perceived to give confidence to carry out their role. Furthermore, Pearson *et al.* 2001 suggest that the uniform can be seen as part of the 'performance' of their role (and conversely, that when it is removed, they are able to take up other roles). Timmons and East (2011) also identify the significance of uniforms for staff, having studied the introduction of a new uniform for all professional groups in one UK hospital, where:

...the only signifier of professions that remained after the change was a small epaulette in the traditional colour indicating profession (royal blue for nurses, green for occupational therapists and navy for physiotherapists). Symbols of rank were also substantially reduced... (p1039)

The introduction of the new uniforms was seen as 'an explicit managerial attempt to reduce the importance of boundaries between (and within) professional groups in hospital' (Timmons and East 2011, p1047). The study concludes that the generic uniforms did not promote a corporate identity (which in itself may not be an identity people viewed positively), and if anything may have exacerbated rather than reduced professional 'tribalism'. Changing the uniform was perceived as 'an assault on professional boundaries' and concerns were raised that it was not possible to tell one profession from another, which in some cases was potentially dangerous; for example, one physiotherapist gave an account of witnessing an auxiliary nurse being shouted at to fetch a crash trolley, a task she was clearly not permitted to do as it was outside of her role (Timmons and East 2011). Thus it can be seen that wearing uniforms is considered to be significant by patients and H&SC professionals alike, and as one of the few 'obvious' signifiers of professional identity they also remain functionally important.

Another signifier of interest is that of the stethoscope. A 'tool of the trade' rather than an item of uniform, the stethoscope has arguably been traditionally associated with doctors; Coombs (1978) argued that professional socialisation for doctors was about '*playing* the role' complete with the 'props' of white coat, stethoscope, clipboard and name badge (p222). These symbols, it has previously been argued, differentiate both professionals and student-professionals from lay people and other professionals (Beagan 2001). However, the stethoscope is not the sole domain of the doctor and has not been for quite some time. In a narrative example given by Chan and Schwind (2006), reference is made to a nursing student being given, alongside her uniform:

...a pair of nursing scissors and a stethoscope, each engraved with my name. All these are to become part of my full uniform, my visible identity. (p306)

Thus while there are 'props' (tools) and symbols that may have previously been associated with certain professions, even the demarcations of these can be seen to be blurring across professions, if not removed completely (as in the case of the white coat). While there is little academic work exploring the impact of this, the loss of 'obvious' signifiers may be a contextual reason for professionals to feel more defensive over their professional identity in terms of job-roles, when they are less-easily identified as 'distinct' from other professionals by sight. This is merely one suggested hypothesis however, and without further work exploring this area it is not possible to say whether changes to uniforms and symbols of professions have had any impact at all on either professional or patient's perceptions.

2.6 Occupational ideology and the notion of vocation

Another, less obvious aspect that can be argued to be common to all H&SC professions is the notion of work as a 'vocation'. The concept of 'vocation' is ideological, and is commonly used with those who enter ministry or religious orders (Mackay 1998) and often refers to the way in which people feel an inclination or 'a calling' to undertake a certain type of work. However, in discussions about the extent to which people feel 'a calling' to join the occupation they have chosen to join, it is also often applied to those who work in H&SC. Occupational ideologies not only inform the way people behave at work (Fox 1971), they also present a view of occupations to society at large, to the public as well as to members of the occupation (Mackay 1998). Any number of (potentially conflicting) occupational ideologies can inform thinking about a profession at any one time, and there has been some debate, particularly within nursing, as to the extent to which the concept of 'vocation' is in contrast to being seen as 'a professional' (see Salvage 1985). Burrage and Torstendahl (1990, p123) note, however, that 'idealised professions' are expected to achieve the substantial formal training while staying 'very close' to vocational work. While it is technically possible for those who work in H&SC to ignore the concept of vocation (Burrage and Tostehdahl 1990), the existence of the ideology in the public mind means it still remains an important potential feature of a professional identity.

2.7 Health and social care professions in competition: Silos and Tribalism

Historically, discussion of differences in professional identity and the culture of working in H&SC have focused on the professions in competition, where they have been variously described as working in 'silos', or as 'tribalistic' in nature.

To a certain extent, the history of the H&SC professions is viewed as a history of competition and claim to the rights about certain roles or aspects

of work (Abbott 1998, Macdonald 1995), with Abbott stating that ‘a fundamental fact of professional life [is] interprofessional competition (1988, p2). The concept of ‘silo working’ is often referred to as an unproblematised given (see Curran and Sharpe 2007) implying that, to a certain extent, it is something we are all aware occurs and understand why it happens. Hall (2005) explores this issue in more depth, however, suggesting that the struggle for each profession to define its own ‘identity, values, sphere of practice and role in patient care’ has been the major contributory factor in determining the way in which H&SC professions have typically interacted:

This has led to each health care profession working within its own silo to ensure its members (its professionals) have common experiences, values, approaches to problem-solving and language for professional tools. (2005, p190)

Thus, Hall proposes that the educational and socialisation processes solidify each professional’s ‘unique world view’ (2005, p190) as each trainee aspires to be seen as professional and learns and repeats the views of professionals who train them. In a review similar to Hall’s, Beattie (1995) describes the development of the H&SC professions as ‘tribalistic’, as a result of the way in which they have evolved separately.

Dalley (1989) also uses the term ‘tribalistic’ to describe the division between agencies providing health care, and those who provide social care. However, in a study exploring the introduction of a new IT system to enable cross-agency working, Baines *et al.* conclude that while differences in professional cultures are often ‘invoked rhetorically as barriers to change’, the more significant impact is actually in the different pressures from everyday practice (2010, p29).

The ‘divide’ between health and social care could be the topic of a thesis in itself, but is succinctly summarised by Lymbery, drawing upon the work of Lewis (2001) and Salter (1998), who describes the hidden policy conflict between health and social care agencies as an inevitable result of the needs

of the service user falling between two agencies (Lymbery 2006, p1121). Critically for this study, Lymbery (following Hudson 2002) goes on to suggest that:

...inter-professional rivalries do affect the quality of collaborative working that can be developed...[T]here are three critical areas in which these rivalries are played out; professional identity and territory; relative status and power of professions; [and the]different patterns of discretion and accountability between professions.

(Lymbery 2006, p1121)

Thus tribalism in H&SC is proposed to occur when the boundaries of groups with roles that are perceived to be distinct appear to be threatened by the integration of different professional groups (Carlisle *et al.* 2004). In 1995, Nolan suggested that – at that point in time – the fact that interprofessional working (collaborative practice) had often remained only rhetoric was attributable to the protectionism over professional boundaries.

The role of socialisation has also been noted to contribute substantially to the ‘development of “tribal” attitudes’ (Carlisle *et al.* 2004, p548; Atkins 1998; Seabrook 1998). What we begin to understand here is the complex and interrelated nature of professional history, culture and identity and the influence of these on interprofessional working. It is apparent that it is not possible to define the professional identities of H&SC professionals without knowing about their relationships with other H&SC professions, while at the same time, interprofessional relationships are potentially influenced by, and can influence, concepts of professional identity and status.

To add another layer of complexity, a further point for consideration is the extent to which ‘traditional’ organisational structures within H&SC are already seen to be changing. Eve and Hodgkin suggest that there is a need to recognise that large organisations such as the NHS are moving from traditional hierarchical structures to webs: ‘multiple small units with many horizontal as well as vertical relationships, rather than a single monolithic

whole' (1997, p82). This, they suggest, results in 'less emphasis on following orders from above [and] more on working out the appropriate local response' (Eve and Hodgkin 1997, p82). The resultant 'boundary blurring' through changing roles such as the introduction of 'nurse consultants' in the NHS in 1999, or even the perception of 'boundary-blurring', causes concern where it is believed to erode roles of certain professions, and therefore create (further) uncertainty in relation to professional identity (Baxter & Brumfitt 2008; Williams & Sibbald 1999).

2.8 Academic Identity

This chapter has identified the importance of the socialisation processes in developing professional identity. Monrouxe (2010) proposes that:

Medical education is as much about the development of a professional identity as it is about knowledge learning. (p40)

The same point may be made for all H&SC professions. The implications of this include the need to understand the development of identities and the processes by which identities are achieved. This includes understanding the positions and opinions of those undertaking the facilitation of identity development, either as academic teachers or clinical teachers.

A separate body of work on the professional identity of academics does exist (Malcolm and Zukas 2009; Beck and Young 2005; Becher and Trowler 2001) much of it focusing on the way that academics achieve or struggle to achieve 'academic identities'. Archer's (2008) study of 'younger academics' for example, suggests that 'becoming' an academic is not a straightforward or linear process, and can involve 'instances of inauthenticity, marginalisation and exclusion' (p387), arising from issues of age, contract status or perceptions of the achievement of 'success'. However, there is little specifically concerning the identity of academics who teach and work in H&SC, who having already 'achieved' one professional identity in health

and social care, may face similar challenges as they enter the world of academia.

For academics who are also H&SC professionals (or who initially trained as such), the extent to which they identify themselves as a professional or an academic / teacher adds a further layer of complexity to issues surrounding their professional identity. Meerabeau suggests that:

It is debatable whether the latter is a distinct occupation (that of the 'don', to use rather antiquated language) or whether the primary identity of the university lecturer, particularly in vocational courses, derives from the discipline which they teach.

(1998, p83)

Thus the extent to which those who teach in educational establishments consider themselves academics, teachers, or purely as members of the profession in which they originally qualified is important when trying to understand influences on the socialisation of H&SC students.

The extent to which practicing H&SC staff perceive themselves as 'teachers' is also of interest. Lake (2004) notes that there is a tendency for doctors who teach to have had little training to do so, and to be told that they are typically poor at supervision and teaching. In these circumstances, the extent to which a teaching identity would therefore be viewed as positive and desirable might also be questioned. Emphasis was therefore given to the questions raised here about academic and teaching identities in the empirical elements of this research. Practicing members of H&SC staff were asked about the teaching elements of their roles to establish how this contributed to their identity as a professional, and the academic staff were specifically asked if they identified themselves in the role of 'teacher' rather than as the profession in which they originally trained.

2.9 Summary

This chapter has explored notions of identity, and has explained how 'professional identity' can and should be seen as one of many simultaneous identities. While identity is undoubtedly unique to each person, a 'professional identity' also contains elements of the 'social' because of its association with a group of similarly qualified people. We have seen that identities are associated with 'performance of a role', and as such they can be interpreted differently by different audiences. There is also scope to understand identities by looking at the 'narratives' that people build about who they are.

The histories of the professions presented here are very broad. Not only have large and complex histories of the professions been explored briefly, but there has been little or no acknowledgement that what has been explored is each profession 'as a whole'. However, there are many different branches and specialties of most professions discussed, each of which have their own nuanced history and potential identity. Whilst this is not a theme of the literature (although it emerges briefly in the 2010 text by Bolderston *et al.* concerning radiation therapists), the fact there are different branches of professions must be acknowledged in any research on identity, because different professional roles will obviously lead to different experiences even if members of a profession are given the same 'umbrella' label that incorporates all. Additionally, it should be acknowledged that interpretations of the 'professional identity' of H&SC professions tend to be presented from the viewpoint of other academic disciplines (sociologists, anthropologists etc.) or from the viewpoint of the professions themselves. The purpose of the 'performance' of the role of any H&SC professional is of course, for the patients and carers, but their views on professional identity, and where it may be viewed as succeeding or failing are not evident in the literature. This may be merely an issue of timing; where the large influential studies of professions and professionalism were undertaken from the 1960s onwards, the consultation and involvement of patients / service users in research has only really been seen in the last ten years,

since when far less attention has been paid to 'professional identity' than other topics. It may be however that a patient viewpoint on identity may help all professions to understand how they are perceived by the people they have trained to help.

In this chapter it has also been established that another key aspect to understanding 'professional identity' is that it is not something an individual (necessarily) chooses to have, but is an (inevitable) consequence of becoming a member of a particular profession. And yet such identities are not static; the roles of the professions change over time and with different influences (professional bodies, policies, and even public perception). Shove (2012) refers to social practice when she states that:

With each transition, elements...the details of know-how, the meanings and purposes of the practice and its characteristics – as entity and performance - have been reconfigured. (p8)

However, if one considers professionalism to be a 'social practice', it can be seen how discourses of professionalism have shaped professional identities over time. Additionally, it can be seen that professional identities are to a certain extent about expectations – what other professionals expect and what the public (and therefore patients) expect of a profession and a professional. And it is precisely because professional identity incorporates these complex and changing elements that those wishing to push for interprofessional collaboration need to understand it, ensuring that IPE leads to collaborative practice and is not seen as a barrier to overcome. The way in which students are socialised into a profession also means that any identifiable 'theory-practice' gap between the theory of what is taught about IPE and what happens in practice has implications for all professions and collaborative working. The following chapter therefore considers the history of IPE, the evidence generated by projects attempting to introduce IPE into undergraduate, and postgraduate curricula and the linkages made between professional identity and IPE thus far.

Chapter Three

Interprofessional Education: Policy, Literature and Evidence

...there is certainly no 'one size fits all'. Willingness to adapt to the various contexts and circumstances of the learning environments with a range of strategies is likely to prove the most adaptable way of working in the future.

(Miller *et al.* 2006, xviii)

3.1 The literature searching process

This chapter examines evidence for the effectiveness of IPE in H&SC education by reviewing published literature concerning the introduction of IPE into curricula in various formats; it also examines discussions that relate IPE to issues surrounding professional identity. An initial literature search was undertaken at the beginning of the research process with the thesis proposal (2008). A more systematic search was conducted at the beginning of 2013, looking at all relevant papers published between 2000 and 2013. The majority of work (over 10,000 papers) published in this field is concentrated around the mid- to late-2000s; given the need for literature to be still relevant within the current structures and curricula of H&SC, papers published pre-2000 were excluded. However, influential papers published prior to this date, or those that have been recurrently cited, have also been included in this review. After this date, content alerts for the *Journal of Interprofessional Care* and *Medical Education* were used to identify further contributions to the field of work.

The literature search itself was carried out using the PubMed databases MEDLINE and CINAHL, as well as the British Education Index, with search keywords: 'interprofessional', 'inter-professional', 'multiprofessional', 'multi-professional', 'inter-disciplinary' and 'multi-disciplinary'. This yielded 9,484 results. These were imported into EndNote Web and filtered for relevance by reading through the abstracts. Certain journals (*Journal of Interprofessional Care*, *Journal of Integrated Care* and *Medical Education*)

were also searched by reading through content lists. These processes resulted in 436 identified papers specifically about IPE initiatives; 121 on 'readiness' or attitudes towards IPE; 85 on staff development and faculty perspectives on IPE; 21 existing literature or systematic reviews; and a further 120 relevant papers, such as those drawing on theories related to IPE or which explored relationships between IPE and learning theory.

From this selection, the papers read in entirety (c. 350) were determined by their availability at my institution of study, but where abstracts indicated that the paper made a significant contribution to the knowledge base on IPE, these were also requested and read. Before the literature is discussed in detail consideration is given to how government policies, its drivers, and curriculum changes across H&SC all resulted in IPE becoming a dominant discourse in H&SC education before evidence for its efficacy had been gathered or agreed.

3.2 Government policies and curricula changes

In the UK, there has been a significant political emphasis on developing interprofessional working and collaborative care, with a succession of papers published by the Department of Health (DH) (1989, 1990, 1998) looking to improve multi-agency partnerships between health and social care services and related to the modernisation agenda for the NHS (Scholes and Vaughan 2002; Ross *et al.* 2005). Political emphasis around the organisational efficiencies of H&SC services have highlighted the need for improved 'joined-up working', a notion that is generally supported by the whole political spectrum as a potential way to use resources more efficiently. Additionally however, there are also political responses to identified failures of the H&SC system; the need for better teamwork and communication skills between professions having been recommended in a number of high profile reports and inquiries, many of which have investigated failures of H&SC to act to the highest expected professional standards. The failures of H&SC are to a certain extent therefore in danger

of being exploited for political means (again, by either end of the political spectrum) where political proposals around reforming the H&SC system become tangled with these failures, and yet H&SC failures do highlight issues of professionalism. One of the main drivers for improved collaboration has been the need to improve both outcomes for patients and patient safety. The Kennedy report into the 'management of the care of children receiving complex cardiac services at the Bristol Royal Infirmary between 1984 and 1995' (DH 2001), for example, recommends 'broadening the notion of professional competence' through 'shared learning across professional boundaries', and suggested that there should be:

more opportunities than at present for multi-professional teams to learn, train and develop together. (Kennedy 2001, p445)

The Laming inquiry into the murder of Victoria Climbié by her guardians, after she had been visited by social workers, recommended that:

The National Agency for Children and Families should require each of the training bodies covering the services provided by doctors, nurses, teachers, police officers, officers working in housing departments, and social workers to *demonstrate that effective joint working between each of these professional groups features in their national training programmes.*

(Laming 2003, p367, emphasis added)

These recommendations were made in high profile public inquiries and stem from a claim that better or more collaborative working (among many other things) might have prevented these incidents. However, it should be noted that these recommendations are vague in nature; for example, the statements 'more opportunities' and 'demonstrate...effective joint working' do not propose how such improved team working should be achieved (but nor was it their remit to do so). Nevertheless, they are often cited as influential policy drivers in the development of IPE (Thistlethwaite 2012; Anderson *et al.* 2010), which, for clarity of definition, can be described as when two or more professions 'learn with, from and about each other to

improve collaboration and the quality of care' (CAIPE 2002). Nevertheless, without existing evidence for these recommendations, it still requires a 'leap of faith' to assume that developing IPE in itself would automatically lead to 'more opportunities' to learn together, or result in 'effective joint working'.

As discussed in Chapter One, the emergence of IPE in the UK as a dominant discourse for improving teamwork and collaboration in H&SC was also driven by the policy agendas laid down by the government in the form of the Health Act 1999 and the Health and Social Care Act 2001 (Cooper *et al.* 2004). In particular the Health Act of 1999 stated that NHS bodies and local authorities:

...shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

(Health Act 1999, Part 1, Section 27)

Craddock *et al.* (2013), following Robson and Kitchen (2007) state that the 'the integration of IPE into prequalifying curricula is mandatory', as introduced by the DH and Quality Assurance Agency (QAA) in 2006. However, the situation is more complicated than this statement suggests. Barr *et al.* (2011) highlight that pre-registration IPE is, and has always been:

...subject to separate regulation within each of the professional courses in which it is embedded. (p30)

This resulted in most professional courses that wanted to introduce IPE attempting to meet two or more sets of requirements. What the QAA published in 2006 was a statement of common purpose for all health and social care professions, which was based upon benchmarking statements from all H&SC professions prepared and gathered from 2000 onwards. Agreed by representatives across many professions, (the Department of Health, Skills for Health, health authorities and universities) the statement:

...encouraged shared learning between students from a range of health and social care professions, but was *not* to be regarded as a national curriculum for such learning.

(Barr *et al.* 2011, p35, emphasis added)

The QAA statement was an agreement in principle across professions, educators and their regulators that IPE needed to be included at pre-registration level. This pressure from policymakers and, in particular, the DH to ensure that IPE was included in all undergraduate training resulted in responses from professional bodies, most stating that students from their respective professions would graduate being better prepared to work in multi-professional teams and across professional boundaries. For example, the 2010 Standards of conduct, performance and ethics published by the NMC states that nurses and midwives must:

...work cooperatively within teams and respect the skills, expertise and contributions of your colleagues [and]...share your skills and experience for the benefit of your colleagues...consult and take advice from colleagues when appropriate...make a referral to another practitioner when it is in the best interests of someone in your care. (p4)

Similarly the 2009 version of 'Tomorrow's Doctors' emphasised the need for doctors to both understand and respect the contributions of other H&SC professionals as well as understand the contribution of interdisciplinary learning and working to the delivery of effective and safe patient care (GMC 2009).

The ability to work cooperatively across professional boundaries is therefore now seen as integral to professional behaviour and responsibility and is clearly something all professions agree contributes to good patient care. Nevertheless, this does not explain how interprofessional education became seen as the way this aim would be achieved, and how it became understood that students from different professions learning together would automatically result in graduates better able to work together.

3.3 IPE as a dominant policy discourse

Despite the lack of clear legislation demanding the provision of IPE in H&SC curricula (although, as explored above, there is much policy pressure in this area), the dominance of IPE as the (theoretical) method to improve collaborative practice implies that, at some point it became tacitly accepted as ‘the way forward’ to achieve the policy aims involved in creating an interprofessional workforce. Needham (2011) looks at the ‘personalisation agenda’ in this same context, exploring how:

...a wide range of actors use policy to convey certain meanings, how far meanings are shared, how some meanings come to be dominant and how they shape practice. (p14)

Needham notes that for personalisation, the cross-political appeal ‘implied the emergence of a new policy orthodoxy’ which made it difficult for anyone to speak out against the agenda being established (2011, p2). The same argument can also be applied to IPE – that, with the inadequacy of previous models of professional working becoming increasingly obvious (and highlighted as the cause for system failures), the need to improve interprofessional collaboration, and to do so through the education of H&SC professionals, appeared self-evident. As this chapter reveals, subsequent attempts to introduce, define and refine IPE varied hugely in scale and results, but the voice of CAIPE (the Centre for the *Advancement* of Interprofessional Education) in the UK must not be underestimated.

Established in 1987, CAIPE was set up by academic advocates of IPE, a concept that CAIPE helped to develop became the most-widely used and recognised definition of IPE. ‘When two or more professions learn with, from and about each other to improve collaboration and the quality of care’ (CAIPE website). The CAIPE website (in 2013) states that:

CAIPE acts on the belief, corroborated by a growing body of evidence, that well planned IPE can cultivate closer collaboration not only between professions but also between organisations and with service users and their carers; collaboration which, in turn,

can improve care and quality of life for individuals, families and communities. (Emphasis added)

While the aim of improving care and quality of life is of course vital to any innovation in H&SC, and is indeed commendable, it is interesting to note that the language of the Centre is one of 'belief' and a 'growing body of evidence' about IPE, as opposed to an *existing* body of evidence and underpinning theory. As an authoritative agency both nationally and internationally, and with strong links the *Journal of Interprofessional Care* (one of the dominant academic journals publishing in this area), the ability of CAIPE to influence how IPE has been perceived and promoted has to be recognised as important to the way IPE became seen as 'the answer' to improving collaborative working.

Another potentially influential factor in the development of IPE was the 2001 call for bids by the Department of Health to:

HEIs and Workforce Development Confederations in England inviting joint applications for funding to support 'common learning programmes for pre-registration students'. (Barr 2007)

This movement resulted in four 'pilot sites' (known as the Common Learning Pilots) being funded in England by the DH to implement an array of IPE initiatives:

- The Common Learning Programme in the North East (CLPNE), which sought to develop and implement practice-based IPE involving multiprofessional groups of students working in teams, shadowing practice with real clients.
- Interprofessional Learning in Practice (ILP) in South East London, which involved developing a course in communication and healthcare ethics for students of all H&SC professional programmes, as well as a practice-based course through which students would 'engage each other in clinical practice'.

- The Combined Universities Interprofessional Learning Unit (CUILU) which aimed to ‘embed emerging practice-based interprofessional learning pedagogy into curricula for students of H&SC’ across two participating universities.
- The New Generation Project, which comprised three mandatory, interprofessional learning units (IPLUs) that were assessed and embedded in all pre-qualifying H&SC programmes across the project partners. (based on Barr 2007)

Each of the four sites conducted their own evaluations and published comprehensively about their experiences, see, for example Gordon *et al.* 2004, Hean *et al.* 2006a, O’Halloran *et al.* 2006 and Pearson *et al.* 2006. Additionally, the DH commissioned an independent team (though some of the named Project Advisory Group were associated with CAIPE) to conduct an evaluation which explored existing evidence for IPE and described in detail the four programmes of work and their impact, as well as making a number of evidence-based recommendations (discussed later) for developing IPE at Macro, Meso and Micro levels (Miller *et al.* 2006).

However, it was not necessarily evaluations of experiences from these sites that acted as a catalyst for other institutions developing IPE; as noted in a monograph detailing the four case studies, many other ‘parallel developments had begun at much the same time’, and the contribution that learning from the case studies made was to the already ‘growing, collective understanding of pre-registration IPE’ (Barr 2007, p72). Nevertheless, the very fact that the DH invested heavily in IPE pilots could have been an influential factor in the considerable attention paid to IPE in other areas (Miller *et al.* (2006) noted that over £3 million was made available to support the initiative). It is conceivable that other educational establishments did not want to be, or even perceived to be, ‘left behind’; others may have developed their own programmes with the hope that further funding would be available to develop them. Whatever the case, it appears that while there was some investment in establishing best-practice and an evidence-base for IPE, a number of attempts to trial various models

occurred before evidence was gathered or published, with the effect that thousands of articles are available on IPE and the 'best ways' to teach it, but still very few contribute to the evidence base on its effectiveness in improving either collaborative practice or patient care.

While all the recommendations made in the evaluation of the IPE pilots were of relevance to introducing IPE generally (including a number concerning the practical aspects of organising IPE), there were four that were specifically relevant to this research:

- There should be a strategic recognition of the need to commit long-term investment in preparing staff for the role of IPE facilitator.
- IPE should take place at least partly in practice settings as recommended in *Working Together, Learning Together* (Department of Health 2011).
- Student groupings should normally reflect naturally occurring professional groupings for those IPE activities that focus on patient / client care (whether involving real or hypothetical patients / clients).
- IPE activities should involve students actively learning with, from and about each other, and include exploration of professional roles and identities. (Miller *et al.* 2006, xix – xx)

These recommendations, all discernibly related to socialisation and socialisation processes, highlight an existing recognition in this field of work concerned with the importance of staff roles in IPE facilitation and engagement, and the need for experiences of IPE to be relevant in both place and context. Furthermore, the explicit acknowledgement of the need to explore the roles and identities of other professionals also implies that the relationship between IPE and professional identity is important. The evaluation found that:

There was evidence of stereotypical attitudes and beliefs amongst first year students. Medical students attracted more attention than students from other disciplines, either as a result of other groups'

prejudices of because their behaviour evoked comment...There was evidence [in one] case that shared status as students and neophyte professionals did not engender a sense of commonality and group purpose, and diversity within the groups served to exacerbate negative stereotyping. (Miller *et al.* 2006, xiii-xiv)

Such findings clearly emphasise the need to explicitly incorporate keen explorations of professional identities as part of IPE, given that exposure to opinions about other professionals could serve to reinforce rather than address negative stereotypes.

This section has given one interpretation on how IPE became dominant in H&SC education policy and curricula, and has taken a summary look at some recommendations from the evaluation of government-funded pilots of IPE. However, the reviewed evaluation did not reveal evidence concerning whether IPE is effective in improving what it is supposed to improve: collaborative working and, subsequently, patient care. The following section therefore examines published evidence for the 'effectiveness' of IPE, drawing on existing literature and systematic reviews focused around this topic.

3.4 Existing literature reviews on IPE

A number of existing reviews that aim to examine evidence for the effectiveness of IPE already exist (Zwarenstein *et al.* 2000, and updated in 2008; and also updated by Reeves *et al.* 2010a, Cooper *et al.* 2001, Freeth *et al.* 2002, Barr *et al.* 2005, Hammick *et al.* 2007 and Thistlethwaite 2012). Nevertheless, it should be noted that the later material often draws heavily on the earlier works. The extent to which it is possible to gather and then provide evidence pertaining to the impact of a particular working practice, such as collaborative practice, has been questioned by others working in this field. In particular questions have been raised regarding whether it would ever be possible to separate and therefore assess the impact of one particular 'practice' on a patient outcome (Pirrie *et al.* 1999; Kilminster and

Zukas 2007). As the reviews of evidence of effectiveness are an important part of the literature base for IPE they must still be considered here despite these considerations. Before attention is given to whether these reviews were able to find evidence of effectiveness for IPE, it is first important to understand that IPE can take many different forms, which in itself contributes to the difficulties of gathering evidence of its 'effectiveness'.

3.41 'Forms' of IPE

Interprofessional education can and has been conceptualised and subsequently introduced in many different forms. Langton (2009) classified university-delivered IPE into five main types:

- A common curriculum across all professions (for all parts of a programme).
- eLearning in parallel with other courses.
- One or more modules inserted into new or existing curricula.
- Within clinical practice as one element.
- Work-based.

However, Langton also acknowledges that IPE may be a combination of two or more of these. There are also a multitude of other variables to be considered, including whether IPE is 'formal' – that is initiatives that are *planned* to involve opportunities for learning and change through interprofessional interaction, or 'informal' - that is more serendipitous interprofessional learning (Freeth *et al.* 2005; Barr *et al.* 2005). Barr *et al.* (2005) also note that whether IPE is compulsory or voluntary impacts upon engagement. While IPE must still be recognised as an experience which is *interprofessional*, defined by Hammick *et al.* 2009 as 'a way of learning and working with others that is respectful of them, and, by implication, of what they know' (p3), it must be understood that the term 'IPE' does not apply to one single type of initiative but is now understood to apply to a variety of scenarios. It is in this context then that the following

discussion on existing reviews of the evidence of effectiveness for IPE must be situated.

3.42 Exploring the evidence for the effectiveness of IPE

The review undertaken by Zwarenstein *et al.* (2000) and published through the Cochrane Collaboration was very specific in its search terms. Firstly, it aimed to assess the effectiveness of IPE interventions compared to uni-professional education, and 'to assess the effectiveness of IPE interventions compared to no education intervention' (Zwarenstein *et al.* 2000, p1). It also restricted the review to papers that used randomised controlled trials, controlled before and after studies and interrupted time series studies. Pirrie *et al.* (1999) are particularly sceptical of this approach, suggesting that it is unlikely there will ever be a 'sufficient number of published evaluations' to ever meet the inclusion criteria in order to make the review meaningful (p305). Indeed in their initial search, Zwarenstein *et al.* did not find any studies that met their criteria. The updated review (published as Reeves *et al.* 2008, and also as Reeves *et al.* 2010a) identified six studies meeting the criteria. However, while the authors consider that the quality of quantitative IPE research is improving, the paper concludes that:

[a]lthough these studies reported a range of positive outcomes, the small number of studies, combined with heterogeneity of IPE interventions, means it is not possible to draw generalizable inferences about the effects of IPE. (Reeves *et al.* 2008, p9)

More particularly, the papers call for further, rigorous mixed methods studies of IPE 'to provide a greater clarity of IPE and its effect on professional practice and patient /client care' (Reeves *et al.* 2010a, p230).

The review by Cooper *et al.* (2001) examined only studies concerning IPE activities that had taken place at pre-registration / undergraduate level, but also considered studies using both qualitative and quantitative methods. The authors explored the effectiveness of 30 articles meeting their

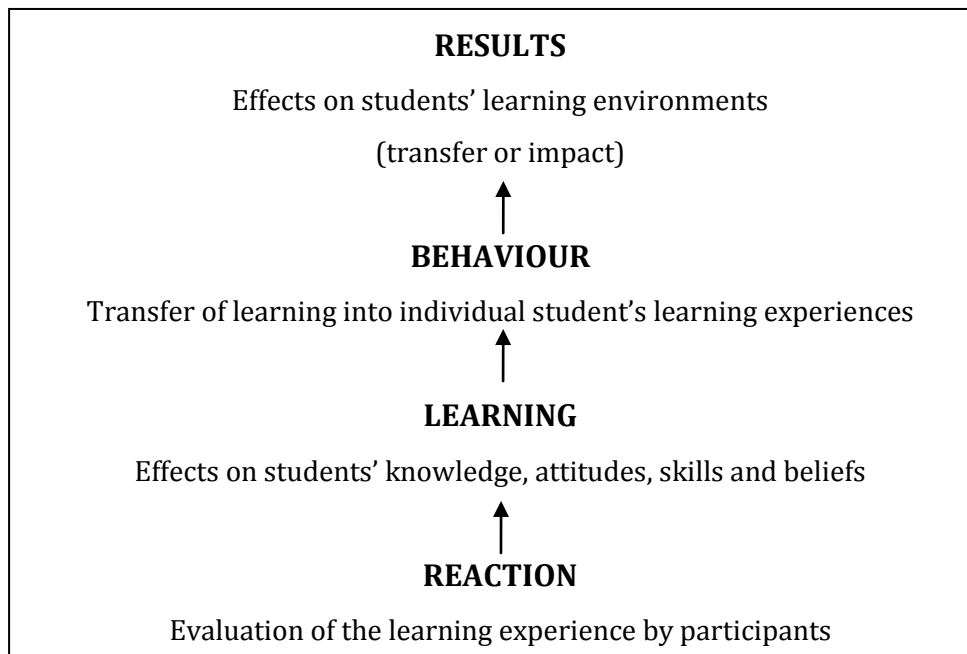
inclusion criteria: the article must be written in English, and the IPE had to be provided for undergraduates while meeting one or more of the following aims:

- To increase interdisciplinary understanding and co-operation.
- To promote competent team work.
- To make effective use of resources.
- To promote high quality, comprehensive patient care.

(Cooper *et al.* 2001, p230)

To judge the effectiveness of outcomes of the IPE initiatives, Cooper *et al.* developed a model based on Kirkpatrick's (1967) four-point typology of educational outcomes (see Figure 3.1).

Figure 3.1: Cooper *et al.*'s (2001) Hierarchical levels of evaluation of IPE interventions developed from Kirkpatrick (1967)



Source: Cooper *et al.* 2001, p233

Within this model, each stage represents an increase in the 'complexity of behavioural change', where 'reaction' is the lowest level and 'results' the highest and most complex level, at which interventions can be judged to

have had an impact on students' learning environments. While Kirkpatrick's typology is widely used in literature regarding training, a number of issues with using such an evaluative tool have been identified, which also apply to Cooper *et al.*'s adaptation. Firstly it has been noted that while the top level of such models are highly desirable to achieve, as they describe an 'impact' of education, they are extremely difficult to assess (Harden *et al.* 1999, p558), requiring information on whether students were able to transfer learned skills into practice (Carpenter 2011). Additionally, Baldwin and Ford (1988) suggest that in order to truly understand the impact of the transfer of skills from training into practice, there are a number of variables that need to be taken into account that are excluded from the one developed by Kirkpatrick and consequently Cooper *et al.* (2001). These include trainee (or student) characteristics, environmental characteristics (including the organisational climate such as favourability towards a new initiative) and the 'conditions of practice' such as how the training is delivered. The difficulties of isolating an IPE intervention have already been noted as problematic (Pirrie *et al.* 1999), and the use of Cooper *et al.*'s model to evaluate IPE interventions can be further critiqued as having excluded the contextual variables identified by Baldwin and Ford. Nevertheless the model has been used and is well-cited in IPE literature.

Cooper *et al.* themselves used their model to align themes and subthemes of IPE interventions they reviewed against each of their identified 'levels of evaluation', in order to evaluate both the educational processes and their effects (2001, p233).

The majority of evaluations Cooper *et al.* reviewed were short-term studies, which, following Hargreaves (1996), the authors suggest provided anecdotal rather than recognised / accepted evidence and outcomes; additionally, the scale of the studies (which generally did not follow up what happened when students went into practice) reduced the likelihood of evaluating the outcomes as reaching the highest level of 'results' against

their model. Nevertheless, Cooper *et al.* did find that the largest effects of the IPE initiatives studied:

...were on students' knowledge, attitudes, skills and beliefs, in particular on understanding of professional roles and team working [and that] early learning experiences were most beneficial to develop healthy attitudes toward interprofessional working. (Cooper *et al.* 2001, p235)

Despite positive findings showing that the interventions were high quality and that IPE may improve attitudes towards collaborative practice, it was noted that there was little reinforcement of what was learned, and the lack of longer-term outcomes meant that there was no evidence for the effect of IPE on professional practice (Cooper *et al.* 2001, p236). In terms of understanding the 'effectiveness' of IPE, the most positive this study was able to be was that there were short term changes to knowledge, attitudes, skills and beliefs as a result of IPE interventions, but no proven longer term outcomes on either collaborative practice or patient care.

Of all the existing reviews, the book by Barr *et al.* (2005), an extension of the review by Freeth *et al.* (2002), has been especially influential, principally because it presented a typology (also an extension of Kirkpatrick's 1967 model – see Table 3.1) with which to classify interprofessional education outcomes. Hammick *et al.* (2007) subsequently used this typology to carry out their own review.

Using a selection criteria that involved looking at the quality of methodology and the sufficiency of information provided, Barr *et al.* (2005) used their classification to review 107 evaluation studies (of 353 initially found) (summarised in Table 3.2) of formal and informal IPE (where formal involves an explicitly planned activity, and informal is ad-hoc encounters between different professionals). Of the papers they reviewed, 79% concerned postgraduate / qualifying IPE; 19% undergraduate or pre-qualifying IPE; and 2% were mixed. 54% of the papers reviewed were from the USA, 33% were from the UK, and 4% were from other European countries.

**Table 3.1: Interprofessional Education Joint Evaluation Team
classification of interprofessional education outcomes**

Level 1	[Learners'] Reaction	Learners' views on the learning and its interprofessional nature
Level 2a	Modification of attitudes / perceptions	Changes in attitudes or perceptions between participant groups and towards the value / use of team approaches to care of a specific client group
Level 2b	Acquisition of knowledge and skills	Including those linked to interprofessional collaboration
Level 3	Behavioural change	Individuals' transfer of interprofessional learning to their practice setting and their changed professional practice
Level 4a	Change in organisational practice	Wider changes in the organisation and delivery of care
Level 4b	Benefits to patients / clients	Improvements in health or well-being of patients / clients

(Barr et al. 2005, p43)

Of particular interest to this study was the absence of studies based on staff-perspectives, with only four using data collected from staff (either clinical facilitators or higher education teachers) (Barr *et al.* 2005, p56). While acknowledging a likelihood that there is a bias towards publishing evaluations with positive rather than negative outcomes, Barr *et al.* (2005) noted that there was a 'predominance of positive findings across all six of the outcome categories' (p74) and that 'most studies reported outcomes at more than one' of their identified levels of classification (p75).

Table 3.2: Summary of outcomes after classification of 107 IPE studies

Level	Outcomes ¹	Typified by...
1 (Learner Reactions)	42% positive 5% mixed	Questionnaire data, information on whether learners enjoyed the IPE experience, their satisfaction with the experience and their rating of the experience
2a (Attitudes/ perceptions)	20% positive 6% mixed 5% neutral	Questionnaire data, outcomes were measured in changes in attitude towards teamwork and other professional groups and / or working with them
2b (Knowledge and skills)	36% positive 2% mixed	Questionnaire data, outcomes concerned reported changes in knowledge or skills such as enhanced understanding of roles and responsibilities of other H&SC professionals and improved knowledge of multidisciplinary teamwork / development of teamwork skills
3 (Behavioural change)	20% positive 2% mixed 2% neutral 1% negative	Often based on simple, self-reported accounts of behavioural change, these studies focused on interprofessional cooperation and communication or development of links between professionals
4a (Organisational practise)	35% positive 6% mixed 2% neutral	Tended to include qualified practitioners who worked on initiatives aimed at improving quality of patient care. Reporting measures included referral practices, inter-organisational working patterns, documentation of patient records and reduced costs
4b (Patients / client benefits)	19% positive 6% mixed 5% neutral	These studies used clinical outcome data to provide insights into the effects of IPE on outcomes for patients, using clinical outcomes such as infection rates, clinical error rates, patient satisfaction data and information on length of patient stay

¹ % of 107 studies.

(Adapted from Barr *et al.* 2005, pp76–79)

It is possible to see that the classification created by Barr *et al.* (2005) (Table 3.2) suggests that there is some evidence for effectiveness of IPE in improving collaborative practice or patient care, provided one directly equates 'positive' outcomes (where the learner valued or enjoyed the IPE) with effectiveness.

However, as highlighted, only 19% of the papers Barr *et al.* (2005) included were based on undergraduate IPE, which makes it difficult to argue that the identified outcomes can be used to make a case for the effectiveness of IPE at pre-qualifying level. Subsequently, the recommendations in the book for pre-qualifying IPE – namely, that IPE should be taught collaboratively through competency-based curricula – are acknowledged not to have emerged through the studies included in the review (Barr *et al.* 2005, p143) and are instead based upon existing knowledge of 'successful' IPE. It is therefore difficult to establish what the Barr *et al.* 2005 review did *add* to the knowledge on improving undergraduate IPE.

Additionally, even where suggestions of improvements to patient care were made (at level 4b), there were perceptible and acknowledged limitations in the type of evidence provided:

Although data about length of stay is relatively easy to collect, it does not provide an accurate indicator of an improvement in clinical care. Indeed, it may suggest that a clinic has increased its throughput, but not necessarily provided better care.

(Barr *et al.* 2005, p79)

This also does not take into account the difficulty of isolating the impact of an IPE initiative over any other activity occurring at the same time, something that may itself have had an impact on clinical outcomes or on length of stay. As such, it is difficult to suggest that the learning outcomes typology presented by Barr *et al.* provides much more than a useful way of categorising the outcomes of studies focused on IPE; an observation also made by Miller *et al.* (2006).

The review by Hammick *et al.* (2007) involved authors who had contributed to some of the earlier Cochrane reviews on IPE and in the earlier review by Barr *et al.* (2005). Using the model presented by Barr *et al.* to identify the outcomes of the studies (see Table 3.1), the review identified the ‘best available contemporary evidence from 21 of the strongest evaluations of IPE’ to explore the proposition that ‘learning together will help practitioners and agencies work better together’ (Hammick *et al.* 2007, p735). The review presents a comprehensive discussion based upon the 3-P (presage – before learning takes place, process - during learning, product – the outcome of learning) model of learning, and identified a number of key messages, lessons for practice, and implications for future evaluations. Of particular interest to this study, the need for staff development to enable ‘competent facilitation’ was recognised as ‘essential’ to the effectiveness of IPE (Hammick *et al.* 2007, p748). The review concludes by identifying four papers where IPE had been evidenced as part of programmes leading to improvements in screening or illness prevention services. While the review acknowledges that conclusions are the opinions of the review’s authors, it nonetheless presents a substantial quantity of learning about ‘some key mechanisms that act to influence the outcomes of IPE’, one of which concerns how IPE may change attitudes towards other professionals. (This issue will be returned to in more detail in Section 3.8 which looks at the existing literature surrounding IPE and socialisation processes.) However, it is also noted that the review does not find overwhelming evidence to support the proposition that learning together results in more effective collaborative practice.

