AMEE Guide No. 12: Multiprofessional education: Part 2—promoting cohesive practice in health care

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SUMMARY The recommendations contained in this guide are derived from a two-year qualitative study of perceptions of multidisciplinary education in health care, funded by the Department of Health. The study was conducted by a multidisciplinary team at the Scottish Council for Research in Education (SCRE), the School of Health at the University of East Anglia, and the Centre for Medical Education at the University of Dundee. Interviews were conducted with course organizers and students, and with health professionals in two contrasting clinical settings: general medical practice and accident and emergency medicine. The evidence suggests that multidisciplinary education is neither an easy, nor a cheap option. It needs to be adequately resourced; the rationale for its development needs to be made explicit to both staff and students; and clear and achievable objectives need to be set for each stage. It requires careful planning throughout, and there should be adequate reflection upon the relative advantages and disadvantages of its inclusion at pre- and post-registration levels respectively. Finally, its success will ultimately depend upon the support and commitment of all staff involved.

Introduction

In March 1996, the Scottish Council for Research in Education (SCRE) was commissioned by the Department of Health to undertake a two-year evaluation of perceptions of multidisciplinary education in health care. The study was undertaken in association with the School of Health (Nursing and Midwifery) at the University of East Anglia and the Centre for Medical Education at the University of Dundee. The project had three broad objectives, namely:

- to ascertain the extent of multidisciplinary provision throughout the UK (Phase 1);
- to investigate perceptions of multidisciplinary education at both undergraduate/pre-registration and postgraduate/post-registration levels (Phase 2);
- to identify factors which either facilitated or inhibited its development (Phase 2).

The guidelines below are derived from data gathered during Phase 2 of the project. Unlike many previous evaluations, which have focused on single initiatives based in individual institutions (for example, Jones, 1986; Leathard, 1992; Carpenter, 1995; MacLeod & Nash, 1994; Bisits & Haertsch, 1994; Forman et al., 1994; Hilton et al., 1995; Greene et al., 1996; Pryce & Reeves, 1997), Phase 2 of the current study comprised 42 individual interviews, five focus groups with course organizers, and 10 with students in 10 HE-based sites throughout the UK. The sites chosen included four courses at pre-registration level and six at post-registration level.

To complement the data gathered from education providers and students, we also gathered information in four work-based sites: two accident and emergency (A&E) units, and two general medical practices, in which we conducted 19 individual interviews with a range of health care professionals; and one focus group discussion with a group of nurses who had attended an Advanced Trauma Nursing Course (ATNC). The rationale for the inclusion of these sites was to illustrate that learning to work together effectively is an iterative process which is not confined to formal learning opportunities.

In addition, we sought the views of a sample of six purchasers and commissioners—those responsible for education and training in NHS Executives, and in the local consortia, since as of April 1998 these have formally assumed some of the responsibilities for education and training.

The guidelines below stem from our analysis of the qualitative data. Our findings relating to the survey of provision have been reported elsewhere (Pirrie et al., 1997; Pirrie et al., 1998).

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The research in context

Much has been written over the last few years about how changes in patterns of health care delivery and in the structure of the NHS itself have impacted upon the development of the health professions (e.g. Biggs, 1993, p. 151; Poulton & West, 1993, pp. 918–920; Shaw, 1993, pp. 256–262; Leathard, 1994, pp. 7–23; Weinstein, 1994, pp. 7–12; Hugman, 1995, pp. 31–45; Mackay et al., 1995, pp. 5–10; Tope, 1996, pp. 57–71). It is beyond the scope of this paper to document these in detail. Nevertheless, it is clear that the development of a primary-care-led NHS, which looks set to continue under the present government, has led to a significant reappraisal of working practices and a renewed emphasis on collaboration and teamwork between health and social care professionals in the best interests of the patient.

In the twin domains of clinical practice and professional education, the focus has gradually shifted from a concentration on the "specific combinations of skills, knowledge and values" (Hugman, 1995, p. 41) that characterize any one health profession to the ways in which health and social care professionals can deploy a range of skills—many of which are complementary or overlapping—in the interests of efficient and effective patient care. This new emphasis on skills and competences which cut across existing professional boundaries has perhaps found its ultimate expression in the development of National Occupational Standards for health care professionals (NVQs and SVQs). This has lent further impetus to the development of a ‘seamless’ service (Hevey, 1992; Barr, 1994; Mathias & Thompson, 1997).

From the commissioners’ perspective, the integration of workforce planning has necessitated a shift from occupation-based manpower planning (traditionally supported by unprofessional education and training) to service-based planning (which, it may be argued, is best supported by multiprofessional education and training).

These developments are occurring at a time when “there seems no limit to our ability to `consume' health care” (Mackay et al., 1995, p. 6). Increasing demands on the service, linked in part to a greater ‘client-centredness’, a rise in patients’ expectations, and the particular demands of an ageing population, have further fuelled attempts to deploy resources more effectively. Many such initiatives have focused on the division of labour between different occupational and professional groups. One example from primary care is the suggestion that:

... some current GP workload could be managed differently through initiatives such as nurse practitioners ... and patient triage at the first point of contact. (The Future Healthcare Workforce, Report of the Project Steering Group, 1996, p. 8)

Supporting changes in health care delivery

So how can professional education respond to these changes and further influence the development of collaborative and cohesive practice in health care? Multi-disciplinary education is widely perceived as one way of equipping health professionals to provide a service which is to all intents and purposes ‘seamless’, although delivered by health and social care workers who have retained their distinct professional identities:

... professional education should ... prepare individual practitioners for ... collaborative working ... to enable each professional to retain certain unique areas of skill and knowledge, while sharing overlapping aspects of knowledge and skills.... The lack of early interdisciplinary training helps to perpetuate misunderstandings about different professional approaches and their underlying values. (In the Patient's Interest. Multi-Professional Working Across Organisational Boundaries, A Report by the Standing Medical and Nursing & Midwifery Advisory Committees, 1996, p. 16)

Each therapist should be aware of the specific skills of others in order to achieve effective and cohesive collaborative working. The philosophy of integration should start at undergraduate level and can be progressed throughout the career development of all therapists. (Promoting Collaborative Practice, Joint Statement by the Councils of the College of Occupational Therapists, Chartered Society of Physiotherapy, College of Speech and Language Therapists, nd)

The study reported here, and upon which these guidelines are based, explores the tensions inherent in such injunctions to 'retain unique areas of skill and knowledge' and yet to 'share overlapping aspects of knowledge and skills'. The in-depth interviews conducted in Phase 2 indicate that many course providers and students think that this balance is singularly difficult to achieve, particularly in a period of rapid change in patterns of service delivery and educational provision. It is possible that injunctions to ‘share’, ‘blend’ and ‘merge’ may have a muted reception as the implications of the integration of nursing and professions Allied to Medicine (PAMS) education into the higher education sector become clear. As one Phase 1 respondent put it, the move into higher education has encouraged nurses to:

... professionalize themselves in a way that’s analogous with the medical profession. So nursing research is becoming a marker of status and professionalism.

This would appear to run counter to much of the rhetoric about dismantling professional boundaries. Another respondent, working in medical education, gave a cogent exposition of some powerful institutional inhibitors to the development of what he termed an ‘integrated pattern of learning’:

I work in a university that prides itself in educating people in a research environment. And research is discipline-based, research is what some heads of department in disciplines would say rejuvenates the practitioner and keeps the field moving forward. Professionalism doesn’t do that. Practitioners don’t do that. Researchers within disciplines do that. And that’s where the tension lies because we could move our students into an integrated pattern of learning quite simply, but the research base wouldn’t let us do that.
Yet such tensions are rarely addressed in the literature, some of which is characterized by ideologically sanguine assertions that ‘learning together’ (effectively) is a necessary and sufficient pre-condition for ‘working together’ (effectively).  

However, the evidence gathered in the course of Phase 2 of this project strongly suggests that the gradual breaking down of professional boundaries which has followed in the wake of changes in patterns of health care delivery has not been universally welcomed. It appears that some health professionals consider that the pace of change in the NHS and the development of new working practices pose a threat to their (in some cases new-found and jealously guarded) professional autonomy. In some cases, this has led to a degree of re-entrenchment, a retreat behind professional ‘boundaries’ and a degree of confusion about what terms such as ‘multidisciplinary’ and ‘interprofessional’ mean.  