In a more recent review by Thistlethwaite (2012), which aimed to explore the ‘context, learning and research agenda’ surrounding IPE, summaries are given of ‘challenges of interprofessional development’, ‘theoretical underpinnings’, and ‘the research agenda’. Thistlethwaite’s review is more of a statement about what knowledge and research already exists rather than an exploration of effectiveness (or evidence for it), but it is noted that

one barrier to evaluating the effectiveness of IPE is the wide range of different activities that can be defined as 'interprofessional', such as those identified previously.

This section has attempted to summarise the most influential and frequently cited reviews of IPE literature. While many did identify useful and key learning about introducing IPE, all of the reviews concluded with expressions of desire to see 'more research' in the field to strengthen the evidence base that would answer more questions about the 'effectiveness' of IPE. It is difficult to pass comment on the studies showing no evidence for the effectiveness of IPE identified in these reviews, as discussions tended to focus on where learning had been around positive outcomes. In their review, Hammick *et al.* (2007) suggest that a note of caution should be raised concerning possible publication bias where 'the need to publish work reporting on positive outcomes might militate against appearance of mainly negative studies' (2007, pp748-749), although their own finding was that negative outcomes were more common in studies looking at changes in perceptions and attitudes to IPE. This issue is explored in more detail in Section 3.6. Firstly, however, consideration is given to learning theories with which IPE has been aligned, to establish what underpins IPE as an educational initiative.

3.5 IPE and learning theories

The introductory chapter outlined that this thesis uses a sociocultural lens to explore IPE, which focuses on the situated nature of learning. From the sociocultural perspective:

...the physical context, the type of participation and the development of relationships, all work to facilitate learning through a process of 'becoming' a member of the professional community and workplace. (Kilminster 2009, p38)

This is clearly only one perspective from which to understand 'how' learning occurs, but such a perspective highlights the importance of understanding the theories that have informed curriculum design and research, and driven educational methods.

There have been several attempts to align IPE with existing learning theories and to design it with reference to a variety of theoretical perspectives. Curran *et al.* (2010) suggest that 'constructivist learning theory has important implications for the design of classroom-based IPE' (p49), because it proposes that meaning making and, consequently, learning occur through interaction and dialogue. Working in small groups for self-directed learning using problem-based learning (PBL) (or case-based learning – CBL) has also been demonstrated to help students on IPE modules 'develop knowledge and language together to build a common value basis' (Wilhelmsson *et al.* 2009, p124). Curran *et al.* note that using such approaches as PBL in IPE:

...should draw upon real-life clinical problems to stimulate interprofessional problem solving and should incorporate small group, experiential methods of learning. (2010, p49)

This is important, D'Eon (2005) suggests, to ensure that learners can transfer their classroom-based learning in context to the 'real-world'. D'Eon also suggests that IPE learning situations need to be structured using five elements of co-operative learning and that the process needs to be approached through an 'experiential learning framework' (D'Eon 2005, p49). D'Eon's paper (entitled '*A blueprint for interprofessional learning*') offers his take on 'the key educational principles and practices that seem most suited to [undergraduate] IPE' (D'Eon 2005, p49). The author argues that the notion of 'cooperative learning' (CL) has previously been demonstrated as an effective tool to promote learning to work in teams, involving students working together to reach a common goal. Additionally, D'Eon notes that the features of CL were identified previously in descriptions of successful IPE in the work of Parsell and Bligh (1998),

although these authors had not labelled or identified these features in the same way. D'Eon's practice points include using cases (either simulated or real) to approximate situations in which interprofessional teams will practice (just as it has previously been argued that the 'best learning' occurs in real life contexts – Blumenfeld *et al.* 1997; Brown *et al.* 1989;), and to progressively increase the complexity of practice cases to 'enhance transfer to practice circumstances' (D'Eon 2005, p57). This application of existing learning theory to IPE appears to take into account many of the challenges previously identified concerning preparing students to be collaborative practitioners.

Nevertheless, such an approach requires IPE to be introduced over an extended period of time (rather than as a 'one off' session) and to be integrated into a curriculum rather than being an optional extra. On a more practical level, Oandasan and Reeves (2005) discuss the design and organisational aspects of small group learning, suggesting that it is important to have an equal mix of learners from each profession to ensure both good interprofessional interaction and that the group should not be 'unbalanced'. However, such proposals, while sensible on the surface, also sound – just like the proposals of D'Eon (2005) – as if they describe an 'ideal type' of IPE, where equally-mixed small groups of student professionals are given an opportunity to explore real cases and to learn together. While this is not to detract from recommendations made on the basis of key learning principles, there should also be some recognition that organising IPE in such a way is probably an unlikely option for many institutions given that the organisation of much university-based IPE involved coordination of multiple course timetables and often involves difficulties in attempting to find appropriate / enough classroom space for combined cohort numbers (see Section 3.64). As a result, IPE is often arranged around practical considerations as opposed to being based on theoretically-driven models.

Owen *et al.* (2012) published a short paper on Collaborative Care Best Practice Models (CCBPMs) which were developed to address 'known

limitations in existing IPE knowledge- and attitude-based educational models' (p153). Drawing upon social and learning theories (including those on social identity), the purpose of CCBPMs is to enable learners to explore 'appropriate collaborative behaviours' in any given scenario using a combination of self-reflection and social learning. The actual process of developing the CCBPMs involves a five step process:

1. Identifying a scenario; targeting learners and associated clinical guidelines.
2. Recruiting expert panels; providing training in IPE and collaborative team facilitation.
3. Identifying a list of critical collaborative behaviours for effective implementation of each step of the guideline, creating the CCBPM and developing associated assessment tools.
4. Developing learning objectives derived from the CCBPM and designing, piloting, testing and implementing IPE experiences that reflect the learning objectives.
5. Assess IPE experience development process and student achievement of IPE learning objectives.

(Based on Owen *et al.* 2012, p154)

This approach, which is both driven by learning theory and places emphasis on contextualising the IPE experience for learners, was argued by the authors to have the potential to link IPE and specified collaborative practice more explicitly. However, given the paper was only published in 2012, there are not yet any published reports on the use of such a model either by those who developed it or by others. As such it remains an interesting potential theoretical model for IPE, but one so far unsupported by a rigorous evidence base.

3.6 Themes and variables in existing studies

There are many documented initiatives that have been aimed at enhancing collaboration between and within groups of students and staff, in a variety

of settings (Miller *et al.* 2006). The majority of H&SC professions (and certainly all those of interest to this study) are represented to some extent in the IPE literature, although a large majority focuses on nursing students. Barr and Sharland (2012) suggest that social workers are underrepresented in the IPE literature and are thus far 'minority collaborators' in both IPE and related research (p204).

The extent to which the documented initiatives are related to any particular learning theory or based upon models of previously successful IPE is variable, with many ostensibly just trials of activities conducted at particular times or with available cohorts of students (either undergraduate or postgraduate). Existing literature suggests that most evaluative studies of IPE for undergraduate / pre-qualifying IPE are based on short initiatives (O'Neill and Wyness 2005; Kilminster *et al.* 2004). This section summarises this body of literature with reference to the general themes identifiable upon reading many studies in this area: issues of 'readiness' for interprofessional learning; the evaluation of IPE initiatives; debates around the timing of IPE (e.g. whether it is better placed in undergraduate or post-graduate education); debates about whether IPE should be carried out online or face to face, in classroom-based settings or in practice settings; and issues of resources and organisation.

Additionally, the question of whether IPE is introduced as a 'core' element of the curriculum or as a voluntary / extra-curricular activity has also been identified as a factor which may influence outcomes or attitudes towards its success (Larkin *et al.* 2013; Curran *et al.* 2010). Gilbert (2005) recommends that IPE should be embedded in core subjects through both teaching and assessment, because it will otherwise have no 'currency or uptake' within a discipline. Barr *et al.* (2005) also highlight that making IPE compulsory is important, because it implies a likely higher level of underpinning institutional support for an initiative than for voluntary aspects of a curriculum. If made explicit, and where relevant, this issue is also examined in the following discussion.

3.61 'Readiness for', and attitudes towards, interprofessional learning

In 1999, Parsell and Bligh developed a questionnaire to assess the 'readiness of healthcare students for interprofessional learning' or RIPLS. The original study invited healthcare students to rate a number of statements about the desired outcomes of shared learning in order to assess the 'readiness' of the students for these activities. 120 undergraduate students from 8 healthcare professions took part in this pilot study, which was based upon three sub-scales that explored team-work and collaboration, professional identity and roles and responsibilities (Parsell and Bligh 1999, p97). The authors note that given the discrepancies between the student numbers from the different departments (professions), the final sample included the entire year group of three of the professions involved; orthoptist, therapeutic radiographers and diagnostic radiographers. For a further three of the professions (physiotherapy, nursing and occupational therapy) a random selection of 15 students from each profession who attended a lecture were approached to take part, while for medicine and dentistry, similar numbers of participants were selected but from much larger cohorts (Parsell and Bligh 1999). Consequently the final sample of participants involved a large representation of some cohorts and a much smaller representation of others. While this is not necessarily problematic to the results it does need to be noted as a potential limitation of the research, in that it privileges the responses of those students from the larger professions who represent a much larger cohort. The authors describe the final sample as a 'small' but 'acceptable minimum' for the method of analysis used (exploratory principal components analysis) (Parsell and Bligh 1999, p99), and the study made a number of observations and inferences based on their results:

- That there is a need to 'cultivate positive relationships between professionals through increased contact before qualification' with a corresponding need for the appropriate supporting educational environment that 'encourages trust and respect between learners'.

- That there is ‘an area of conflict between the retention of professional identities through adherence to a discipline-based approach to learning, and a “readiness” for sharing expertise with other students through team-based approaches to learning’.
- And finally that ‘[c]urrent professional practice reinforces the idea that some health care roles should be subservient to others’ with the doctor typically identified as the ‘team leader in patient management’; however, there is a ‘shift towards the belief that the team leader should be dictated by the context in which the team operates’, which may not be the doctor.

(Parsell and Bligh 1999, p98)

Finally, it was proposed that the RIPLS tool may help to provide evidence of changing attitudes towards team-working and collaboration. After some queries were raised about the stability of the scales of the original RIPL scale, McFadyen *et al.* (2005, 2006) revised and published details of a 4-factor version of the tool. Use of RIPLS has subsequently been reported in a number of studies that have developed the tool for a variety of purposes. For example, some studies have utilised the tool with postgraduate students (Reid *et al.* 2006), others have made cross-faculty or cross-institutional comparisons of the results (Larkin *et al.* 2013; King *et al.* 2012) or have explored uses of the tool in other countries (Lauffs *et al.* 2008). This is just a selection; as part of the literature searching process, 121 papers which discussed ‘readiness for’ or attitudes toward IPE were identified. The volume of work in this area is interesting given that the link between actually changing attitudes towards teamworking and collaboration and measuring the ‘readiness’ of students for it is not always immediately clear. It may be that as one ‘quantifiable’ aspect of a concept such as IPE notoriously difficult to measure, changing student attitudes towards IPE may have been seized upon enthusiastically as a way of showing some ‘outcomes’ from time invested in IPE programmes.

In a review of research instruments used to explore interprofessional collaboration, Thannhauser *et al.* identify that RIPLS is one of only two psychometric tools that has been developed and used with large-scale cohorts, with large numbers of papers describing the validity and reliability of the tool. (The other tool identified in the same way by Thannhauser *et al.* being the IEPS – the Interdisciplinary Education Perception Scale, first published by Luecht *et al.* 1990). Nevertheless, Thannhauser *et al.* also note a number of limitations of using such tools, including the reliance on using self-reported data to measure respondent perception, and ‘the numerous perspectives on IPE that need to be taken into account’ (2010, p340). Additionally, Thannhauser *et al.* (2010) note that all the psychometric instruments they identified focus only on ‘interactional factors’, where ‘systematic factors’ and ‘organizational factors’ have also been noted to influence collaborative relationships (Martin-Rodriguez *et al.* 2005). This is a similar observation to that regarding the model of evaluation developed by Cooper *et al.* (2001), and indicates the difficulty of trying to evaluate one educational initiative in the incredibly complex context of H&SC practice. As with the model developed by Cooper *et al.* 2001, RIPLS and other similar tools have been used to explore issues around IPE and collaborative practice, and it is worth noting the outcomes of some of these papers even with the acknowledgement that they are only ‘measuring’ part of the picture.

As the result of one longitudinal study measuring attitudes to collaborative learning and working (not based on RIPLS but on a specifically developed instrument), Pollard and Miers (2008) concluded that professionals who had experienced IPE throughout their pre-qualifying (undergraduate) education were more confident about their ability to work collaboratively and more positive about interprofessional relationships than professionals educated on uni-professional courses. This study, which presented data based on opinions of 414 professionals (275 of whom had experienced the interprofessional curriculum), was the final stage of a large study which previously administered a questionnaire to students at three points: as

they entered a healthcare faculty, during their second year of study, and at point of graduation (Pollard and Miers 2008, p402). As such the research responded to some criticisms made against other evaluations of IPE, namely that they were often based on relatively small-scale initiatives (Ker *et al.* 2003) (although the authors acknowledge that in comparison to the earlier data collection points the response rate had 'dropped considerably' – Pollard and Miers 2008, p413). Nevertheless, the findings remain based on a relatively substantial number of respondents and indicated that confidence and attitudes towards interprofessional working were enhanced by pre-qualifying IPE (Pollard and Miers 2008, p414). The results of the study, however, also indicated that 'professionals were more critical of IPE than they had been as students', which is noteworthy from a socialisation perspective. This issue is raised again in the discussion of the findings of this study in Chapter Six.

At least two recent studies, one utilising RIPLS (Larkin *et al.* 2013) and another using their own attitudinal survey (Curran *et al.* 2010) similarly found that introducing IPE during an undergraduate curriculum did 'not appear to have any significant longitudinal effect on attitudes towards IPE' (Curran *et al.* 2010, p41) or collaborative practice. However, the three year study by Curran *et al.* (2010) exploring attitudes towards IPE also looked at the satisfaction of students after a voluntary ('extra-curricula') IPE module, and did observe significant differences in attitudes of students from different professions towards IPE (2010, p51). Specifically Curran *et al.* (2010) found that the satisfaction scores were significantly lower for medical and nursing students than those of the other professions in year one of the study; significantly lower for medical students in year two of the study; and, significantly higher for pharmacy students than for medicine and nursing students in year three of the study. This is consistent with previous findings from other studies that have suggested that attitudes towards IPE differ according to professional background. Morison *et al.* (2004), for example, in a small scale study involving 30 students, concluded that student medics viewed IPE as a means to learn only about team-

working and the roles of other professionals, but otherwise preferred a profession-specific approach; and that students from both medicine and nursing viewed IPE as disadvantageous if it was perceived to impede their own professional learning.

In evaluating a common foundation programme (CFP) for degree students in medicine, radiography, physiotherapy and nursing, Tunstall-Pedoe *et al.* (2003) similarly found that the majority of students had positive attitudes towards the programme, although the attitude of medics was notably less positive than all other students: over 70% of medics and over 90% of all other students felt that 'learning together would enhance their own learning and would lead to better patient care' (p164). Additionally they found that both perceptions of how IPE affected learning and attitudes towards each other's professions became less favourable by the end of the CFP. While establishing that the 'overall attitude of medical students to other disciplines was less positive' they also noted a 'significant shift downwards in AHP and nursing students' attitudes to the medical students by the end of term' (Tunstall-Pedoe *et al.* 2003, p164). Basing their discussion on the 'contact hypothesis' proposed by Hewstone and Brown (1986) the authors suggest that when two groups are brought together, it is possible for attitudes to change if certain conditions are met. In this instance, however, they suggest that while the CFP did have institutional support, issues such as 'time-tabling and traditional geographical boundaries may have hindered positive attitude change' (Tunstall-Pedoe *et al.* 2003, p170). While this may explain why student attitudes did not become more positive, the authors did not however identify any other specific explanation for why the attitudes of students may have become more negative after the CFP. However the study did conclude that students arrived at university with stereotypical views of other professions, and that this was more pronounced when their parents were healthcare professionals. Despite these apparently negative findings, including some evidence that early exposure to other professionals did not prevent stereotypical or 'tribal' viewpoints, the study concluded that IPE:

...*must* be the way to prepare graduates for an environment where effective team working is so important, and we believe that IPE should feature from the very beginning of healthcare courses.

(Tunstall-Pedoe *et al.* 2003, p174)

This appears to provide more evidence about the way IPE has been adopted as a dominant discourse as 'the way forward' for H&SC. In this instance, despite the fact that their own study indicated that the initiative they introduced resulted in some worsening of attitudes towards IPE and other professions, Tunstall-Pedoe *et al.* still conclude that IPE is the way to prepare graduates for collaborative practice.

Carlisle *et al.* (2004) explored the 'feasibility of introducing IPE within undergraduate healthcare programmes' through a systematic review and focus-group interviews (p545). Their study involved 34 participants, including undergraduate and postgraduate students (n=8), patients with chronic diseases (n=5), academic staff (n=12) and practitioners (n=9). While drawing on a small sample (the authors acknowledge that 'the patient voice' in particular was probably underrepresented), the participants were found, similar to other studies of this nature, to strongly support IPE, while recognising the organisational challenges that present difficulties for implementation (see 3.54). Of additional interest was that all focus groups 'felt it was important to understand how professional identity could be influenced by IPE', with discussion focusing on how both students and qualified staff act as 'gatekeepers to professional role identity' (Carlisle *et al.* 2004, p550). Such findings, the authors suggest:

...point to the need to start IPE as early as possible, thereby integrating the evolution of role development into the evolution of 'other' role awareness. (Carlisle *et al.* 2004, p550)

Nevertheless, the authors conclude that further research is required to establish whether the effects of IPE are variable, depending on the timing of its introduction into a programme. The issue of when IPE should be introduced is an identifiable theme in literature (see Section 3.63).

The substantial body of work on attitudes towards IPE has generated a wide range of results over the years (unsurprising in different contexts and with different respondents) and it is worth asking what work looking at attitudes towards IPE is adding to the IPE field. One methodological criticism that can be made against all such studies (based upon RIPLS or otherwise) is that they are based upon self-reported attitudes, which may be misleading for a number of reasons – for example, respondents wanting to appear more positive towards IPE to please the researchers, or indeed, conversely, not wanting to give a positive reaction if peers are also more negative. Indeed, Pollard and Miers (2008) conclude their own study, based upon a longitudinal data collection of attitudes towards IPE, by suggesting that:

...this study reinforces the argument that individuals' perceptions of their own educational experience are not adequate for comprehensive evaluation of IPE initiatives. (p414)

Thus, while RIPLS and similar studies provide interesting contextual information, even some who have published in this area have called for further research to establish more conclusively the long-term effects of IPE on collaborative practice.

3.62 Student evaluations of IPE initiatives

A number of articles focus on describing IPE programmes or pilots, and contextualise this information with evaluation of the programme. Some provide detail of resources devoted to providing the courses, but the focus is usually on evaluations of how students and / or staff (and sometimes service users) regard these courses (Peloquin *et al.* 2007; Anderson *et al.* 2010; Layzell and Chahal 2010). However, such reports are often based on small-scale pilot studies, and offer little in the way of evidence of the effectiveness for the IPE initiative they describe. Anderson *et al.* (2010), for example, conclude that their evaluation evidence:

...suggests that it is possible to develop effective practice-based interprofessional *learning opportunities*, which meet the learning outcomes of the different professions drawing on resources within the community. (p237, emphasis added)

It could be suggested that the potential to develop a learning *opportunity* for health professionals in a practice environment was self-evident, and that this was why the initiative the authors described was developed in the first instance, rather than being the study's conclusion. For the evaluation to be anything other than a description of what occurred, it would have been useful for readers to be shown an analysis of the effects of the intervention. Unfortunately, this was not possible based on the use of only post-course questionnaires, focus groups with students and interviews with service users, which gathered only *opinions* about the course and its effects. This is not a criticism levelled specifically at Anderson *et al.* (2010), but rather at the number of IPE evaluations that exist in this format. At most, these reports are useful for establishing what sort of interprofessional curricula (or pilots) existed at certain times in certain institutions. While some papers, such as Peloquin *et al.* (2007), do make some recommendations for others wishing to set up similar IPE initiatives, the problems identified with RIPLS literature are also relevant here: that the most the reports can offer is contextualising information, in this instance, about what other IPE initiatives exist and what students thought about them. If anything, the volume of such reports offer more evidence of IPE as a dominant discourse regardless of the lack of a solid evidence-base or accepted theoretically grounded approach.

3.63 The timing of IPE

The 'right' timing of IPE – that is, when to introduce it into curricula – remains a keenly debated issue, with Curran *et al.* (2010) arguing that current research in the area 'has yet to determine an ideal time or process', something that has 'largely been attributed to a lack of methodological

rigour and longitudinal studies examining such concepts' (p48). However, this assumes that work and learning practices can be 'decontextualised' (Kilminster and Zukas 2007) and that the impact of timing of one intervention could be proven to have an impact on patient care much later on in time. The debates around the 'timing' of IPE are therefore considered here in the context of a query over whether such evidence could really ever be proved.

Lave and Wenger's notion of 'communities of practice' (explored briefly in Chapter 2 with reference to identity formation) based on situated learning theory is sometimes used for understanding debates around the timing of IPE. Just as when they are developing their own professional identity, students undertaking interprofessional activities can be seen first as observers on the peripheries of their own profession, then as understanding their own role within that profession, and then finally as interacting with members of other professions, initially as observers and later as team members (Thistlethwaite and Nisbet 2011). In this way, students can be seen to learn 'with, from and about' each other through knowledge exchange and knowledge transfer (Thistlethwaite, 2012, based on Kaufman and Mann, 2007), although again the notion that 'interprofessional activities' can be separated from all other elements of professional learning process might be questioned. Harden (1998) proposed that first year students have an 'unsettled' professional identity, based on prejudices, and that this results in assumptions about other professions. As such, there is some debate as to whether it is appropriate to introduce students to interprofessional activity when they are still at the periphery of their own professional 'community of practice', unable to fully understand their own role within their own profession, and (arguably) much less likely to understand and interact appropriately with students from other professions.

In contrast, Thistlethwaite (2012), drawing on a study by Hean *et al.* (2006b), proposes that there is no reason to delay IPE once professional training has started:

Most health care students are able to differentiate their own profession from other groups early in their education, at least in relation to some attributes, which suggests there is no reason to delay interprofessional interaction until later in training.
(Thistlethwaite 2012, p66)

While not concerned explicitly with timing, the results of research by Hammick *et al.* in (2007) suggested that exposure to IPE usually results in positive effects in both students' reactions towards IPE and in changes in knowledge and skills. This could be interpreted as implicit support for the assertion that 'the earlier IPE is introduced the better', given that one would want to have students with positive attitudes towards IPE and collaborative practice as early as possible in their professional careers.

Nevertheless, arguments against introducing IPE early, and in particular the concern that students are not yet familiar enough with their own professional roles to be able to meaningfully engage with, or understand, the roles of others, means that attention must also be paid to the findings of studies that have introduced IPE initiatives at postgraduate or post-registration level.

Gaskell and Beaton's (2010) paper, for example, merely describes an MSc in Advanced Practice, which is both practice-based and embedded (as opposed to a pilot), but the authors claim that that:

...IPE at this level facilitates a greater understanding of the connectivity between professionals working in the health care system in the UK; a better understanding of the skills and knowledge base of colleagues; more inter-professional working and appropriate referrals in the work place. (p274)

Watts *et al.* (2007) suggest that their work differs from existing studies into post-registration IPE because the initiative introduced was done so in active (i.e. existing) clinical teams. The programme involved nine teams being presented with a series of aims relating to improving team performance, communication and patient care over an eight month

timeframe, during which each team had five meetings 'co-ordinated by an educational facilitator' (Watts *et al.* 2007, p444). Evaluation of the study was conducted by a series of questionnaires (at zero, four and eight months). Watts *et al.* suggest that their results show that IPL programmes such as the one described, 'can improve team functioning and raise awareness of professional roles in established clinical teams', although the need for a 'skilled educational facilitator' to support the process is also observed (2007, p447). Nevertheless, it is noted that results need to be treated with caution as only 42/71 participants completed all three phases of the questionnaire, and that 'further research is needed to improve our understanding of the impact of effective team functioning on patient care' (Watts *et al.* 2007, p448). Furthermore, no mention is made of the transitory nature of health care teams, where even 'established' teams are likely to have junior members who may be on rotation or in their first short-term posts which may make long term evaluation of, or intervention with, the 'team' difficult. It could be suggested that the transitory nature of healthcare teams makes a greater case for raising awareness of other professional roles at undergraduate level, ensuring that students and subsequently graduates know how to work with different team members at different times, and how to be prepared for the changing nature of their 'teams'.

One study by Rice *et al.* (2010) of a pilot post-graduate interprofessional intervention on general internal medicine hospital wards in Canada found no impact on anticipated changes in communication and collaboration between professionals. The intervention involved one-to-one training for the senior professionals from each profession on the ward who were asked to cascade this in a half-hour session with team members. The study's findings suggested that despite initial willingness to engage with the intervention, few front-line staff were made aware of it or supported by senior staff to engage with it. The primary reasons were cited as the 'fast-paced work environment and medical hierarchy' (Rice *et al.* 2010, p355), and in particular that medics on these wards were not used to inviting

professional opinion from others, and doing so would require considerable behavioural changes needing more than a single, half-hour discussion to implement. The paper concludes that the intervention, which was designed to be 'minimally-intrusive', was ineffective, and that:

In a healthcare setting where face-to-face spontaneous interprofessional communication is not hostile but is rare and impersonal, the perceived benefits of improvement are insufficient to implement simple and potentially beneficial communication changes in the face of habit, and absence of continued senior clinician and management support. (Rice *et al.* 2010, p350)

While based upon a small-scale pilot study, these findings could be interpreted as being indicative of the idea that if professionals are *not* introduced to IPE and socialised into communicating and collaborating with others from an early stage, a great deal of effort will be required to address their non-consultative approach to practice. However it could also be the case that the content of the intervention – a four-step semi-scripted process that was intended for use during all interactions related to patients between members of different healthcare professions – was not appropriate to meet the aims of the programme. Implementing such a complex and 'false' element of interaction into everyday conversation would be extremely complicated, even if all parties were interested in doing so.

A study undertaken by Jakobsen *et al.* (2011) indicated that perceptions of the most important learning outcomes of interprofessional training differ according to career stage / over time. The study involved a cohort of 428 students describing the most important outcomes from their experiences of an interprofessional training unit after they had completed the training, and asked them again after they had graduated. Jakobsen *et al.* found that while for undergraduate students the most important learning objectives were viewed as 'uniprofessionalism' (learning about own profession / relevance to own profession) followed by 'interprofessionalism' (team-

working and learning about the roles of others), alumni viewed 'professional identity' (improvement of professional responsibility and ability to make decisions) and 'interprofessionalism' as the two most important features of the training (2011, pp444-445). Jakobsen *et al.*'s suggestion that this change of opinion may arise from respondents developing new perspectives based on 'increased professional experiences' (2011 p445) is important because it suggests that IPE can have different aspects valued at different points in a career, and that initial responses students give might not represent the longer term 'take home message'. Where one might have dismissed the study presented by Jakobsen *et al.* as ineffective if only the first tranche of evaluation had been carried out, the longer view showed that introducing the concept of IPE to students in this instance became more relevant as soon as they were practicing professionals. Such findings reinforce the notion that there is a need for more longitudinal evaluation of IPE, as highlighted by existing literature reviews discussed earlier in this chapter.

Additionally, it should be noted that reports concerning the introduction of IPE either at undergraduate or postgraduate level do not usually compare or contrast the two. More commonly, IPE – or an interprofessional intervention – has been introduced at *either* undergraduate or postgraduate level, and it is being discussed in this single context. It is therefore unlikely that the debate concerning the 'right' time to introduce IPE will advance until it is possible to make longitudinal comparisons of students introduced to IPE at different points in their careers; this would be incredibly challenging and probably far less likely to occur when most courses are now introducing IPE at undergraduate level. To a certain extent, the way IPE is now considered to be a compulsory element of undergraduate curricula has made the debate about not introducing IPE until a postgraduate level irrelevant, even if evidence to settle it was never forthcoming.

The point at which IPE 'should' be introduced in undergraduate courses has had less attention than the debate concerning whether it is more

effectively introduced at undergraduate or postgraduate level, although it has been noted that many institutions 'introduce IPE early to their health professional students, often in the context of a large-scale event in Year 1' (Rosenfield *et al.* 2011, p471). A study by Cooper *et al.* 2005 evaluating an IPE intervention introduced to first year undergraduates across four professional courses identified that there are specific benefits to introducing IPE in the first academic year, specifically referring again to 'the need to start IPE early in students' training before professional doctrines have been built into their learning' (p492). However, it is acknowledged that IPE is often introduced at a time point which is 'advantageous from a specifically administrative perspective' (Rosenfield *et al.* 2011, p471), although as is seen in a discussion of the findings of this paper (Section 3.64) this does not always result in positive outcomes for participants.

In one final study of note on this topic, a mixed-method student evaluation of an introductory IPE event, Anderson and Thorpe (2008) explored whether student age influenced perceptions of interprofessional interactions. Students from ten professions accessed the IPE event within six months of starting their chosen professional course; of which 754 (84%) completed a pre- and post-course questionnaire, with 81 of these students taking part in (uni-professional) focus groups (Anderson and Thorpe 2008). They found that students who were younger in age appeared to gain the most from early IPE initiatives (with the exception of Speech and Language Therapy students who expressed concerns that the IPE was 'too early' in their course), while all graduate entrants also increased their learning 'but were more critical of the learning materials, requesting a more clinically relevant and challenging introduction' (Anderson and Thorpe 2008, p279). Reflecting that one possible reason for this was that age can be an indicator for experience, Anderson and Thorpe (2008) note the importance of considering past experience and maturity when planning IPE, which has implications when courses have high levels of graduate entrants for example. As a result of their findings they

recommend that graduate entrants are paired together ‘and the content reflect their prior experiences of interprofessional working’ (Anderson and Thorpe 2008, p280). In addition to the suggestion that early exposure to IPE is important for its’ effectiveness, the other concluding point to note is that the relevance of the IPE initiative to the student group is also important to the likely success of the initiative. However, these two conclusions may be seen as offering slightly conflicting advice. In order to ensure that IPE experiences are relevant for all participants, it may be more appropriate to mix groups of students at different stages in their professional careers and experiences. This means that some students will be exposed to a practical element of IPE ‘earlier’ than others; in order to for some students to be introduced to IPE ‘early’ it may therefore be more appropriate to introduce the concept rather than the ‘doing’.

3.64 Resources and organisation

A number of papers exist that describe the resources or organisational challenges of interprofessional initiatives. Peloquin *et al.* (2007), for example, present the ‘progress and development’ of an IPE programme, and report on the lessons learned:

Understand that curricular upgrades in any of the disciplines, whether related to higher degree requirements or the institution of distance learning, will constrain student availability and challenge interdisciplinary efforts. (p5)

There are two recurring themes in terms of resources and organisation that arise in reports of organising IPE, namely the issues of finding teaching space large enough to accommodate extended group sizes generated by IPE and the difficulties of organising IPE sessions with different professions, who invariably have different timetables (Begley 2009; Solomon *et al.* 2010) which can be exacerbated by the demands of placements. Mayers *et al.* (2006) also discuss both the practical requirements of securing ‘buy-out’ of key faculty team members to ensure staff have enough time to devote to

developing and sustaining IPE, and the importance of having administrative support to assist with running multi-professional interventions.

There is little academic debate to be had about such issues; developing programmes of work across professional groups perhaps geographically separated across a campus, institutionally separated across faculties, and with full timetables is bound to pose practical issues for those tasked with organising it. Nevertheless, these issues need acknowledging because they are consistently raised as potential barriers to the development of meaningful interprofessional contact in educational settings.

Furthermore, the findings of Rosenfeld *et al.* (2011) also have implications for the organisation of large-scale IPE activities. Using focus groups, Rosenfeld *et al.* explored the opinions of 23 students from five different professions who had attended an IPE event delivered to nearly 1,200 students each year. They noted that although the students felt there was 'value and merit' in IPE for their own professional education, their recollections of their first IPE experience were largely negative, due to the size of the event and the 'poor fidelity of the interprofessional scenarios employed' (Rosenfeld *et al.* 2011, p474). The students reported that the size of the event meant that they found it difficult to engage in interprofessional discussion as 'interaction was rather cursory in nature' and the scenarios used to demonstrate were 'limited and forced', which meant that the message of improving interprofessional collaboration was somewhat 'lost' (Rosenfeld *et al.* 2011, p475). As a result of these findings, Rosenfeld *et al.* conclude that:

Educators engaged in IPE should ensure that they create meaningful and relevant interprofessional experiences, which emphasis clinical correlates. Careful attention should be paid to the size of the event and the relevance of learning activities.

(Rosenfeld *et al.* 2011, p476)

Thus the organisation of IPE initiatives with large cohorts may be not only difficult, but also less effective – or more difficult to make relevant - than smaller workshop-based sessions. Consequently, it must be acknowledged that delivering IPE needs to offer opportunities to stimulate student interest in collaborative working and not be entirely about convenience or ‘box-ticking’ to get all students in a single place at one time. However, it should also be noted that there is often an imbalance in student numbers on different professional courses (i.e. where some year cohorts are of 300 students for one profession and 12 for another), and that putting students from all H&SC courses in one room at one time may be the only way to ensure that each profession within one institution have opportunities to encounter one another. However if this then means that IPE is less relevant or useful than it should be, then those responsible for arranging such IPE need to consider carefully for what purpose it is being undertaken.

3.65 IPE delivered through e-Learning

Given the practical difficulties in finding suitable times and spaces to accommodate large IPE sessions, it is not entirely surprising that there have been attempts to deliver IPE online, allowing options such as discussion boards to facilitate interaction between as many different learners / professionals as desired without them needing to be present in a room at the same time. Oliver (2010) reports on the logistical advantages of using technology for IPE, including the facilitation of more fluid discussion and allowing students more flexibility in the way they can use resources (personalisation or learning resources). Nevertheless, reports on the effectiveness of e-learning-based IPE are mixed, with not all particularly well-evidenced and many scant in detail (see Williams and Lakhani 2010; Berg *et al.* 2010). For example, Berg *et al.* suggest that:

Distance education technologies have the potential to facilitate interprofessional education for students, particularly when

simulation and faulty resources are limited, and professional schools are not co-located. (2010, pp603–604)

However, the project upon which this claim was based involved a pilot study involving sixteen students, not all of whom had completed the evaluation survey. Pulman *et al.*'s (2009) paper focuses much more on evaluating the technological tool they used to deliver *part* of an interprofessional curriculum for a much larger cohort (n=600), but still concludes that they were a 'long way' from providing the envisaged 'totally immersive, engaging, interactive simulated experience' (p238).

A study by Carbonaro *et al.* (2008) compared the outcomes of an IPE course delivered in different formats; the course discussed was initially 100% face-to-face, but was then altered to a blended learning format where 70% was delivered using technology. The study collected demographic data and information on computer experience at the start of the course, and also administered pre- and post-test questionnaire of team attitudes, knowledge and skill (the University of West England Interprofessional Questionnaire), 'random classroom observations and polling of student perceptions' (Carbonaro *et al.* 2008, p28). The first of three main findings showed that there were no significant differences between the student groups receiving the different forms of facilitation on 'team process skills'. However, there were some differences observed in the team dynamics of the different groups. These were viewed to be symptomatic of the various formats that the students were using; for example, students in the face-to-face class would often interrupt each other during discussions, and this was not possible in an online environment. Finally, the students in the blended learning class were more positive about their achievement in one of the class learning objectives, which concerned increasing understanding of the roles of other health care professionals and their ability to collaborate effectively with both professionals and patients. The authors felt that this could not be explained by differences in the team process outcomes nor skills of the facilitators, which were not judged to differ significantly, but it is worth noting that students who

attended the blended learning option were self-selecting (and needed a computer meeting the requirements of supporting software) while face-to-face groups were randomly selected to create comparison teams from a larger cohort of students. The conclusion of the paper was that further research was required 'in order to evaluate the effectiveness' of the approach (Carbonaro *et al.* 2008, p31). But there are very few papers comparing the delivery of IPE across online and face-to-face formats; most papers concerning online IPE tend to describe it as a course in its own right.

Clouder *et al.* (2011) raise one area for concern about their observations on undergraduates using online discussions as part of an 'interprofessional learning pathway'. In the cases they examined, the professions involved and the scale of the number of students (n=2,800) necessitated the need for interprofessional e-learning, with students divided into independent, closed groups able to set their own ground-rules. First year students studied a scenario over a 4-week period where students were tasked with 'identifying what they would do or say as health professionals' faced with a given situation (Clouder *et al.* 2011, p114). From their observations of these discussions (and those between second year students, which were specifically about issues such as professional roles), Clouder *et al.* noted an inclination for all participants to start their responses to previous posts by agreeing with what the previous person had said, which was consistent with other research on online discussion forums (Guiller and Durndell 2006). While the study's aim was not to quantify this, the authors highlighted that the tendency for online interprofessional discourse to rarely involve disagreement did not mirror interprofessional practice, nor prepare students for dealing with professional disagreement:

If groups do not readily feel able to disagree with one another and debate their different stances to reach a level of understanding that promotes mutual respect and collaboration, we are missing the opportunity to help them develop the skills that will prepare them for practice. (Clouder *et al.* 2011, p117).

A later paper by the same research team (Dalley-Hewer *et al.* 2012) discusses the need to facilitate 'meaningful disagreement' among participants, noting that this was possible yet challenging, requiring careful construction of learning resources and expert facilitation.

In their chapter on 'invoking educational technology in IPE', Barr *et al.* (2011) suggest that while technology may have the potential to be 'so powerful in IPE that it is driving the agenda', they hope that this is not the case, preferring instead that it structures the directions and trends in interprofessional teaching and learning. Indeed, the evidence suggests that while technology may solve some of the practical issues posed by delivering education to large numbers of students who are geographically separated (which may assist in learning about the roles of other professions), its use raises different challenges about whether the experience of online discussions are close enough to work-based scenarios to be of use in developing team-working and negotiation skills.

3.66 Classroom versus clinical based IPE

A further debate in the literature is whether classroom-based IPE is as effective as interprofessional education or experiences occurring within workplace settings (i.e. in clinical or community environments). There are also 'interprofessional training wards' that offer students from a variety of H&SC professions an opportunity to work together (with real patients) under the direction of qualified staff.

One systematic literature review concluded that classroom-based training for hospital staff from all professions is a 'recommended way to improve patient safety' (Rabøl *et al.* 2010, p10). However, Sheldon *et al.* (2012) suggest that classroom based IPE limits early and consistent exposure to other professions, allowing exploration of only 'core competences' together. In their systematic review of evidence, Hammick *et al.* (2007) suggested that there was a need for more evaluation of IPE in both simulated and real practice settings. While work in this area remains

scarce, perhaps indicating that formal IPE is still much more likely to occur in classroom / educational based than in practice settings, there is emerging evidence that placement-based IPE develops additional learning opportunities to those found in the classroom, particularly where interprofessional teams of students provide care while supervised by qualified H&SC staff (Pelling *et al.* 2011; Ponzer *et al.* 2004; Reeves *et al.* 2002).

Based upon their own experiences of implementing a pilot course in a clinical environment (in Canada), Sheldon *et al.* (2012) propose that universities need to work in partnership with hospitals to deliver more meaningful, effective and sustainable IPE, which includes student ability to develop effective communication skills. Similarly, Dando *et al.*'s (2011) report on a small-scale pilot of an interprofessional practice placement in an in-patient palliative care unit (in the UK) notes that the placement was positively evaluated and that students (n=59) 'reported an increased understanding of both their own role and that of others professionals in the team' (Dando *et al.* 2011, p178). While this finding has been established elsewhere through classroom-based interventions (Hammick *et al.* 2007) Dando *et al.* found that 'additional learning opportunities' arose for students as a result of being in the placement setting, and in particular involvement in 'managing a death' and resultant understanding of the importance of being part of a multi-disciplinary team during this time (2011, p181). However it should of course be recognised that such events may or may not occur while students are in placement settings, and as such provide learning based upon 'opportunistic' occurrences rather than being based on something that can be planned.

These results support findings from studies of longer-established interprofessional training wards such as that in Linköping in Sweden where the majority of students reported their experiences on the ward as valuable and believe it clarified future professional roles, as well as resulting in improved understandings of the roles of others (Wahlström and Sandén 1998; Wilhelmsson *et al.* 2009). However, this arrangement

brings its own organisational challenges. Dando *et al.* note that comparatively low student numbers in some of the professions means that mixing student teams can be challenging and may result in some students gaining more exposure to interprofessional working than others (2011, p183), which is a similar point to that noted with the difficulties of organising classroom-based IPE with professional groups of differing sizes.

Again, one of the barriers to advancing this debate is the lack of work actively comparing the outcomes of classroom-based interventions with those based in practice. From the sociocultural perspective it would be argued that it is impossible to separate out the effect of an IPE intervention in practice with other practice-based experiences, and that there could therefore never be a satisfactory amount of 'evidence' to support the notion that classroom-based IPE is as effective as workplace learning. Nevertheless, introducing the concept of IPE and why it is important in the classroom, before ensuring that the relevance of placement experiences is reflected upon, does at least allow for students to think about their own roles as part of collaborative practice – their interprofessional responsibilities - even where it is not practical or feasible to deliver IPE in placement-based settings.