This has done little to foster the principles and practices of multidisciplinary education. As the following quotation makes clear, there are negative as well as positive dimensions to the evolving context of health care delivery, both of which impact upon multidisciplinary education and practice:

... the workplace is changing ... the word ‘interprofessional’ ... no longer has much meaning ... all these words have come to mean something and nothing to everybody, and they’re thrown about ... that’s actually what’s happening in the workplace ... because there are pressures from different directions to require ... organizations to work together ... to cut costs ... people are being moved and shunted from A to B ... people who have been trained as doctors and nurses and social workers are having to assume new roles as the purchaser/provider split moves and modifies into new formations, and so in a way the professional base begins to lose its meaning. (MSc course organizer)

There is, it appears, a very fine line between ‘assuming new roles’ and ‘being shunted about’. At one level, our own multidisciplinary research endeavour comprised drawing out that fine line.

Perceptions of multidisciplinary education and practice

There is ample evidence in the literature that the perceived benefits of multidisciplinary education at pre- and post-registration levels are widely appreciated in Europe (Areskog, 1988, 1992; Goble, 1994) and in the USA (for example, Clark, 1993; Casto, 1994; Casto & Julia, 1994) and further afield (WHO, 1988). Nevertheless, as Carpenter (1995) points out, “none of these programmes seems to have been satisfactorily evaluated” (p. 265). It appears to be easier to adduce evidence for the impact of multidisciplinary education on attitudes (towards both patient care and collaborative practice) than it is on outcomes such as improved patient care.

The qualitative data gathered during Phase 2 indicate that many of the course organizers we interviewed were also convinced that multidisciplinary education could indeed influence ‘stereotypical attitudes’, and saw a direct correlation between a satisfactory experience of learning with other professional groups and working together effectively as a team. The net result was perceived to be a reduction in the duplication of service provision. Discussion tended to focus upon the stage at which multidisciplinary provision was included in the curriculum, rather than on an assessment of its perceived advantages or disadvantages. This appears to indicate that despite the lack of ‘hard’ evidence in terms of measurable effects on patient outcome, course providers were generally convinced of the rationale for its inclusion. The following quotations from the Phase 2 data provide clear illustrations of this:

The literature and the seminars I’ve been to at CAIPE (Centre for the Advancement of Interprofessional Education) ... all seem to advocate that the sooner you start shared learning to break down stereotypical attitudes, and to develop interpersonal skills, communication skills, teamwork skills, that this should begin as soon as possible. (Undergraduate course organizer)

I hope that they take on board the perception ... that by working as groups in college it is easier to work in teams in departments. (Undergraduate course organizer)

... it’s important because we’re working together and the work environment is commonly multidisciplinary. So therefore shouldn’t our postgraduate education also be on a multidisciplinary basis? (Postgraduate course organizer)

I think people have been forced to acknowledge each other’s contribution, and to stop being territorial and to see things in a much wider way. (ATNC course organizer)

I think it is important that students get that concept of working in teams and that they will always work in teams, passing information backwards and forwards to other agencies such as social services, and so it is important to inculcate this into their learning and development. (Undergraduate course organizer)

I do think that there has been an awful lot of waste of time and effort in health care so far because I’m sure you and I ... can think of all sorts of times when treatment’s been covered by more than one person and it’s been duplicated. (Postgraduate course organizer)

So what are the perceived benefits of multidisciplinary education? Despite the tensions outlined above, the evidence from this study suggests that it has the potential to:

- enhance personal and professional confidence;
- promote mutual understanding between health and social care professionals;
- facilitate intra- and inter-professional communication;
- encourage reflective practice.

Nevertheless, the extent to which these can be achieved
depends, of course, upon the ability of course organizers to make informed choices about the stage (pre- and/or post-registration) at which to introduce multidisciplinary education. It is only by making informed choices of this order that some of the inhibiting factors outlined below can be mitigated.

Policy makers and education commissioners also have a key role to play in overcoming these pitfalls. Before we turn to the recommendations, let us consider what the evidence suggests is the most appropriate time to introduce multidisciplinary education.

**Pre- or post-registration?**

At what stage is multidisciplinary education perceived to have most impact? And in what areas of the curriculum is it likely to be most successful? On balance, the course organizers and students we interviewed considered that it had a greater impact at post-registration level, or at a later stage in pre-registration curricula.

It is evident that it is only at post-registration and continuing education level that students can be encouraged to reflect upon their practice. The potential for multidisciplinary education to enhance personal and professional confidence was also greater at the post-registration stage. Many pre-registration students’ understanding of their own practice and value systems was perceived to be fairly rudimentary. This meant that they were unable to extrapolate from the experiences of other professionals and use them as a basis upon which to reflect on their own practice.

There was widespread recognition that no single profession had a monopoly of the knowledge base required to deliver effective patient care. As a result, post-registration students in particular felt empowered to change their practice, or to initiate change. The extent to which they were able to do this, of course, depended upon the willingness of their colleagues to cooperate. Perhaps the most compelling example of cohesive teamwork facilitated by multidisciplinary education was in accident and emergency medicine (A&E), where, as a registrar explained:

> Because all the nursing staff here have done ATLS and we all work on the same system, almost invariably when we have a major trauma resuscitation everything comes to hand. The nursing staff are there thinking of the same things as you’re thinking of ... I would say our Advanced Trauma Life Support has a very strong implication there because it means that we all speak the same language ....

In the case of the pre-registration students, we were unable to ascertain the extent to which these perceived benefits were sustainable in a practice environment.

On balance, course organizers thought that pre-registration students had not yet developed a ‘relatedness to the discipline they were going to join’, and had insufficient clinical experience to envisage how they might draw upon the knowledge base and skills of other groups in the workplace. Nor did the students themselves consider that they had had time to develop their own professional role—to become, in the words of one pre-registration nursing student, ‘established in themselves’. This was their priority, and in some instances they seemed unclear as to the rationale for the inclusion of a multidisciplinary element in an essentially unprofessional degree course. Some pre-registration course organizers believed it important to honour their students’ preconceptions of what their profession might be, however naive these were. As one nurse educator explained:

> I think some of it’s about professional identity, that they feel that they came to be nurses and they want to be on something that is clearly defined as a nursing course. Which I think links up a bit with what I was saying earlier about the stereotypical viewpoint or the misconceptions about what you should be studying when you are learning to be a nurse and we are thinking we need to address that to some extent perhaps in the new degree perhaps by increasing the amount of time they have as a nursing group in that first year and looking at perhaps trying to thread shared learning through the degree and not have this big bulk of it at the beginning. I think that is causing some problems, not massive ones, but things that we think can be improved around that. ... It’s not a problem of the shared learning *per se*, but is a problem of how we’ve got it in our programme at the moment.

The evidence suggests that multidisciplinary education at pre-registration is qualitatively very different from that at post-registration levels. As one Director of Education and Training in an NHS Executive put it:

> ... my perception is ... that multidisciplinary education tends to be limited to groups of people who are doing different courses, attending joint sort of training seminars, and, you know, you put them all in a room together and listen.

There was a view expressed by some course organizers that such an approach entailed ‘diluting single professional inputs’ and was difficult to reconcile with the ‘moral obligation to produce safe practitioners’. It would appear from the data that there is a variety of motives for ‘putting students all in a room together’, significant among which is, in the words of one pre-registration course organizer, the ‘imperative to pack as many in as possible, you know, and conserve staff time for research’. It is thus perhaps not surprising that many pre-registration students we interviewed were often rather unclear as to the rationale for the inclusion of multidisciplinary course elements. Nor is it surprising that in some cases such initiatives “may simply reinforce the barriers that exist for the very purpose of defining different professions” (Clark, 1993, p. 218).

At pre-registration level, teaching styles appeared to vary considerably, and included both large-scale didactic variants and interactive, small-group teaching approaches: for example in one site (A), there were various initiatives: some ‘shared teaching’ in core modules (social and behavioural sciences, anatomy, physiology, clinical skills training, research methods and statistics) between nursing students and students from the Professions Allied to Medicine (PAMs). In addition, there was some interactive prob-
lem-based shared learning in small groups. This was in an early stage of development, and involved students from a variety of professional groups (nursing, medicine, and PAMS), all of whom had had some clinical experience. This second variant was generally considered the most productive teaching style, as it facilitated greater exchange between students from different professional groups.