3.7 Staff

While a majority of papers exploring IPE focus on the attitudes of, or impact on, students, there is a growing body of work that recognises the importance of developing research on, and with, staff involved in delivering IPE, either reporting on the impact of initiatives designed to support them, or dealing with their attitudes towards IPE and / or collaborative practice more generally. This stems from an increasing recognition that 'many educators have little personal experience' of IPE themselves, but that, as IPE now appears in most health and social care programmes in the UK and with the GMC encouraging adoption of it, there is an increasing need for educators to teach or facilitate interprofessional groups (Anderson *et al.*

2011, p11). The next section explores both these areas of work in more detail.

3.71 The need to support staff as IPE facilitators

To some extent, the need to support staff as IPE facilitators should be fairly self-evident, but has also been confirmed by research studies. A survey undertaken by Curran *et al.* (2007) suggested that gender and previous experience appeared related to the attitudes of faculty members towards IPE and interprofessional teamwork, with those who had previously experienced IPE more positive about its potential outcomes. Pearson *et al.* (2007, online) identified that some potential facilitators for the Common Learning Programme in the North East reported feeling 'ill-equipped' to facilitate interprofessional groups, and in particular lacked confidence in their ability to teach a mixed group, or incorporate students of professions with which they were unfamiliar into teaching scenarios. The need to train and support staff who had not previously been involved in IPE or experienced IPE (as well as those who had) is therefore crucial. Barr *et al.* (2011) note that none of the quality standard for teaching in H&SC higher education has ever included the requirement that the teachers have 'an understanding of interprofessional learning' (p38). Barr *et al.* also note that most university and practice teachers had not experienced first-hand any form of IPE themselves, resulting in much early IPE being facilitated by unprepared, unconfident teaching staff (p39). Further studies have established that faculty members not only need preparation to facilitate IPE effectively (and in particular to bring groups together and to manage group conflict) but also that ongoing support for faculty is every bit as important, ensuring that staff do not feel isolated, can sustain commitment to the IPE teaching, and can ensure that departments can learn from collective experience (Freeman *et al.* 2010; Anderson *et al.* 2009). The need to train and support staff is also important from a socialisation perspective, an issue explored in more detail in section 3.8.

3.72 Staff perspectives on IPE and collaborative practice

In addition to a need to train staff to become effective IPE facilitators, a body of relevant work taking into account staff perspectives on IPE and collaborative practice is of interest here. Anderson *et al.* (2011) interviewed 13 novice IPE facilitators both before and after their involvement in delivering (as co-facilitators) an IPE session taking the form of a classroom-based workshop. Interestingly, and in contrast to findings from some RIPLS studies undertaken with students, Anderson *et al.* found that while only four respondents suggested there was a likely positive outcome for either staff or students before the IPE, *all* post-teaching interviews involved an ‘appreciation for the merits of IPE’ (p14). While only a small scale study, Anderson *et al.* propose that one possible reason for this was that all novice teachers were paired with experienced IPE facilitators who may have acted as positive role models, and that after teaching, interviewees may have reflected on the development opportunities that getting involved in IPE facilitation had or would offer them. However, the authors also noted that when talking about the challenges faced while facilitating a group consisting of different professions, some aligned their comments about dominating or less forthcoming students to particular professions, which, Anderson *et al.* propose highlights:

...their inexperience and inability to become truly non-judgmental
(2011, p15)

In particular, this inability to stem even implicit judgemental comments is important in the context of this thesis; even when staff are (or claim to be) committed to the aims and objectives of IPE, it is still possible that what they say and subsequently what is being ‘learned from’ them is not compatible with improving collaborative practice.

Baker *et al.* (2011) reported on an evaluation of a multi-site IPE programme in North America, which involved interviews with 132 staff members from a range of professions. During initial analysis, ‘power

imbalances amongst the professions' emerged as a key theme, although this was not one of the original foci for the evaluation (Baker *et al.* 2011, p100). Subsequently, taking a sub-set of 25 transcripts representing professionals from eight different professions, this issue was examined in more depth. Some limitations of the study are acknowledged, in particular that the research was based only on those who initially volunteered to take part in an IPE initiative, leaving the voice of those who did not take part unheard. Nevertheless, the findings did raise a number of issues for IPE – for example, suggesting individuals perceived that the different socialisation processes for each profession affected how professional groups viewed themselves; while physicians viewed themselves as leaders or decision makers, nurses, therapists, pharmacists, dieticians and social workers saw themselves as 'team members with a holistic approach to care' (Baker *et al.* 2011, p100). Additionally, the fact that medics were ultimately accountable for any decisions was noted by all professions as a way of legitimising the position of doctors at the top of the 'health professional hierarchy' (Baker *et al.* 2011, p101). There was also recognition that those in the medical profession were responsible for 'setting the tone of local team culture', even when they were in relatively junior positions (Baker *et al.* 2011, p101). This resulted in a feeling of disempowerment for other team members. These findings are important in the context of Baker *et al.* finding that non-medics in the study perceived that physicians lacked interprofessional awareness and were reluctant to get involved in IPE. While one physician claimed that a lack of engagement was due to an absence of empirical rigour associated with IPE, other participants suggested this was a 'convenient excuse' to avoid engaging in IPE. One physician admitted to feeling threatened by a potential loss of power, income, autonomy:

...interprofessionalism is just another word for further diluting the quality of work that a physician had previously enjoyed.

(Physician quoted in Baker *et al.* 2011, p102)

Such concerns, whether legitimate or an 'excuse', remain important barriers to improving collaborative practice and subsequent attitudes toward IPE. This thesis took as its starting point the proposal that staff perspectives on professional identity, IPE and collaborative practice were important, as it was apparent that, without effective facilitation, IPE was likely to be unsuccessful in its aims. Results from the literature search discussed in this and previous chapters have also highlighted that current understandings of the way professional identity develops raise further questions about the way students are socialised into professions, especially where it has become apparent that opinions about other professions and IPE are formed as a consequence of informal learning and not just formal IPE. The findings of Anderson *et al.* (2011) and Baker *et al.* (2011) are therefore significant for this study, because they show how facilitators and staff more generally often hold unacknowledged views about other professions, which might easily 'leak out' or become apparent to students or newly qualified professionals.

The concept of '*habitus*', as described by Bourdieu (1998), is relevant here. *Habitus* is understood as a partly unconscious adoption of rules and values from our cultural epoch and history, which informs both choices and actions. Exposure to context in which there is a willingness to engage with IPE may result in preparedness to work with other professionals. Alternately, one might envisage a situation where the findings of Baker *et al.* (2011) become self-fulfilling, where senior staff suggest that doctors do not engage with IPE and junior doctors come to believe that 'doctors do not engage with it' and are consequently reluctant to do so themselves. This does not reduce the need to consider the debate that doctors – or anyone else – fails to engage with IPE because of concerns over a lack of empirical evidence about its effectiveness; as has been explored in this chapter, there remain many questions in this area. This renders the implications of poor IPE facilitation, or general negative opinions of IPE / collaborative practice, extremely important and influential. Ultimately it almost does not matter how effective IPE interventions are proven to be in terms of explicit or

implicit negative attitudes towards collaborative practice, because without changes here, there will always remain a barrier to cross-professional co-operation.

3.8 IPE, socialisation and professional identity

Finally, and arguably most importantly for this study, there is increasing acknowledgement of a link between socialisation into professional identity and attitudes towards IPE and collaborative practice. Barr *et al.* (1999) suggested that attitudinal barriers to collaborative practice were attributable to both lack of knowledge and unrealistic expectations about the roles of other professionals, while Nolan (1995) identifies the way in which tensions concerning role boundaries and autonomy result in increased defensiveness in scenarios where team working is necessary. One of the purposes of IPE at undergraduate level is therefore to 'prevent these professional jealousies developing in the first place' (Carlisle *et al.* 2004, p545). However, there is some evidence to suggest that students arrive at university with 'an established and consistent set of stereotypes about other health and social care professional groups' (Hean *et al.* 2006a, p162; see also Tunstall-Pedoe *et al.* 2003), which suggests that some students are already fixed in how they think about their chosen professions' identity, and the identities of others, before being exposed to the socialising influences of university and placement learning. There is also an expanding body of work, however, that identifies concerns about incidents which have occurred during pre-registration socialisation into professions.

After interviewing 52 pre-qualifying students from across 10 health and social care professions, Pollard (2008) established that most students had been exposed at some stage in placement settings to 'examples of both effective and poor collaborative working' (p12). As a consequence, Pollard identified that some students could have learned 'inappropriate behaviours' with reference to interprofessional working and suggested that

while students were not necessarily expected to understand the importance of organisational systems that establish and maintain interprofessional collaboration, there were implications arising from some staff in practice also appearing to be unaware of these issues and their actions in relationship to them (Pollard 2008, pp21–22). As a result of these findings, Pollard concludes that:

Supporting placement staff to cultivate their own collaborative practice appears to be a key issue in affecting their ability to support students' interprofessional learning and working in practice. In particular, academic staff may need to negotiate with senior placement staff in order that appropriate collaborative opportunities for students can be jointly identified...

(Pollard 2008, p23)

In her review of the theoretical underpinnings of IPE, Thistlethwaite also suggests that:

...for students to feel positive about interprofessional activities, they need to be exposed to educators and clinicians who are also interprofessional. They also need to observe and participate in authentic team situations in clinical settings, although such experiences may not be available to all learners. (2012, p66)

One of the difficulties, Thistlethwaite (2012, p65) suggests, is establishing whether the 'communities of practice' in which learners are placed are actually interprofessional, or whether the professions are 'working in parallel in separate communities', something that hinders IPL and collaborative practice. Once again returning to the sociocultural perspective it could be argued that it is extremely difficult to decontextualise the experience of being a member of one 'community of practice' from all other practice and educational experiences, regardless of whether it is interprofessional or otherwise. However, combined with the emerging evidence that interprofessional experiences on placement are more effective demonstrators of collaborative practice than classroom-

based initiatives, the findings of both Pollard and Thistlethwaite provide a powerful message for all those wishing to establish IPE in undergraduate curricula.

Furthermore, in their 'best evidence review', Hammick *et al.* 2007 noted from the studies they explored that:

Participants *bring unique values about themselves* and others into any IPE event which then interact in a complex way with the mechanisms that influence the delivery of the educational event.
(p748, emphasis added)

Thus, while not explicitly making reference to 'identity', self-conceptions were recognised as important in the context of IPE delivery. In addition, the review established evidence suggesting that perceptions and attitudes towards others could deteriorate after IPE (but with the caveat that 'this is unlikely to be across the whole cohort' – Hammick *et al.* 2007, p749). Nevertheless, there is a potential to worsen attitudes towards other professions in terms of 'applying knowledge and skills in practice'; significantly, the review established that:

...changes in perceptions and attitudes [towards other professions] are more likely to show mixed results than the other outcome measures
(Hammick *et al.* 2007, p749)

This is important in the context of the review's other findings about IPE being 'generally well received by participants', and that, resultantly, IPE 'enables practitioners to learn the knowledge and skills necessary for collaborative working' (Hammick *et al.* p748); this implies that IPE is less able to influence attitudes and perceptions towards other staff members than it is to, say, teach them team-working skills. The significance, if this is true, is that IPE alone may not be enough to develop sustainable collaborative practice where barriers concerning negative attitudes towards other professions persist.

3.9 What next for IPE?

A recent discourse analysis exploring interprofessional collaboration has raised questions for H&SC education by identifying that two separate discourses concerning 'interprofessional collaboration' exist and are in simultaneous use: utilitarian and emancipatory (Haddara and Lingard 2013). The utilitarian discourse, based in positivism, is identified as being concerned with the search for evidence that interprofessional collaboration improves patient care and outcomes. The emancipatory discourse however, from a more constructivist approach, views interprofessional collaboration as necessary to providing a 'means to diminish medical dominance' (Haddara and Lingard 2013, p4). The authors suggest that all clinicians and educators involved in collaborative interprofessional initiatives may find it useful to 'acknowledge the existence and legitimacy of both discourses' (Haddard and Lingard 2013, p6). Both the identified discourses are evident in various parts of the literature discussed throughout this chapter, and while there was no obvious tension presented in any of the literature examined concerning those delivering IPE pulling in different directions, the recommendations of the authors to ensure that everyone 'is on the same page' regarding the aims and purpose of interprofessional collaboration are a good starting point.

In 2004, Carlisle *et al.* concluded that:

Little empirical work exists on the potential effects of IPE on patient outcomes. Much of the current work focuses on educational outcomes...and any effect on healthcare outcomes appears to be limited to anecdotal evidence on students' career choices... (p550)

This review has, to a certain extent, sought to establish if this statement holds true, as this has certainly been the conclusion of more recent studies (Khalili *et al.* 2013; Reeves *et al.* 2010b; Zwarenstein and Reeves *et al.* 2006). Exploration of existing literature reviews on this topic highlighted both the paucity of studies contributing to evidence of the impact of IPE on

patient outcomes, and also the difficulties of producing convincing empirical work in the area, owing to the number of initiatives labelled as 'IPE', as well as the difficulty of isolating effects of an educational initiative from other changes occurring in a health service at any particular time. Existing studies reviewed specifically for this chapter also appear to reinforce the notion that most work on IPE remains focused on educational outcomes.

The 'correct' timing of IPE is one of the key themes in the IPE literature. As well as being problematic from the perspective that it is difficult to decontextualise one intervention or experience and claim that this was what had the impact on patient care, it might also be proposed that this debate might not arise if one considered 'interprofessional responsibility' as part of each individual professions' identity. If one is socialised into a profession where an understanding of the importance of interprofessional roles and responsibilities was seen as an everyday part of a professional role (as indeed it is) and 'taught' as such, it would no longer need to be seen as something 'extra' that requires specific initiatives to become effective. As such, the need to develop an ability to work as an effective collaborative practitioner might be introduced earlier rather than later in health and social care curricula. Nevertheless, as has been established here, whether or not IPE is the way to achieve this (even in part) has been theorised as depending on the scale, relevance and applicability of the learning scenarios for all professions taking part. Khalili *et al.* (2013) propose that what is required is a shift towards 'interprofessional socialization' (IPS) so that educators may help students develop a 'dual identity' that involves an 'interprofessional identity' as well as their existing professional identity. This, they suggest, would help overcome the barrier of uniprofessional identity to interprofessional collaborative person-centered practice. To achieve this, Khalili *et al.* propose using an 'interprofessional socialization framework', a three stage iterative process by which it is proposed learners can break down barriers, learn about interprofessional roles and collaboration, and develop a dual identity (although the framework is yet to

be empirically tested). Given my own understanding of identity as something that is fluid and multiple at any particular time, I would question the need for health professionals to develop a 'dual identity' and would instead propose that 'interprofessional responsibility' be taught and considered to be a core part of each uniprofessional identity. However, the notion of IPS is useful as a discussion tool, and could easily be used to advance debates concerning how best to improve the development of learners for collaborative practice, including ensuring that IPE is seen and undertaken as more than a single, one-off intervention.

Finally, in the context of a huge amount of academic debate around IPE, it is also worth observing that collaborative practice is something that *has* to occur regardless of what IPE interventions students have been through, or when and where. To a certain extent, considering 'collaborative practice' and 'IPE' as separate 'initiatives' to be achieved may pose more problems than they solve. In the UK, these are concepts that have risen to prominence due to failings in the H&SC systems, because they have been perceived as lacking; they have become academic concepts, but in reality professions in health and social care have to work together on a daily basis regardless of how their work is labelled, and indeed there must be many examples of doing so effectively for them to achieve their daily tasks. When H&SC professions fail to work together well, or fall into 'tribalistic' behaviour, there are huge implications for patient safety, as indicated by the reporting of events concerning hospitals in the Mid Staffordshire Trust. Clearly, H&SC professionals need to learn to collaborate and work together. However, it could be questioned whether the concept of IPE and all the debates about how to introduce it, detract from achieving its aim, because people view it as an additional entity separate from core H&SC curricula rather than as a vital part of H&SC professional identity.

Chapter 4

Methodology

This chapter describes in detail the methods and approach used to address the research questions defined in Chapter One and the issues surrounding these questions discussed in previous chapters.

4.1 The importance of staff perspectives

As the work introduced in Chapters One and Three has already suggested, there is some recognition of the idea that, for IPE to be successful, there needs to be engagement from both academic and practice staff, as well as students who undertake IPE initiatives or have IPE-based activity in their curricula. Thus, to add something of value to the already large volume of work on perspectives of IPE, it was important to seek out the underrepresented voice of qualified staff.

There are, however, a number of implications of conducting research with staff instead of students. As Denscombe (2010, p108) highlights, 'all research designs have their limitations', and in this instance that arose from the fact that both practicing and academic health and social care staff work in time-pressured environments, and as such the methods used needed to be appropriate in terms of the time commitment asked of research participants. The consequence was that methods used had to be time efficient; gathering the most data in the shortest time possible, so as not to burden participants with significant time commitments, either during working hours or from personal time.

Nevertheless, as suggested in Chapter One, conducting the research with qualified staff was more appropriate in the context of identity being something that develops over a period of time (Breakwell 1986) with professional identity something that is achieved through socialisation into

that profession (Cohen 1981; Moore 1970). While conducting the research with health and social care students may have been easier as they may have more time to participate in research, the results would potentially have been different and presented an 'incomplete' picture. Students, it has been argued here and elsewhere (Howkins and Ewens 1999; Wenger 1998; Becker *et al.* 1961) are still being socialised into their profession, as well as possessing an identity as a *student* health or social care practitioner. Students would also not yet be entirely 'independent workers' and can only have experienced working practices on placement settings. As such, not only would it have been irrelevant to discuss the impact of IPE on their professional working practices, research with those with a 'student' identity would have added a further complication to understanding how research participants perceived their professional identity and that of those around them. Despite practical limitations resulting from this decision, it was therefore more appropriate in the context of debates around identity development to conduct the research with qualified staff.

4.11 The practicalities of gaining staff perspectives

The decision to conduct the research with practicing health and social care staff meant that ethical approval had to be gained from the relevant bodies (see Section 4.2). While there was a standardised and centralised process to gain access to NHS employees in the form of the Integrated Research Application System (IRAS), Leeds Local Authority stated that no such standard process existed to gain permission to involve staff employed by Local Authorities (with social workers being of interest to this study) and that, while no specific permissions were needed to conduct a survey with anonymous social workers, permission was required to interview them. Subsequently, a set of forms was sent concerning research with social workers relating only to gaining permission to access client notes and files. Calderdale Council gave the same advice regarding permission to involve social workers, but were unable to provide any forms. Despite several attempts to find someone who could assist with this issue, no satisfactory

response was forthcoming. As a result, it was not possible to interview practicing social workers. This was particularly disappointing because, as highlighted in Chapter Three, social workers have been under-represented and are perceived to have been 'minority collaborators' in IPE and related research (Barr and Sharland 2012, p204). Nevertheless, after four months of attempting to find out how to gain permission to include them, it was apparent that this would take more time than was realistic for the sake of including one profession. It was still possible to include social workers in both surveys and to invite social workers employed as academics to take part in interviews, and so their views are not missing entirely from the research; but the inability to include practicing social work staff as interview participants is acknowledged as a limitation of the research.

4.2 Ethics

In order to survey and interview staff employed by the NHS, ethical approval was sought from IRAS, which was necessary under arrangements for ethical review at the time the fieldwork was completed. Bulmer asserts that in the NHS, 'ethical review is an established part of all research with patients and staff, whether biomedical or social and economic' (2008 p158). Such ethical approval protects participants and the liability of government or public sector departments (including NHS settings) in which research might take place (see Smyth and Williamson: 2004 p212).

Ethical approval was granted by the Leeds East Research Ethics Committee in June 2010. I attended the panel in person and was asked to provide a few minor points of clarification. A copy of the research protocol submitted and the approval letter are included as Appendices 1 and 2. Research and development approval was then sought from Leeds Teaching Hospitals NHS Trust (LTHT) through a Site Specific Information form. Given that it was impossible to state which staff would volunteer for interviews (and therefore to know which Heads of Department should be approached for

consent), the head of the R&D service signed the project off on behalf of all departments at LTHT, with final approval achieved in September 2010.

In March 2012, ethical approval was granted by the University Research Ethics Committee for the surveys and interviews with academic staff; a copy of the approval letter is included in Appendix 3.

4.3 Approach to research and mixing methods

There are many approaches to conducting research. In a caricatured view, those researching from a positivist approach place more emphasis on data gained from the 'testing of theories' and quantitative methods, whilst interpretivists favour qualitative methods (Alexander *et al.* 2008; Gilbert 2008). Interpretivists usually argue that the social world can only be known through exploring people's perceptions of it (Neuman 2003; Scott 2002), and research undertaken from this standpoint tends to look for only 'local, historically contingent meaning' (Alexander *et al.* 2008, p138). However, many researchers take a pragmatic approach, and can see the value of a variety of research on its own terms, resulting in the use of a mix of both paradigms and methods (Alexander *et al.* 2008; Mason 2006; Bryman 1988).

There are many justifications, and discussions of justifications, for adopting a mixed methodology approach (see for example Bryman 1988; 1992; Brannen 1992), but Hammersley (1992, p39) suggests that 'the distinction between qualitative and quantitative is of limited use, and indeed carries some danger'. Hammersley's argument is that to break down research into dichotomous viewpoints oversimplifies decisions and standpoints and that selection of a position on research ought:

...to depend on the purposes and circumstances of the research, rather than being derived from methodological or philosophical commitments. (1992, p51)

The approach adopted for this study therefore utilises a mixed methodology, based upon the perceived value of different methods to achieve data collection for different aspects of the research questions.

It must be noted, however, that the mixing of methods has its own consequences. Brannen, for example, suggests that:

The combining of different methods within a single piece of research raises the question of movement between paradigms at the levels of epistemology and theory. (1992, p3)

On a more practical level, Kvale highlights that there are issues of interdependence between methods that are chosen, suggesting that ‘a decision at one stage has consequences that both open and limit the alternatives available at the next stage’ (1996, p99). Nevertheless, utilising a mixed methodology approach was important to achieve the range of data required to answer the aims and objectives of the research. The following sections discuss in detail the actual methods used and why, as well as any limitations or challenges that using such methods involved.

4.4 Research Phases

The research was carried out in two phases, with phase one consisting of the survey and phase two consisting of semi-structured interviews. Additionally, the research was split, so that the phases of data collection were conducted first with practicing H&SC staff, and then with academic staff. This was primarily for practical reasons; having to gain IRAS ethical approval to conduct the research with NHS staff was known to be a longer process than gaining ethical approval to conduct the research with academics. Therefore, gaining IRAS approval and getting this part of the research underway was prioritised to ensure the research was not delayed by the ethical approval process. Additionally, while the survey tool remained more or less the same for NHS staff and academic staff (and was intended to be, see Appendices 4 and 5), the interview schedule changed

(see Appendices 6 and 7) as parts of the interviews with academic staff were used to collect data for the case study element of the research on the ALPS CETL. As such, it was also important to keep the two stages of data collection separate for both conceptual and organisational purposes, so that interview data did not become muddled as a result of two different interview schedules being used simultaneously. The phases of the research were as follows:

Phase 1a – Online and paper survey of NHS / practicing staff

Phase 1b – Online and paper survey of academic staff

Phase 2a – Semi-structured interviews with NHS staff

Phase 2b – Semi-structured interviews with academic staff.

4.5 Surveys

This research aimed to do more than ‘typical’ studies of IPE which explore ‘before and after’ perceptions of working with other professions (see Chapter Three), and aimed instead to collect perceptions about, and experiences of, IPE from a large number of professionals from different H&SC backgrounds. Using a self-completion survey seemed the most appropriate method to achieve this, as surveys enable the acquisition of information from a large number of people distributed over a wide geographical area more efficiently (in terms of time and money) than by using any other method of data collection (Simmons 2008; Sapsford 1999).

Sapsford notes that what differentiates surveys from other types of research is that they involve *systematic* observation or *systematic* interviewing, often involving the researcher dictating the range of answers that can be given:

Standardization lies at the heart of survey research, and the whole point is to get consistent answers to consistent questions.

(1999, p4-5)

The purpose of using a survey as part of this study was to use the methodology to full advantage to collect this standardised data for the three types of information associated with surveys:

- basic facts/descriptors such as age, gender and occupation;
- information on behaviour (what people do);
- people's judgements and preferences (their opinions).

(see Gillham 2008, p2)

It is worth noting at this juncture that other studies exploring professional identity and attitudes to interprofessional education have already successfully used surveys, and as such it was also a 'tried and tested' method to generate relevant information for the study. In 1986, social psychologists Brown *et al.* published a highly influential and much-adapted scale to explore intergroup rivalry in a paper factory. They asked respondents to rate how strongly they identified with aspects of being part of their 'group' within the factory setting, with a view to exploring intergroup differentiation and rivalry. The methods they used to develop their scale (for which they reported both validity and reliability data) were based upon previously developed social psychology measures. While this study did not aim to conduct a piece of research grounded in social psychology, nor to replicate one, the study by Brown *et al.* was useful in that it showed how to structure statements that would elicit responses describing the extent to which respondents identified with their occupational role and 'group'. For example, among other things participants in Brown *et al.*'s study were asked to rate on a five point scale whether they identified with their work group ('I am a person who identifies with the _____ group'); whether they felt they belonged to a group, whether they were glad to belong to a group or whether they felt held back by belonging to a group (Brown *et al.* 1986, p276). This was

something I wished to explore as part of this study, particularly with reference to strength of feeling about having a 'professional identity'.

Additionally, the 'Readiness for Interprofessional Learning Scale' (RIPLS) (Parsell and Bligh 1999; Parsell *et al.* 1998), and the 'Interdisciplinary Education Perception Scale' (IEPS) (Luecht *et al.* 1990) as discussed in Chapter Three, are much cited and adapted scales (see for example McFadyen *et al.* 2005 and 2006) used to explore attitudes toward, and perceptions of, interprofessional issues. Again, the success of these survey instruments made it apparent that people are prepared to respond to attitude statements about the fairly complex subject of IPE.

Designing the survey was an iterative process completed in several stages, to ensure that basic errors of questionnaire design were avoided, and to ensure that the questions used were reliable and valid measures (Fowler Jr 2009; Oppenheim 1992). Both *reliability* and *validity* are 'technical terms', and while overlapping, are distinct and of great importance to questionnaire design (with both terms derived from measurement theory and psychometrics) (Oppenheim 1992, p144). Oppenheim states:

Reliability refers to...consistency of a measure, to repeatability, to the probability of obtaining the same results again if the measure were to be duplicated. Validity...tells us whether the question, item or score measures what it is supposed to measure.

(1992, pp144-145)

It should be acknowledged that ensuring the reliability and validity of factual questions is different from ensuring the reliability and validity of subjective ones (Fowler Jr 2009; Oppenheim 1992), but other than asking for gender, age and profession details and training (which are not verifiable, but can be requested in such a way as to avoid ambiguity), this survey was more concerned with subjective questions in the form of opinions concerning IPE and professional identity. Consequently, in terms of ensuring as far as possible the reliability of the subjective questions, this involved avoiding questions with incomplete wording; avoiding leading

questions and / or prompts; and ensuring that question terms that were fully defined and avoided multiple questions (see Fowler Jr, 2009, pp88-94).

Ensuring the validity of subjective questions is a little more complicated, as there is no external criterion by which to judge validity:

...one can estimate the validity of a subjective measure only by the extent to which answers are associated in expected ways with the answers to other questions, or other characteristics of the individual to which it should be related.

(Turner & Martin 1984 discussed in Fowler Jr 2009, p110)

Fowler Jr goes on to suggest that for subjective questions to be valid, they first need to be made as reliable as possible, ensuring no ambiguity of wording (as outlined above) and that scales used are i. appropriate; ii. only deal with one issue; and iii. are presented in order (Denscombe 2010, pp143-149; Fowler Jr 2009, p110; see also Oppenheim 1992, pp144-149). Additionally, given that some respondents tend to avoid extreme categories, thought must be given to the number of categories in every continuum; too many categories make it difficult for respondents to discriminate their feelings between one category and another, while too few may force a respondent into a response they do not truly agree with (or force them to opt out of the question using the 'don't know' option) (Fowler Jr 2009). Using multiple questions with different forms helps to iron out idiosyncrasies and is claimed to improve the validity of the measurement process (Fowler Jr 2009; DeVillis 2003). Reviewing questions on several occasions and after each version of the questionnaire draft was therefore important to ensure that the questions were as 'reliable and valid' as possible, or rather that the design of the questions did not cause issues for the reliability or validity of data.

After the drafting process was complete, the survey was piloted as a paper questionnaire with eight H&SC professionals, who represented a mix of professions, some of whom had academic roles and some of whom were

practicing members of their profession with no academic roles. The piloting of surveys is an established part of good research design, which allows researchers to trial their research instrument design (Denscombe 2010) and to test how questions work in the 'real world'. Those involved in piloting the survey were also asked to provide feedback on any questions they found difficult to answer, or if they had perceived issues with question wording. None of the pilot respondents highlighted issues of this nature, but as a result of the piloting process further comment boxes were added where participants had written comments after the questions without being asked for them (Appendix 4, questions 8a, 8b and 14).

4.51 Sampling

Sapsford (1999) highlights that in the 'real world' it is unlikely that researchers running social surveys have a 'complete and accurate' sampling frame (that is, a 'complete and accurate list of the population to be sampled') and that the practicalities of undertaking social research often dictate the sampling method (1999, pp81-100). This survey was no different, and there were two key features that led to decisions taken on sampling: i) the practicalities of the population to be sampled; and ii) the stipulations laid out in the ethical approval process. Nevertheless as is outlined in detail in Section 4.53, the survey did achieve a high number of responses representing a large range of professions.

The research was designed in such a way that any practicing or academic member of H&SC staff in the world could take part. However, this clearly amounts to countless people, with a hugely diverse range of backgrounds and experiences. Consequently, for the research to become more focused, it was necessary to define the population of potential respondents as 'practicing or academic members of H&SC staff *in England*'. This was a logical choice, not least for the practical reason that the research was undertaken in England; but also limiting the research to one country meant that all respondents were working within one health system (albeit an

extremely diverse one) and one education system, which, it was assumed, would ensure that respondents' experiences were more comparable than if they had been working across a range of countries incorporating multiple health and education systems. Limiting the potential population further to just those members of staff working within one health trust / local authority area was another possibility, but this would have given rise to the possibility of being unable to recruit enough people take part.

As part of the ethical approval process, it was stipulated that the researcher could send copies of the survey only to existing contacts, or to advertise the survey on relevant web-based discussion forums. (This was the case for the survey used with practicing H&SC staff and the version used with academic staff.) This clearly had implications for the sampling method used, which, under such a restriction, could only be a 'haphazard' sample, consisting of volunteers who had seen the study advertised (either by email or on a web forum) (Sapsford 1999, p90). It also meant that the study was reliant upon the 'snowball' sampling method, which is defined as when:

...the researcher samples initially a small group of people relevant to the research questions, and these sampled participants propose other participants who have had the experience or characteristics relevant to the research. (Bryman 2012, p424)

There are several implications for the data generated by this project having used these methods. The first is that the majority of respondents recruited through contact with myself or a colleague helpful enough to forward the questionnaire are more likely to be involved or aware of IPE than a 'random' selection of staff would be. Given that myself and many of my colleagues work, or have worked, on IPE related projects, it is probably accurate to assume that many of our contacts will be aware of this, if not directly involved themselves. Secondly, as Sapsford (1999, p90) notes:

...[t]here is clearly no good reason to suppose that those who choose to volunteer are a random subset of the population which

includes volunteers, non-volunteers and those who did not even see the notice or advertisement.

It is also probably an accurate assumption that many people volunteering to take part in a study for which there is no material reward for themselves are more likely to have an interest in the topic being surveyed about than those who did not feel inclined to volunteer; indeed, there are many studies which have explored the differences between volunteers and non-volunteers (see, for example, Rosnow and Rosenthal 1976), the conclusions of which, however, are applicable regardless of sampling or research methodology. Nevertheless, in this instance, it is worth noting that other than those recruited via email, other participants in the survey were members of profession-specific online discussion forums. It is possible to make an assumption that these people already differentiate themselves from non-members of such forums by using their spare time to take part in such work / profession related activities.

Finally, 'choosing' this sampling method meant that it was not possible to calculate a response rate to the survey, as there was no way of knowing how many people forwarded the email advertising the survey and to how many people the original recipients sent it on to.

However, these issues are only problematic if results from the survey were intended to make claims about the 'population' they represent. Given that the topic of the study is related to personal experiences of IPE and perceptions of professional identity, I would suggest (regardless of any concerns with the sampling method) that it would be inappropriate to make generalisations about the H&SC staff population from my findings. The survey method adopted here was a way of collecting a larger volume of data concerning personal opinions and experiences than could ever be done with qualitative methods alone, and to provide some contextual data for the development and analysis of the interview and case study work, but it was never intended to be the only source of data to 'answer' any of the research questions.

4.52 Distribution

The survey was distributed in two formats: online and on paper. The online survey was distributed via email to colleagues who then circulated it to colleagues *et al.* (see discussion of snowball sampling in section 4.51), and was also posted as a link on some profession specific online discussion forums. The survey was hosted on Bristol Online Surveys (BOS). The paper-based survey was distributed in the same way as the email link, passed to colleagues who were willing to forward to those interested in taking part. All paper versions of the survey were sent out with a freepost envelope to ensure no cost implication for participants. The online and paper versions of the questionnaire contained the same questions presented in the same order. As the BOS system allows for only simple routing of questions and follow-up questions, this sometimes dictated the question numbers, but did not affect the question content.

There are numerous academic works concerning the advantages and disadvantages of both online and paper versions of questionnaires. However, as the limitations set down by the ethical approval for the project determined the sampling and recruitment method of the survey, the decision to attempt to collect data via two methods was a pragmatic one, as using a mixture of modes to collect data:

...offers opportunities for compensating the weaknesses of individual modes, for example, increasing response rates and thus eliminating non-response biases.

(de Leeuw 2005 quoted in Vehovar and Manfreda 2008, p185)

Best and Kreuger (2008) suggest that when designing online studies, it is important that researchers are 'particularly attentive' to their design choices 'to ensure that instruments are presented and delivered in a uniform, yet usable manner' (p217). However, the same is true of paper surveys, with the design aiming to prevent errors occurring through faults in layout and question routing. As such, careful attention was paid to

ensuring that the layout of both formats of the questionnaire was as straightforward as possible.

4.53 Respondent numbers

Using the snowball sampling method and being reliant upon colleagues to pass on the email link, and on volunteers to take part in the research, it was not possible to predict the number of likely respondents that would be recruited. With the sampling frame being wide-ranging (practicing or academic staff in England) it seemed likely that the survey might achieve a healthy number of responses, and it was hoped that the survey would achieve at least 100 respondents across a range of professions in each phase (practicing staff and academic staff). Dates were planned at which to review the respondents' status (in terms of profession and seniority level). In the event, in phase 1a the survey had achieved over 200 responses at the review date. However, it was noticeable that some professions were more heavily represented than others, with some professions represented by over 20 respondents and some represented by less than 5. At this point the use of adverts on online forums became relatively strategic, with links to the study only placed on forums targeting specific professions who were less-well represented in the responses. This was a practical (and beneficial) approach, as it was a time-consuming and at times frustrating task (with some forums not having administrators to request permission to join and post a link) and there would not have been time to find forums and try and recruit participants from all different H&SC professions. Phase 1a ended with 290 responses, 2 of which were excluded because they were from non-H&SC professions (1 chaplain and 1 IT consultant).

Phase 1b, with academic staff, was conducted in exactly the same way, with email and paper options for the survey. Despite repeated attempts at recruitment, and asking a growing number of colleagues to forward the survey, this phase ended with only 31 responses after ten months of attempted data collection (1 of which was excluded as it was completed by

a chaplain). The full distribution of survey respondents upon which the analysis is based is shown in Table 4.1.

Table 4.1 Professional background of survey respondents

	NHS / Practicing Staff	Academic
Audiologist	1	-
Dentist	3	-
Dietician	1	1
Doctor	92	3
Health visitor	3	-
Midwife	20	1
Nurse	35	11
Occupational therapist	21	7
Pharmacist	8	-
Physiologist	-	1
Physiotherapist	30	3
Podiatrist	-	1
Social worker	18	4
Speech and language therapist	56	-
Vision impairment rehabilitation	-	1

While respondents from the practice side can be seen to represent a broad range of professions, the resulting limitation of having only a small number of academic respondents is that the results cannot be compared across professions for the academics, and it is only the views of two professions (nursing and occupational therapy) which are really represented in those results.

4.6 Interviews

As I have argued in Chapter Two, identity, professional identity and education are all perceived and experienced differently by individuals, and as such exploration of this topic required a methodology that allowed the researcher to explore these issues with individuals. To explore perceptions of interprofessional education and professional identity in depth, I conducted a series of semi-structured interviews with both practicing and academic staff.

The interview schedule consisted of a list of open-ended questions (and follow-up prompts if they appeared relevant), to allow for exploration of key themes led by participant's own priorities and perceptions. Of the four philosophical approaches to qualitative research interviewing outlined by Kvale (1996), my own approach resembles most closely the phenomenological in that it involves an:

...openness to the experiences of the subjects, a primacy of precise descriptions, attempts to bracket foreknowledge and a search for invariant essential meaning in the descriptions. (p38)

Fontana, following Dingwall (1997) suggests that from a phenomenologically informed perspective:

...individuals in interviews provide organizing accounts; that is, they turn the helter-skelter, fragmented process of everyday life into coherent explanations, thus co-creating a situationally cohesive sense of reality. (Fontana 2001, p166)

Taking this phenomenological approach, 'describing the world as experienced by the subjects, and with the assumption that important reality is what people perceive it to be' (Kvale 1996, p52), respondents were allowed to take the interviews in a direction they wished, and so the interview structure was not always stuck to rigidly. The result was that while most of the topics on the interview schedule were usually addressed at some point during the interview, they were not always addressed in the

same order. As Holstein and Gubrium (1995) note, the ability to be relatively flexible is important in an 'active interview' so that the:

...respondent's positional, linkages and horizons of meaning take precedence over...the predesignated questions that the interviews is prepared to ask. (pp76-77)

Holstein and Gubrium go on to state that such an approach allows the 'responses to determine whether particular questions are necessary' which they suggest results in an 'improvisational, yet focused, quality to the interview' which is important for the meaning-making process of the conversation (1995, p77). Thus utilising such an approach is not necessarily problematic in that it is viewed to highlight the priorities of the respondent rather than being led by the research questions. As most of the topics were covered in all interviews, and transcripts were transcribed verbatim and could be reflected on in the analysis, I believed that such an approach was beneficial to the quality of the data collected rather than detrimental in any way.

Due to requirements of the ethical approval, recruitment of interview participants was achieved by asking people to give personal details at the end of the survey, or through pre-existing contacts. Most of the interviewees who were practicing staff were recruited through them providing their details at the end of the survey. However, when ten interviews had been completed it became apparent that the majority of my volunteers were senior level staff. Yet during the interviews, many of the respondents would make comments such as 'I may have felt differently about this earlier in my career'. As a result it became desirable to interview some professionals who were not as established in their careers to see if their views *were* any different. Additional emails were then sent to contacts asking specifically for volunteers for interview who were within three years of graduating from their course, which yielded five respondents who fitted the criteria.

Due to the low number of responses to the survey with academics (and therefore lack of volunteers recruited via this method), and because a further purpose of interviews with academics was to contribute to the case study work (see Section 4.7), most of the academic interview respondents to take part in the study were personally approached and invited to take part, having previously been involved in the ALPS CETL. This meant that I already knew the majority of the academic interviewees but had not previously met any of the practicing staff who were interviewed. However, the interviews were carried out in the same way for all respondents (at a time and location convenient to the respondent, usually at the University of Leeds or in their workplace) and no questions were excluded from the interview even when I had met the respondents previously and may have 'known' the answers (how they became involved in the ALPS CETL for example). While knowing some of the research participants could lead to a critique of 'objectivity', I would suggest, following Hamersley and Gomm (1997), that 'all accounts of the world are...constructed on the basis of particular assumptions and purposes' (p5) and that as such, there is no such thing as an 'objective' perspective. As Denscombe writes:

Each researcher produces an account of a social phenomenon which is unique to himself or herself and each account stands in its own right as a statement about that phenomenon – no better and no worse than others – just different. (2010, p89)

From this perspective, regardless of whether I knew any of the respondents, I would still end up with my personal and unique interpretation of the data. The fact that I did know some of them is then important contextual information that is recognised and reflected upon where relevant in the analysis.

There is a body of work on 'interviewing experts' which needs to be acknowledged here, as both practicing H&SC staff and academics fall into the category of 'professionals' who have acquired a 'canonized special knowledge asset via an institutionally specialized and...formalized training'

(Pfadenhauer 2009, p88). However, I was not seeking to interview them in their capacity of holders of professional knowledge *per se*; it was rather to interview them as individuals about their experiences of being professionals. As such, the methodological texts written on this field are not particularly relevant, as they focus mainly on the difficulties of interviewing when there is a power imbalance, or on the challenges associated with gaining information from 'elites', neither of which was relevant in this instance. I did, however, always introduce myself by acknowledging that I had a background in sociology as opposed to H&SC, to ensure that, while dealing with questions about perceptions of their own profession and other professions, respondents did not view me as a 'potential critic' (Bognor and Menz 2009).

Kvale and Brinkmann (2009) note that different interviews have different purposes, and as such there are different forms that interviews may take. However, the purpose of undertaking interviews in this instance cuts across their proposed typologies, being in part 'conceptual', in part 'narrative', and to a certain extent being grounded in a 'discursive' background (Kvale and Brinkmann 2009, pp151–158). In terms of 'conceptual clarification', one purpose of these interviews was to 'chart the conceptual structure' of respondents' conceptions of both interprofessional education and professional identity. As is common with this type of interview, respondents were asked to give 'concrete descriptions' of these terms, and, in theory, this part of the interview data could:

...serve to uncover respondents' discourse models...their taken-for-granted assumptions about what is typical, normal or appropriate.

(Gee 2005 quoted in Kvale and Brinkmann 2009 p151)

Some aspects of the interview were narrative, with the respondents being asked to give accounts of their professional background and their experiences of interprofessional education, as well as other 'stories' offered spontaneously during the course of interviews. Again, this is a commonly

recognised and well-trodden path when conducting interviews, with Mishler suggesting that:

...there is a wide recognition of the special importance of narrative as a mode through which individuals express their understanding of events and experiences. (1986, p68)

However, Mishler also highlights that there are several implications of such an approach, including the unavoidable nature of the interviewer becoming coparticipant in the discourse:

Differences in whether and how an interviewer encourages, acknowledges, facilitates, or interrupts a respondent's flow of talk have marked effects on the story that appears...interviewers and interviewees are both aware of and responsive to both the cultural and research contexts within which a particular interview is located. (1986, p105)

Nevertheless, the narrative aspects of the interviews were useful. In particular, the biographical aspect of asking respondents to describe their professional background was central to exploring individuals' perceptions of their own professional identity. Roberts suggests that:

In the face of debates about the 'fragmentation' of identity or 'multiple identities', with discussion often more in the realms of abstract theory rather than based on 'lives', the appropriateness of the study of biography becomes ever more apparent in seeing how identities are formed and grounded within spatial, organizational and other structures. (2002, pp170-171)

Returning to the notion of the importance of 'plot' to narrative (as discussed in Chapter Two), when analysing narrative, Propp (1975) looked to reveal the underlying plot summaries of stories, by producing a series of statements that summarised the main features of the story. The advantage of this technique is that it results in a list of 'who did what to whom in

which order', which includes a 'list of characters with their spheres of action and styles of enactment' (Beech and Sims 2007, p294). In order to achieve this, once the interviews had been transcribed, index cards for each of the interview respondents were created which outlined the main 'plot points' of their professional histories. Not only did this help with exploring each individuals' narrative of their own professional histories, they were also useful aide memoires for remembering each participant and for looking at their responses in context. Combining the conceptual and narrative approaches was therefore useful for understanding as far as possible how each respondent understood and described their own professional role and background (narrative), and what they understood by the term 'professional identity' (conceptual) and how this related this to their opinions of IPE.

Following Potter and Wetherell (1987), Kvale and Brinkmann (2009, p156) also suggest that while all interviews are naturally discursive, interviewers working within a discursive framework will be attentive to issues such as variation in responses, will use techniques which allow rather than disable diversity, and will view interviewees as active participants rather than 'speaking questionnaires'. Assuming aspects of this approach was important for this study in that one of the key aims was to establish what participants thought about IPE. To do this in the interviews, I first asked interviewees to define what they thought professional identity was, and then developed the conversation about professional identity regardless of how they defined it as one of the key aspects of discourse analysis is to 'focus on how knowledge and truth are located within discourses' (Kvale and Brinkmann 2009, p155). While not based on an entirely discourse-analytic approach, using such an interview technique was important in helping to understand how people were able to conceptualise both professional identity and interprofessional education, and how they thought that understanding both was an integral part of becoming a professional.

4.61 Interview participant numbers

16 practicing staff and 17 academic staff were interviewed (I had aimed to interview 15 in each group). As recruitment was based upon a mixture of those who volunteered after the survey and pre-existing contacts (for academic staff) it was not possible to aim to interview a certain number of respondents from any single profession. Instead, I decided to interview a wide a range of people from as many different professions as possible, with the aim of hearing many different 'narratives' about professional role and background. The number of representatives from each profession interviewed is indicated in Table 4.2.

Table 4.2: Current role or professional background of interview respondents

	Practicing Staff	Academic Staff
Audiologist	-	1
Dietician	2	1
Medic	4	2
Midwife	1 *	1 *
Nurse	2	5 *
Occupational Therapist	2	2
Pharmacist	2	-
Physiotherapist	1 *	1
Radiographer	-	1
Speech and Language Therapist	2	-
Social Worker	-	2
Vision impairment rehabilitation	-	1

* Denotes that at least one respondent classified under different professional role or background indicated that they also trained and worked for the indicated profession for a period of time.

4.7 The ALPS CETL Case Study

In addition to literature reviews, surveys and interviews, this research is also partly based upon a case study of the Assessment and Learning in Practice Settings Centre for Excellence in Teaching and Learning (ALPS CETL). The data collection for the case study involved specific questions

included in interviews to ALPS participants (the majority of academic staff interviewed) and some analysis of key ALPS documents such as planning materials and reports, to look for evidence of issues and successes arising from attempts to introduce interprofessional assessments through inter- and multiprofessional working. This introduces a further methodological dimension to the study in the form of what Webb *et al.* (1966) call 'unobtrusive methods'. This refers to 'data gathered by means that do not involve direct elicitation of information from research subjects' (Lee 2000, p1). In theory, such sources can be advantageous as it removes 'impression management' (such as the tendency to over-report socially 'desirable' behaviours) by respondents in interviews and surveys, which can potentially distort data (Webb *et al.* 1966; Bradburn *et al.* 1979; Lee 2000). However, it should also be noted that documents themselves are recorded for a purpose. For example, some of the reports published by the ALPS CETL were written at the request of their funders to show what progress had been made in implementing the programme, thus they do not present in detail any discussions and negotiations that occurred between different programme partners. In essence, they are a 'cleaned' version of events that project partners were happy to leave as a public record of events, and so even this data needs to be used with a certain amount of reflexivity.

Consideration was given to undertaking some content analysis on the ALPS documents, which in its simplest form consists of computer-assisted techniques to generate word counts, although the wider definition of the methodology concerns reducing 'freely occurring text to a much smaller...representation of its meaning' (Marshall 2008, p114). However an initial reading of ALPS documents indicated that this might be problematic in that some key words of interest had multiple meanings; while there seemed to be some difference applied to the use of the terms 'interprofessional' and 'multiprofessional' (although the distinction was not always explicitly made), the concept of 'collaboration' was applied to multiple scenarios, being relevant to cross-HEI, cross-profession and cross-agency working. To count instances of the word 'collaboration' in the

documents would therefore have been potentially meaningless in this context, as this thesis is less concerned with the cross-HEI partnerships to which the term might be referring. Coupled with the fact that there was no certainty that the terms 'interprofessional' and 'multiprofessional' were used in a consistent manner, it was more significant for the purposes of this study to concentrate on reading the documents with reference to the context in which they were written, giving consideration to both who authored the papers and who the intended primary audience for them was.

Case study methodology can involve both multi- and single-case studies (Yin 2009; Bryman 1988), but in this instance, a single-case design has been used. This follows the rationale for a single case study design where the case represents an extreme or unique case (other rationales may include a single case study as a critical case against which to test a theory, or as a representative or typical case) (Bryman 1988; p47). Silverman also highlights that:

Purposive sampling allows us to choose a case because it illustrates some feature or process in which we are interested. However...[it] demands that we think critically about the parameters of the population we are studying and choose our sample case carefully on this basis. (2010, p141)

ALPS was atypical in terms of its size and consequent ambition for a multiprofessional / interprofessional programme of work. ALPS included 16 H&SC professions in both the design and delivery of assessment and learning in practice settings, and as such potentially offers up experiences of this multiprofessional and interprofessional working that smaller scale studies are not able to. Issues around negotiations of language, large-scale decision making and organisational practicalities are all key issues which will increase difficulties for IPE teams in relation to the number of professions involved. As such, using ALPS as a case study may present some findings that case studies exploring other smaller scale initiatives may take longer to encounter. Nevertheless, there are other larger scale IPE

programmes that are useful for comparison: the Common Learning Programme (CLP), for example, which involved students from the Universities of Newcastle, Northumbria and Teesside in partnership with two local Workforce Development Confederations. Evaluation reports and other published findings from such projects have been used to contextualise the case study work.

Much of the (large quantity of) existing work on case studies concentrates on debates around the generalisability of case study data (Silverman 2010; Yin 2009; Blaikie 2000; Donmoyer 2000). However, Gilbert (2008) acknowledges that for case study research 'there is [usually] no attempt to select a random or a representative sample of cases' (2008, p36). Indeed, in this instance, the purpose of using a case study is not to extrapolate the results to claim that the experience of the ALPS programme is representative of other multi- or interprofessional initiatives. Rather, talking about ALPS in the interviews was useful for exploring participants' perceptions of the processes involved in introducing a multi- or interprofessional programme, and their perceptions of the impact of working on such a programme. The advantage of using the ALPS CETL programme to do this was having worked for the ALPS CETL, I was very familiar with the initiative, the context of the programme and some decisions made within it. It must therefore be acknowledged that one of the primary reasons for selecting ALPS as a case study was that I was confident that I could build up a comprehensive picture of the programme for a case study, as well as gain access to key documents and interview participants. Clearly, this situation does have potential implications for data collection and analysis, but Denscombe (2010) highlights that it is usual for social researchers to be involved in research in which 'they have a personal interest' (p28). Indeed, from my interpretivist standpoint, I would argue that my position as a researcher is an 'inescapable factor' in any social research, and that a reflexive approach around my own position and background would be an important part of the analysis regardless of whether or not I had been employed by the subject of the case study

(Denscombe 2010; Finlay 2002). As such, I do not view my position as overly problematic, but do acknowledge the need to explain how I was involved and when. While I was employed in the ALPS CETL when I started this research, by the time I came to plan and undertake the interviews, neither the CETL nor the extension project (in which I was not involved) were still active. This afforded me the fortunate position of looking at the CETL and its impact as an 'insider' for the original part of the programme but as an 'outsider' for the latter part of its work. Additionally, the case study is only a small element of this research; it was included in the study because it was both interesting and relevant for the topic at hand, and as a larger scale interprofessional initiative, it was worthy of study for this research regardless of my involvement.

4.8 Analysis

The approach adopted for analysis can be loosely described as a 'grounded phenomenological interpretivist' approach, which is to say that the analysis is as grounded in the data as possible; is phenomenological in that it is 'primarily open-ended...searching for the themes of meaning in participants' lives' (see Rossman and Rallis 2003, p276); and is interpretivist in that it seeks to find the meanings that underscore people's opinions about their professional identity and IPE. However, I remain mindful of a presentation given by Zukas (2012) who suggested that researchers can spend too much time and effort defining their analytic standpoint, often to the detriment of their study. While it is important to acknowledge this approach has been taken (as opposed to seeking to prove a hypotheses or to create an ethnography of H&SC professions) I have already highlighted that, from the perspective of there not being such a thing as 'objectivity' (see section 4.6), the analysis can only result in a unique interpretation of data, whichever approach is taken. However, the analysis did involve a number of standard elements of research work to achieve the most grounded scrutiny of data possible, and this is described below.

As the majority of the variables explored in the survey were categorical, the main analysis of data was carried out using non-parametric statistics to explore relationships between the variables. In particular, the independent variables of 'profession', 'stage of career', and 'prior experience of IPE' were explored with reference to a number of other variables, including opinions of IPE and attitude towards working with other professions. Exploring the relationships between different variables has been done through the use of cross-tabulations to examine percentage differences, and where relevant, the strength of apparent relationships have been tested using the Pearson's Chi-square and Cramer's V statistical measures. Chi-square (χ^2) is a test specifically designed for use with categorical variables and determines if there is a discrepancy between observed values and the expected values if data is distributed proportionately (Walker and Almond 2010). The resulting calculation indicates the likelihood with which it is possible to reject the null hypothesis that there is no relationship between the variables being explored. In order to interpret the results of the test and establish the extent to which a χ^2 value may be considered significant, a distribution table is required; for the results described in this thesis a table produced in SYSTAT's Data Basic and published in Wright (2002, p138) was used.

Cramer's V can be used on a variety of variables (binary, nominal or ordinal scales, or any combination of the two) and can be used on any size of table (Kent 2001). Importantly for this study, it also does not revert to zero when one or more cells of a table is empty, which sometimes occurs in the data set used here. For the Cramer's V results, $V = 0$ shows that there is no association between the variables and $V = 1$ indicates that there is unity or complete association between the variables explored.

As with all statistical tests, there are acknowledged limitations associated with the use of both Chi-square and Cramer's V . For Chi-square when the numbers in tables are small the approximation of expected results is poor (Campbell and Swinscow 2009), and with larger data sets, small variations can produce results that are 'significant'. Similarly for Cramer's V there is a

reliance on calculating Chi-Square, which itself assumes large values (Kent 2001). To ensure the statistics are not misused, it is generally understood that they should only be calculated when 'fewer than 20 per cent of all cells have expected frequencies of less than five' as well as 'that no cell has as expected frequency has less than one' (Kent 2001, p112). This rule has therefore been applied in the analysis undertaken here. Despite these limitations, these tests are useful tools in establishing whether results are likely to be significant (that is, would not have occurred if the null hypothesis were true). Cramer's *V* is also useful from the perspective that it makes no distinction between independent and dependent variables, which is particularly useful in this research where it may not be possible to claim that opinions on one element (such as professional identity) are dependent upon experiences of another (such as IPE) given the individual nature of such experiences, but where it might be useful to establish if there is any apparent association between the two. This analysis was used to explore whether there was any apparent relationship between profession, stage of career, prior exposure, or involvement in, IPE initiatives and opinions about IPE and interprofessional working. The open-ended questions were coded as per the qualitative data (see below). This was subsequently used to describe whether there were any themes relating to how people describe their professional identity, which in part informed some of the questions used in the interviews.

The interview analysis started with notes that were taken during each interview, and the interviews were transcribed verbatim as soon as possible, enabling what Rossman and Rallis (2003, p271) describe as 'learning as you go'. Interview transcripts were annotated with immediate thoughts while transcribing, with the latest transcriptions and notes revisited before conducting a further interview. The coding was undertaken manually, through reading and re-reading the data, and by writing notes and suggested code headings on to interview transcripts. This inductive approach is better suited to explorative inquiry and allows for themes to emerge from the data, in contrast to attempting to fit these into a pre-

existing coding frame built upon the preconceptions of the researcher (Braun and Clarke 2006). Individual sheets of paper were then created for each code and relevant quotes related were recorded on them, sometimes creating 8 – 9 sides of quotes per code. Codes were created for phrases, statements or narrative that recurred between interviews or specifically addressed one or more of the research questions (Koh *et al.* 2014). Sub-codes were created for minority opinions or for opinions that differed from the majority of opinions expressed. While doing this manually was relatively time-consuming, this method was the most convenient for making the best use of time to undertake the analysis. While computer programmes such as nVivo and Dedoose were both explored as possibilities for use in coding, the manual process including writing out relevant quotes meant that familiarity with the data and available quotes was achieved in a way which seemed less likely had a computer programme been used.

The analysis itself was thematic, for both the narrative elements and open-ended responses to questions in the interviews and surveys. As just one of a number of recognised methodologies of analysing narrative data (see Riessman 2008), this seemed the most appropriate way to deal with both the volume of data and the fact that interviews contained a mixture of narrative and descriptive responses. Where the theming of narrative involves coding 'sequences' of responses rather than 'segments' (as is usually done in thematic analysis of qualitative data), the process was relatively similar (Riessman 2008, p74). Having had no previous experience of working with narrative data this was also the method that was the most straightforward to attempt. Thematic analysis of narrative is acknowledged for the limitation that readers must assume that everyone in a cluster means the same thing in their statements, which has the potential to obscure 'meanings-in-context' (Riessman 2008, p76) although the same limitation must be acknowledged for the theming of any qualitative data. Ultimately this method was used because it allowed for the discussion of the results to be as grounded in the data as possible.

Case studies themselves are a form of analysis, intended to 'capture the complexity' of (in this instance) a particular programme of work: the ALPS CETL (see Rossman and Ross 2003, p278). The case study of ALPS was particularly focused on establishing how a large scale multi-professional programme of work was introduced and established, how the concepts of IPE and interprofessional assessment were introduced into curricula and in practice what decisions were taken, and what influential events occurred along the way. Texts from the ALPS CETL and relevant interviews undertaken for this research (i.e. with staff members involved in ALPS) were therefore read and coded, being context-driven by this set of questions (rather than data-driven).

This chapter has described the methods and phases of data collection used to collect the data for the research presented in the following chapters. It has described the importance to the research of staff opinion, and has outlined some issues associated used with the chosen methodologies of questionnaires, interviews and case studies. As with all interpretive research it is acknowledged that the researcher's position of investigating a given topic places on it an emphasis which may not have otherwise have had for the respondents. Nevertheless in order to advance understanding of conceptualisations of professional identity and interprofessional education, the methods chosen have been justified here as the most appropriate to do so. The following chapter introduces the work of the ALPS CETL in detail, and describes the results of the case study.

Chapter Five

Exploring the impact of a large-scale interprofessional programme of work.

Case study: The ALPS CETL

5.1 Introduction

This chapter uses the Assessment and Learning in Practice Setting (ALPS) Centre of Excellence in Teaching and Learning (CETL) as a case study, exploring longer-term impact on both the curricula and staff of institutions taking part in a large scale multi- and interprofessional programme of work. More specifically, this chapter seeks to address the following question:

What impact does the implementation of a large-scale interprofessional programme have on staff involved in delivering the programme?

To do this, the ALPS programme and its aims are described in detail. Using evidence from programme documents (evaluation and research reports; the website / documents published via the website) and interviews, attention is paid to how the project was implemented across programme partners, including consideration of recorded barriers and successes. Themes drawn from interview data are also used to examine the perceived impact of the ALPS CETL programme on both the staff and institutions involved, including staff who participated in its delivery and implementation.

5.2 The ALPS CETL

ALPS was one of 74 CETLS funded by HEFCE (the Higher Education Funding Council for England) after a successful bidding process in 2004. The original ALPS partnership was initially funded as a five-year programme, running from 2005 to 2010, but the partnership was awarded

further funding by the (then) Yorkshire and Humber Strategic Health Authority (YHSHA) and subsequently funded for a further 12 months (to 2011).

ALPS was a regional consortium of five West Yorkshire-based Higher Education Institutions (HEIs), consisting of the Universities of Leeds, Huddersfield, Bradford, Leeds Metropolitan and York St John (York St John College at the time of initial bidding). These five HEIs were collectively responsible for delivering courses which covered sixteen different H&SC professions. The ALPS collaboration was thus unique in size and structure; in terms of partner numbers, it was the second largest CETL, and involved the largest number of professions of any of the CETLs. The CETL programme had two main aims; to reward excellence in teaching practice, and to invest in that practice, bringing further benefits to students, teachers and institutions (HEFCE Website).

The overarching rationale for the ALPS CETL was:

...to ensure that students graduating from courses in H&SC are fully equipped to perform confidently and competently at the start of their professional careers.

(ALPS 2004 p2, original emphasis)

Based on the notion that students value accurate and fair assessment processes which provide both effective feedback and a basis for reflection, the original ALPS bid suggested that its overarching aim would be achieved through the development of a series of work-based assessments. These assessments would measure, both formatively and summatively, a series of core competences which would inform students' portfolios of evidence, with feedback provided from peers, tutors, patients and self-reflection. Ambitiously, it was claimed that ALPS would:

...permanently change the culture of the organisations involved, in line with relevant strategic changes in workforce planning and the delivery of patient care (stemming from the NHS Plan, DH 2000).

(ALPS 2004, p2)

To achieve this, it was suggested that the CETL would bring together 'uniprofessional expertise in workplace H&SC assessment' which would then be disseminated via good practice 'within and across the institutions'. The multiprofessional element of ALPS involved bringing together experts from different professions to strengthen H&SC assessment frameworks which, it was proposed, would drive learning. It was hoped this would bring about benefits for institutions through sharing of knowledge and resources;

By looking for commonality of purpose across H&SC education and sharing scarce resources to assess common outcomes, we can provide a more robust framework for the assessment of clinical competence and use this assessment to drive strategic learning.

(ALPS 2004, p3)

Additionally, ALPS aimed to introduce or improve interprofessional teaching and learning across all partner cohorts, while improving students' understanding of, and competence to undertake, interprofessional working. This included the proposal that such skills would be assessed. It was hoped that improvements in assessment would provide 'more opportunities for interprofessional learning' in practice settings with peers, and it was proposed that as a result of the ALPS programme:

Students will benefit from interprofessional and multiprofessional teaching to support their practice-based learning experience, providing a range of different professional perspectives on patient / client care.

(ALPS 2004, p21)

Furthermore, it was suggested that increased attention on interprofessional working and learning would result in benefits for staff involved in delivering the ALPS programme:

- By undertaking assessments interprofessionally, staff who currently act as uniprofessional role models for students will be encouraged to reflect on their pedagogic approaches and this

will enhance their own interprofessional patient focussed practice.

- The improved support and clarity of purpose for clinical educators will better prepare them to cope with the conflicting demands of workforce development and service delivery.

(ALPS 2004, p21)

Thus the aims of ALPS relating to both interprofessional learning and working were relatively broad and ambitious, consistent with the size and scale of the programme.

5.21 The ALPS programme of work

To meet the proposed objectives, the ALPS programme of work involved a number of strands for developing interprofessional learning and assessment. The main focus was the development of three 'maps' of essential competences for all H&SC professions: *communication*, *team working*, and *ethical practice*. The mapping process was achieved through a number of stages: agreeing a structure for each competence; developing statements which described each competence and splitting these into themes and 'hierarchies'; and developing performance criteria which related to each statement (Holt *et al.* 2010).

The overarching context of this mapping process was that these performance criteria would ultimately form the content of common assessment tools for inter-professional learning.

(Holt *et al.* 2010, p266)

When each map was drafted, it was subjected to an extensive consultation process which involved ALPS stakeholders at every level, including Professional, Statutory and Regulatory Bodies (PSRBs), service users and carers, academic staff, and representatives from practice (usually Practice Learning Facilitators) (Holt *et al.* 2010).

The completed maps were used as both standalone resources to be used with and by students to develop understanding of the competences, and as the basis for five interprofessional assessment tools, which were developed as workplace-based assessments (WBAs). While there are a range of WBA tools in widespread use (Fuller *et al.* 2009), the language and conceptualisation of assessments carried out in the workplace as 'WBAs', as well as literature exploring their use, has been informed by medicine (see Kogan and Holmboe 2013). However, within ALPS, the language of 'WBAs' was accepted and there was a recognition of advantages in their use which would apply equally to all ALPS professions. If used effectively, WBAs are formative assessments which aid student learning by identifying learning needs via feedback, while also allowing faculty to 'track student attainment' (Fuller *et al.* 2009, p368). The WBAs developed for ALPS were not based on any existing tool and were designed to be used in 'generic practice scenarios' (Dearnley *et al.* 2013, p437), with the intention that they would be used by all H&SC professions. The five scenarios were:

- Demonstrating respect for a service user during an interaction
- Gaining consent
- Knowing when to consult or refer
- Providing information to a colleague
- Working interprofessionally

(Dearnley *et al.* 2013)

Each tool was developed with the same format and all had a mixture of Likert scale ratings, multiple-choice questions and open-response sections which allowed for more detailed feedback. The tools were divided into segments, allowing students to collect feedback from a variety of sources: practice assessors (from their own profession), an interprofessional assessor (a qualified member of staff from a profession other than their own), and peers (students). Norcini and Burch (2007) have identified that WBAs can be ineffective when there is poor quality feedback from assessors, or where there is no clear link established between an

assessment and a learning outcome. The ALPS assessment tools attempted to address such concerns by providing space for students to reflect on feedback they received and the capacity to develop an action plan based on this (if required) which could be signed off by a practice educator.

To support the student assessments, a 'large scale mobile technology' programme was also introduced in order to 'enhance student work-based learning' (Davies *et al.* 2010, p8). The purpose of developing resources to be used on mobile devices (phones) was allowing students to gather instant feedback on assessments while on placement which would contribute to an electronic record (e-portfolio) of their work and progress. Capturing this data electronically also meant that tutors in universities could log in to the e-portfolio system, or be notified instantly, of results of placement assessments. The advantage of this process was that students could access support from their university-based tutors while still in placement settings, where previously they could not do so without returning to their institution. However, given the number of students involved in ALPS across all five partner HEIs (c.9,000 per year) and the number of mobile devices purchased to support the programme (900), the ALPS tools were ultimately developed for use on both mobile devices and on paper, ensuring that those students who were not allocated a device were still offered an opportunity to use the tool and gain more feedback while on placements.

5.22 ALPS programme implementation

The ALPS programme of work was undertaken and implemented by a series of management and working groups, whose membership varied depending on expertise, but was made up of representatives from all five ALPS partner HEIs, members of the SHA (where appropriate), and members of the ALPS Core Team (the central full-time team who supported the running of the ALPS CETL, the structure of which is outlined in Appendix 8). Table 5.1 outlines the different working and management

groups responsible for delivering proposed work in the ALPS programme, as well as their function (a diagram of group structure can be found in Appendix 9). In addition to the working and management groups, each of the ALPS partner HEIs had a 'Partner Site Implementation Group' (PSIG) responsible for acting on decisions taken by the working groups in order to implement the ALPS programme at their own HEI.

5.23 Context

While other large-scale interprofessional programmes exist (for example, the Aberdeen Interprofessional Health and Social Care Initiative or the Interprofessional Training Wards at the Karolinska Institutet), the scale of ALPS in terms of number of institutional partners (five), the number of professions involved (16), and the number of students potentially involved per year (9,000), meant that the ALPS programme was an interesting case study for this thesis because of its relatively unique size. However, the context of the programme was also unique and must be given consideration before attention is turned to its outcomes.

As has been made clear in Section 5.21, while a large portion of the work (such as the competency mapping and development of generic assessment tools) contributed to the improvement of interprofessional education and working, the ALPS programme had a number of aims relating to other educational developments. Thus, unlike other large-scale interprofessional initiatives, improved interprofessional outcomes were not the only focus of the programme. Additionally, as a CETL, ALPS held an unusual status for an academic programme of work. CETLs were funded based on recognition for existing excellence in teaching and learning, acknowledging that existing reward systems within HEIs were more likely to reward excellence in research than in teaching (SQW 2011).

Table 5.1: ALPS Management and Working Groups and their function

Group	Function
Advisory Board	Senior management group, responsible for overseeing strategic direction of ALPS, financial planning and monitoring of all other management groups and embedding strategic and operational activities of all parties.
Baseline, Outcomes and Research	Group tasked with carrying out specific research – namely, to identify and develop mechanisms for measurement of validity and reliability of practice-based assessments.
Common Competence Mapping	Group that defined ‘common competency mapping tool’, ‘common assessment tool’, and mapped out requirements for these by developing a shared, agreed understanding and definition of common areas (communication, team working, ethical practice).
Dissemination and Impact	Responsible for Dissemination & Impact Strategy; helped to identify a network of influential individuals and organisations to ensure they were aware of ALPS and its activities and built links with the Higher Education Academy and other CETLs.
e-Valuation	A sub-group of both the IT and Research Management groups, this group was responsible for delivering the research and evaluation of all e-learning elements of the ALPS programme.
IT Group	Group responsible for leading the technical elements of the ALPS programme and for implementing the mobile technology and supporting structures in each of the ALPS partner sites.
Joint Management	Main management group attended by all ALPS partner leads and chairs of all groups. Responsible for overseeing financial management and project plans, and facilitating communication between all ALPS partners and groups.
Monitoring and Evaluation	Group tasked with establishing the standards and quality against which ALPS milestones and objectives were measured. Responsible for wide ranging evaluation of ALPS activities including effects on areas such as capacity building, value for money, cost effectiveness and communicating feedback to ALPS students, staff and stakeholders
Research Management	Responsible for overseeing all research-related activity and ALPS research groups. Developed and implemented the ALPS research strategy, monitored research outputs and quality of outputs from all ALPS partners.
Risk Assessment	Responsible for monitoring management of performance against targets; Core Team performance and identifying any issues of a strategic nature & report accordingly to the Advisory Board.
Service Users and Carers	Responsible for developing and enhancing the role of service users and carers in assessment, and learning in practice settings; advising other groups on membership in line with best practice.
Tools	The remit of the Tools Group was initially to synthesise evidence and information from the ALPS Groups in order to identify a set of tools to be used in assessing common competences of health and social care students in practice using mobile technologies, and later to develop work developed by the Common Competence Group into common assessment tools.

However, as a result of how CETLs were funded and monitored, there was no penalty for 'failure' nor any evaluation framework in place at the launch of the CETL initiative; this made outcomes difficult to measure (SQW 2011). HEFCE's management of the CETL programme was deliberately 'light touch' (Saunders *et al.* 2008) but, in line with all other CETLs, HEFCE did not place any requirements on any activity becoming embedded in any of the partners' H&SC curricula (although the extent to which it did so is explored in Section 5.6). For ALPS however, it was hoped that by choosing competences that were common to all professional groups involved that the maps would become embedded within each individual curricula, with the assessment tools as an additional option that could also be easily assimilated into individual curricula. As a result, ALPS was slightly different from other large scale interprofessional programmes because, while it was hoped it would be embedded within core curricula, it was monitored by the funders as a five-year programme that might cease once funding ended. Consequently there was less external pressure on project partners to embed the programme than there might otherwise have been. Additionally, within the five partner HEIs, ALPS was also only a part of the whole picture; most if not all professions at each ALPS partner already had elements of IPE in their programme. The ambitious aims of ALPS to improve interprofessional learning and working across all partners were therefore not the only elements of IPE in which some academics were involved.

Finally, the work of ALPS was based upon the concept of 'interprofessional assessment', a term which has more commonly been used to describe the assessment of interprofessional learning outcomes (see Morison and Stewart 2005). The aim of the ALPS tools, however, was to enable students to gather feedback from a variety of sources, including qualified staff from professions other than their own, a process more accurately described as part of gathering 'multi-source feedback' (MSF). Indeed, interprofessional ALPS assessment was not a stand-alone process but incorporated into a tool, enabling students to gather feedback from a variety of sources, and so

was itself a form of MSF. MSF is a recognised method of assessing performance, used by a variety of professions (including those outside H&SC), and has been shown to provide high levels of feasibility, reliability and validity in fields such as medicine (Donnan *et al.* 2014). The ‘interprofessional assessment’ developed by ALPS needs to be understood in this context, as opposed to being viewed as a new, different, and perhaps less-proven form of assessment.

5.3 Programme Outcomes and Evaluation

The purpose of this case study is to understand the impact of a large-scale interprofessional programme on the staff involved in implementing it. To address this, the processes undertaken to implement ALPS have been described, but clearly give no indication about the extent to which implementation was successful, nor its impact on staff. The following section will therefore examine some of the research and evaluation documents produced by ALPS in order to explore how successful implementation of the programme appears to have been. At this juncture it may be useful to note that in the initial round of CETL applications there was no mention of research requirements, with the implication that research would not be funded by the programme. This stance was somewhat softened in the second round applications although there was no systematic emphasis on research or evaluation within the CETL programmes. The extent to which each CETL ended up with planned research and evaluation outputs therefore depended somewhat on their interpretation of what would be ‘allowed’ at this second stage.

The ALPS programme did make some investment in evaluating ‘softer’ outcomes of the programme, by commissioning The ROI Academy to undertake a Cost Benefit Analysis (CBA) of the assessment and learning approaches which arose from ALPS (ALPS and The ROI Academy 2010). At the time of the report (2010) the conclusion from the CBA was that ALPS had produced a higher than expected return on investment of

approximately 50% of the original investment, with 'the greatest return' at that stage being:

the human capital asset base of expertise in collaborative, interdisciplinary and interprofessional working skills and expertise in mobile, e-learning and development of shared services. (ALPS and The ROI Academy 2010, p2)

In addition to the results showing an impact on creating value through increased staff knowledge, they also indicated that there was 'substantial potential to create value for students (and hence employers) on wider deployment' (ALPS and The ROI Academy 2010, p3). Unfortunately the timing of the CBA was such that it is not possible to state whether ALPS met this predicted potential, but it is interesting to note that the increase interprofessional skills was highlighted as being an area of great return.

The CETLs were asked to produce evaluations of their work at two stages. The first, an interim evaluation report was produced in July 2007, and the final summative evaluation in 2010. In addition to the self-evaluation produced by the CETLs at each phase, HEFCE commissioned simultaneous independent reviews of the CETL programme. However, these were not evaluations of each CETL, rather summaries and evaluations of activities of the whole CETL programme. At the mid-point, this evaluation included evidence gathered from: interviews and visits to 36 of the 74 CETLs, key informant interviews, a survey of CETL Directors, and an overview of the CETL self-evaluation reports (Saunders *et al.* 2008). The final summative report, which was completed in three months, was primarily based on the final-evaluation reports produced by the CETLs (SQW 2011). It must therefore be recognised that much of the evaluation material was produced by the CETLs and could be construed as a non-impartial evaluation of the programme, especially as there was a clear need for CETLs to ensure that funders received the best possible impression of their work. King (2010) noted that the self-evaluation methodology, coupled with a lack of both a pre-arranged evaluation framework or agreed interpretation of 'impact',

was also problematic for CETLs at the midpoint evaluation, where CETL teams were to identify only able 'limited impact' of their programmes (p44). Documents drawn upon here for evidence must be viewed in this context.

The interim report produced by ALPS was based upon evidence from case studies of activity written by both ALPS partner HEIs and working groups, as well as the annual reports either written for, or by, ALPS management groups. The report noted that the first phase of ALPS activity, planned to span the first three years (2005–2008), was intended to be the 'descriptive and developmental' period of the programme, concentrating on:

...mapping the competences, developing and piloting tools...[and] engaging with practice staff, students, service users and carers.

(ALPS 2007, p7)

Two further proposed (overlapping) stages were the 'transformative' phase 2 in years 3 – 5, and the 'evaluating and embedding' phase 3, envisaged to take place from year three onwards. Therefore the interim report could discuss in detail only the developmental phase of the programme. Accordingly, it was reported that much of the work up until that point had been concerned with 'establishing the collaborative arrangements across the five universities and NHS partners', as well as starting agreed work plans (ALPS 2007, p7). The report highlights that, in terms of collaboration (which involved both cross-institutions and cross-professional working), ALPS was based upon an 'ambitious model':

...aiming as it does to change practice whilst collaborating across Five Higher Education Institution [sic] and involving health and social care partners.

(ALPS 2007, p30)

Nevertheless, it was also reported that as a result of ALPS there had been 'increased collaboration', resulting in:

...more sustainable joint working and the spreading of good practice and innovations in learning and teaching across the partners. (ALPS 2007, p30)

The evidence included reports from partner sites suggesting that individuals who had previously worked predominantly inside their own professional 'silos' were beginning to 'look and be aware of good practice in other professions' (ALPS 2007, p21). It was also reported that the ALPS work programme had led to opportunities for senior staff from different professions in the same institutions to come together and share expertise when they 'would not normally work together' (ALPS 2007, p19). While it was acknowledged that it had taken time to build respect and trust between colleagues, the positive outcomes included people attending ALPS groups due to a 'genuine interest in collaborative discussion regarding practice', as well as colleagues drawing examples from different professions (for the first time) when looking to develop profession-specific practice assessments (ALPS 2007, p21).

Nevertheless, the report also contains details where working collaboratively had been a challenge for ALPS participants. With reference to the formation of the Management Groups, for example, it was stated that:

Although it was agreed that representatives from each and every partner to a Group were not necessary, it is probable that there had not been enough trust established by this stage to allow some partners to take the lead and others to take more of a back seat.

(ALPS 2007, p8).

It was also noted that:

...poor communication and lack of engagement is a major barrier for partners with some professions less engaged than others.

(ALPS 2007, p21)

Similar issues were noted in the independent formative mid-point evaluation of the CETL programme commissioned by HEFCE. The report

noted that working across disciplines, faculties and departments had been difficult for some CETL staff and that, as Universities were typically 'compartmentalised', there was occasionally a 'silo' mentality, which was outside of the control of CETLs but did cause some considerable challenges (Saunders *et al.* 2008, p71). However, none of these issues were identified explicitly either by ALPS or by the wider evaluation as either being caused by, or symptomatic of, interprofessional or even multi-professional working. Nevertheless, this does not suggest that these tensions were *not* due to issues relating to professional boundaries; it can only be understood from documentation that it is *possible* that they were. As made clear in Chapter 4, the fact that the ALPS CETL involved 'collaboration' in a number of new ways for project partners – across profession, agency and institution – means that these issues can only be ascribed with certainty to new 'collaborations', cross-profession or otherwise.

The final summative evaluation of the entire CETL programme was, as already highlighted, rather limited in scope, based primarily on self-evaluation reports written by CETLS. A small amount of additional primary research was also conducted: two e-surveys (one of Pro-Vice Chancellors, and one of teaching and learning practitioners) and eight thematic case studies, which again drew evidence from CETL self-evaluations, as well as being based on further 'selective consultations with key individuals and organizations, where appropriate' (SQW 2011, p2). The report focuses on evaluating the scale and scope of the CETL programme, exploring the impact of the CETLS on institutions involved and the wider academic community, and on the sustainability of the programmes of work launched by the CETL. There is little in the report of relevance for this research, although, where relevant, it will be used to contextualise discussions concerning the ALPS CETL evaluation.

The format of the final evaluations produced by the CETLS was prescribed by HEFCE and very limiting in terms of the information requested. The first section was entitled 'statistical information', containing information about capital expenditure and income earned, as well as details of where staff

would go once the CETL had ended and details of dissemination materials (conference and journal papers). Section two was 'evaluative reflection', containing twelve open-ended questions about the work of the CETL (although each question had a word limit of 600-1,000 words). As such, the report is of fairly limited use as a complete record of ALPS outcomes, because the information had to be necessarily selective in order to meet the word-limits, and was therefore probably not wholly representative of what staff involved in the CETL would have presented at the close of the programme. Nevertheless, the report did contain reflection on aims to improve interprofessional collaboration and working. In response to the question 'reflecting on the last five years what other important messages are there that you would want to convey about your CETL?' the report notes (among other things) that as a result of ALPS there was:

- Impact on the reputation of the professions with their PSRBs [Professional Statutory Regulatory Bodies]: demonstrating leadership, innovation and interprofessional cooperation for the good of the academic development of the professions, and thus potential improvement in care standards
- A framework for interprofessional education in practice settings which provide a framework to meet the aims outlined by Darzi in 'High quality care for all: NHS Next Stage Review final report': where ALPS has undertaken three research projects which involve interprofessional working, learning and strategy.

(ALPS 2010, p11)

Given the report's nature, no evidence is offered to support these statements, which makes it problematic to assess the claims made using it alone. However, at the end of the programme, a variety of staff wrote reflective pieces about their experiences of being involved in ALPS. One such piece by the ALPS Director on leadership highlights the importance of establishing trust as vital to developing cross-profession and cross-institutional relationships, and encourages leaders to be open to different points of view in order to allow multi-layered projects to develop (Roberts

2010). While again offering little in the way of a measurable outcome, such reflections do lend support to the notion that the impact of ALPS could be seen in the interprofessional (and cross-institutional) collaboration which was established during the course of the ALPS programme.

Such claims gain further support from another ALPS publication which arose from research undertaken by some of the ALPS partners in collaboration with an external evaluation team from the University of Birmingham. 'Strength in Numbers' by Hargreaves *et al.* (n.d.) set out to explore ALPS's 'collaborative approach to innovation in professional education'. In their study, Hargreaves *et al.* identified that there was interchangeable use of the terms 'collaboration' and 'interprofessional', a characteristic of ALPS documentation noted earlier in this thesis (see Chapter 4):

It was self-evident from the data analysis that many of the themes and sub themes were related to interprofessional working, education and learning. Rather than treating this as an extra theme, we acknowledged it as an overarching consideration for many participants; that sometimes 'working collaboratively' meant 'working interprofessionally'. (n.d., p8)

The consequence for Hargreaves *et al.* was that many of the themes emerging from their research had a 'broad consensus with much interprofessional literature' (n.d., p8). Although it is important to note that it is still not possible to separate out which aspects of collaboration (interprofessional or cross-institution) are being discussed, using documentary analysis, individual interviews, reflective accounts and nominal group technique (a four stage technique employed in a focus group, involving individuals and groups identifying the most important points of discussion they have), Hargreaves *et al.* identified four general themes relating to the perceived impact of collaboration between ALPS partners. Additionally, 'engagement with the PSRBs' emerged as a topic for discussion, even though this concerned collaboration outside the ALPS

partnerships. While participants in the study were not specifically asked about PSRBs, Hargreaves *et al.* found that engagement with them was 'unanimously seen as a successful outcome' of ALPS (n.d., p8). In particular, concerns that the PSRBs would be resistant to, or even block, interprofessional assessments proposed by ALPS were not confirmed. Although it is not possible to determine whether this attitude by PSRBs was facilitated by the ALPS programme, the fact that lack of resistance to the idea was established had a positive effect on ALPS partners, as it meant they were able to develop and promote the concept of interprofessional assessment without concern that this was against the wishes of their professional bodies (Hargreaves *et al.* n.d., p9). This finding seems to lend support to the claim made in the final ALPS evaluation report suggesting that ALPS' engagement with the PSRBs led to improved interprofessional cooperation.