In another pre-registration site (B), small mixed groups of medical and nursing students shared a clinical skills teaching facility. Shared courses in communication skills and cardiopulmonary resuscitation (CPR) were also being developed for nursing students and medical students in the early stages of their curricula. A course organizer in site B outlined the rationale for selecting these areas of the curriculum as follows:

[we thought] medical students and nursing students might usefully come together because they did certain things that didn’t require possibly very much pre-knowledge on either of their parts... things like communication... certain clinical skills. Ethics was another one.

However, his counterpart in site A drew our attention to some of the limitations of bringing together students with neither ‘pre-knowledge’ nor clinical experience in order to consider ethical issues:

... ethical and moral issues could be taught together, but I think you can only teach those to people who’ve got some knowledge of what practitioners are going to do in practice, they must be people who’ve had clinical experience, or else you’re not going to relate to it, unless you took something like euthanasia, but even then, the naive person might think you should never kill anybody, but when you see other circumstances in your clinical practice, you might think well in these circumstances I would...

It would appear from the foregoing examples that multidisciplinary course development, particularly at pre-registration level, represents a somewhat uneasy balance between rationale and expediency. It is difficult to envisage how this could be anything but the case. Nevertheless, we hope that our recommendations will make such a balance more robust and sustainable.

We will now set these in context by outlining the factors which inhibit successful course development.

Factors inhibiting multidisciplinary course development

Internal inhibitors

Respondents in the HE-based sites identified a range of logistical factors which they considered impeded multidisciplinary course implementation and development. Many of these affected pre-registration courses in particular, as the number of students was greater. In several cases, entry gates were not compatible, which meant that course organizers were faced with the problem of identifying the correct level at which to pitch their teaching. This problem was exacerbated by the fact the pre-registration students with little or no clinical experience upon which to draw were frequently unable to extrapolate from examples drawn from the clinical practice of other groups. In many cases, it was not possible to achieve an optimum balance in numbers of students from different professional groups. In some teaching situations, a single professional group dominated, which had the unfortunate effect of reinforcing negative stereotypes. In addition, it was often difficult to find suitable accommodation for large- and small-group teaching. Library and IT facilities were severely stretched; and timetabling across groups with discrete, discipline-specific timetables sometimes presented problems for course organizers.

It appears from our data that the development of multidisciplinary provision, particularly at pre-registration level, is often piecemeal and opportunistic. This in part explains the wide range of forms of course organization and development; teaching styles (whether large-scale and overtly didactic or small-scale, problem-based and interactive); and range of participants.

It also appears that key individuals with a strong personal commitment to the principles and practices of multidisciplinary education play an important role in identifying opportunities and initiating course development in their home institutions. It is significant that in some cases the success of an initiative was attributed to one individual’s contribution. Although such individuals are undoubtedly great assets to their institutions, it is possible that an initiative will not be sustained if such a ‘product champion’ moves on, or that the rationale for including a multidisciplinary element may not be clear to their colleagues. If this is the case, it seems unlikely that students will be clear as to the rationale for multidisciplinary learning, and that the success of any such initiative will be jeopardized.

This ad hoc pattern of implementation may be successful in the short term. However, the absence of an overarching, strategic vision as regards the future development of such provision may ultimately compromise the degree to which such initiatives can be sustained in the longer term. We might add that it also makes it difficult to identify examples or models of good practice that are applicable across a range of sites and circumstances.

External inhibitors

In addition, respondents identified a range of external factors which they considered inhibited the development of multidisciplinary education. We have already drawn attention to the perceived need to maintain professional identity, standards and value systems. To varying degrees, course organizers and students saw this as conflicting with the perceived drive to ‘go multidisciplinary’. This issue was also raised in the general practice sites, but was not such a significant issue in the data gathered in the two A&E units.

Allied to the maintenance of professional standards is the role professional bodies play in maintaining distinctive professional cultures. The requirements of professional bodies in terms of the number of hours of clinical practice required also provided course organizers with logistical problems. These were exacerbated by the fact that validation cycles were unsynchronized. In one institution, course organizers pressed for the introduction of more core
courses involving nursing and the professions allied to medicine (PAMS) in an attempt to mitigate the effects on multidisciplinary course development of individual uniprofessional courses coming up for validation at different times.