As made clear, the ALPS programme had a number of strands, and there was suggestion in the report by Hargreaves *et al.* that some participants felt that collaborative aspects around interprofessional / multi-professional assessment 'had been sacrificed to the development of the mobile technology' (n.d., p9). However, Hargreaves *et al.* suggest that this view tended to be held by those participants less keen on technological aspects of the programme. As with all evaluations, participants views differ depending on personal priorities, but this highlights the potential difficulty of interprofessional collaboration being just one aspect of a wider programme of work aimed at those for whom it was a priority; it clearly cannot always be the primary aim / focus when other parts of a programme have to be achieved. Hargreaves *et al.* suggest, however, that the result of collaborative work of ALPS primarily resulted in an overarching theme, with participants feeling that 'we got further than we would have done on our own' (n.d., p9). This related to three further sub-themes; *culture*, *trust*, and *leadership*, of which *culture* is particularly relevant for this discussion.

The concept of *culture* was, for ALPS participants, sometimes perceived as a barrier to collaboration where:

...defensiveness, 'tribalism' and shared histories about how collaborative ventures had fared in the past all had a bearing on the progress of ALPS. (Hargreaves *et al.* n.d., p10)

As discussed in Chapter Two, the complex inter-related nature of professional histories, culture and identities is known to influence interprofessional working (Carlisle *et al.* 2004; Atkins 1998), and, as a consequence, perceptions of it. To some extent, it is unsurprising to find concerns raised about differing 'cultures' causing problems for a large-scale collaboration, and yet this was not the only finding. The ALPS participants also noted that strong relationships began emerging where there was perceived to be a shared 'culture' (defined as a 'similar outlook') between professionals (Hargreaves *et al.* n.d., p9). This was extremely positive for ALPS, where it led to greater participation in the programme, and as seen in Chapter Six, this is significant for this research, where a perception of 'shared culture' is believed to result in more relevant and effective IPE experiences.

One final noteworthy element from Hargreaves *et al.*'s report, which is again of specific interest to this research, relates to the theme of 'size'. Clearly, the size of the ALPS CETL is one reason why it made a unique case study. Indeed, whether ALPS was 'too big' was a question raised by Hargreaves *et al.*, but the authors suggest that this was difficult to answer at 'the distance' from which they were evaluating the programme (n.d., p12). However, it was noted that:

...the plan for ALPS was wide and ambitious. Six overarching aims led to a strategic plan that included more than a hundred objectives. The sheer volume of work to be completed and the complex communication systems needed to support it meant that the progress of any one strand of work could be jeopardised or significantly slowed down by the process of organizing meetings and other opportunities to get work done.

(Hargreaves *et al.* n.d., p12)

In Chapter Three of this research, it was highlighted that reports of many IPE initiatives reflect upon the structural and organisational barriers that contribute to difficulties in its implementation. It is perhaps not surprising, but nonetheless worth noting, that a larger scale programme appears to have encountered these difficulties in proportion to the project's size. The extent to which connections made between institutions and professions were 'natural' or rather 'manufactured' as a result of the ALPS programme's success in bidding for funding was also queried by Hargreaves *et al.*, but the authors were unable to provide an answer, concluding that, irrespective of whether the collaboration might have occurred naturally, ALPS resulted in:

...an effective network which cuts across professional and institutional boundaries. (n.d., p12)

The work undertaken by Hargreaves *et al.* has therefore provided a helpful snapshot of a perspective of ALPS when the work and collaboration was still funded, as well as offering further evidence for claims made in the final ALPS report regarding outcomes of the programmes, including improved interprofessional collaboration. This theme, and other points raised by the Hargreaves *et al.* report and also discussed here, are readdressed later in this chapter and in Chapter Six, with reference to findings of research carried out specifically for this thesis.

5.4 Collaborative Networks extension programme

When the initial funding from HEFCE came to an end in 2010, the ALPS CETL was awarded some continuation funding by NHS Yorkshire and the Humber, specifically to develop, embed and disseminate the work of ALPS. Subsequently, six collaborative networks were formed based upon the 'shared interests and expertise' that had developed over five years of the ALPS programme (ALPS website). While all six networks remained, to a greater or lesser extent, multi-professional (in that they involved any interested parties, from whichever profession they came), the ALPS

Common Competency and Patient Safety Network was the only one that explicitly referenced ALPS' ambitions to improve interprofessional working. In fact, it is worth noting that none of the networks attempted to take forward the use of interprofessional / generic assessment tools developed by ALPS, focusing instead on Common Competency Maps, which were the framework for the ALPS assessment tools. The Common Competency and Patient Safety Network webpage stated that:

The work of ALPS is based on the hypothesis that if students receive feedback from different sources in diverse practice situations, then confidence, competence, assessment reliability and interprofessional working skills will all be improved.

(ALPS Website)

This description is less detailed than the original ALPS proposals to improve interprofessional patient-focused practice via the use of interprofessional assessment. However, the page also stated that:

Interprofessional education is a crucial element of all health and social care programmes and the common competency maps enable consistent, agreed and comprehensively understood language, which is essential for working together effectively and improving patient safety.

(ALPS Website)

Nevertheless, it proceeded to direct to the site visitors interested in further developing IPE to an IPE programme at one of the ALPS partners, which had existed and developed independently of all the ALPS programme. While this is not intended to suggest that the ALPS programme had no impact on interprofessional education, working or relationships (perceptions of this are explored in Section 5.6), it is important to note that the original interprofessional aspirations of ALPS were much less evident in the Collaborative Networks than in the original bid as well as evaluations of the original five year programme of work.

5.5 Evaluations of other large-scale IPE programmes

As made clear throughout this thesis, the size of ALPS (and in particular the number of professions involved) was one of the features that made it an interesting case study, particularly as little evidence from other large scale IPE initiatives exists. This means, however, that comparatively little other evaluation data of larger scale initiatives is available, ruling out contrast to the findings of this case study. It is particularly hard to find staff views of large-scale programmes as, similar to the majority of IPE evaluations, most published material about larger scale programme focuses on student views. As such, the discussion that follows is based upon information on other large scale programmes, but was not necessarily chosen because it is directly comparable.

The 'Common Learning' programme (originally known as the New Generation Project), which was conducted at the Universities of Southampton and Portsmouth, was introduced in 2003 and now involves around 3,500 students each year (CL Website). The New Generation Project was one of the Common Learning Pilots – the evaluation of which was discussed at length in Chapter Three – and, as this project has continued, it is worthy of further discussion. Although no published evaluation of this programme is available on the project website, a number of academic papers about the programme were published in the early stages. A 2006 paper by O'Halloran *et al.* describes the process of curriculum design, with reference to the teaching model originally developed, which had been validated by the relevant bodies of 17 pre-qualifying programmes involved in the project (O'Halloran *et al.* 2006, p25). The paper also describes the programme's design, which originally offered three modules with a mixture of campus-based and placement experiences. However, this has now been reduced to one placement-based module, which:

...provides students with an opportunity to work together on an audit, and apply their team working and negotiation skills in an inter-professional context. (CL Website)

While a longitudinal study of attitudinal and knowledge change among students was being undertaken from 2002 onwards, the extent to which this is relevant now is questionable, given that the programme was reduced from one module from three modules. While this reduction in modules went against recommendations of another paper that emerged from the programme, which suggested a need to further extend the concept of IPL within undergraduate teaching and for post-graduate learners as well (Humphris and Macleod Clark, n.d.), it did follow the Quality Assurance of Basic Medical Education (QABME) report on the School of Medicine in 2008 which expressed a number of concerns about 'the views of students and those responsible for the IPL programme' (GMC 2008, p12). In particular the GMC noted that there were high numbers of critical comments from both students and clinical staff about the programme, and that while students understood the aims of the programme, the content and timetabling did not facilitate them being met. The consequence of this, the GMC concluded, was that potentially 'professional stereotyping is reinforced rather than reduced' (GMC 2008, p12). The recommendations made from the QABME review included Southampton looking at restructuring their IPL provision, and asking the School to demonstrate that the delivery of IPL met the needs of medical students. One might therefore question whether the scale of that particular programme was sustainable, and the evidence from the GMC report suggests that it was not, or at least not in a way that was viewed as meeting both the needs of medical students and the aims of the IPE programme. This highlights further the difficulties in discussing programmes or their elements that are perceived to be 'unsuccessful' (or perhaps less successful than interested parties would like them to be), as these are rarely discussed in published papers, rendering information on the programme difficult to find, analyse, or build future learning on.

The other three Common Learning Pilots were not continued for similar reason as the New Generation project, although research and final reports are available on some. Of particular interest to this research is a case study

of the Interprofessional Learning in Practice in South East London (ILP) which notes that the potential size of the programme (5,900 students per year) was a barrier to overcome, with the result that the programme was piloted rather than introduced to the entire cohort at once. The pilot involved 610 students from 10 H&SC professions (D'Avray *et al.* 2007); each student attended three two-hour sessions in a mixed group of 7 – 10 linked to a clinical area. Session one involved constructing a map of a patient journey; session two involved a visit to practice in pairs to interview informal carers and professional staff, and to review client documents; and session three involved students meeting to discuss what they had experienced in practice. While the case study suggested that students generally enjoyed positive experiences from the ILP programme, it was noted that the recruitment of facilitators was uneven, with a lack of engagement from some professions, and particularly in medicine, where staff supported the course but did not volunteer to facilitate sessions (D'Avray *et al.* 2007). Lack of engagement by medical professionals was a theme in the earlier IPE literature (Whitehead 2007) but did not arise as an issue for the ALPS CETL. Indeed, there was instead a recognition that engagement of the Medical School had been informed by strong leadership from the Director of the CETL, a finding similar to Fook *et al.* (2013) who noted that inspiring leadership from the medical faculty ensured engagement by all staff. The ILP case study also suggested that while the ILP exercise had proven to be deliverable, this was probably because of its 'modest size', suggesting that a larger programme (i.e. which all students could have attended) would have been too costly and difficult to sustain (D'Avray *et al.* 2007). To embed the programme, it was suggested that the responsibility for running it would need to be moved away from the project team and into the health schools (D'Avray *et al.* 2007). This was similar to the ALPS experience, where the project was seen as innovative and was well supported, but the motivation for making it happen and, in particular, the administrative functions were carried out by a core project team. Once these resources were no longer funded or existed, it was unlikely that institutions would carry forward the activity by themselves (although in

the case of ALPS, elements of the programme were adopted by individual professions or institutions). Again, this raises questions about the sustainability of large-scale IPE programmes, and in particular those like the ILP, of which it was suggested:

...it is not possible to prove that patient care will benefit from this particular course... (D'Avray *et al.* 2007, online)

In a time of restricted budgets, it seems unlikely that IPE on this scale, which cannot be demonstrably linked to improvements in patient care, would be continued.

One larger-scale IPE course that still in operation is the Aberdeen Interprofessional Health and Social Care Education programme. Begun in 2003/4 as a series of interprofessional workshops for all first-year H&SC across Robert Gordon University and the School of Medicine and Dentistry at the University of Aberdeen, this IPE programme of classroom based workshops is now embedded in first and second year curricula across ten professional courses at these institutions (Aberdeen website). It is noted that from year three onwards, IPE is experienced in practice placements (Aberdeen website). An evaluation of this work prepared for the Scottish Government (who funded the evaluation) was published in 2008, although information presented in it was primarily based upon exploring student perceptions of IPE and interprofessional working. The extent to which the programme has had any benefit for patient care is once again unknown, although it is interesting to note that this programme, which grew from a funded pilot, has been sustained while other programmes have not. The model of larger-scale IPE, involving delivering classroom-based workshops to all H&SC students within an institution or with a partner institution, is possibly more common-place now, with at least three of the five ALPS partners now incorporating it into their own IPE teaching. While the Aberdeen model was of particular note in 2008, when IPE teaching on this scale was less usual, it is only the length of time this programme has been sustained which is now of interest. With a lack of research or evaluation

material, it is also not possible to understand the impact of this programme on patient care or on students' ability to work as part of an interprofessional team in a meaningful way.

The most similar noteworthy programme of work to ALPS was the CETL4Health North East, which was again a HEFCE-funded CETL that involved a collaboration of five Higher Education Institutions and a number of NHS partners. CETL4HealthNE was very similar to ALPS in that the interprofessional education aspect was only part of a programme whose overall aim was that H&SC students should be 'fit for purpose, fit for practice as well as fit for award' (Powell and Scott 2013). In the final evaluation of the CETL (which should be subjected to the same caveats regarding purpose and authorship as the ALPS final evaluation) it was suggested that:

For us, learning needs to impact not only on outcomes for students but also, through them, on outcomes for patients.

(Hammond *et al.* 2010, p11)

To recognise this impact, CETL4HealthNE used their fellowship scheme, although it is not made clear what impact on patients was recorded. IPE was one of six key areas for this CETL, which aimed to expand its partners' existing IPE into 'new contexts and with new participants' (Hammond *et al.* 2010, p13). The report notes that there was a 'considerable expansion of IPE across partners' (Hammond *et al.* 2010, p13), including engagement of new professions as participants, but again it is not clear how much was a direct impact of the CETL activity and how much may have occurred in project partners anyway. However, the CETL secured continuation funding and went on to deliver two practice-based IPE initiatives whose evaluation is presented in an extensive report (Powell and Scott 2013). This detailed document describes the two initiatives, and drawing on Pawson and Tilley's (1997) 'realistic evaluation methodology', it adopts a methodology to explore how 'context + mechanism = outcome' can be used to interpret the processes of delivery of 'interprofessional medication safety seminars'

(Powell and Scott 2013, p3). The evaluation found that one of the main benefits identified by students for the session entitled 'Hard Day's Night' was the 'realism' that it offered: students perceived that they could practice roles and responsibilities under pressure in real-life situations (Powell and Scott 2013, p5). The relevance of the IPE to student's future roles was therefore a key feature of this programme. In the second programme of work, 'Patient Safety Day', findings included the fact that there was a need for facilitators to be trained specifically in IPL facilitation, was avoiding confusion about the role of the facilitator in sessions (Powell and Scott 2013, p6). Powell and Scott also found evidence to suggest that as a result of the session, students:

...were able to identify major patient safety incidents/errors and recognise their own and others' professional practice could contribute to them, but were less certain about identifying 'minor' errors and 'near misses'. (2013, p7)

It is very difficult to do justice to such a comprehensive evaluation in this short summary, but the points covered illustrate cohesion with other research on IPE facilitation (see Chapter Three) as well as point to a legacy from a larger-scale IPE programme (numbers accessing the programme are not clear) that does at least have some impact on patient safety, while other large-scale IPE projects (and IPE initiatives in general) have struggled to evidence this.

The following section explores the impact of the ALPS programme on ALPS staff (from their own perspective) as well as any apparent wider legacy of the ALPS programme on IPE, collaborative practice, or organisational culture.

5.6 Impact of the ALPS programme staff

After discussing some existing documents relating to outcomes of the ALPS programme, this section uses data collected specifically for this study in

order to explore perceived impact of the ALPS CETL on the staff involved in delivering it.

44 of the 289 (15%) NHS staff who responded to the survey had heard of ALPS. As the survey was in part distributed via national internet forums and respondents could subsequently be from any part of the country, this is not unexpected. The majority of those who had heard of ALPS had done so via a leaflet or presentations at conferences and were not involved with any aspect of delivering the programme. Of the 35 academic staff who responded to the survey, 30 (86%) had heard of ALPS. Six had been members of an ALPS working group, but again a majority of the group had only heard of ALPS because they worked for one of the ALPS partner institutions. There were therefore insufficient survey respondents who had been engaged in the ALPS programme in any meaningful way to explore potential differences in responses to survey questions between those involved with ALPS and those who were not.

Similarly, none of the NHS staff interviewed had been involved in delivering the ALPS programme, although some had heard of it. Again, the way respondents were recruited (via self-selection from completing the survey) may have impacted upon that. There were not many practice staff directly involved with ALPS, and in order to interview them, I would have needed to approach them directly. By the time I was conducting interviews for the research, many had moved on to other posts and their contact details were not known to those who had worked with them.

However, all academic interview respondents originally approached to take part were selected because of their involvement in the ALPS programme. As a result of referrals made during these interviews – usually to colleagues involved in other IPE programmes – three academic interview respondents had not been involved with ALPS directly, although all were aware of it, as they all worked at ALPS partner institutions. Themes emerging from interviews concerning the impact of the ALPS CETL programme on staff are therefore drawn predominantly from 14 of the 17

interviews with academic staff, although all 17 interviews were analysed in the same way. Where any respondent quoted was not directly involved with the ALPS programme, this is noted if relevant. It should also be observed that while ALPS was a large programme with many strands of work, the discussions here, unless otherwise stated, refer to interprofessional elements of ALPS, which was the focus of the ALPS-related interview questions (see Appendix 7).

5.61 Themes from interview data

The following discussion outlines themes that arose from interrogating interview data. However, the section on 'ALPS Legacy' is more descriptive of the narrative emerging from all the interview responses about the impact staff members believed the ALPS programme had had on them as individuals and on the institutions they worked for; this is because capturing the range of responses was important for the ensuing discussion.

5.61i Some partners benefitted more than others

There was a general feeling among participants that some 'got more out of ALPS than others:

I think it is fair to say there were pockets of people and courses and students who got more out of it than others. (HEI02)

In particular, there were a number of suggestions that those who most benefitted from the ALPS programme were smaller professions / institutions, who enjoyed benefits that would not have otherwise been achieved. For example, respondent HEI4 reflected how involvement in ALPS had put the institution for which he worked in a different position regarding local policy discussions from other local institutions who had not been ALPS partners:

For [ALPS institution] it has really positioned itself strongly within the Strategic Health Authority...recently...there's been a working group which included all the universities and reps from all the services and [ALPS institution] sits in a different position because of ALPS – I do think we would have continued to be sidelined...it has [also] made it easier for us to move to international working which we didn't do five years ago. (HEI04)

Similarly, HEI17 reflected on the benefits of ALPS involvement for his profession:

I think that we [Audiology] were looking for inroads into places and ALPS provided that. It gave you a reserved place at the table and that can often be the most difficult thing to do, that foot in the door...because I was involved in ALPS I was invited to that second project with the School of Medicine so that wouldn't have happened otherwise. (HEI17)

These kinds of responses were not in evidence from respondents who worked in larger institutions / professions, who possibly already have more opportunities to engage in policymaking or work across professional boundaries; however, they do tie in with the theme identified in work on ALPS by Hargreaves *et al.* as 'we got further than we would have done on our own'. The implications of this finding are also linked to the second emergent theme from interviews with ALPS participants: that IPE was already occurring in most ALPS partners in one form, but not necessarily with the range of professions involved in ALPS.

5.61ii IPE / collaborative practice happens anyway

One of the difficulties participants had in describing the 'legacy' of the ALPS programme of work was that many institutions involved in ALPS already had some elements of IPE established or set-up during the life of the programme. As such, some participants could not separate out changes to

IPE and attitudes towards it that may have occurred as a direct result of the programme:

I'm not sure really, I think, I'm not sure if that came from ALPS or if it came from elsewhere but we have a really interprofessional way of managing our placements. (HEI16 not directly involved in ALPS)

For some respondents, the idea that IPE happened anyway was marked by the way they viewed their own profession / professional identity as being interprofessional:

I think opportunities to work together, see, as an Occupational Therapist it is very much part of our philosophy that the value of work, the value of being engaged in a meaningful purposeful occupation together in terms of how it impacts on the way you think and the way you behave is really strong...actually the opportunity to work together is key. (HEI04)

I come from a strong tradition, I was a Sure Start midwife, and a teenage pregnancy midwife, so my professional background is collaborative working, I don't come from a uni-professional background, and I do think that has a fundamental difference in your – your perspective is different. (HEI10)

For other respondents, good interprofessional practice was something they either often experienced at work or witnessed happening anyway within practice settings:

...in many ways ALPS and other things have just reinforced my prejudices about what matters to...people, and what matters to professions in terms of really working together as part of a cohesive team...I see on my base ward...there is much more professional respect, we can run a very flat structure in terms of everybody pitching in. (HEI07)

Separating out the 'ALPS effect' on all these existing perceptions of IPE is therefore impossible. Nevertheless, ALPS partners did often state that

what the ALPS programme did was facilitate collaboration both across institutions and across professions that would not have occurred otherwise. In the institutional context this was not viewed as surprising given that ALPS brought together a number of HEIs who had previously been 'competitors' for both research funding and students.

I've got a greater awareness of what is going on in other universities...Sometimes it takes a project like that doesn't it to force people to work together because people don't have time to do it once the institution is committed to it you have to do it.

(HEI08)

...it helped to crystalise and develop the professional learning and the interprofessional learning, it was a fantastic time for dialogue with other professions and that has a legacy...it's also opened links between the school of healthcare and the medical school... (HEI17)

This ties in with the discussion in research by Hargreaves *et al.* about the extent to which emerging collaborations from ALPS were 'natural' or 'manufactured'. To a certain extent, however, this does not seem to matter; some of the impact of the ALPS programme appears to have been to improve interprofessional working and relationships across professional boundaries for academic staff involved, though not because of the adoption of specific interprofessional initiatives that ALPS developed. Instead, it appears that it was simply opportunities that arose to work with professions that might not otherwise have been encountered which had a longer lasting effect.

There are several implications of the two foregoing themes from ALPS participant interviews. In particular, as the smaller professions (and institutions) both claimed and were viewed by others to have benefitted most from the programme, important philosophical questions are raised for 'larger professions' or institutional partners regarding their role in IPE. Specifically, is there any sense in which these 'larger professions' (probably characterised as medicine and nursing) have a responsibility to ensure that

smaller professions are i. encouraged to take part in and / or ii. involved in IPE initiatives, to ensure that best-practice is developed and shared as widely as possible (where relevant)? Ultimately it may be that involving partners 'less likely' to be involved in IPE results in benefits larger professions if it means that all professions prepare for collaborative practice together. This is conjecture and a definitive answer is unknown, but it is an interesting question to raise while thinking about the future of interprofessional programmes.

5.61iii Politics and existing working cultures as a barrier to the implementation of IPE

As well as identifying benefits of the ALPS programme, participants raised a number of issues which they perceived to be barriers in implementing a large scale IPE programme. For the most part, these can be described as 'politics and cultural reasons' why IPE programmes were seen as difficult to implement, aligning with the findings of Hargreaves *et al.* (n.d.) However, in this research, there were several comments about specific resistance to the ALPS programme:

I think there's always been a bit of resistance here to ALPS and it's always felt very hard in trying to promote it...I don't think there's ever really been a positive attitude towards interprofessional education. (HEI1)

...it just seemed to me that some institutions seemed to be much more on board with it... (HEI2)

In addition to HEI1 suggesting general resistance to IPE within the institution, it was also suggested by the same participant that resistance to ALPS may have stemmed from the fact that the bid was written by more senior staff who did not subsequently lead or engage with the programme, handing it on to other people to 'do the work'. Connected to this was the notion (expressed by a number of participants) that ALPS was seen as just 'one more additional thing' to be done:

I felt that, as so often happens in big organisations it became a kind of bureaucratic process rather than 'look what exciting learning and teaching innovation this is' so people were kind of a bit turned off about it thinking 'oh this is another additional stress' or whatever rather than 'wouldn't it be great to get involved in this'.

(HEI2)

I think there's a combination of people not liking change and anything new is confusing so there was some resistance to change, some of it was just the sheer practicalities of things being seen as an add-on and an extra piece of work. (HEI15)

Existing 'political' concerns and the culture of institutions were also proposed as a barrier to successful implementation of IPE:

Well they have their own activities but I think probably the bottom line is that they are in another department and it's not, it's probably the wrong thing to say but it's easier...it's more political that it doesn't happen

(HEI3 on the exclusion of a profession from a local IPE initiative)

I sat on some of the things in relation to the interprofessional competency things but that didn't float my boat, I think that was less about the subject and more about some of the other partners.

(HEI07)

Finally, a number of participants made points which either explicitly or implicitly implied that professional identity and socialisation processes were barriers to the implementation of ALPS and / or other IPE:

I think the difficulty is that when students go into practice they want to succeed, they want to be part of the team, they want to be liked, they want a job, they want to pass, and I think they will behave as their mentors behave, because the reality is that if as a student you challenge then there will be implications for you.

(HEI10)

It's a huge generalisation, but nevertheless some of the feedback we get, they didn't know what an occupational therapist was for example...and similarly from the feedback we get from the occupational therapists because it's often around the stereotypes, and for some individuals it's around 'we assumed social workers only took children away'. (HEI3)

I think it's probably in all professions, they soon develop a strong identity and they feel they are exclusive, and therefore no-one else can be the same as them, and so if anyone that doesn't have the label of their own profession is pointless. But what they don't realise it that if you actually take those labels off, it's like a pair of jeans, a pair of jeans is a pair of jeans, you know whether it's Levi or whether it's Asda... (HEI17)

It is interesting to note, however, that these latter examples concern the professional identities of *students* as a barrier for IPE initiatives, and as such, does not take into account the idea that staff could have influence over these identities. Only one respondent reflected on the professional identity and working culture of staff as a potential barrier to the successful introduction of IPE:

...they're [staff] not actually that signed up. I think that they see the value [of IPE], and see the worth, and can talk the talk, but actually it's a big jump in doing that. (HEI10)

As evident in the discussion in Chapter Three, the notion of barriers for IPE stemming from existing working cultures of institutions is relatively common within IPE literature, and based on these findings, these issues appear no different in larger scale programmes than in smaller ones. However, while discussing during interviews how respondents had become involved in ALPS, it was apparent that the majority of staff, generally invited to join by managers, got involved in a way that enabled them to engage only with strands of work that were of most interest to them / relevant to their current role. The interprofessional element of the ALPS

programme was therefore led by staff who already had an interest or a role involving IPE. It was not apparent from interviews that staff not already interested in IPE got involved in delivering this aspect of the programme (although staff involved in all aspects of the programme reported benefits of working with new professional partners, as explored in the previous sections). This can be explained by the fact that no ALPS activity could have progressed without working across professional boundaries, given that the programme had to be implemented across partners. However, where literature examined in Chapter Three raised questions about the extent to which IPE needed to be made compulsory to enable for students to engage with it, this reflection on the ALPS programme also highlights whether IPE is an 'optional' activity for staff and whether they will engage with it if they feel they do not need to. This returns to the question about whether professions, and in this instance, individual professionals either have or should have a responsibility to get involved in interprofessional programmes, ensuring that best practice is shared.

5.61iv. The ALPS legacy

To fully understand what impact the implementation of a large-scale interprofessional programme has on staff involved in delivering the programme, interview respondents were explicitly asked what legacy they believed the ALPS programme had on their own professional working practices and on institutions involved in delivering them. None of the interview respondents felt that ALPS had resulted in cultural or organisational change for NHS partners involved in ALPS. This was seen in part as a consequence of there being only a 'minimal level' of contact with NHS staff, who tended to be in Practice Learning Facilitator roles and were not senior enough to influence organisational change:

I think we failed to influence high enough up at that level we looked at working with people who took students on placement rather than their managers. (HEI4)

A number of respondents also commented that elements of the ALPS programme had only just become established when the programme ended, with the view that five years was not a long enough period to achieve all the programme's aims:

I think unfortunately it was only a five year project, had it been a ten-year project, we were just beginning to get some really successful hits with our tools, but obviously as research projects go, there are just a few of us left trying to still sort of infiltrate you know systems and organisations. (HEI09)

If you accept that there was major change in practice needed, I think we need longer...I think that would have been very interesting to see if there had been any more impact. (HEI10)

The theme that the CETL programme was not 'long enough' to achieve the CETLs' ambitious aims was highlighted in the final CETL report (SQW 2011). The idea that longer funding periods result in more successful IPE projects was, however, dispelled by Fook *et al.* (2013) who highlight that, in contrast to the four well-funded Common Learning Pilots:

...recipients of much less or no external funding, managed successfully to introduce, sustain and evaluate innovative examples of IPE (Colyet 2008; Joseph *et al.* 2012; Miers *et al.* 2005). (Fook *et al.* 2013, p286)

The view for some that the CETLS would end when the funding ended, rather than be developed and embedded may explain the lack of longer-term impact, rather than the time-period for the programme itself being the issue. For ALPS specifically, where embedding the tools was a specific aim, it may be the case that the fact that as a number of staff moved or changed role towards the end of the ALPS programme (many, almost ironically, being promoted thanks to their involvement in the ALPS programme) there were too few original ALPS staff left with the right knowledge of the ALPS tools to establish a longer term legacy that involved using them.

One of the most interesting findings about the impact on staff that involvement in implementing an interprofessional programme had is that all participants involved in delivering the programme reported positive personal experiences as a result of this. Many respondents commented on promotions or job opportunities that had arisen as a result of having a large interprofessional project on their C.V.s, with both respondents, HEI03 and HEI08 saying that they had been able to move to more interprofessional roles specifically because of their involvement in ALPS. It appears therefore that being seen to have an involvement with ALPS as an interprofessional programme of work is a positive thing, regardless of whether any improvements in IPE or collaborative practice were evidenced. In line with the finding mentioned earlier concerning increased working with new partners, many respondents described their own personal network of contacts expanding across professions and institutions, and having retained these contacts after the ALPS programme ended.

There was also some evidence from respondents that ALPS had an impact on interprofessional assessment and interprofessional working practices within the ALPS partner HEIs. In some institutions or professions, the ALPS tools, or elements of the tools, had been adopted and were still in use (this was mentioned by respondents from three different HEIs). More importantly for the majority of respondents, however, was that ALPS had 'raised awareness' of co-operation between professions (HEI05), 'proved the concept' of both peer and interprofessional assessment (HEI09), and resulted in a lot of learning about interprofessional working that was now being used to inform new IPE developments (HEI04, HEI07, HEI08, HEI17). The biggest impact of ALPS from the perspective of participants in this study therefore appears to relate to 'lessons learned', which has resulted in much progress being made by individuals and institutions, but not explicitly because of adoption of interprofessional tools developed by ALPS, as originally hoped.

The final section of this chapter will examine how far it has been possible to answer the research question posed concerning the impact of a large-scale interprofessional programme. In light of the findings about the ALPS programme as well as discussion of other larger scale initiatives, it also questions whether large-scale IPE is sustainable.

5.7 Summary

The purpose of this case study was to answer the question: ‘what impact does the implementation of a large-scale interprofessional programme have on staff involved in delivering the programme?’ The responses to this question based upon the case study findings presented here, and to all other research questions posed at the start of this thesis, is examined in Chapter Seven. The main themes of the chapter have been identified as positive personal experiences that arose for CETL staff and improved collaborative working relationships, although these have been identified alongside perceived barriers to IPE. The discussions in this chapter also raised questions about both the sustainability of larger scale IPE programmes and whether larger professions should have any responsibility to involve smaller professions in IPE initiatives. This responsibility, would, theoretically, ensure that best practice was shared with smaller professions and create opportunities for smaller partners which may not previously have existed. This raises the notion of an ‘interprofessional responsibility’ on a whole-profession scale, the implications of which would have far-reaching effects for the introduction of future IPE initiatives. The conceptualisation of such a ‘responsibility’, its implications, and its relationship to ‘interprofessional responsibilities’ on an individual level, are discussed in the concluding chapter (Seven). The following chapter examines the data gathered from the surveys and interviews in order to explore the other research questions posed in Chapter One.

Chapter Six

Exploring perceptions of professional identity via experiences of interprofessional education and collaborative practice

6.1 Introduction

This chapter draws upon survey and interview data gathered for this thesis to explore how both practicing and academic H&SC staff perceive 'professional identities', and how they interpret their experiences of IPE and collaborative practice. It is questioned whether there is an interrelationship or 'link' between perceptions of interprofessional experiences and perceptions of professional identity. Specifically, the analysis seeks to address the following questions:

- 1. How do practicing H&SC staff conceptualise their professional identity, and the professional identity of other professions with whom they work or learn?*
- 2. Do practicing H&SC staff perceive that 'professional identities' are reinforced, challenged or changed by IPE and / or collaborative practice?*
- 3. What implications do conceptualisations of professional identities and IPE have for the implementation of educational initiatives aimed at improving teamwork between professions for the ultimate aim of improving service user care?*

The purpose of this research is to understand if interpretations of professional identity by members of H&SC staff have implications for the way IPE is developed and delivered. Implications of findings from this research are discussed during both this and the final chapter.

6.2 Survey respondents

321 survey respondents represented 15 different professions (see Table 4.1, Chapter 4). 288 respondents worked solely or primarily practicing their chosen profession; 33 were solely or primarily academic staff. Seven professions were represented by over twenty respondents or more (see Table 4.1, Chapter 4). Where comparisons of respondents by profession have been undertaken, it is between these seven professions only; the 20 other respondents, representing eight professions, were excluded from this type of analysis. As practicing and academic staff were asked slightly different questions regarding their professional histories and roles, these are described here separately.

The majority (60%, n=172) of practicing staff who responded to the survey described themselves as a 'senior' members of staff (having been given the options to rate themselves as junior, middle or senior). 63% of practicing staff had graduated from their chosen profession 11 years or more ago. Only 2.2% (n=7) of respondents had graduated within the last 12 months. The self-rated seniority was an approximate indicator of time since graduation, and age, although there were three respondents who rated themselves as 'junior' who had graduated over six years earlier and two respondents over 45 years old who also stated that they held junior roles.

The purpose of asking respondents to rate their seniority was to understand whether respondents at different levels had similar amounts of interaction with groups of students (with a view to exploring the implications for socialisation processes). Academic staff were not asked to rate their seniority, as they were likely to be in contact with students regardless of position. However, they were asked how long they had worked in higher education (HE). The majority (88%) (29 of 33) had done so for over six years, and all for a minimum of three years. Of the eight (24%) academic respondents still working / practicing in their chosen profession, five (15%) did so once a week or more regularly.

The majority of survey respondents were therefore quite ‘established’ in their professions, with few respondents having only just qualified. This could be considered both a strength and a limitation of this data. In a project concerned with exploring professional identity, the fact that the majority of respondents have spent some years practicing their profession or teaching elements may mean they are more certain of their ‘professional identities’ and what they mean to them. However, a lack of respondents only recently qualified means that differences in opinion between newer graduates and more established professionals may not be apparent.

6.21 Experiences of IPE

61% of respondents reported having undertaken some IPE as part of their professional training. This was a mixture of classroom and practice based experiences at both pre- and post-registration level (Table 6.1).

Table 6.1: Types of IPE experienced by survey respondents

Type of IPE experienced	N	%
Classroom-based pre-registration only	19	6.0
Work-based pre-registration only	14	4.4
Classroom and work-based pre-registration	16	5.1
Classroom based pre-registration and post-registration	17	5.4
Work-based pre-registration and post-registration	13	4.1
Classroom and work-based pre-registration and at post-registration level	39	12.3
At post-registration level only	74	23.4
No	113	35.8
Don't know / can't remember	11	3.5
Total	316	100

Table 6.1 also highlights that respondents’ experiences of IPE were highly varied, and the majority of those who had experienced IPE had received it only as part of their post-registration education. Perhaps unsurprisingly, given that IPE has only been come to prominence in the last decade, staff who described themselves as ‘junior’ were more likely to report having experienced IPE as part of their education (Table 6.2). It should be noted that responses to this question relied upon respondents remembering

specific from their professional training, which, it is acknowledged, may contribute to inaccuracies in the data. However, based on responses given, statistical tests indicate that results are unlikely to be due to chance. The Chi-square result $\chi^2=10.194$, d.f.=2, $p=0.006$ indicates significance at the 1% level – i.e. that only 1% of the time would a value this high or higher be expected if there was no association in the population. The Cramer’s V² value of $V=0.192$ also suggest a small association between level of seniority and likelihood of having experienced IPE.

Table 6.2: Reported experience of IPE and self-rated seniority

Had any IPE?	Junior		Middle		Senior	
	n	%	n	%	n	%
Yes	25	92.5	53	64.6	102	61.1
No	2	7.4	29	35.4	65	38.9
Total	27	100	82	100	167	100

n=276

Nursing staff were much less likely than the other professions to report having experienced IPE as part of their education (Table 6.3). While a similar number of doctors also said they had not received any form of IPE, the percentage saying that they had experienced IPE was much closer to that of all other professions who responded. The literature review did not identify that any professions were more or less likely to be involved in IPE (although Whitehead 2007 did suggest that doctors were sometimes less willing to collaborate in IPE due to perceived threats to status), but there was no evidence in the literature that nursing is likely to be excluded from such initiatives.

² The Chi-square and Cramer’s V tests are explained in full in Chapter Four.

Table 6.3: Experience of any IPE as part of professional training by professional background

	Medicine		Midwifery		Nursing		Occupational Therapy		Physiotherapy		Social Work		Speech and Language Therapy	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Had any IPE?														
Yes	65	73.0	16	80.0	17	37.0	19	67.9	20	60.6	15	71.4	33	62.3
No	24	27.0	4	20.0	29	63.0	9	32.1	13	39.4	6	28.6	20	37.7
Total	89	100	20	100	46	100	28	100	33	100	21	100	53	100

The finding here suggests that nurses who responded to this survey had experienced less IPE than other professions who responded, or may be less likely to recognise that they have experienced IPE. Again, statistical tests suggest that there was a relationship between these variables. The Chi-square result $\chi^2=20.837$, d.f.=6, $p=0.002$ indicates a significance at the 1% level, and the Cramer's V value was $V = 0.268$.

If one assumes that IPE experienced by participants had achieved its aims in improving communication and / or understanding of different professional roles (although findings from the literature review in Chapter Three suggests this could be an inaccurate assumption), it might be viewed as a 'positive' result that over half of respondents reported that they had received some form of IPE. However, the extent to which this represents experiences of IPE as understood as a situation in which professions have *learnt with and from* one another is questionable. In addition to reporting IPE experiences, respondents were asked what they understood IPE to be, using an open text response. There were a variety of responses, many of which might be labelled as misunderstandings of IPE to various extents:

One profession teaching others (N44)

Many professions being taught together (N103)

Different professions having some lectures and teaching in common
(A21)

There were also descriptions of IPE that more accurately reflected its generally accepted definition and aims:

Learning with and from other professionals in a true spirit of mutuality. Training, observing and co-operating across professions with practitioners from different disciplines. (N206)

Being aware of variety of disciplines involved in patients care and how these wide variety of professions interact and how this can be taught / learnt. (A4)

Reported experiences of IPE bore no relation to whether an accurate description of IPE was given. However, more respondents were able to define the 'main purpose' of IPE than were able to describe it accurately:

That where feasible, undergraduate students of different courses share training, in order to cultivate shared knowledge and identity and to cultivate mutual respect and understanding of each others' roles. It should and can also continue once qualified. (N82)

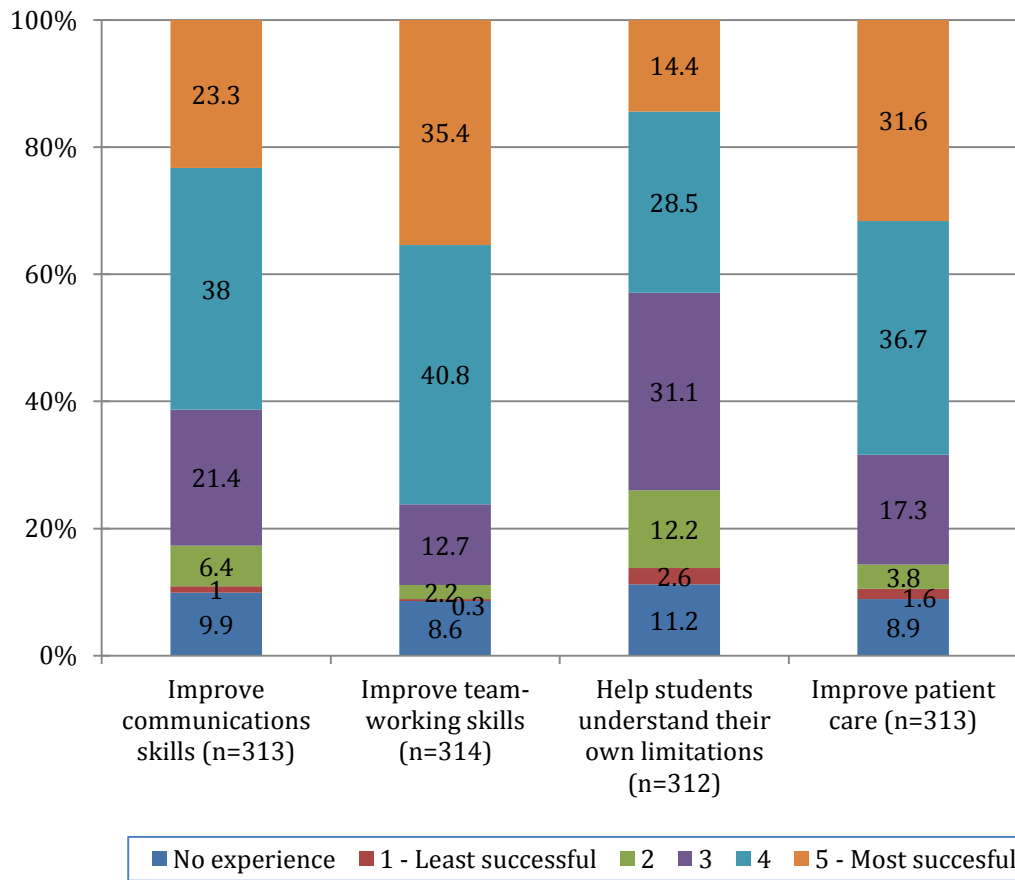
Understanding each other so that different professions work as a team which ultimately provides quality of care service. Improves communication which provides increases safety for the patient / public / client. (N111)

While the accuracy of respondents' self-reported participation in IPE can be questioned, the fact that many respondents could identify with the aims of IPE is 'positive' in terms of recognising that one of the drivers for IPE is improved patient care. As respondents were not always able to accurately describe IPE but were more likely to identify with its aims, this raises the question about whether 'IPE' is merely a label understood by academics to mean something quite specific, but less likely to be recognised or remembered by practicing members of H&SC staff. The extent to which this matters is also debatable if H&SC staff (or a majority of them) can show an appreciation of what IPE initiatives attempt to achieve.

6.22 Opinions on IPE

Based upon their experiences, respondents were asked to rate how successful they believed IPE could be in improving communication skills, team-working skills, enabling students to understand their own limitations and in improving patient or service user care. Respondents were most pessimistic concerning the ability of IPE to help students understand their limitations, but 75% rated IPE as successful (scoring it 4 or 5 out of 5) in improving team-working skills (see Figure 6.1).

Figure 6.1: Respondents' ratings of how successful they believe IPE can be in achieving certain aims

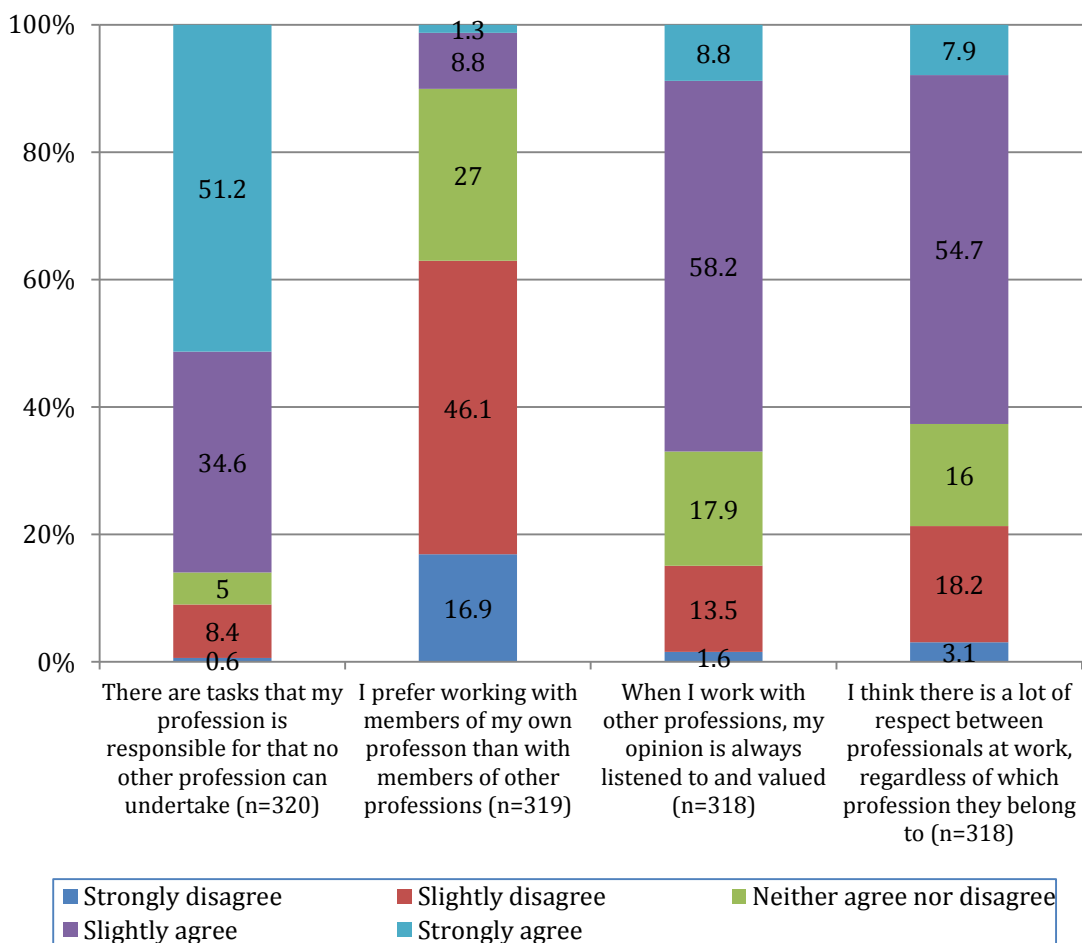


There were no observable differences in opinions concerning IPE by gender, age or profession. There were also no observable differences between those who had experienced any type of IPE, and those who had not, concerning the perception that IPE might be successful in some of these aims. Given the range of different forms of IPE experienced by participants, combined with the difficulty respondents had in recognising or recalling IPE, this finding may be unsurprising. It is still worth noting, however, that for participants in this study, experiences of IPE did not appear to result in different opinions regarding its likely success in achieving its aims. This may have implications for opinions on IPE such members of staff are prepared to express in front of students.

6.23 Attitudes towards collaborative practice

Respondents were asked their opinion on a series of statements related to how they felt about their professional roles and about various aspects of working with other professions. While 86% of respondents agreed with the statement that there are ‘tasks which my profession is responsible for that no other profession can undertake’, only 10% of respondents agreed that they ‘preferred to work’ with members of their own profession (Figure 6.2). This suggests that recognition of role boundaries by respondents does not equate to ‘silo working’. However, results also indicate that there remains room for improvement; just over 30% of respondents did not agree that their opinion was *always* listened to and valued when working with other professions, and nearly 40% did not agree with the statement, ‘I think there is a lot of respect between professionals at work, regardless of which profession they belong to’.

Figure 6.2: Respondents’ views on collaborative practice



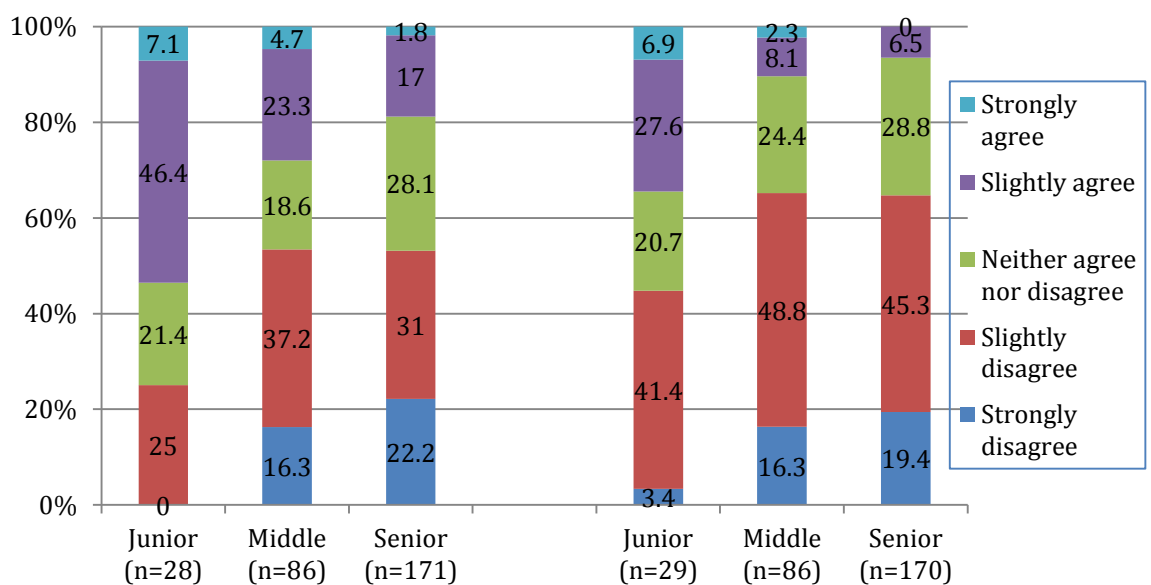
Tables 6.4 and 6.5: Opinions of task specificity and respect between professionals by professional group

Table 6.4	There are tasks that my profession is responsible for that no other profession can undertake													
	Medicine		Midwifery		Nursing		Occupational Therapy		Physiotherapy		Social Work		SLT	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Strongly Agree	55	58.5	11	52.4	13	28.3	9	32.1	18	54.5	10	45.5	39	69.6
Slightly Agree	30	31.9	10	47.6	16	34.8	13	46.4	14	42.4	9	40.9	13	23.2
Neither agree nor disagree	2	2.1	0	-	6	13.0	4	14.3	0	-	1	4.5	1	1.8
Slightly disagree	6	6.4	0	-	10	21.7	2	7.1	1	3.0	2	9.1	3	5.4
Strongly disagree	1	1.1	0	-	1	2.2	0	-	0	-	0	-	0	-
Total	94	100	21	100	46	100	28	100	33	100	22	100	56	100
Table 6.5	I think there is a lot of respect between professionals at work, regardless of which profession they belong to													
	Medicine		Midwifery		Nursing		Occupational Therapy		Physiotherapy		Social Work		SLT	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Strongly Agree	7	7.5	1	4.8	2	4.4	3	10.7	2	6.1	2	9.1	8	14.3
Slightly Agree	62	66.7	9	42.9	21	46.7	15	53.6	22	66.7	6	27.3	26	46.4
Neither agree nor disagree	8	8.6	3	14.3	8	17.8	5	17.9	6	18.2	4	18.2	12	21.4
Slightly disagree	13	14.0	7	33.3	13	28.9	4	14.3	3	9.1	6	27.3	10	17.9
Strongly disagree	3	3.2	1	4.8	1	2.2	1	3.6	0	-	4	18.2	0	-
Total	93	100	21	100	45	100	28	100	33	100	22	100	56	100

Consistent with Etzioni's (1969) observation that nurses possess a less specialised body of knowledge, nurses who responded to this survey were less likely to agree with the statement that 'there are tasks that my professions is responsible for which no other profession can undertake' (Table 6.4). Social workers were much more likely to disagree with the statement about there being respect between professionals (Table 6.5), which may support the view discussed in Chapter Two that in complex cases, social workers are often portrayed as 'folk devils' (Warner 2013; Clapton 2013). As a large number of cells in these tables (>50%) had expected counts of less than five, it was not possible to run statistical tests on these cross-tabulations with accuracy.

Interestingly, results from this part of the survey appear to suggest that for NHS staff, effective collaborative practice comes with experience. Junior members of staff were more likely than senior staff to agree that they found it easier to communicate, and preferred working with, members of their own profession (Figure 6.3).

Figure 6.3: NHS respondents' attitudes towards collaborative practice by self-rated level of seniority



At work I find it easier to communicate with members of my own profession than members of other professions

I prefer working with members of my own profession than with members of other professions

This is important as it highlights that some attitudes or opinions towards collaborative practice (and possibly IPE) may only come with experience, and that it cannot be 'taught'; rather, these 'behaviours' are learned over time.

The implications for those looking to prepare students for collaborative practice may involve reconceptualising IPE and its aims, recognising that IPE may not lead directly to improved communication between professionals, but *can* result in an understanding that good communication between professions is important, and that each profession has a responsibility to ensure this occurs for effective patient care.

6.24 Perceptions of professional identity

Respondents were asked their opinions about how they felt about their own profession, and the concept of professional identity as a whole. Results reinforced the individual nature of experiences of identity: 16.4% of respondents felt that being a member of their profession *always* defined who they were, while 4.7% stated that it *never* did (Figure 6.4).

Similarly, 35% of respondents felt that they *always* belonged to their profession where 6% stated that they seldom or never did. There were no observable differences between responses by age, gender, different professional groups or seniority, and length of time since graduation.

Responses to the second set of statements also highlighted the fluid nature of identity and how it can mean different things at different times. Over 91% of respondents agreed that they had a clearly defined professional identity and role, but 48% of respondents agreed that they preferred not to be defined by their profession outside of work. Only 3.5% of respondents agreed that the idea of having a professional identity is now 'out of date' and irrelevant (Table 6.6).

Figure 6.4: Respondents' perceptions of professional identity

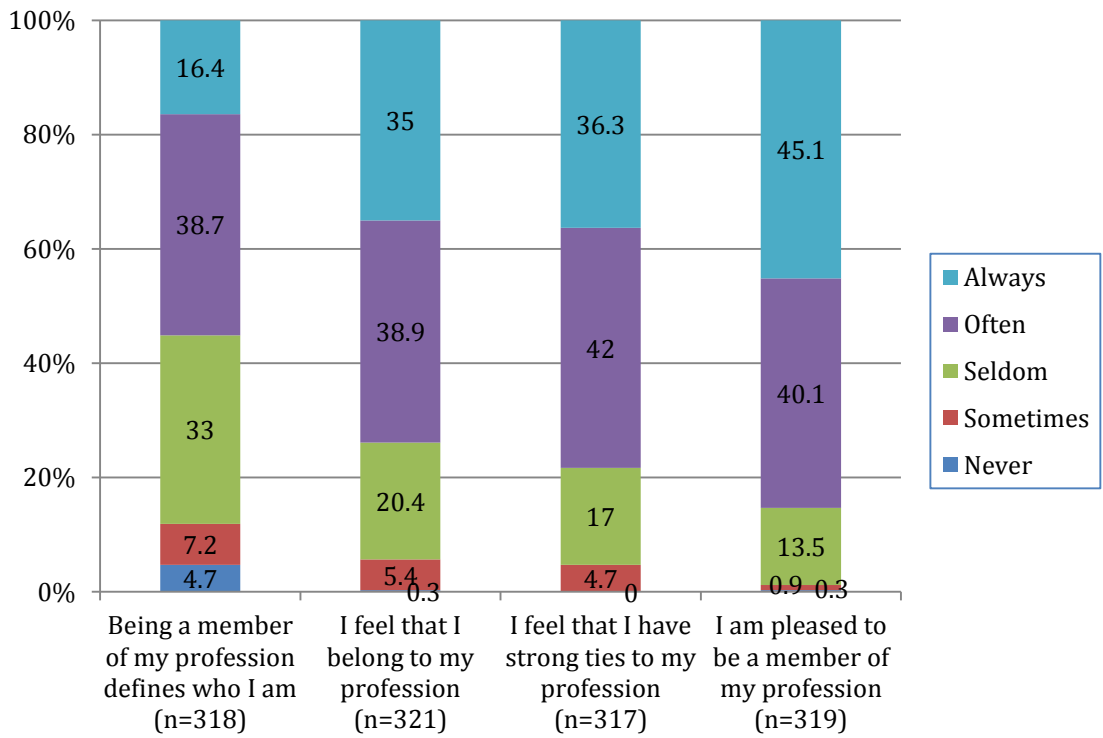


Table 6.6: Respondents' opinions on professional identity and role boundaries

	I have a clearly defined professional identity and role		I prefer not to be defined by my profession outside of work		The idea of having a professional identity is out of date and irrelevant now	
	n	%	N	%	n	%
Strongly agree	126	39.6	42	13.2	-	-
Agree	164	51.6	109	34.3	11	3.5
Neither agree nor disagree	17	5.3	90	28.3	52	16.5
Disagree	9	2.8	52	16.4	178	56.3
Strongly disagree	2	0.6	25	7.9	75	23.7
Total	318	100	318	100	316	100

Academic staff were asked one additional question about whether they viewed their identity as more of a teacher / educator, the profession in which they qualified, or rather as a mixture of the two. There was an even split between the number of respondents who felt they were a teacher / educator and those who felt their identity was a mix; only one respondent said that they felt that their professional identity was that of the profession in which they had qualified (Table 6.7).

Table 6.7: Academic staff view on their own professional identity

If asked are you more likely to describe yourself as...		
	n	%
...a teacher / educator	16	48.5
...the profession I qualified in	1	3.0
...mixture of teacher and profession I qualified in	16	48.5
Total	33	100

The literature review did not identify existing studies in this area, but perceived professional identity of academic staff may be an important factor in the socialisation of H&SC students. Although based only on a small number of respondents, the split result here indicates that this may be a topic worthy of further research.

6.25 Relationship between perceptions of professional identity and opinions of IPE

Results did not suggest any relationship between how respondents felt about their professional identities and their opinions of IPE / collaborative practice. This was explored by cross-tabulating all statements relating to professional identity with all those relating to IPE and collaborative practice. As both these concepts are based on personal opinion and difficult to quantify with statements, it is perhaps not surprising that there were no apparent relationships between them in results of a survey. However, the context of this will be considered when discussing interview data relating to the same relationship.

6.26 Contact with students

Given associations identified between professional identity formation and ‘socialisation’, one final aim of the survey was to establish how much contact respondents had with students. Most (91.6%) NHS staff stated that they were ‘sometimes’ or ‘often’ observed by student members of their own profession. In comparison, 88% of staff said the same about student members of other professions, although this was more likely to be ‘sometimes’ rather than ‘often’ (Table 6.8).

Table 6.8: NHS respondents’ level of contact with students on placement

Students from own profession								
	Students observe my work		Supervise students on placement		Teach students on placement		Formally assess students	
	n	%	n	%	n	%	n	%
Never	11	3.9	31	11.4	40	14.7	59	21.7
Sometimes	118	42.3	107	39.2	105	38.5	91	33.5
Often	150	53.8	135	49.5	128	46.9	122	44.9
Total	279	100	273	100	273	100	272	100
Students from professions other than own								
	n	%	n	%	n	%	n	%
Never	32	11.2	180	69.5	126	48.1	217	84.4
Sometimes	202	70.6	63	24.3	112	42.7	26	10.1
Often	52	18.2	16	6.2	24	9.2	14	5.4
Total	286	100	259	100	262	100	257	100

However, staff were less likely to teach or supervise students on placement from other professions than they were to supervise members of their own profession. Only 15% of staff stated that they ever assessed students from other professions (compared to 78.4% of staff who had assessed student members of their own profession). These findings are not in surprising but fit with the notion that placement experiences offer a lot of interprofessional opportunities. However, it is not clear that these are always used as part of ‘teaching’ or socialising students into thinking about collaborative practice. The fact that so many NHS staff have contact with students from their own and other professions reiterates the importance of

exploring perceptions of professional identity and IPE, particularly the views and opinions students are potentially exposed to during training. Drawing upon interviews gathered for this research, the following section explores in depth the views of participants about professional identity and IPE.

6.3 Interview data

Data explored here is taken from 33 interviews (16 with NHS staff, 17 with academic staff) carried out for this research. The professional background of respondents is described in Table 4.2 in Chapter 4. The data presented is a mixture of narratives and themes that emerged from the interviews, but it must be emphasised that each interview concerning identity represents the experiences of only one individual. The purpose of drawing themes from the interviews was not done to suggest that individual experiences associated with identity or education and training can be generalised to the whole population of H&SC staff, but rather to identify common elements in experiences that might enhance the way the relationship between IPE and professional identity is understood.

6.31 Conceptualisations of 'own' professional identity

While all respondents had their own story to tell about 'how' and 'why' they became a member of their profession (in this context, the one in which they most recently qualified and were being interviewed about), there were some common themes to the narratives respondents developed about their path to becoming a professional. These are defined here as professional role as: 'finding a niche', 'convenient', and 'not a deliberate choice'. These elements of narrative are not mutually exclusive; rather, they represent three common threads of stories participants told about how they found themselves in their professional roles. Figure 6.5 contains example quotations for each definition.

As illustrated by examples in Figure 6.5, 'finding a niche' can take place very early in a career – for example, while making a decision about which profession to apply to – or may not occur until after qualification, when experiences of working in one particular area have influenced decisions about what roles an individual will seek to remain in. Respondents who talked about 'finding a niche' often did so while discussing the vocational nature of their role and the desire to do something to 'help others', which often originated early in their lives. However, some respondents acknowledged having reached this point later in life, having had careers in different, unrelated fields. At least one respondent had been through some experiences with family members that had persuaded them to enter a H&SC profession and 'give something back to the system' (NHS14).

Narratives of professional role that suggest it arose through *convenience* or through a series of circumstances that did not involve a deliberate choice are interesting in that participants had not always planned to achieve that specific identity. There was nothing different about respondents who developed these narratives, and certainly no difference between them and other respondents in terms of how much they advocated their professions or the importance they placed on effective collaborative practice and patient care. These findings therefore serve as a reminder that each story about 'becoming' a professional is individual and different, but that this does not necessarily have an impact on the care or education each individual strives to provide.

Figure 6.5: Common narrative elements in describing professional roles

Professional role as finding a niche	<p><i>When I started my training I thought I was going to work with children, but as the training went on I really enjoyed my adult placements...I worked with one of the best neurologists for stroke and I got into working with people with degenerative conditions (NHS01)</i></p> <p><i>I first wanted to be a physio...and you start looking into what goes on in each of the jobs and I felt it was less what I wanted to do and I wanted to do something that was more about people and their whole life rather than just one specific part which obviously for physio is the muscle mobility (NHS13)</i></p>
Professional role as convenient	<p><i>I chose psychiatric nursing essentially because we lived near the local psychiatric hospital so it was easy to do the training (NHS07)</i></p> <p><i>My decision was influenced by economics and personal situation rather than through career choice (NHS08)</i></p>
Professional role as not a deliberate choice	<p><i>I don't really know how I got into pharmacy other than my dad was an industrial chemist and I liked my sciences and I read a booklet...and I came across pharmacy (NHS02)</i></p> <p><i>Well I wanted to be an archeologist! ...I got to a point where I had to make a decision at A-Levels – I hated the prospect of A-Level history...biology was a doddle, so I did not think of not being a doctor, I don't know why I just honed into it (HE111)</i></p>

One respondent struggled with the notion of professional identity; when asked to describe her professional identity she responded:

It's not something I've ever been asked to do um [pause] are you allowed to give any clues? (NHS05)

While this is the only example from this study of someone responding to the question this way, other respondents sometimes struggled to articulate an answer. This raises the issue of how important it is not to assume that H&SC professionals are aware of the concept of 'professional identity' and what these identities might mean in, and for, practice.

6.32 Defining moments

During the interviews, respondents often identified what they saw as 'defining moments' on their path to developing a professional identity and 'becoming' a professional. These were often described without prompts, although respondents were specifically asked if they had had any 'defining moments' concerning their professional identity if they did not spontaneously mention them. The most common theme in these discussions concerned respondents identifying a time when they needed to take responsibility for tasks they had not previously done. Often this was during, or just after, the point of graduation:

When you qualify...you have got the skills to do the job and I think perhaps going onto the ward on the first day is probably one of the most frightening experiences in your life but people look at you and you've got a badge on that says 'physio'. (NHS06)

I think the first person that broke down on me when I was sitting in their living room, and they had become vision impaired...it really was that moment that I found my career. (HE112)

However, some respondents identified as a defining moment periods during their training when they had felt a greater responsibility:

[There was] some intense patient contact you know, there were less junior doctors around and being a medical student was much more of an apprentice model, and the patients are all telling me this and will let me stick needles in them and this sort of thing – they must be taking me fairly seriously. (NHS04)

We were left in charge of wards at the beginning of year three – I suppose it was being given that responsibility you know you had to perform and you had to achieve and you had to be seen to do that. (NHS07)

As both these respondents explained that they had trained some years ago and believed that such responsibility was not given to students now, it may be true that these are identical experiences for younger respondents who identified moments of responsibility that coincided with graduation / registration.

For others, 'defining moments' were associated with the responsibilities of working in a multi-disciplinary team and a realisation about their contribution:

Well there's the first time you diagnose someone with MND – Motor Neurone Disease...and that happened a couple of times where you were going down one route and the doctors were going down another....and realising that your assessment can contribute to the overall management. At the time I thought 'this patient's not a stroke, it's something else, I need to let the doctors know'. (NHS01)

In an IPE day, a lady service user came to talk to us about her daughter...She said 'you all need to work together for my daughter at the end of the day, I don't care how you do it but you need to work together' and for the first time I thought 'now how would I deal with her daughter? What would I do and how would that interact with what other people are doing' and I think that was the first time I really thought 'oh god yeah I'm a dietician now and I really need to think about what I am doing for this person' (NHS14)

These responses are interesting in the context of 'interprofessional responsibility', which for these participants already appears to be a conscious part of professional identity. Most importantly, it is possible to see that responsibility towards working effectively with other professions is associated with doing what is best for the patient. The key question arising from this is how to most effectively establish such an identity and associated attitude in student H&SC professionals, and to understand whether this can be done via, or with the help of, IPE.

One other recurrent 'defining moment' of interest was the observation by many respondents that 'becoming' a professional was associated with putting on a uniform or an item associated with it:

I know exactly where it did happen, and that was at graduation, when my parents had got my College of Radiographers badge and they gave it to me then, and then that sort of said to me 'right now I belong, now I am a radiographer' and it was a bit, it was quite an overwhelming thing actually, but I don't think until then I'd actually got that 'professional identity'. (HE113)

In the days when I was a student nurse you used to wear uniforms in the classes. That dates me doesn't it? But you did, and I remember the first time I put a uniform on was probably day 1 or 2 of the course, and I remember feeling physically sick at that point because I didn't know what I was expecting. (HE110)

For one respondent, being unable to wear a uniform they felt they had earned was problematic, because this denied them confirmation of their identity and subsequently how they viewed their role:

...because my first job role was private sector and wasn't technically a bread and butter OT role I kind of had to justify a lot more how it linked in, so to actually put on the uniform and to get the first job in the NHS and to wear a badge that says 'Occupational Therapist' suddenly I thought 'I'm here, I've done it and I've got the job' but I was using all of the skills before. (NHS13)

The idea that for some H&SC professionals, uniforms or items associated with them can be interpreted as symbols of legitimacy to practice fits in with findings from earlier studies (Spragley and Francis 2006; Timmons and East 2011). As identified in Chapter Two, the consequences of the loss of 'obvious signifiers' of all professions are unknown, and it may be that there are perceived threats to identity when professionals feel they are less easily recognised by sight. However, it may also simply be true that in being unable to wear items they feel they have earned, professionals feel they have lost part of their identity they would like to retain:

...green is the OT colour and the trust that I work for did a survey of all the patients and decided that they didn't care what colour people are wearing or what the uniform was they just wanted to be able to tell what level you were...so we all wear blue, all the healthcare assistants, nurses, therapists, all wear some form of blue. I feel like I've been stripped of my identity a bit because I don't get to wear my green – as much as I hate green, it's awful! (NHS13)

Physical identifiers such as uniform, badges and even colours therefore still play an important role in self-perception of identity for some H&SC professionals, with potential consequences for how professionals believe they can 'play their role' without something they consider an inherent part of it.

6.33 The 'academic' identity

In addition to narratives identified above concerning professional identities, and defining moments that occur in reaching those roles, academic staff also presented accounts of how and why they had chosen a career in teaching. Again, there were similarities between some of these narratives, with three identifiable themes emerging; the *calling to teaching*; the *wish to become an educator because of (a) good role model(s)*; and *chance*. Examples of each of these narratives can be found in Figure 6.6.

Figure 6.6: Common narrative elements in describing reasons for becoming a H&SC academic

The calling to teaching	<p><i>In the back of my head I think I've always had that I wanted to be a teacher...in the sport I play I always end up taking the coaching qualification so that facilitation of learning is always something I've done. (HEI08)</i></p> <p><i>I very much wanted to do the teaching although I very much wanted to be an audiologist, I was drawn by two callings (HEI17)</i></p>
Good educator role models	<p><i>Well very early on when I started my nursing training I realised I wanted to go into education...I think I had a particularly good role model in one of the lecturers (HEI03)</i></p> <p><i>I had an exceptionally good clinical tutor and she actually asked me right at the very end where I saw myself in ten years time...I said "in ten years time I want your job" (HEI13)</i></p>
Chance	<p><i>As always it's opportunity...at the time pre-reg nursing was only at Diploma level, I was the only one in the county that had the Diploma so I was approached (HEI01)</i></p> <p><i>I'd love to say it was planned, you know it wasn't I just drifted from one thing – I didn't drift but opportunities came along and I was just in the right place at the right time (HEI02)</i></p> <p><i>Teaching was a serendipitous thing. On the day I got my first psychology degree I was offered some lecturing and thought I would have a crack at it instead of going straight back to clinical work and it snowballed from there. (HEI06)</i></p>

Accounts given about why people had gone into teaching were sometimes coupled with expressions of desire to do 'something more' than practice. HEI01, for example, discussing the completion of a Diploma course, stated '*I knew I couldn't go back to just being a community nurse*'. There was, however, no suggestion from participants that they had chosen to teach because they did not want to remain in practice (and indeed some academic participants still did practice). Indeed, when considering their own identity, the lack of opportunity to practice was seen as problematic for some respondents:

I see myself more as an academic than a social work identity, and I struggle with that because I remain proud to say I am a social worker and a registered social worker and a qualified social worker, but the reality of my current role is that I no longer practice...I think my identity is vague and mixed (HEI14)

For NHS staff, many of whom also claimed that a major strand of their identity concerned being an 'educator', the fact that they still practiced was seen as legitimising their position as someone able to teach:

I do quite a bit of work in that area [mental health], and I do some in hospital to ensure my practice is up to date. Because I'd lack a bit of credibility otherwise I think. (NHS07)

For some academic and NHS staff, a lack of opportunity to practice in their chosen profession was therefore seen as problematic for both the perception they had of themselves as professionals, and their credibility to teach students of that profession. The fact that many respondents had not actively chosen to go into teaching (but had rather done so because opportunity had led them there), coupled with survey results suggesting that academic staff might view themselves as either educators or a mix of educator and the profession in which they had qualified, renders the professional identity of academic H&SC staff an interesting one for further study. In particular, it could be questioned whether a lack of current practice causes tensions between the way NHS staff perceive academic

staff, and the implications this might have for both teaching and the socialisation of students.

6.34 Socialisation

Unsurprisingly given the topics being discussed, the theme of ‘socialisation’ was very prevalent in the interviews. There was a great deal of acknowledgement of the idea that the majority of professional identity formation occurs in placement settings, with respondents recognising that this was the case for their own professional identity and also for present students. There was also recognition of the idea that the majority of learning about the roles of other professionals occurs on placement /work settings.

Learning about roles of other professionals happened more on wards than in the classroom. (NHS10)

You get professionalised as you train. As you go on wards you see people that you do want to be like and people that you don't want to be like. (HEI05)

I think people get socialised into the sorts of requirements of the profession, so irrespective of what kind of stuff we are doing in the classroom when they get into practice settings they are going to mix with people that are there – their professional group. (HEI02)

Such opinions fit with Pollard’s (2008) observation that role-modelling is an important part of the ‘hidden curriculum’, and that non-formal processes involved in learning behaviours occur regardless of whether observed behaviours are desirable (Cheetham and Chivers 2005). Certainly the ‘dangers’ of the wrong message reaching students through socialisation were apparent in some responses offered:

I think any epistemological belief you have about your own profession or anything personal - your students will pick it up. It becomes part of their belief system. (NHS07)

Being an OT they drill into you from the start that nobody knows what we do. (NHS13)

With such a high level of recognition that work-based experiences are important to both the identity-formation process and in learning about other professions, some respondents questioned whether those responsible for H&SC education should emphasise these issues to students, making more of work-based experiences than they currently do:

I think integrating IPE as part of training would help break down a lot of barriers. I think once you get engrained in that then everything you see reinforces that idea. The earlier you can reinforce a different kind of thought pattern the better. (NHS12)

One of the challenges is influential colleagues who are 'old school'. Maybe it's about bringing in people who have been in challenging interprofessional services into education rather than trying to get some of the 'old school' giving the wrong messages. (HEI04)

These suggestions fit well with the concept of 'interprofessional responsibility', ensuring that staff both think in such terms and can 'model' such behaviour to trainee members of all professions who may observe them.

6.35 'Strength' of professional identity

After describing their professional identity, respondents were asked if they felt if they had a 'strong' professional identity. Many claimed that they did so, mainly because they viewed their profession as part of who they are, or because they were passionate about it:

It's a part of who I am because I feel like I've been doing it for so long, and I'm really passionate about being a speech therapist.
(NHS01)

For academic staff in particular, values associated with their professional identity were perceived as being entrenched in 'part of who they were':

I've often thought – 'no I don't think about myself as a learning disability nurse', and then I've kind of been aware that it's just become part of the taken-for-granted me, for example part of the learning disability work is about being politically conscious of the words that you use, the language that you use, the way that you interact with others, and I find that that rolls out in every part of my life... (HEI01)

I still see myself as a doctor and I still think about practice as a doctor, I don't mean clinical work because I gave that up but I think you know the ethics, the morals and all those types of things, those are still important (HEI11)

There was only one respondent who expressed negative opinions about her professional role and identity. Describing her own profession as 'a bit of a waste of time', she felt that because interventions she and colleagues started did not instantly solve problems, people referred to them only as a 'last resort'. Her thoughts about her profession also appeared to be related to a belief that other professions did not know what they did (although, as explored in Section 6.4, this respondent was not the only person to express this concern):

My identity is vague...as a dietician, people think you are an SLT, or someone with menus asking what food they want...I get a lot of questions professionally about what comes under my role.
(NHS15)

The participant suggested that part of the way she felt about her professional identity related to never having long term contact with

patients; her team offered what they could to patients while in hospital but it was likely that, once discharged, they would never see them again or find out the outcome of interventions they had put in place. This, she reported, made her feel that her profession was 'a bit useless', despite admitting that these feelings might change if she was in a specialist team. This illustrates how professional identity can be context specific, an issue explored in more detail below (Section 6.36). While this was the only example of very negative views about a profession, it highlights that it should not be assumed that H&SC staff will always be advocates for their profession, and that this might be problematic for the socialisation of students into particular professions. As survey results indicated that the majority of staff have at least some contact with students on placement, consideration must be given to how to prepare students who might encounter such negative views, even if these are rare.

One final noteworthy strand about participant's perceptions of the 'strength' of their professional identities concerns reference to seniority of status. Staff more recently qualified reported that they did not yet have a stable professional identity, which they ascribed to the rotational nature of their roles. However, there was also recognition among these participants that they would achieve a more stable identity once they held a more permanent role:

I think because I'm a junior member of staff and as I said a rotational member of staff at the moment my identity fluctuates and changes quite a lot – I suppose you are a bit of a chameleon at this stage in training...I wouldn't say I have an allegiance or that this is where I see myself going as a specialist... (NHS12)

Talking more generally about the concept of professional identity (rather than specifically about their own), other respondents echoed these thoughts about senior status and identity:

I think the more senior you get the more people acknowledge your professional identity. (NHS09)

I would imagine [that] as you get more senior and you have more influence that you would feel even more that you had some sort of stronger identity. (NHS13)

The idea that professional identity becomes more secure with experience is not that surprising (and many respondents acknowledged that their identity had changed over time and continued to change). However, when combined with results from the survey suggesting that H&SC staff engage more effectively with the concept of collaborative practice as they become more experienced / senior, it could be claimed that those with more secure professional identities are better able to work collaboratively. This may be because they feel less threatened by the concept of interprofessional collaboration and / or better understand how working in this way improves patient care; they may acknowledge the responsibility they have to work in this way. Again, an important consideration arises concerning how something which appears to arise from experience can be 'taught' to student and young H&SC professionals.

6.36 The intra-professional identity

One theme emerging from the responses of interviewees about professional identity concerned 'intra-professional' identity. That is, rather than ascribing themselves (or others) an identity aligned with a particular profession, many associated themselves with a sub-unit of a profession, either a particular branch or specialty. This was often accompanied by claims for uniqueness of the branch to which they were aligned themselves:

...a big part of the professional identity for me has been a learning disability nurse and I think that is quite unique within the family of nursing and also within the family of health and social care and I'm quite happy to describe myself as a learning disability nurse...I think that it brings with it um, a certain set of values and attitudes

that I'd like other people to think I would have as a nurse and personally as well. (HEI03)

The broad professional identity would be doctor err and then within that I think there would be anaesthetist because it's a fairly large subgroup. (NHS04)

It depends who I'm talking to, um, well as a group we call ourselves specialist midwives so I suppose that's how I think of myself. I still think of myself as a midwife but that I specialised in a slightly different role to most other midwives. (NHS09)

The fact that H&SC professionals are often likely to align their identity to an intra-professional identity (as opposed to a whole-professional-identity) raises questions for both the future study of professional identities and for IPE. Professional identities in H&SC have typically been described and studied through over-arching professional labels; this may be unhelpful in understanding professional identity and its implications if this is not the way that professionals themselves perceive their identity. Intra-professional identity also has implications for the conceptualisation of IPE. On this topic, many respondents commented that their branch of a profession was more closely aligned to branches of other professions undertaking similar roles. For example, one respondent working in child social work said they felt more professionally aligned to child nurses and learning disability nurses than they did to adult social workers (HEI14). With this conceptualisation of professional identity, it can be asked whether IPE should be thought of as something that needs to occur between branches of professions. Alternatively, if they do not usually work together, IPE might be about ensuring specific branches of professions have opportunities to learn and work together, ensuring that students experience the most relevant situations.

6.37 Professional identity as context specific

One final noteworthy theme concerning perceptions of professional's own identity related to the way it was often viewed as context specific. As already mentioned, for the respondent with a negative opinion of her profession and identity, there was acknowledgement that this might change if her job situation changed and she worked in a different environment. Another respondent reported that the way in which identity was context specific related to who else was available in the team at any time:

...when I am on nights I am the only person of my grade covering everything...so in that respect I am an integral sort of the team and very much needed, but then on another day if I'm on the ward I'll be one of let's say five people at a similar grade, so it really varies how and where you are in the teams. (NHS12)

For another respondent, identity concerned differing job roles and people involved:

I think my professional identity has changed over time because of the job roles, because I've left front line nursing it has become different because I'm dealing with a different group of people. (NHS07)

For another, the notion of a professional identity being context specific was related to the concept of the intra-professional identity:

I don't think the profession as a whole [has a strong professional identity] because it is so varied in terms of the different areas and departments because an OT working in social services would be completely different to an OT working in forensic mental health for example, you know so that vast difference makes it very hard - in essence OT has a professional identity in each area. (NHS13)

Such views fit in with the notion of identity as fluid, but also suggest, as Lawler (2008) describes, that identity is not 'foundational and essential' but is produced through the narratives that individuals use to understand

their lives. The findings here also imply that being a member of a profession does not result in a shared group identity which is understood to be the same by all members, even when the identity of being a member of the profession is earned only via similar training processes and the need to meet identical standards; a finding which mirrors the earlier work of Machin *et al.* (2011) into the identity of health visitors. In this study, this appears to be due to the complex ways in which health and social care professionals work; therefore conceptualisations of their identities are associated with a specialty, a certain client group, the physical location or the team within which they work. This means that for many H&SC professionals, even their 'professional identity' can change from one moment to the next.

6.4 Conceptualisations of the professional identities of others

In addition to perceptions H&SC staff have of their own professional identity, this thesis is also interested in exploring conceptualisations staff have of the professional identity of other professionals. The research explored this by asking two key questions concerning the identity of others, the first being: 'do you think that some professions have a stronger identity than others?' Responses to this question were unsurprisingly varied, with several different professions identified as having strong identities. Interestingly, however, these were rarely the respondent's own profession.

I think nursing has got a very strong one...they can very quickly identify that this is not nursing or this is nursing.

(NHS06 – physiotherapist)

Medicine very much so and I think professions aligned to medicine you know occupational therapy, physiotherapy particularly are very strong. Nursing I never really felt as being truly strongly professional um I think it was sort of more because it was an apprentice training and they had to fight to say 'we have a professional identity'.

(NHS07 – nurse)

I do think probably OT does have the least professional identity...because no-one outside the profession really understands what we do so that can either make you really strong in what you do or water it down and kind of become more generic working...

(NHS16 – occupational therapist)

There was an observable process of ‘othering’ in responses to this question, where a ‘strong identity’ was often viewed as something other professions had, but not commonly claimed for a respondent’s own profession. As highlighted in the final quote above, the lack of a strong professional identity for one profession (or a stronger identity in another) was often associated with the perception that others were not able to identify what a certain profession does:

I honestly don’t think that doctors know what we do...again I think because OT is so different in so many different areas I makes it difficult for people to understand...I think what happens a lot of the time is that they see somebody and they think they need to be seen by a physio their mobility is terrible and they just go ‘oh if they are seeing a physio they better see an OT’, but they don’t really know where we come in and from an OT point of view you think ‘well what do you want me to assess?’ (NHS13 – occupational therapist)

This ties in with the findings of Machin and Pearson (2013) who noted that a lack of awareness of the health visiting role hindered the potential input of health visitors into interagency teams (p36). The quote here also reinforces the notion that intra-professional identities change according to context, and highlights that for some professionals, their perception of other professions is based on the largely negative opinion that members of other professions do not understand what they do. For other respondents, strength of their own profession’s identity, or that of another profession, was based on whether they believed members of the public understood what they did:

I do think that people don’t know about speech therapists so it keeps us under the radar - you know there are pros and cons to

it...so you know, nurses have a hugely strong identity, and you can see why, you know I think they're brilliant, amazing people, I could not be a nurse, but you know you never hear of anybody going on a march saying 'we need more speech therapists or we need more occupational therapists'. (NHS01 – speech and language therapist)

Where IPE might make a difference in addressing concerns that professionals should be able to identify each others' roles (thus potentially strengthening one element of professional identity), little can be done to address a perceived weaker identity that arises from a lack of public knowledge about what each H&SC profession does. Many respondents reported that the public understood what they did only if they had had personal experiences or encounters with a profession, and that as such they were most likely to understand the roles of doctors, nurses, midwives and pharmacists.

The second interview question directly related to exploring H&SC staff's perceptions of the professional identity of others asked 'are there some professions you find it easier than others to work with than others?' Many respondents felt that finding someone easy to work with or otherwise was less about professional backgrounds than individual personalities. For others, however, a perceived relationship between their own profession and another meant that they commonly considered these other groups easier to work with:

Speech and language therapists because we are so closely associated in what we do...we have an affinity perhaps more naturally. (NHS14 – dietician)

I think maybe physio just because we kind of do work closely together...I've never had much cause to work with radiography. Speech and language therapists I've worked with a little bit when I did learning disabilities I did find them easy to work with, they are kind of working towards the same goals.