In addition, the existence of separate levies for medical and dental education and training (MADEL) and non-medical education and training (NMET) was perceived to do little to promote attempts to break down the boundaries between professions and to facilitate educational initiatives involving a range of different professional groups. However, a Director of Education and Training in one NHS Executive put forward one possible way of obviating some of the difficulties posed by the existence of separate training levies:

... we still have a raft of contracts for physiotherapy, occupational therapy, diagnostic therapeutic, radiography, which had just grown, like Topsy. So they’re a ragbag of contracts…. So what we agreed, through the Regional Education Development Group ... is that we would commission all those for professional, educational and those people in professional groups collaboratively.

Promoting collaborative and cohesive practice in health care

We recognize that multidisciplinary education is constantly evolving, and that there are no hard and fast models of good practice that can be successfully implemented across the board.

Nevertheless, the following set of recommendations is designed to help pre-and post-registration course organizers overcome some of the difficulties we have outlined, and to make an effective contribution towards the promotion of collaborative and cohesive practice in health care.

Recommendations for course organizers

The evidence gathered during this project suggests that course organizers should:

- make explicit the rationale for the inclusion of multidisciplinary provision, particularly at pre-registration level;
- convey this rationale to the students as they embark upon the course, e.g. in course documentation and introductory sessions;
- set clear objectives which relate to how multidisciplinary education should evolve throughout pre-registration courses as a whole, and at what point they should begin;
- consider how the objectives for the unidisciplinary and multidisciplinary elements might be mutually reinforcing and sustaining;
- ensure that staff sympathetic to the aims of multidisciplinary education are involved in the delivery of the multidisciplinary elements of courses;
- develop problem-based multidisciplinary case study material which could be taught by members of different professions;
- involve students in the formative assessment of multidisciplinary practice;
- honour pre-registration students’ apparent desire to develop what they consider a profession-specific knowledge and skills base;
- make students aware of the degree of interdependence between the uni- and multidisciplinary elements of their course in order to increase their understanding of and commitment to multidisciplinary education;
- reflect further on the advantages and disadvantages of introducing multidisciplinary education at pre- and post-registration levels respectively.

Recommendations for policymakers and education commissioners

It is widely acknowledged in the literature that many health professionals have complementary and overlapping skills which can be deployed in new ways in the patients’ best interests.

This renewed emphasis on collaboration and teamwork may present new challenges for those in clinical practice. It also has clear implications for education commissioners and providers, who must ensure that workforce planning meets the changing demands of the service, and that practitioners are adequately prepared for their changing roles in health care delivery.

We therefore recommend that NHS policy makers:

- make explicit the policy for promoting multidisciplinary education and practice;
- define terms used to describe various forms of ‘multidisciplinary’ provision;
- specify aims and objectives for each type of initiative;
- convey strategic policy on multidisciplinary education to education commissioners by providing examples of good practice in their local area;
- recognize that effective multidisciplinary education requires more rather than fewer resources and provide adequate resources for such courses;

and that:

- both policy makers and education commissioners make explicit the rationale for the promotion of multidisciplinary education;
- education commissioners clearly define roles and responsibilities in relation to the promotion of multidisciplinary education;
- reflect upon the advantages and disadvantages of introducing multidisciplinary education at pre- and post-registration levels respectively.

It is clear that there are considerable benefits associated with multidisciplinary education in health care. Nevertheless it is neither an easy, nor a cheap option. Successful multidisciplinary provision needs to be adequately resourced. The rationale for its development needs to be made explicit to both staff and students, and clear and achievable objectives need to be set for each stage. It requires careful planning throughout, and there needs to be adequate reflection upon the relative advantages and disadvantages of its inclusion at pre-and post-registration levels respectively. Finally, as with all educational initia-
tives, its success will ultimately depend upon the support and commitment of all staff involved.

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Notes

[1] We use the expression ‘multidisciplinary education’ as a generic term to describe a range of situations in which students from different health and social care professions come together to enhance their knowledge and understanding of particular elements of their professional practice


[3] For a full discussion of issues surrounding the use of terms such as ‘multidisciplinary’ and ‘interdisciplinary’, see Pirrie et el. (1998).

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