(NHS16 – occupational therapist)

Probably nurses and midwives...because I can make reference to them, but having done critical care it is not too difficult to talk with the radiographers because you worked with them all the time anyway. (HEI06)

Similarly, respondents who named certain professions as harder to work with recognised that this was mainly because these were professions with whom they had very little contact, because of either their job role or organisational structure:

There are professional structures and when one particular profession dominates the structures within an organisation, maybe it is the organisation that becomes difficult to work with
(HEI04 – occupational therapist)

...only because I don't come into contact with them that much so consequently I probably know less about them but I wouldn't say it was any barrier particularly only a bit of an unknown factor. For instance I don't really have much contact with physiotherapists or occupational therapists. (NHS08 - pharmacist)

From a nursing perspective it's probably much easier to work with ward based professions than people who come on the ward and do their bit and off they go. (HEI05 - nurse)

These reflections raise a number of issues concerning professional identity and IPE. In the first instance, finding some groups of professionals easier than others to work with (because of having previously worked with them) relates to the idea that effective collaborative practice is learned through experience and not easily taught. Secondly, it can be questioned whether it matters if some professions are perceived as easier than others to work with on the basis of being closely related in job role. If professionals are unlikely to come into contact with one another, such perceptions will have little impact; similarly, if contact with other professionals is only infrequent, it seems unlikely that such perceptions will change. This raises a significant question about whether IPE should focus only on bringing

professions together who work together in practice (i.e. as being the most relevant experiences). Providing relevant IPE was certainly identified as a recommendation of the common learning pilots (Miller *et al.* 2006) and has remained a theme of much literature since (Anderson and Thorpe 2008; Rosenfeld *et al.* 2011).

Finally, there were some views of professions who were perceived as easier than others to work with, not based on anything other than a judgment about professional differences:

Social workers were the ones I found very difficult to work with...that's probably my prejudices, I found the 'how is this for you?' round the houses approach very difficult to cope with but I would say that is more a sad indictment of me than of social work.

(NHS07 – nurse)

I've always found health visitors a bit odd but er that's just me, I don't know whether health visitors are picked from the cradle, that's just a joke aside. (HEI02 – nurse / midwife)

These comments are related to the final theme in this section: 'negative perceptions or stereotypes of other professions'. These were not responses that emerged as a result of a specific question, but rather comments made about other professions during the course of interviews which were surprising in the context of discussions around interprofessional education and collaborative practice. This occurred more commonly in interviews with academic staff members than with practicing staff, which may reflect the fact that I knew or had previously met many of the academic respondents and that this meant that they were more comfortable expressing negative views to me than the NHS respondents who had not met me previously. Nevertheless some examples of such comments emerged from across the range of interviewees:

*The doctor is still king and if he isn't then he still thinks he is.
They've maybe come down a peg or two to a lower prince.*

(NHS3 – speech and language therapist)

I don't think physios have ever struggled [with their professional identity] I think physios just fix bones and muscles don't they? I think nurses have become confused, she says in an opinionated way, I think the role of nursing has really really changed um and are they now pseudo-doctors? Are they, I mean in some settings certainly medical health they are trying to be OTs as well, they are running the groups, they are doing the occupational therapy bits without the training or understanding how to do that...and then social workers sort of know what they do. They're just bank managers aren't they? (HEI08 – occupational therapist)

In this example, it might be claimed that concern over professional boundaries relating to nurses taking on aspects of an occupational role is justified if concerns exist that they have not been properly trained to do so. However, comments made about other professional groups are relatively unnecessary.

Um you know there are different nuances with different professional groups, I always think that dieticians are quite picky, speech and language therapists are – I hate to use the word anal, very attention to detail type thing, I think physios have a broader, you know a broader view of things generally and OTs tend to be very particular. Um but you know there are different ways of working. I find it easier to work with AHPs than I do with nurses.

(HEI09 – dietician)

As these comments were made by a dietician, it would seem unlikely that they were intended to be negative *per se*, but the concern is that if they are expressed to students, they could result in students holding unfair and / or untrue opinions about professional colleagues. Despite all respondents being aware of IPE and its principles, and many having been involved in

interprofessional initiatives, it appears that there is some distance to go before perceptions of professional identities are seen always as less of a barrier to collaborative practice.

6.5 Experiences of IPE

While experiences academic staff had of being involved in attempts to implement a large-scale interprofessional programme of work were explored in Chapter Five, this research was also concerned with staff experiences and perceptions of any IPE they had received themselves. To facilitate exploring this, the interview included a question about whether IPE had been part of respondents' professional training at undergraduate level. As with the survey respondents, experiences were mixed, and not many could remember having had received anything formally called (or assessed as) IPE. Of those who could remember IPE, only two spoke positively of their experiences:

We had a two-week placement on an IPE ward. That was actually really good because it's quite nice having a chat with other students, um we were all at a similar stage in our training, coming up to the end but none of us were quite there yet (NHS12 – doctor)

However, this respondent went on to explain that this placement had since been stopped and that, while he had enjoyed and found it useful, many colleagues had complained about having to do it. He reflected that students get out of it what they put in, and believed he was lucky to have joined a group that was committed to benefitting from it. Respondent NHS13 also expressed positive thoughts about IPE received during her undergraduate training:

I had a placement on an interprofessional training ward...you got to understand what other people's difficulties were in their own roles which meant you could think about how to help them...but I only got to do it because I found out about it. So I had that

experience but there were about 80 or 90 people in my year.

(NHS13 – occupational therapist)

Respondents' positive IPE experiences were therefore somewhat limited. More respondents reflected on IPE experiences that had had a more negative impression:

We had one day where we mixed...there was probably like a token dietician who said 'this is our role' that was it, there was nothing about how do we work together.

(NHS01 – speech and language therapist)

We all hated communication skills – we had to do role-play but it wasn't relevant and the scenarios were contrived.

(NHS16 – occupational therapist)

Even one of the respondents who had spoken of positive experiences suggested that not all university-driven IPE was effective:

Some of the things at university did seem really false and just exercises, more tick-box, you know? (NHS12)

For a couple of respondents, negative experiences of IPE were associated with the way in which members of their groups failed to engage with the task. NHS14 described how, in small interprofessional groups, they were expected to watch a video and then discuss it together; however, other members of her group had just wanted to sign the form to say they had participated even if they had not. She found this frustrating and had to argue to get them to undertake the task. Similarly, NHS15, who attended large-scale IPE days at her university, had had someone allocated to her group whom she considered unprofessional; consequently she was '*put off the concept of IPE completely*'. Nevertheless, even when respondents described personal negative experiences of IPE, they remained positive towards the notion that IPE could improve team-working and, ultimately, patient care. No single respondent claimed that they did not feel it could achieve such aims, although many said that they only 'hoped' IPE could do

so. There was, however, no sense in which negative personal experiences of IPE had led to a negative perception of IPE in general. This may be an effect of the self-selecting nature of respondents, many of whom may have felt positively inclined towards IPE to take part in a study looking at it. However, the fact that negative personal experiences did not seem to lead to negative opinions about the possibilities of IPE is worth noting, and mirrors the findings of Rosenfeld *et al.*, who, as was discussed in Chapter Three, found that despite their respondents' recollections of their first IPE experience being largely negative, still felt that there was 'value and merit' in IPE (2011, p474).

Many respondents reported that they had not received IPE as part of their undergraduate training because they had trained at a time before IPE was conceptualised as it is now. However, many felt that interprofessional working was part of placement learning and was a requirement of the course:

What existed would have been on placement.

(NHS03 – speech and language therapist)

There was no IPE, it was 1975! Interestingly we did have good interprofessional working [but] nobody had invented that term yet.

(HEI02 – nurse)

When I was a student you had working with other people as a learning outcome, you had to pass a placement, so that's massively embedded. (HEI04 – occupational therapist)

The extent to which the academic concept of IPE has 'replaced' something that was previously informally learned on placement was not a topic raised in interviews. Nevertheless some responses suggested that the most relevant strands of placement-based IPE, that are proposed today as best-practice, happened anyway as part of training which was more – and in some instances, entirely – ward-based. The extent to which this has been lost through moving healthcare professional training into universities is an interesting issue for debate, but also raises questions about whether there

remain many excellent IPE opportunities occurring in placement settings that are 'missed' because they are not flagged as IPE. This in turn raises questions about whether IPE is merely an academic label for something which has always been a fundamental part of H&SC professional education.

Finally, it is worth noting that in addition to experiences of IPE as students, some staff also had experiences of facilitating IPE (in addition to that discussed in Chapter Five as part of the ALPS programme). In line with existing literature, many respondents identified the organisational barriers to implementing IPE, including difficulties of time-tabling across large cohorts of students and negotiating time within already busy curricula to incorporate IPE events.

Only two of the NHS respondents had experience of facilitating IPE, but both expressed positive views about the perceived impact sessions they had been involved in had on students. Similarly, academic staff, who described a number of different IPE initiatives, from one-off annual days to trans-disciplinary first years, were all positive about the potential outcomes of IPE experiences they offered students. As one respondent said when asked if they believed that IPE would make a difference to the way in which health professionals think about their professional working practices:

I'm hoping it will I suppose – I must think so otherwise I wouldn't be spending so much time on it. (HEI06)

Many respondents were pragmatic about their institution's approaches to the provision of IPE, as illustrated by this quote from respondent HEI04:

The first thing to understand is that things go in a circular, so we had IPW [interprofessional working] as a module, the evaluation would always then show that it would be better if it was threaded through the whole curriculum, so the next time we revalidate we spread it through the whole curriculum, somebody will come up with the bright idea that it would be better if you can consolidate it. I think that is driven by different learning styles – so you will

always have the students whose learning style is not met who say it would be better if we did it the other way...I think the whole issue about being seen to do it rather than being trusted to do it drives us towards a more reductionist approach. (HEI04)

The notion that benchmarks from regulators drive policy concerning the provision of IPE meant that, for many academic respondents, the notion of 'ticking the box' and being seen to be doing it was the most important factor in its provision. While this is not intended to suggest that effort does not go into providing IPE, there was a worrying undercurrent in academic responses suggesting that the provision of IPE was often more about paying lip-service than concentrating on changing working practices, either for students (future graduates) or even themselves. Respondents HEI14 and HEI15, for example, from the same institution, spoke of their profession being excluded from interprofessional initiatives because their department had been moved out of a building they had previously shared with other H&SC professions; the implication was that moving out of the same physical location had meant it was no longer relevant for their students to have opportunities to work and learn from students of other professions. Positive attitudes towards the potential for IPE to make a difference, and the recognition that this needed implementing in a relevant way, did not always seem to fit with practices described about the way in which IPE is designed and implemented.

6.6 Collaborative practice

Respondents spoke about collaborative practice at many points during the interviews; three themes emerged concerning their reflections of working in practice across professions.

The first is called 'collaborative practice occurs anyway' – that is, without a specific interprofessional initiative or IPE. When asked which elements of their roles could be described as 'uni-professional', academic staff sometimes spoke of teaching they gave to one specific profession; however,

both academic and NHS staff often struggled to think of any elements of their roles in practice they would describe in such terms:

Everything we do is interprofessional, you couldn't work by turning up and doing things on your own...this includes admin staff. (NHS12)

On the stroke ward at the hospital it was so evident that everybody is a piece of the jigsaw and without all the pieces coming together the person is not going to rehabilitate. (NHS14)

When I think about my GP practice and the way they work together – so it was ever thus. It feels a bit like emperor's new clothes to me sometimes (HEI2)

The idea that the majority of work in practice involves a collaborative element – and has done for many years – again raises a question about the extent to which 'interprofessional education' is an academic interpretation of something that must occur anyway.

Related with this is the second theme from this data, which concerns the extent to which being able to collaborate effectively in practice is something that is learned through experience. This ties in with survey results presented earlier which showed that senior members of staff were more comfortable working and communicating with members of other professions than their junior counterparts. Some respondents spoke of difficulties involved in capturing this experience for students:

I think the challenge is to harness it – to capture it on a day-to-day basis. (HEI05)

It's not that they don't get exposure I just wonder whether we are not capitalising and using that and students need a lot of help signposting, that kind of thing. (HEI02)

We could teach students for years and years and years, what we can't give them in the classroom is experience. (HEI15)

It comes through experience...knowing where to ask for help

(NHS06)

Others discussed the fact that effective collaborative practice occurred when people had worked for a long time in the same team:

It's about being able to put a face to a name – that breaks down barriers...Familiarity and trust come as a gradual thing. (NHS09)

Nurses pick up on how different doctors conduct their ward rounds, but it's informal and learned through observation.

(NHS11)

These issues clearly pose considerable challenges for the conceptualisation of IPE as a separate initiative – that is, it is impossible to teach anything which is only learned by experience. However, if the concept of 'interprofessional responsibility' was incorporated into H&SC training and into the identities of all H&SC, it may be true that this would prepare students in more consistently for these experiences.

This discussion also ties in with the theme identified in the literature concerning the 'right time' to introduce IPE. Anderson and Thorpe (2008) concluded that younger IPE participants appeared to gain the most from early IPE initiatives while Thistelthwaite (2012) argued that there was no reason to delay IPE once professional training had started. This ties in with the thoughts of the participants in this study; the vast majority of whom, when asked about the 'right time' to introduce IPE, suggested that it should be taught at least as a concept from 'day one'. A few respondents however did recognise that it was particularly difficult to identify the 'right' time:

I have thought about that but I am not sure whether there is a right time...if you introduce it at the beginning...you change people's concepts and ways of thinking straight away, whilst the argument is that if you so not know much about your own profession how are you going to understand how the other profession works?

(HEI05)

Such dilemmas may be solved by the introduction of the concept of 'interprofessional responsibility' was incorporated early into H&SC training, leaving that which is potentially more 'easily' learned through experience to come later when students are better prepared for it.

The third interview theme, which relates to points raised above, concerned perceived 'missed opportunities' for collaborative practice, or missing opportunities to introduce the concept to students.

When we are on the wards we work very closely with physios but not as closely as I'd like – there is a lot of duplication. (NHS16)

If you don't introduce IPE in day one they become established in friendship group and then IPE gets introduced as something different. I think we're setting ourselves to alienate students against it. (HEI01)

This is important as it recognises that, despite many respondents identifying areas of effective collaborative practice, there is still work to be done in addressing areas of role-duplication and perceived barriers caused by professional identities while working together. The next section explores in more detail respondents' reported perceptions about the relationships between professional identity, IPE and collaborative practice.

6.7 Professional identity, IPE and collaborative practice

During interviews, there were some instances where the way professional identity and IPE or collaborative practice are directly related were discussed. The first emerged as a theme from responses to a number of questions – namely, that 'professional identity can be a hindrance to patient care'.

Students get introduced to the concept of the MDT [Multi-disciplinary team] but often then get told 'but remember you're a nurse'. Loyalty should be to a patient not to a profession. (NHS07)

I think in terms of service delivery to shape services around professional identity is wrong and outdated and I think perhaps the two things are entangled in a way they shouldn't be (HEI04)

I think yes, it's important to remember you're a professional, but I think the label of 'professions', oh I know radiographers are going to hate me for saying this, you know I don't think we should be locked into these camps. I know a lot of us are probably quite precious about our professional status but I think it does get in the way sometimes. (HEI13)

This issue presents a challenge for the whole H&SC sector, and relates to the way roles are conceptualised and tasks distributed. It may be true that large organisational change is required for this to occur, that changes are required which are beyond the influence of IPE initiatives. That this concern exists for both NHS and academic staff suggests that debates on the way professional identity is conceptualised must be revisited.

Secondly, respondents were asked directly if they believed that an increased focus on IPE would change the way people felt about their professional identity. Only one respondent suggested that people could be defensive about their professional identity and view IPE as a threat (NHS06). Some felt that IPE would not make a difference to professional identity (NHS08); two accounted for this by suggesting that it was because in practice so many people have an 'ingrained professional identity' or are 'set in their ways' (NHS07; NHS15).

For the most part, however, respondents were very positive that professional identities could, or *should*, change as a result of IPE:

I think IPE does change the way you think about your professional identity and I think it gives you more knowledge about other people's professional identity which is important for the bigger picture. (NHS13)

IPE should change the way we think about professional identity, otherwise we are wasting our time. (HEI04)

For some respondents, their perceptions were less that *professional identities* would *change* as a result of IPE, and more that IPE would result in what was understood about the roles of other professions:

Part of having an identity is knowing where your boundaries are. (NHS09)

I think by focusing on it, it makes you realise where you fit into it all and therefore what responsibility you have not just for your own learning and professionalism but for those of others, because others can't act professionally unless you do your part. (NHS14)

If it is introduced early on whilst learning all those other new things you just take it for granted and IPE is part of how this profession works, so it's not going to be a threat. (HEI05)

Such views tie in with the notion of interprofessional responsibility as part of professional role. However, academic staff were much more sceptical than NHS staff about the ability of IPE to make a difference, particularly as an isolated initiative:

It depends what is going on outside of that and the attitude of people within the uni-professional elements and the influence that has on students. I think we just need to keep chipping away at people and challenging them...to think differently. (HEI01)

I think you've got people who will always bang away at that particular professional identity drum. It's hard to see how educating people or how IPE alone would actually make huge strides in it because of socialisation. (HEI02)

I: Do you think that IPE changes the way that people think about their professional identity?

I think that if it's at undergraduate level not necessarily and I think you might continue the differences between HEIS and trusts. I think certainly IPE at CPD level and post-graduate level should help to reduce some of those tensions but only for that very tiny minority of people who access post-grad. studies. (HEI10)

These responses relate to many issues explored earlier in this chapter and in literature about concerns over socialisation processes and their effects. The difference in conceptualisation between academic staff and NHS staff over whether IPE could change the way people think about their professional identity could be related to the fact that NHS staff may think more about the 'training' and 'doing' of collaborative practice, as opposed to IPE as an element of education (however, it is not possible to say this with any certainty as it was not apparent in the interviews). As already noted, nearly all respondents suggested that IPE should be introduced early in the undergraduate curriculum (year one, at least, and many said 'day one'), but again, academic staff were far keener on introducing the *concept* of IPE early, and less convinced that any practical element should be involved until later in a course. Respondents from across the NHS and academia stressed the importance for any IPE to be relevant before it was considered meaningful.

Perhaps most interestingly, attitudes expressed by respondents concerning IPE and collaborative practice did not seem related to whether or not respondents had experienced IPE themselves. Many respondents were positive about the potential for IPE to change the way H&SC students viewed professional roles and boundaries when they had not experienced IPE themselves, and some were positive about the potential for IPE to make a difference even if they had described a negative experience of IPE. The implications, and of all the findings from the research presented here, are discussed in the following, final chapter.

6.8 Summary

This chapter has presented, in as much detail possible, results from the empirical elements of this study. While it attempted to cover the results most relevant to the research questions, as well as those most interesting to arise in relation to topics of interest, it has been necessarily selective. As with all research of this nature, one limitation to acknowledge is the researcher focusing certain results over others. Nevertheless the results presented here are intended to show both the strongest themes to emerge from the research and a range of participant perceptions on, and attitudes towards, professional identity and IPE, as well as their views about relationship between the two. A summary of key findings from this chapter is presented in Table 6.9. The final chapter, following this one further summarises the findings of this chapter with reference to the research questions included at the beginning of the thesis, and then discusses these in relation to existing literature on relevant topics (as outlined in Chapters Two and Three). Finally, it discusses implications of findings from this research and concludes with recommendations drawn from what has been learned.

Table 6.9: Key Findings from Empirical Research

<p>Respondents in this study were more likely to align their identity with a branch or sub-group of a profession than they were with a 'whole profession'; conceptualising H&SC professionals as having an intra-professional identity may therefore be more useful than using whole-profession labels</p>
<p>Professionals who rated themselves as more 'senior' were more comfortable working across professional boundaries, and there was also some recognition that professional identity develops with experience and seniority. It should therefore be recognised that collaborative practice and confidence in a professional identity are particularly difficult, if not impossible to 'teach'; as such educators should look to <i>prepare</i> students to work collaboratively</p>
<p>All professionals have a responsibility to work across professional boundaries in order to ensure the best patient care is provided. This can be conceptualised as 'interprofessional responsibility', that can and should be incorporated into each individual professions' identity, and introduced to student professionals as early as possible.</p>
<p>Staff who teach often feel they have a different identity to the one aligned to the profession that they trained in. Conceptualised here as an 'academic identity', this may have implications for the way in which students they encounter are socialised into professions, and is an area worthy of further study</p>
<p>Professional identities are often understood to be 'fluid'; for H&SC professionals, identity can depend on context (shift, team-structure, rotation) which has implications for the way in which students are taught to think about their identities and the way in which they are encouraged to adapt to different situations</p>
<p>Negative views of professions, either of one's own, or others, can have damaging effects on the way in which students perceive identities. Negative perceptions of all professions should be avoided as part of the 'interprofessional responsibility' described above.</p>

Chapter Seven

Conclusion: Professional identity in an interprofessional world

7.1 Introduction

The primary objective of this research was to explore the interrelationship between perceptions of professional identity and the way in which H&SC professionals interpret and experience interprofessional education and collaborative practice. It is important to note that the literature reviewed as part of this research suggested that evidence that IPE actually leads to improved cross-professional working remains partial at best, although there is increasing evidence that relevant practice-based IPE initiatives improve understandings of the importance and need for collaborative practice. While this research did not set out to prove that there is a link between perceptions of professional identity and IPE (and indeed it was acknowledged that there being 'no link' would be significant of itself), the findings have shown that the way in which professional identities are perceived can have a substantial impact on attitudes towards other professions. These attitudes subsequently impact upon attitudes towards, and likely success of, IPE and collaborative practice. In turn, there remains a danger that negative attitudes towards other professions that impact on collaborative practice will result in less than optimal patient care. Furthermore, where it is staff members expressing negative attitudes towards other professions (and evidence gathered for this research indicates that this does happen), it is possible that student professionals are socialised into finding it acceptable to hold and express negative opinions about other professions. This 'learned' behaviour further increases the likelihood that IPE and / or collaborative practice will be dismissed as unimportant or irrelevant.

Throughout this thesis it has been noted that it is impossible to conduct any form of research without the position of the researcher having an impact on the analysis of the results. As previously stated, the research

was conducted under the assumption that it was possible for there to be no link between IPE and professional identity, however there were certain assumptions made at the start of the research process which may have influenced its course. Having worked as part of the ALPS-CETL and being introduced to IPE in that way, this shaped my initial approach to the research undertaken here. The research was always concerned with exploring the relationship between professional identity and IPE, but it was only during the literature review stages that it became apparent that there was only a small amount of evidence for the efficacy of IPE. As a result of this, the way I came to think about the relationship between professional identity, IPE and collaborative practice shifted somewhat, and subsequently the way I thought and talked about IPE became much more about the 'potential' for it to make a difference rather than being based on the difference that IPE *does* make. Additionally, my own preconception was that there would be differences of opinion between the professions concerning attitudes towards IPE. Subsequently the survey in particular was designed to draw out differences in opinions between professions. The analysis of the survey results however, revealed very little difference between professional groups and their opinions (the exception being those already identified in Chapter Six, concerning the fact that nurses were more likely to disagree with the statement that their profession is responsible for tasks that no other profession can undertake, while social workers were less likely to agree that there was respect between all professionals). To a certain extent this felt surprising in the context of literature regarding tribalism and silos. However in relation to the emerging finding of this research that many professionals have more of an 'intra-professional' identity than one aligned to a whole profession, it was on reflection perhaps not all that surprising that analysing the results by 'professional group' did not reveal that each profession held an identifiably cohesive set of views and opinions on any topic explored here. This also strengthened my perception that the concept of 'intra-professional' identity was one worthy of further exploration.

This final chapter summarises the findings from all the research presented in this thesis, drawing on both discussions of existing literature and original data collected specifically for this project. Each key finding related to the research questions is presented as a statement, followed by an explanatory summary. The chapter concludes with implications and recommendations based on the findings, presented in the same way as the key findings, and suggesting how debates about 'professional identity in an interprofessional world' might progress.

7.2 Summary of Findings

How do practicing H&SC staff conceptualise their professional identity, and the professional identity of other professions with whom they work or learn?

1. There is no single experience of identity formation, but defining moments involving responsibility are often important for H&SC professionals

Literature reviewed in Chapter Two identified difficulties of conceptualising a 'group' identity, in particular where identity is understood to develop from personal and unique experiences. Goffman's (1959) proposal that individuals 'perform roles' laid a foundation on which later theorists constructed theories about how one person may have many, simultaneous identities which change both over time but in context. More recently, identity theorists have focused on ways in which people contribute to shaping their own identities (Woodward 2002), using narrative as a tool to explore and explain who they, as individuals, are (Lawlor 2008). Nevertheless, survey data presented here revealed that a fairly large proportion of H&SC staff questioned felt that they had strong ties to a 'group' identity – namely, that of their profession. 73.9% of respondents suggested that they always or often felt that they 'belonged' to their profession. For 16.4%, being a member of their H&SC profession *always* defined who they feel they are. As the literature review identified no 'single professional identity' which describes any one profession, these

results serve as a reminder that there is no 'single' or unified experience of any particular identity. However, as part of their individual identity, some people do identify with certain groups, and in many instances this involves their profession, or a sub-unit of their profession. More in-depth results from the interviews confirmed that respondents expressed many different narrative accounts of how and why they chose to become a member of a certain profession, but for many, the 'defining moment' that confirmed their professional identity involved an element or realisation of responsibility towards both colleagues and patients / service users. This relates to a concept developed in this thesis, that of 'interprofessional responsibility', and indicates that for some H&SC professionals, such responsibility is already part of their professional identities.

2. Socialisation is key to professional identity development in H&SC

Literature on professions also identified the significance of the process of 'socialisation' in the development of professional identity, including the importance of mentors and learning environments (Lindquist *et al.* 2006; Gray and Smith 1999). Results from the survey indicated that the majority of NHS staff were involved in some way with students from H&SC professions, even if this was only providing them with opportunities to observe what they do. Unsurprisingly, respondents felt that they were much more likely to work with student members of their own profession than with those of other professions, and as for directly influencing students from other professions (through assessment, for example), only 15.5% of respondents stated that they ever do so (and only 5.4% did so 'often'). The theme of 'socialisation' also strongly emerged from the interviews. Participants acknowledged the influence of their work-based experiences in developing professional identities, and in particular, the importance of having positive role models, and sometimes, conversely, the impact of observing examples of behaviour in practice they did not wish to emulate. This theme is revisited in the summary of findings exploring the

relationship between collaborative practice and professional identity (question 2).

3. The concept of 'academic identity' with specific relation to H&SC staff is worthy of further study

The literature review did not identify work specifically concerned with exploring the identity of H&SC academics, although the 'teaching identity' was sometimes discussed in other works (Lake 2004; Meerabeau 1998). Both the survey data (albeit based on small numbers of respondents) and interview responses indicated that academics were split in terms of views on their professional identity, with some relating themselves to the role of 'teacher' and others more to the profession in which they qualified. Many academics interviewed also indicated that teaching was not something they had actively sought, rather that they had often started work in academia because an opportunity had presented itself at a particular time. While it is possible that this has no impact on the professional identity of staff, 'academic identity' may be an area worthy of further study, particularly for those with an interest in socialisation processes.

4. Existing academic conceptualisations of 'professional identity' do not align with the way in which H&SC professionals actually perceive their own identity; conceptualising H&SC professionals as having an intra-professional identity may therefore be more useful than using whole-profession labels

A large body of work concerning the development of professional identities of a number of different professions was discussed in Chapter Two. Debates surrounding each professional identity could be linked to the history of the profession; for example, where it has been identified that nurses feel a lack of socio-professional recognition, it could be seen as emerging from a long debate concerning whether an occupation involving

'caring' should be defined as a profession. It has been proposed that rather than thinking of professions along a continuum, where one profession is viewed as more professional than another, it might be more useful to think of each occupation as 'differently professional', so that strengths each profession brings to a team can be valued equally. Again, this can be conceptualised as aligning identity with an understanding of interprofessional responsibility. Some interview respondents identified instances where this already happens, describing working life as impossible without interprofessional collaboration. Nevertheless, missed opportunities for collaboration and the difficulties of passing on this experience to students were acknowledged. However, where respondents sometimes viewed some interprofessional responsibility as part of their own identity, they were less likely to identify with a professional label such as those described in Chapter Two, and more likely to define themselves by their *intra-professional* identity or role. This was sometimes context dependent (i.e. professionals taking on different roles in different teams) and often related to the specialty or branch of a profession to which they were aligned. However, this conceptualisation of identity is in notable contrast to much of the literature which describes professions as a whole (i.e. as 'nursing' rather than child nursing, adult nursing and learning disability nursing, for example). One possible consequence is that academic descriptions of professional identities are misaligned with the reality of professionals' interpretations of their own identity, which has implications for the further study of both professional identity and IPE (see Section 7.2).

5. Perceived 'strength' of professional identity does not translate to the core values of a profession

Participants' perceptions of the strength of professional identity were particularly interesting. While talking about their own professional identities, a feeling of a strong identity was often aligned with being passionate about one's profession and the values of the profession being

embedded in who they were as individuals. To an extent, this may be related to the type of professional more likely to take part in such a study as this, who are potentially more likely than others to be advocates for their profession. There was also some discussion about a stronger sense of professional identity aligning with senior status, again implying a relationship between professional identity and responsibilities. However, in talking about professions as a whole, respondents were much less likely to claim that their own had a strong identity, and more likely to suggest that *other* professions had a stronger identity. While there does appear to be some support for the notion that a strong individual identity is linked to core professional values, these core professional values do not appear to translate into a strong identity for a profession as a whole. As noted in Chapter Two, however, the mantra of 'our profession does not have a strong identity' seems prevalent in literature about some professions, particularly occupational therapy; it may therefore be the case that students are socialised into stating that this is the case even when it may not be true. It may also be true that a profession as a whole with a perceived strong identity is seen in a more negative light, even though this did not appear to be the case for respondents here; rather, they felt that their own professions had weaker identities because their roles were not always recognised and understood by other professions or the public.

6. Negative attitudes concerning other professions are sometimes expressed despite acknowledgement that IPE is important

Finally, on perceptions of identities of other professions, there was an element of 'negative leakage' in opinions expressed during interviews. While respondents did not make direct negative comments concerning another profession or their identity during interviews, a number of comments expressing less than favourable opinions about other professions 'leaked out' during the course of them. This occurred despite the fact that all respondents expressed a positive attitude towards the

concept of IPE and its aims. While this may not indicate a problem in itself, it may be the case that such opinions are expressed in front of, or directly to, students; for this reason, implications arise concerning socialisation and the impact of such negative comments. Indeed, this finding may strengthen the already strong case presented by work discussed in Chapter Three, which identifies the need to support staff as IPE facilitators to ensure that staff can sustain commitment to IPE, in terms of both time and attitude (Curran *et al.* 2007; Freeman *et al.* 2010; Anderson *et al.* 2009; 2011).

Do practicing H&SC staff perceive that 'professional identities' are reinforced, challenged or changed by IPE and / or collaborative practice?

As expected, respondents' experiences of IPE varied greatly. From analysis of the survey data, there was no evidence that experiences of IPE resulted in differing attitudes towards professional identities or collaborative practice, although this is a very 'blunt instrument' for exploring a complex interaction where the impact of IPE was never likely to be separated from respondents' other experiences. It was always unlikely that a relationship between these variables would be apparent in the survey data.

7. Attitudes of H&SC staff towards the concept of IPE are generally positive, regardless of personal experiences

The interviews explored this topic in a more nuanced way. Many respondents felt that IPE *should* change professional identities in a positive manner – that is, by enabling people who receive IPE to have a better understanding of their roles and a clearer notion of their responsibilities for collaborative working. (This was in contrast to survey respondents who were asked, based on their own experiences, to rate how successful they felt IPE could be in achieving certain aims. Their responses suggested that IPE was most successful in improving team-working and patient care, but less likely to be successful in helping students understand their own

limitations.) Yet opinions expressed in the interviews were seemingly not based on experiences of IPE. Indeed, those respondents who reported having negative experiences of IPE still suggested that attitudes towards collaborative practice could be positively changed by IPE. Thus, such opinions were not based on experience but rather expressed as a hope for what IPE might achieve. In Chapter Three it was argued that part of the way in which IPE has been viewed as ‘the answer’ to issues in H&SC has been because of the dominant policy discourse it has occupied in both politics and for the regulatory bodies; this might help to explain why, despite negative personal experiences of IPE for some staff, and admissions by others that what they delivered was about ‘ticking boxes’ rather than quality provision of interprofessional experiences, IPE was generally discussed by participants in a positive light.

8. Both professional identity and the ability to work collaboratively appear to strengthen with experience rather than through being taught

It should also be noted that some respondents felt that IPE could not change professional identities, due both to socialisation processes and to the fact that, once in practice, people become entrenched in their own professions. This fits in with literature discussed in Chapter Two, which suggested that socialisation processes lead to ‘tribalistic’ behaviours (Beattie 1995; Hall 2005). However (despite some negative comments about other professions, as discussed previously), there was no evidence of particularly ‘tribalistic’ behaviours or ‘silo working’ in either survey or interview responses. What the survey results did imply was that junior staff were more likely to agree that they found it easier to communicate and to work with members of their own profession. One interpretation of this finding is that being able to collaborate effectively across different professions develops with experience, and as such is a difficult skill to ‘teach’. Nevertheless, this could also be related to the suggestion made

earlier that professional identity becomes stronger with experience, and that as individuals develop stronger professional identities – or a sense of a professional identity – they are better able to work with other professions. This is not to suggest that one of these occurrences (a stronger professional identity or ability to work collaboratively) causes another, but that as both can be seen to develop with experience, it appears that a stronger professional identity is related to the ability to collaborate across professional boundaries.

9. Role-models of both ‘good’ and ‘bad’ professional behaviours are identifiable in practice experiences

As highlighted in the discussion concerning perceptions of professional identity, many interview respondents in this study cited the importance of good role models in developing both their own professional identity and collaborative practice. Some respondents also identified that where they had seen examples of ‘bad’ practice, giving them an understanding about how *not* to behave. This is slightly at odds with Pollard’s (2008) observation that students may learn ‘inappropriate behaviours’ from examples of poor collaborative working. While this may of course be true, it may also be the case that some students are mature enough to recognise poor behaviours, as appears to have been the case for interviewees in this study. Nevertheless, whether through witnessing poor, exemplary or any other type of behaviour, the pivotal role of practice-based experiences in forming both professional identity and opinions towards IPE and collaborative practice has been acknowledged in existing literature (Dando *et al.* 2011; Wilhelmsson *et al.* 2009; Wahlström and Sandén 1998;) and in the findings of this study.

10. The concept of 'professional alliances' may be useful to educators when planning the development of IPE

In exploring the way in which professional identity may be perceived as being influenced by IPE and collaborative practice, this research has several times discussed the concept of 'professional alliances'. The concept emerged when respondents were asked to identify if there were some professions they found it easier than others to work with. Responses either concerned the fact that ease of working with others was due to individual personalities, or because certain professions were more 'naturally' aligned with their own. Occupational therapists, for example, spoke of how they worked closely with physiotherapists; speech and language therapists talked of working with dieticians. Respondents reflected that this 'ease' of working with particular other professions was because staff came from a similar evidence-base or worked towards the same patient-focused goal/s. The notion of 'professional alliances' can also be perceived in the notion that IPE initiatives need to be made relevant to students for them to be most effective; this was again a suggestion made by respondents when asked about the most appropriate time to introduce IPE, but also identified in IPE literature (Rosenfeld *et al.* 2011; Anderson and Thorpe 2008). The notion of professional alliances can also be seen in the previously discussed concept of intra-professional identity. Where interview respondents identified themselves by their specialty or branch, this was often accompanied by reflection that they were more closely aligned to branches of other professions than with different branches of their own; for example, a child social worker aligned his working practices with child nurses rather than with adult social workers. The concept of professional alliances may therefore be useful for educators to consider when aiming to develop effective, relevant IPE that changes professional identity in a positive way (through the introduction of the concept of interprofessional responsibilities, for example).

11. IPE appears to be more about ‘ticking boxes’ for some academic institutions, rather than about improving collaboration and standards of patient care

Finally it should be noted that although some respondents were able to talk about positive experiences of IPE, others – in particular academic respondents – reported that in some cases, IPE had very much become a ‘tick-box’ exercise, which was done to show it was being done, rather than as a meaningful experience for students. A question therefore remains about the extent to which IPE has become a ‘mantra’ for educators, one driven by policy changes and regulatory body requirements (discussed in Chapter Three), and which has since lost its purpose and meaning. The importance for educators of returning to the underlying ethos of IPE, educating H&SC students to learn with and from and about one another to improve collaboration and the standards of patient care, remains as important today as it ever has been.

What impact does the implementation of a large-scale interprofessional programme have on staff involved in delivering the programme?

Chapter Five outlined the activities of the ALPS CETL, which was chosen as a case study for this research due to its unusually large size as an interprofessional programme of work. Incorporating five West Yorkshire Universities and sixteen H&SC professions, the ALPS CETL aimed amongst other things to introduce an interprofessional element into work-based assessments. As part of the development work for the CETL, staff involved in the collaboration worked with colleagues from professions and institutions with whom they had previously had no contact. This research was interested in establishing what long term impact, if any, being involved in such a large-scale interprofessional programme of work would have on the staff involved. In addition to the contribution that this element of the work made to the question previously summarised concerning whether perceptions of professional identity are challenged, reinforced or changed

by IPE, a number of findings specifically related to the experiences of those involved in the ALPS CETL also emerged.

12. Staff perceived benefit from involvement in a large-scale IPE programme through working with professions they would not normally work with

Responses given by interview participants indicate that involvement in ALPS resulted in some positive personal experiences and results, but not necessarily ones expected or aimed for at the beginning of the programme. Due to the multi-faceted nature of ALPS, it initially appeared difficult to separate out the impact of interprofessional working from other elements of the programme, but after closer interrogation of data, it emerged that staff working in all aspects of the programme had benefitted from its interprofessional nature, often involving exposure to working with partners they would not otherwise have worked with.

13. 'Barriers' to IPE are often perceived rather than evidenced

Both this research and ALPS documents / research reports highlight that engaging in interprofessional working involved certain challenges. However, as noted in the literature review, it is also apparent that these challenges are typical of all interprofessional programmes, regardless of their size. To some extent, these challenges are not about 'inter-professional' strands of work, but rather concern perceived barriers in the form of regulatory bodies and practical elements (Baines *et al.* 2010), as well as physical locations, opportunities, time, and space in which to meet people from outside one's own profession in an academic environments (Solomon *et al.* 2010; Begley 2009; Mayers *et al.* 2006). However, staff from the ALPS programme still perceived barriers for effective IPE which related to protectiveness over professional identity formation among

students (although for the most part, no recognition was given to the impact that staff may have on this through socialisation processes).

14. 'Unusual' interprofessional collaborations in education may result in learning, but may not be sustainable working partnerships

The case study has also raised a question about whether large scale IPE is sustainable. Clearly this will depend upon the definition of 'large-scale', but it is noticeable that the majority of large-scale (cross-institution, five+ professions) funded programmes of IPE are either scaled-back or disappear completely once funding ends. The difference with funded programmes of work, and those perhaps that develop more 'organically', is that funded programmes often bring professions together who may not have considered working together previously (and are possibly funded specifically for this reason). However, once funding has ended, those professions may not have identified further reasons to work together if IPE has not been made relevant to their profession. For example, one profession involved in ALPS was dentistry, which was not represented in this study but also not mentioned by any participant in the research. The reason is probably its lack of relevance to any other working practice; it is unlikely that the majority of other ALPS professions will come across, or need to work with, dentists in their professional lives. Indeed, for dentists themselves, the most relevant 'interprofessional' collaborations will be with other dental professions (dental hygienists or dental nurses, for instance). It might therefore be proposed that large-scale programmes based on 'unusual' collaborations do not need to be sustained; once 'doors have been opened' and the programme of work has been achieved, it might be questioned what further, similar collaborations can achieve. In the case of ALPS, it appears that the most important outcome for most professionals was the impact of *learning* during the programme and projects that emerged as a result.

With only 2 – 3 years between the end of the main ALPS programme and the majority of this research being conducted, it is too soon to judge whether this will be the most enduring ‘legacy’ of the ALPS programme; as ever with curriculum initiatives, it becomes problematic to separate out the impact of one project from developments that might have occurred anyway. At the time ALPS participants were interviewed, however, the development of more relevant IPE initiatives improved on the basis of lessons learned from ALPS were the most important result, and, as discussed in Chapter Three, some literature suggests that it is such ‘relevant’ programmes that are more likely to be sustained, as well as having more meaningful impact for participants (Miller *et al.* 2006; Anderson and Thorpe 2008).

7.3 Implications and recommendations

The final research question posed at the start of this thesis was:

What implications do conceptualisations of professional identities and IPE have for the implementation of educational initiatives aimed at improving teamwork between professions for the ultimate aim of improving service user care?

The following section considers these implications, and makes recommendations for educators and others based on the findings from this research.

1. ALL H&SC professionals need to recognise their responsibilities towards collaborative practice as part of their identity

The research identified that for some H&SC professionals, responsibilities towards working with other professionals were seen as defining elements of professional identity. However this was not the case for all respondents. Where there is a recognition that collaborative practice needs to occur for

all H&SC systems to work, the implication is that all H&SC professionals need to recognise this responsibility as part of their identity, and that education and training initiatives must focus on developing it in H&SC students early in their training.

2. All H&SC staff need to be mindful of opinions they express regarding all professions, particularly in front of students

While identity has been recognised in this thesis as unique for each individual, it has also been possible to see that the socialisation processes in H&SC are remarkably influential in the formation of identity. All H&SC staff, both practicing and academic, need to be mindful of this and the impact that they have on future generations of professionals. This includes the importance of having personal ‘interprofessional responsibility’ when expressing opinions concerning IPE, collaborative practice or other professions.

3. IPE should be delivered across or between professional boundaries that are seen as most relevant to practice experiences

The way in which some staff conceptualise their identity in an intra-professional way (rather than aligning their identity to a professional label) also has implications for the design of IPE. This was related to the notion of ‘professional alliances’ – that is, that some professions found it easier to work together because of a closely shared ethos or client base. Conceptualisations of IPE have typically (but not always) concerned working across professional boundaries, yet it may be true that, *if relevant*, IPE should also relate to working between branches of professions. Alternatively, ensuring that IPE incorporates those professions most closely aligned may be another way to ensure IPE is as relevant as possible for students. However, this should not be done to the detriment of relationships with other H&SC professions, and caution may be required to

ensure different 'tribes' do not emerge out of 'allied' professions. The notion of intra-professional identities is also important for the study of identity in H&SC more generally, as it appears to be relatively unrecognised in literature at the moment.

4. Further work on 'academic identity' in H&SC is required

A further area of work on identity that appears relatively under-studied is that of the academic identity of those who teach H&SC professions. This research identified that academics who work in this field often do so because they happen to have been 'in the right place at the right time', but are relatively ambivalent about their identities. It is not possible to state from research conducted here whether this has implications for either staff or students, but, as it is possible that this may influence the way students form their own identities and think about their future teaching roles (all H&SC roles involve some element of teaching), this is also a worthy area of further study.

5. Educators need to prepare students for collaborative working, but should recognise that alongside professional identity, the ability to do this effectively is something that develops with experience

There was some recognition from participants in this study that some things cannot be taught, such as those things learnt from experience, which include particular collaborative working practices and (for some) a stronger sense of professional identity that develops over time. Instead of trying to teach these things, educators need to focus on preparing students to understand that they will develop over time. Simultaneously, it should be recognised that the mantra of 'our profession has a weak identity' can become a self-fulfilling prophecy as students become socialised into this way of thinking.

7.31 Further implications and going forward

In addition to the outlined implications of this research that have arisen out of perceptions of professional identities and IPE, some further implications specifically concerning the provision of IPE are also evident in the findings. These implications are noted here, alongside some suggestions for additional lines of inquiry for those interested in improving best practice in this area and further recommendations for those implementing IPE.

6. Further research is needed in order to understand if undertaking IPE with one professional group impacts on changes in ability to undertake collaborative practice with all professions

The literature review identified that there was some increasing evidence that if IPE was carried out in relevant and timely ways in a practice environment, then this often has a positive impact on attitudes towards, and understandings of, collaborative practice. However, given the practicalities of organising and running IPE in this way, combined with the issue of uneven student numbers from different professions, this is not always a feasible model. What is not clear from the literature is whether undertaking IPE with one other professional group would have a beneficial impact upon attitudes towards, or ability to undertake, collaborative practice with any other, or indeed all, professions. This may be an interesting avenue of further research that may help to address the practical and organisational issues surrounding the delivery of IPE which many institutions face.

7. Educators should seek to move away from IPE as a box-ticking exercise, and seek out examples of good collaborative practice and placement learning opportunities

The research found that staff are able to identify that many opportunities for IPE and collaborative practice are missed, particularly with reference to

learning from placement experiences. In conjunction with the finding that some IPE provided by HEIs is viewed as little more than 'box-ticking' by staff providing it, there is a responsibility for educators to move away from this type of provision and to seek examples of good collaborative practice already occurring, enabling students to make the most of their placement learning opportunities.

8. Students need to be taught to recognise poor collaborative behaviours

Where positive role models have always been recognised as influential, this research has found that poor behaviour can also influence students to react in a positive way, giving them an example of behaviours they do not wish to exhibit themselves. However, the implications are that students need to be able to recognise poor collaborative behaviours, and that when they do witness them, they also need to recognise that they can learn from these examples without needing to mimic them. This reinforces the suggestion that it is important to introduce the concepts of IPE and collaborative practice early in H&SC professional training, and that incorporating 'interprofessional responsibility' into all H&SC identities may assist with this.

9. IPE needs to be relevant to all participants

While already identified in existing literature, the findings of this research have reinforced the importance of the need for IPE to be relevant to participants. Not only should IPE not be about 'box-ticking' and getting it completed, relevance needs to be made clear to all those involved; otherwise, as with participants in this study, they will identify that the IPE served more of a purpose for the institutions delivering it than for them as students.

10. Educational institutions have a responsibility to ensure professions of all sizes are able to join or learn from IPE initiatives

The case study research also raised a question concerning whether larger professions have responsibilities to involve smaller professions in IPE programmes, ensuring best practice is shared. While this is perhaps the case, it would undermine arguments made here if this was done to the detriment of the initiative's relevance. In this instance, it may be the responsibility of the wider academic institution to ensure that professions of all sizes can share best practice around IPE initiatives, and that, where possible and relevant, smaller professions are invited to take part or encouraged to develop their own IPE. However, it should also be pointed out that learning outcomes from an IPE initiative do not need to be the same for all professions involved. As long as each professions' learning outcomes from IPE are relevant, there is nothing to suggest that professions cannot be brought together to learn something different from same experiences.

11. All professions need to understand their interprofessional responsibilities in order to ensure the best possible patient care

Finally, at certain points in this thesis it has been suggested that as collaborative practice 'happens anyway', and has to some extent always happened, 'IPE' might be considered a false construct which was created and is understood by academics, but is less clear in practice. While this may be true, the fact that failures of patient care in the H&SC system are still attributed to an inability of H&SC professionals to communicate or work effectively together implies a need for continued focus on improving this element of H&SC work. Whether all H&SC staff precisely understand the definition of IPE and its aims is less important than the need for them to understand responsibilities towards working together effectively, providing the best possible care to all patients and service users.

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Glossary

ALPS	Assessment and Learning in Practice Settings
BASW	British Association of Social Workers
BMA	British Medical Association
BOS	Bristol Online Surveys
CAIPE	Centre for the Advancement of Interprofessional Education
CBA	Cost Benefit Analysis
CBL	Case-based learning
CCBPM	Collaborative Care Best Practice Models
CETL	Centre for Excellence in Teaching and Learning
CFP	Common Foundation Programme
CIPW	Creating an Interprofessional Workforce Programme
CL	Cooperative Learning
CLPNE	Common Learning Programme in the North East
CQC	Care Quality Commission
CUILU	Combined Universities Interprofessional Learning Unit
DH	Department of Health
GCC	General Chiropractic Council
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council

GPC	General Pharmaceutical Council
GSCC	General Social Care Council
H&SC	Health and Social Care
HCA	Healthcare Assistant
HCPC	Health and Care Professions Council
HE	Higher Education
HEFCE	Higher Education Funding Council for England
HEI	Higher Education Institution
HSE	Health and Safety Executive
IEPS	Interdisciplinary Education Perception Scale
ILP	Interprofessional Learning in Practice
IPE	Interprofessional Education
IPW	Interprofessional Working
IRAS	Integrated Research Application System
LTHT	Leeds Teaching Hospitals NHS Trust
MDT	Multi Disciplinary Team
MSF	Multi-Source Feedback
NHS	National Health Service
ODP	Operating Department Practice
OT	Occupational Therapy
PBL	Problem-based learning
PSIG	Partner Site Implementation Group

PSRB	Professional, Statutory, Regulatory Bodies
QAA	Quality Assurance Agency
QABME	Quality Assurance of Basic Medical Education
RIPLS	Readiness of healthcare students for interprofessional learning
SIT	Social Identity Theory
SHA	Strategic Health Authority
SLT	Speech and Language Therapy
UK	United Kingdom
WHO	World Health Organisation
YHSHA	Yorkshire and the Humber Strategic Health Authority

Appendix 1: Research Protocol submitted to IRAS

27th April 2009

Version 1

REC Reference: 09/HI306/58

RESEARCH PROJECT PROTOCOL

Study title: Does interprofessional education and working have any impact on the formulation of perceptions of professional identity and organisational culture?

Researcher: Viktoria Joynes (PhD student)

Supervisors: Trudie Roberts, Sue Kilminster, Paul Armstrong

Overview of the Project

The purpose of this research is to explore the experiences and opinions of all health and social care staff towards interprofessional education (IPE), interprofessional working and their own professional identity. The work of the Assessment and Learning in Practice Settings (ALPS) Centre for Excellence in Teaching and Learning (CETL) will provide a case study with which to explore these issues in depth.

For the most part, existing work on IPE focuses on student attitudes towards IPE programmes. For IPE to achieve its aims however, it needs to be taught effectively, which means that staff (both academic and practice) need to be engaged with IPE and the reasons for teaching it. Additionally, as health and social care students learn a lot from their placement experiences, the attitudes of practice staff are important because of the potential influence this will have on student opinion. A greater understanding of staff attitudes towards IPE is therefore required in order to understand if staff attitudes have any implications for implementation of IPE programmes.

It is therefore hoped that the results of the study will include recommendations for the way in which IPE is introduced into health and social care curriculums in the future.

Research Objectives and Questions

The principal research objective is to explore the experiences of health and social care staff with reference to interprofessional education and working. This is being done in order to investigate whether experiences of interprofessional education and working have any impact on perceptions of professional identity and organisational structure. The issues raised will be explored with reference to existing theories of professional identity and organisational culture.

The research questions are as follows:

1. What are the opinions of health and social care staff about IPE and interprofessional working?

2. Do health and social care staff conceptualise all health care delivery as 'interprofessional'?
3. Can – and do – experiences of teaching IPE to students change the way in which health and social care staff interact with other professions?
4. How do health and social care staff describe their own professional identity, and the professional identity of other H&SC staff?

Methodology

The research for this project will be carried out in two phases. The ethical approval submitted refers to both phases of the research. Throughout the application the research is referred to as Phase 1 or 2:

Phase 1. Quantitative questionnaires to be completed online or on paper

Phase 2. Qualitative semi-structured interviews (n = 15).

Phase 1: This quantitative questionnaire will ask respondents about their professional background, and ask them to rank statements about their opinions of professional identity and interprofessional education and working.

This is an exploratory study, and participants will 'self select' to take part in the research by completing a questionnaire online by clicking in a link in an email, or by filling out a paper questionnaire. As such it is not possible to say how many people will take part in this questionnaire, but a number in excess of 200 is hoped for.

Any qualified, practicing member of health and social care staff in England is eligible to take part in phase 1 the study.

The data from phase 1 of the research will be analysed in terms of looking for trends in opinion across participants and exploring if there are any differences of statistical significance between respondent groups (particularly professional groupings).

Phase 2: This qualitative face-to-face interview will cover the same themes as those raised in phase 1 of the research but in more depth, with more focus on personal experiences of participants in terms of interprofessional education. It will also take the ALPS CETL as a case study and ask respondents about their perceptions of the impact of ALPS as a large-scale IPE programme. Obviously the pre-requisite for phase 2 of the research is a level of familiarity with the ALPS programme, and as such potential respondents will be identified by the researcher. As the ALPS programme is based in West Yorkshire, the chosen research site for this research is the Leeds Teaching Hospitals trust, where the majority of staff who will have come in to contact with ALPS will be based. For similar reasons Social Work staff from Local Authorities in West Yorkshire will be asked to participate in this phase of the research.

Interviews will last approximately 45 minutes and will take place at a location of the participants' choice. Each interview will be audio recorded using a digital voice recorder. Interviews will then be transcribed by the researcher and the results analysed. Responses will be grouped and coded, and then subject to thematic analysis.

Participants do not have to taken part in phase 1 of the research in phase 2, or vice versa. However should participants be eligible to take part in both phases of the research they will be able to do so.

Recruitment

Phase 1: As this survey is exploratory in nature, potential participants will not be 'identified', rather they will be recruited via email or web adverts or by being given the opportunity to fill out a paper version of the survey. As such, participants will 'self-select' to take part in this phase of the research. Adverts for the online survey will be placed on online forums and online and paper bulletins (such as the Practice Learner Facilitators Forum). Potential participants will be able to access the survey directly from a link placed in these adverts. In addition the researcher will send out email adverts to colleagues and ask them to forward the link to any health and social care staff who may be interested in taking part.

A similar method will be used to distribute paper a version of the survey, with the researcher giving copies to colleagues and asking them to advertise the survey to health and social care staff who may be interested I taking part in the survey.

Phase 2: As outlined in the Methodology section, participants for phase 2 will need to have some degree of familiarity with the work of the ALPS CETL. Potential participants will therefore be identified by the researcher (who works with ALPS herself) as having some degree of familiarity with ALPS. They will then be sent an email to invite them to take part in the research. Participants will express their interest in taking part in the research by sending a return email.

It will be made clear to potential participants in both phase 1 and phase 2 of the research that their participation is entirely voluntary.

Expenses

No incentives are being offered to take part in this research. Participants in phase 1 will not incur any costs to take part in the research. However it is possible that participants in phase 2 will have had to travel to take part in an interview. In the instance that these participants do incur travel costs to take part in an interview these will be reimbursed.

Consent

Phase 1: Phase 1 participants will be asked to tick a box either on the paper or online questionnaire to show that they have given their consent to take part in the research.

Phase 2: Participants in phase 2 of the research will be asked to sign a consent form at the beginning of their interviews to show that they have given their consent to take part in the research and that they are happy for their interviews to be audio-recorded and then transcribed.

Confidentiality

Phase 1: No identifying information is being recorded as part of phase 1 of the research. As such all survey results will remain anonymous and there will be no way to identify respondents from their survey answers.

Phase 2: Transcriptions of the recorded interviews will be stored using pseudonyms. These pseudonyms will be used when quoting in subsequent papers. No personal information about respondents will be stored with the data itself, and the contact details of those who do take part will be kept on a secure server at the University of Leeds until no longer needed (at the end of the study), when they will be destroyed.

Dissemination of results

The main purpose of this data collection is for a PhD study, and as such the results of the study will appear in full as part of the resulting PhD thesis. Additional papers covering aspects of the research may also be produced for conferences and journals.

Appendix 2: Approval letter received from Leeds East Research Ethics Committee

Leeds (East) Research Ethics Committee

Room 5.2, Clinical Sciences Building
St James's University Hospital
Beckett Street
Leeds
LS9 7TF

Telephone: 0113 2065652
Facsimile: 0113 2066772

12 June 2009

Ms Viktoria Joynes
ALPS Research Officer
ALPS CETL
University of Leeds

Room 7.09
Worsley Building
LS2 9NL

Dear Ms Joynes

Study Title:	Does interprofessional education and working have any impact on the formulation of perceptions of professional identity and organisational culture?
REC reference number:	09/H1306/58
Protocol number:	1

The Research Ethics Committee reviewed the above application at the meeting held on 2 June 2009. Thank you for attending to discuss the study.

Ethical opinion

At the meeting, members asked whether you expected professional and inter professional identity to be dependent or independent variables. Members were happy with your explanation that IPE had the potential to impact on perceptions of professional identity and the aim of the study was to investigate whether there was a relationship between the two.

The method for choosing staff for interview was queried. You explained that

you would know the people involved in IPE locally. A decision would be made in conjunction with your supervisors after the completion of Phase I on which professions would be best targeted; you particularly wished to include medical staff and social workers. Members were satisfied with this approach.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

After discussing the study further after you had left the room, members suggested that the study should either be confined to participants experiences, or if a comparative element was included, you should make strenuous attempts to ensure that it was clear whether participants had, or had not, received IPE. Please note that this is a suggestion rather than a condition of the favourable opinion.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		28 April 2009
Application		24 April 2009
Investigator CV		27 April 2009
CV of Trudie Elizabeth Roberts		
Letter of Invitation: Phase 1 - Paper Survey	1	27 April 2009
Letter of Invitation: Phase 1 - Online Survey	1	27 April 2009
Participant Information Sheet: Phase 1: Online or Paper Survey	2	27 April 2009
Letter of Invitation: Phase 2 - Face to Face Interview	1	27 April 2009
Participant Consent Form: Phase 2 - Face to Face Interview	2	27 April 2009
Participant Information Sheet: Phase 2 - Face to Face Interview	2	27 April 2009
Interview Schedules/Topic Guides	3	27 April 2009
Questionnaire: Phase 1: Double sided format to be presented to respondents	7	27 April 2009
Questionnaire: Phase 1: Single sided format	7	27 April 2009
Letter from Sponsor		24 April 2009
Compensation Arrangements		02 October 2008
Protocol	1	27 April 2009

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully

with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
 - Progress and safety reports
 - Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H1306/58	Please quote this number on all correspondence
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With the Committee’s best wishes for the success of this project

Yours sincerely

Dr John Holmes
Chair

Email: ann.tunley@leedsth.nhs.uk

Enclosures:	List of names and professions of members who were present at the meeting and those who submitted written comments “After ethical review – guidance for researchers”
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Copy to:	Mrs Clare Skinner, University of Leeds R&D office, Leeds Teaching Hospitals NHS Trust
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Appendix 3: Approval letter received from the University Research Ethics Committee

Faculty of Medicine and Health
Research Office

Room 10.110, Level 10
Worsley Building
Clarendon Way
Leeds LS2 9NL

T (General Enquiries) +44 (0) 113 343 4361
F +44 (0) 113 343 4373



UNIVERSITY OF LEEDS

Ms Viktoria Joynes
Room 14.02
Social Sciences Building
University of Leeds
LEEDS LS2 9NL

21 March 2012

Dear Viktoria,

Ref no: EDREC/11/025

Title: Exploring the professional identity of health and social care staff via experiences of interprofessional education and working

I am pleased to inform you that the above research application has been reviewed by the Medicine and Dentistry Educational Research Ethics Committee (EdREC) and I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation as submitted at the date of this letter.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information (fmhuniethics@leeds.ac.uk)

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I wish you every success with the project.

Yours sincerely

A handwritten signature in black ink, appearing to be 'J Sandars'.

Dr John Sandars
Chair, EdREC

Appendix 4: Survey tool for NHS staff

27 April 2009
Version 7

Questionnaire: Perspectives on Interprofessional Learning and Working

This survey is part of a PhD study which aims to explore how health and social care professions work and learn from each other. As part of this work, I would like to find out about your own training and experiences of working with other professions, as well as your opinions about 'interprofessional education' and 'professional identity'. The survey should take no longer than 10 minutes of your time. All responses will be anonymous, and no attempt will be made to identify you from your responses. If you choose to give your email address at the end of the survey then this information will be stored separately from survey responses.

Alternatively, if you would rather fill out an online version of this questionnaire, you can do so by visiting the following URL:

www.survey.leeds.ac.uk/jpl

Please note that you only need to fill out ONE version of the questionnaire to take part in the research – the online and paper versions of the surveys are identical.

The closing date for this survey is **December 30th 2009**. Please return your completed survey by placing it in the stamped addressed envelope provided.

If you would like to know more about the research then you can contact me using the details given below.

Best wishes

Viktoria Joynes, v.c.t.joynes@leeds.ac.uk, 0113 343 6970

Consent:

Please indicate in the box below that you have read the information sheet provided with this survey and that you give your consent to take part in the survey:

Yes

No

Section 1: You and your training

1a. Please indicate your profession:

Audiologist

Clinical Physiologist

Dental Nurse

Dentist

Dietician
Doctor
Midwife
Nurse
Occupational Therapist
Operating Department Practitioner
Optometrist
Pharmacist
Physiotherapist
Podiatrist
Radiographer
Social Worker
Speech and Language Therapist
Other (please specify:)

1b. What specialty or area do you work in?

2. Would you describe your current role as...?

Junior Middle Senior

3. How long ago did you qualify in your chosen profession?

Within the last 12 months

1 – 2 years

3 – 5 years

5 – 10 years

11+ years

4. Where did you undertake your professional training?

United Kingdom

European Union – (including European Economic Area)

Outside the European Union

5. In which of the following places do you currently a. work and b. supervise, work with or train health or social care students? (please tick all that apply)

	Work	Work with Students
Acute Trust		
Primary Care Trust		
Child and Adolescent Mental Health Service		
Mental Health Trust		
Social care organisation/government organisation		
Social enterprise organisation		
Voluntary or '3rd Sector' organisation e.g. charity		
Private or independent health or social care provider (hospital setting)		
Private or independent health or social care provider (community setting)		
Educational establishment (e.g. University)		
Other (please specify)		

6. In your current position, how often do you work with students who are training to become members of your profession?

	Never	Sometimes	Often
I provide an opportunity for students to observe/learn about my work			
I supervise students on placement			
I teach students on placement			
I am involved in formally assessing students as part of their work-based placements			

7. And how often do you work with students who are training to become members of professions other than your own?

	Never	Sometimes	Often
I provide an opportunity for students to observe/learn about my work			
I supervise students on placement			
I teach students on placement			
I am involved in formally assessing students as part of their work-based placements			

Section 2: Opinions about professional identity

8a. The following questions will ask you about how you feel about your own profession and 'professional identity'. There are no right or wrong answers – rather, it is your opinion that matters here.

Please indicate one answer for each statement

[SCALE:] **Don't Know - Never – Seldom – Sometimes – Often – Always**

- i. Being a member of my profession defines who I am
- ii. I feel that I “belong” to my profession
- iii. I feel I have “strong ties” to my profession
- iv. I am pleased to be a member of my profession

If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

8b. Please indicate how much you agree or disagree with the following statements:

[Scale:] **Don't Know - Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree**

- i. I have a clearly defined professional identity and role
- ii. I prefer not to be defined by my profession outside of work
- iii. The idea of having a 'professional identity' is out of date and irrelevant now

If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

Section 3: Your Experiences and Opinions about Interprofessional Education and Working

9a. This survey is interested in finding out your opinions about 'interprofessional education'. What do YOU think that the term 'interprofessional education' means?

9b. And what do you think that the main purpose of interprofessional education is?

10. Was interprofessional education part of your own professional training?
(please tick all that apply)

Yes – in classroom based lessons

Yes – in work or practice-based lessons

No

Don't Know/Can't remember

Please feel free to add additional comments:

11a. Do you think that teaching students from different professions together can result in them being better prepared to work in health care teams?

Yes – always

Yes – from classroom teaching only

Yes - from work based/practice based teaching only

No

Don't Know

11b. Please give a reason for your answer given in 11a:

12. Do you think that interprofessional education should be taught at undergraduate or postgraduate level? (tick all that apply)

-Undergraduate

-Postgraduate

-Don't know

Additional comments:

13. In your experience, please rate how successful you think interprofessional education can be in achieving the following, with 1 being the least successful and 5 being the most successful:

1 - 2 - 3 - 4 - 5 - No experience

- a. Improving communication skills
- b. Improving team-working skills
- c. Helping students understand their own limitations
- d. Improving patient care/service user care

14. Please indicate how much you agree or disagree with the following statements:

[Scale:] Don't Know - Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

- a. There are tasks that my profession is responsible for which no other profession can undertake
- b. At work, I find it easier to communicate with members of my own profession than members of other professions
- c. I prefer working with members of my own profession than with members of other professions
- d. I feel that members of my profession have the same career opportunities that members of other professions have at work
- e. When I work with other members of other professions, my opinion is always listened to and valued
- f. I think that there is a lot of respect between professionals at work, regardless of which profession they belong to
- g. I think that some professions are given more respect by patients/service users than others

If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

15. Have you heard of the ALPS CETL (Assessment and Learning Practice Settings centre for Excellence in Teaching and Learning) programme?

Yes

No

16. If yes, how did you hear about ALPS? (please tick all that apply)

Leaflet or poster

I am, or have been, a member of an ALPS working group

I have been trained to use the ALPS Assessment Tool

I have attended an ALPS workshop

I have attended a conference where ALPS has been represented

Academics who I work with have told me about ALPS

Practice staff who I work with have told me about ALPS

ALPS website

PLF forum

Other (please specify)

Demographics

17. Are you...

Male

Female

18. Please indicate your age

18 – 25

26 – 34

35 – 44

45 – 54

55 or over

Prefer not to say

Thank you for your time. To follow up from this survey I would like to interview people to gain a more in-depth perspective on some of the topics I have asked you about here. If you think you would be interested in taking part in one of these interviews then please fill out your email address in the space provided below:

If you have any queries about this research, or would like to find out about the results of this research when it is complete, please contact me on the details provided below:

Viktoria Joynes, Room 7.09, Worsley Building, University of Leeds

v.c.t.joynes@leeds.ac.uk 0113 3436970

Appendix 5: Survey tool for academic staff

10th February 2012

Version 1

Questionnaire: Perspectives on Interprofessional Learning and Working

This survey is part of a PhD study which aims to explore how health and social care professions work and learn from each other. As part of this work, I would like to find out about your own training and experiences of working with other professions, as well as your opinions about 'interprofessional education' and 'professional identity'. The survey should take no longer than 10 minutes of your time. All responses will be anonymous, and no attempt will be made to identify you from your responses. If you choose to give your email address at the end of the survey then this information will be stored separately from survey responses.

Alternatively, if you would rather fill out an online version of this questionnaire, you can do so by visiting the following URL:

www.survey.leeds.ac.uk/hei-ipl

Please note that you only need to fill out ONE version of the questionnaire to take part in the research – the online and paper versions of the surveys are identical.

The closing date for this survey is **DATE** Please return your completed survey by placing it in the stamped addressed envelope provided.

If you would like to know more about the research then you can contact me using the details given below.

Best wishes

Viktoria Joynes, v.c.t.joynes@leeds.ac.uk, 0113 343 9211

Consent:

Please indicate in the box below that you have read the information sheet provided with this survey and that you give your consent to take part in the survey:

Yes

No

Section 1: You and your training

1a. Please indicate your profession:

Audiologist

Clinical Physiologist

Dental Nurse

Dentist

Dietician

Doctor

Midwife
Nurse
Occupational Therapist
Operating Department Practitioner
Optometrist
Pharmacist
Physiotherapist
Podiatrist
Radiographer
Social Worker
Speech and Language Therapist
Other (please specify:)

1b. What specialty or area do you work in?

2. How long ago did you qualify in your chosen profession?

Within the last 12 months

..... years

3. Where did you undertake your professional training?

United Kingdom

European Union – (including European Economic Area)

Outside the European Union

4a. Do you currently work in a Higher Education Institution?

Yes

No

4b. If yes – how long have you worked in Higher Education?

Up to 12 months

.... years

5. Do you currently still work / actively practice in your chosen profession?

No

Yes – more than once a week

Yes – once a week

Yes – 2-3 times a month

Yes - once a month

Yes – less than once a month

Please provide comments if you wish...

6. In which of the following places do you currently a. work b. supervise or train health or social care students? (please tick all that apply)

Work Supervise or train students

Acute Trust

Primary Care Trust

Child and Adolescent Mental Health Service

Mental Health Trust

Social care organisation/government organisation

Social enterprise organisation

Voluntary or '3rd Sector' organisation e.g. charity

Private or independent health or social care provider (hospital setting)

Private or independent health or social care provider (community setting)

Other health care settings (please specify)

7. In your current position, how often do you work with students who are training to become members of your profession? (please tick one option for each statement)

Never Sometimes Often

I teach students in University-based settings

I provide an opportunity for students to observe/
learn about my work

I supervise students on placement

I teach students on placement

I am involved in formally assessing students
as part of their work-based placements

8. And how often do you work with students who are training to become members of professions other than your own? (please tick one option for each statement)

Never Sometimes Often

I teach students in University-based settings

I provide an opportunity for students to observe/
learn about my work

I supervise students on placement

I teach students on placement

I am involved in formally assessing students as part of
their work-based placements

Section 2: Opinions about professional identity

The following questions will ask you about how you feel about your ‘professional identity’. There are no right or wrong answers – rather, it is your opinion that matters here.

9. If asked, would you be more likely to describe your professional identity AT THIS POINT IN TIME as...

A teacher / educator

The health or social care profession in which you are qualified

A mixture of educator and the health or social care profession in which you are qualified

10a. With reference to the HEALTH OR SOCIAL CARE PROFESSION IN WHICH YOU ARE QUALIFIED Please indicate one answer for each statement

[SCALE:] **Don’t Know - Never – Seldom – Sometimes – Often – Always**

i. Being a member of my profession defines who I am

ii. I feel that I “belong” to my profession

iii. I feel I have “strong ties” to my profession

iv. I am pleased to be a member of my profession

If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

10b. With reference to the YOUR TEACHING ROLE Please indicate one answer for each statement

[SCALE:] **Not Applicable - Don't Know - Never – Seldom – Sometimes – Often – Always**

- i. Being a member of my profession defines who I am
- ii. I feel that I “belong” to my profession
- iii. I feel I have “strong ties” to my profession
- iv. I am pleased to be a member of my profession

If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

11. Please indicate how much you agree or disagree with the following statements:

[Scale:] **Don't Know - Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree**

- i. I have a clearly defined professional identity and role
- ii. I prefer not to be defined by my profession outside of work
- iii. The idea of having a ‘professional identity’ is out of date and irrelevant now

If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

Section 3: Your Experiences and Opinions about Interprofessional Education and Working

12a. This survey is interested in finding out your opinions about ‘interprofessional education’. What do YOU think that the term ‘interprofessional education’ means?

12b. And what do you think that the main purpose of interprofessional education is?

13. Was interprofessional education part of your own professional training?
(please tick all that apply)

- Yes – in classroom based lessons
- Yes – as work or practice-based experience
- No
- Don't Know/Can't remember

Please feel free to add additional comments:

14a. Do you think that teaching students from different professions together can result in them being better prepared to work in health care teams?

Yes – always

Yes – from classroom teaching only

Yes - through work based/practice based experiences only

No

Don't Know

14b. Please give a reason for your answer given in 14a:

15. When do you think is the best time for interprofessional education to be introduced? (tick all that apply)

-During undergraduate / pre-registration training

-At postgraduate / post-registration training

-Don't know

Additional comments:

16. In your experience, please rate how successful you think interprofessional education can be in achieving the following, with 1 being the least successful and 5 being the most successful:

1 - 2 – 3 – 4 – 5 - No experience

a. Improving communication skills

b. Improving team-working skills

c. Helping students understand their own limitations

d. Improving patient care/service user care

17a. With reference to the HEALTH OR SOCIAL CARE PROFESSION IN WHICH YOU ARE QUALIFIED, please indicate how much you agree or disagree with the following statements:

[Scale:] Don't Know - Strongly Disagree – Disagree – Neither Agree nor Disagree – Agree – Strongly Agree

- a. There are tasks that my profession is responsible for which no other profession can undertake
- b. At work, I find it easier to communicate with members of my own profession than members of other professions
- c. I prefer working with members of my own profession than with members of other professions
- d. I feel that members of my profession have the same career opportunities that members of other professions have at work
- e. When I work with other members of other professions, my opinion is always listened to and valued
- f. I think that there is a lot of respect between professionals at work, regardless of which profession they belong to
- g. I think that some professions are given more respect by patients/service users than others

17b. If you have any comments you would like to make about the answers you have given above, please do so in the space provided below:

18a. Have you ever heard of the ALPS CETL (Assessment and Learning Practice Settings centre for Excellence in Teaching and Learning) programme?

Yes

No

18b. If yes, how did you hear about ALPS? (please tick all that apply)

Leaflet or poster

I was a member of an ALPS working group

I was trained to use the ALPS Assessment Tool

I attended an ALPS workshop

I attended a conference where ALPS was represented

Academics who I work with told me about ALPS

Practice staff who I work with told me about ALPS

ALPS website

PLF forum

Other (please specify)

Demographics

19. Are you...

Male

Female

20. Please indicate your age

18 – 25

26 – 34

35 – 44

45 – 54

55 or over

Prefer not to say

Thank you for your time. To follow up from this survey I would like to interview people to gain a more in-depth perspective on some of the topics I have asked you about here. If you think you would be interested in taking part in one of these interviews then please fill out your email address in the space provided below:

If you have any queries about this research, or would like to find out about the results of this research when it is complete, please contact me on the details provided below:

Viktoria Joynes, Room 14.02, Social Sciences Building, University of Leeds

v.c.t.joyes@leeds.ac.uk 0113 3439211

Appendix 6: Interview Schedule with NHS staff

Phase 2: Interview Schedule/Topic Guide

Perspectives on Interprofessional Learning and Working

27 April 2009 Version 3

Each participant to be given an information sheet and asked to sign a consent form to show that they are willing to take part in the research, and that they are willing to have their responses recorded and transcribed.

Questions

1. Ask respondent to describe their professional background and their current job role.

2. First of all I'd like to ask you about some of your own experiences of interprofessional education and working. Was there an emphasis on interprofessional education and working as part of your own professional training? [Explore – what, classroom or practice based, which other professions involved, undergraduate or postgraduate]

3a. What sort of interprofessional working do you and your staff engage in now? [Explore – context - is this every day? How easy or difficult is it to define interprofessional working compared to 'non-interprofessional' working?]

3b. And do you work or supervise students in practice? [If yes] Are students introduced to interprofessional team working when they come to work in practice? [explore – what knowledge of interprofessional working do students tend to come to their placements with]

4. Interprofessional education aims to improve the communication and team-working skills of those who undertake it – which has the ultimate aim of improving patient (or service user) care. How successful do you think interprofessional education – or working – is in achieving this aim?

5. Are there some professions which you find it easier to work with than others? [Explore - is there an organizational structure which means you end up working with some professions more than others?]

6. A slight change of topic now – thinking a bit more about the idea of 'professional identity'. Do you feel you have a strong 'professional identity'? [Explore – do you

describe yourself by your profession in and out of work? Is the concept of 'professional identity' outdated?]

7. Do you think some health and social care professions have a stronger professional 'identity' than others?

8. Do you think professional identity is something that you develop? Or do you think people start their training with a fixed idea of what their 'professional identity' will be?

9. I'd like now to talk a little bit about the work of the ALPS CETL and its programme of interprofessional work and assessment. Can you just briefly outline for me how you are involved with ALPS? [Explore – how became involved, how ALPS was introduced in practice]

10. And are you aware of, or have you been involved in, any other large scale interprofessional education initiatives? [Explore – scale of initiatives, how involved].

11. Do you think that ALPS – and similar programmes of work – have, or will – make a difference to the way in which health professionals think about interprofessional education and working?

12. And do you think that an increased amount of focus on interprofessional education will change the way that people think about their professional identity? [Explore – impact on perceptions of health professionals versus perceptions of public/patients/service users].

13. Finally, one of the main aims of ALPS is to introduce a series of generic skills assessments to undergraduates. So for skills such as communication, team-working and ethical practice, the aim is that any student could be assessed by any qualified member of another health and social care profession. I'd be interested to know what you think the benefits and challenges of introducing this interprofessional assessment for generic skills are.

Appendix 7: Interview Schedule with academic staff

Phase 2: Interview Schedule/Topic Guide

Perspectives on Interprofessional Learning and Working

10th February 2012 Version 1

Each participant to be given an information sheet and asked to sign a consent form to show that they are willing to take part in the research, and that they are willing to have their responses recorded and transcribed.

Questions

1. What is your current job and professional background? [Explore – teaching role and h&sc professional background]

2. [Using the responses given in their questionnaire explore...]

a. What do you understand by the term professional identity?

b. How would you describe your own professional identity?

c. Do you feel you have a strong 'professional identity'?

d. Do you describe yourself by your profession in and out of work?

3. a. How and when do you think that professional identity develops? [Explore if not mentioned – for students – on courses, on placement etc]

b. At what point do you think your own professional identity 'formed'? Do you think your professional identity has changed over time? (how/why) [Explore - Who or what were the influences that helped you form this identity?]

c. Were there any specific incidents or times which you think were instrumental in forming your professional identity? Can you describe those to me?

4. In your experience do students have any notion of professional identity when they apply to do their course? If so, where do you think they get their ideas about this?

5. In your experience do you find some health and social care professions have a stronger professional 'identity' than others? [Explore response – why have answered yes or no]

Can you elaborate on your views?

6. What would you say to the suggestion that the concept of 'professional identity' is outdated and irrelevant now? [If required – that people are no longer defined by their work or their professions]

7. I'd now like to ask you about some of your own experiences of interprofessional education and working.

Was there an emphasis on interprofessional education and working as part of your own professional training? [Explore – what, classroom or practice based, which other professions involved, undergraduate or postgraduate, what sort of experience they had, what did they learn from the IPE setting that was different to the rest of their professional education?]

8. a. What sort of interprofessional working do you engage in now? [Explore – context - is this every day or one-off? Is it through teaching or working in practice?]

b. Are there some professions which you find it easier to work with than others? [Explore – if yes - why? Is there an organizational structure which means you end up working with some professions more than others?]

c. Is any element of interprofessional education offered as either a compulsory or optional part of the course or courses which you teach on now?

d. If yes - what does the IPE consist of? How do the a. students b. other academic staff and c. staff in practice [if relevant] react to it?

9. Do you work with or supervise students in practice? [If yes] Are students introduced to interprofessional team working when they come to work in practice? [explore – what knowledge of interprofessional working do students tend to come to their placements with]

10. Interprofessional education aims to improve the communication and team-working skills of those who undertake it – which has the ultimate aim of improving patient (or service user) care. Do you think interprofessional education can be successful in achieving this aim? If so how?

11. [If relevant] One of the reasons that I became interested in the topic of interprofessional education was that I worked with the ALPS CETL, which involved five universities and sixteen health and social care professions. One of the main aims of ALPS was to introduce interprofessional assessments in a series of generic skills such as communication, team working and ethical practice.

a. Can you remember how you heard about ALPS and were you involved in any of the ALPS initiatives? [Explore – how became involved]

b. Were you involved in introducing any of the ALPS assessments in to practice with students whom you supervised? Is so – can you describe this process? What were the opportunities and challenges involved in this work?

12. Are you aware of, or have you been involved in, any other large scale multi or interprofessional education initiatives? [Explore – scale of initiatives, how involved].

13. Do you think that large scale IPE initiatives such as ALPS – have, or will – make a difference to the way in which health professionals think about their professional working practices?

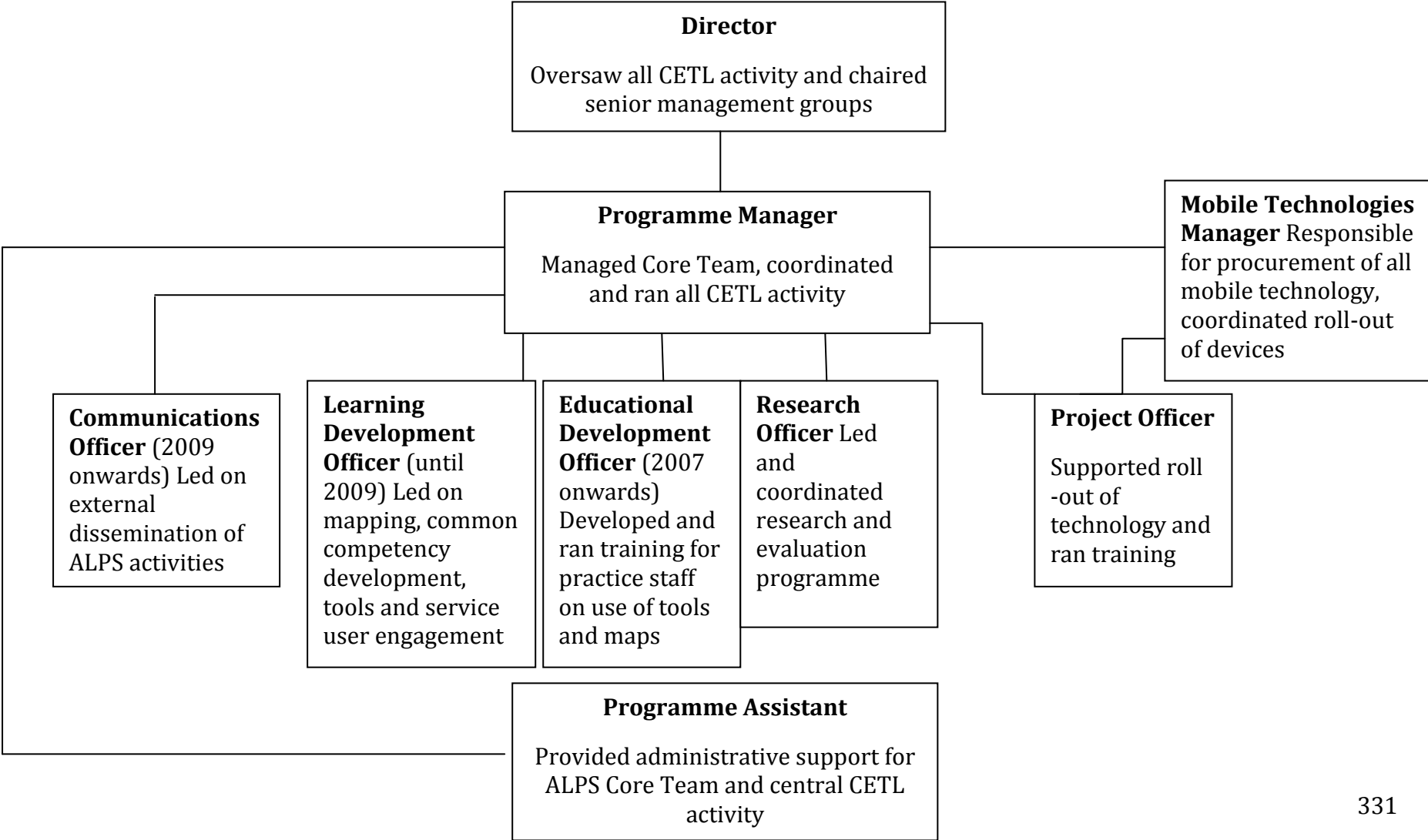
14. Do you think that ALPS has had any long term legacy for either a. your own professional working practices, b. the academic institutions that were involved in ALPS c. the practice staff who were asked to become involved in the ALPS work [Explore – what and how OR if not, why not]

15. a. And finally do you think that an increased amount of focus on interprofessional education will change the way that people think about their professional identity? [Explore – impact on perceptions of health professionals versus perceptions of public/patients/service users].

b. When would you say is the right time to introduce interprofessional learning? What would you say to the suggestion that introducing IPE too early – or IPE in general, could be perceived as a threat to professional identity formation?

Thank you very much for your time. Do you have any questions for me, or any further comments you would like to make?

Appendix 8: Structure of the ALPS Core Team



Appendix 9: ALPS Organisational Structure: Management and Working Groups

