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Introduction of Interprofessional Education in Turkey with Appropriate Learning Theories

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Abstract: Interprofessional learning is embedded within health and social care professional curricula in many countries. Interprofessional learning has become synonymous with modernization of helping to breakdown traditional ways of teaching, preparing students in a reformed and innovative ways. The new learning methods will enhance the team working and partnership work once health and social care students are educated together that will prepare them to work collaboratively in delivering their professional input more efficiently. There is a need to install mechanisms of quality assurance for interprofessional education programmes by creating specific working models, procedures and tools in Turkey. There is a plethora of learning theories that could be adapted to interprofessional learning. IPE is the only way of developing more team work approaches to the multi-faceted health and social care problems that patients experience. There are many learning theories related to interprofessional education some of which were presented in this article in a broader way.

Keywords: Interprofessional education (IPE), collaborative practice, interdisciplinary team work, health and social work education, curriculum alignment.

Özet: Disiplinler arası öğrenim batılı ülkelerin çoğunda sağlık ve sosyal bakım profesyonellerinin müfredat programlarına yerleştirilmiştir. Disiplinler arası öğrenme, sağlık ve sosyal alanlarında eğitim alan öğrencilerin, ortak öğrenme metodlarıyla, eğitime katılarak yeterliliklerini, kabiliyetlerini ve kendilerini tanımalarını sağlayacak modern öğretim metodlarıyla geleceğe yönelik iş gücünün yaratılmasını sağlar. Sağlık ve sosyal bakım alanlarında işbirliği ile çalışarak daha iyi sonuçlar alabilmek için modernize edilmiş müfredatlar Türkiye'de uygulamaya geçirilmelidir. Özel çalışma modelleri, prosedürler oluşturarak disiplinler arası eğitim programları için kalite güvencesi mekanizmalarının kurulmasına ihtiyaç vardır. Ortak eğitim programları daha küçük ölçekte sağlık ve sosyal bilimler fakültelerinde test edilebilir. Asıl sorun disipliner arası öğrenmenin uzun vadede yükseköğretim programlarına yerleşmesi olacaktır. Disiplinler arası öğrenmede uygulanacak bir çok öğrenme teorileri mevcuttur. Bu yazıda öğrenme teorileri ana hatlarıyla sunulmuştur.

Anahtar Kelimeler: Disiplinler arası eğitim, işbirlikçi pratik, disiplinler arası ekip çalışması, sağlık ve sosyal bilimlerde eğitim, müfredat ayarlaması.

Interprofessional education (IPE) is described as collaborative, democratic, group directed, experiential, reflective and applied learning within health and social care students. World Health Organisation (WHO) (2010, p.63) defined IPE is 'it occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes'. IPE requires interprofessional interaction between students during the learning process. IPE has a long history and over the last decade has become established as a necessary teaching method within health and social care curricula. IPE aims to advance the quality of patient care through improving working relationships between health and social care professionals who can promote collective responses to patient's and populations' needs (Barr, 2002). As such it follows that health and social care students when qualified should be able to work together to advance the care of individual's and populations. IPE aims to prepare students for the complexity of team working and collaborative practice in the caring professions. (Barr, Freeth, Hammick, Koppel, Reeves, 2005; Hammick, Freeth, Koopel, Reeves and Barr, 2007; Rice, Zwarenstein, Gotlib Conn, Kenaszchuk, Russell and Reeves, 2010). IPE is a synonymous word for collaborative learning which focuses on diverse workgroups that promotes new ideas, areas, and practices that would ultimately increase the quality of life for patients.

IPE is a response to specific changes within health and social care delivery in the twenty first century, intended at facilitating the delivery of integrated services and patient-focused care. IPE is shaped by a commitment to safe patient-centered collaborative practice by national governments worldwide, for example, the United Kingdom (UK) (Department of Health, 2001), Canada (Health Canada, 2001), Australia (Australian Council for Safety and Quality in Health Care, 2005) and the United States of America (USA) (Cerra and Brandt, 2011) as well as global policy responses to a range of health care issues including patient safety, safeguarding and workforce/health human resources demands (WHO, 2010). It is estimated that the current worldwide shortage of nearly 4.3 million doctors, midwives, nurses, support and social workers is expected to worsen in future years. In addition, an ageing health workforce has also compounded the challenges of service provision to developing countries, rural and remote areas, ethnic and indigenous communities, and in particular areas mental health, older people and disability services. This is an ongoing concern for the WHO in coming years. There is a

link between health workforce shortages and IPE which is about how interprofessional practice can enable competent and effective use of the current global health workforce. IPE is the only way of developing more team work approaches to the multi-faceted health and social care problems that patients and families experience. These widespread global problems in health and social care directed WHO and its partners to create an innovative strategy that aims to prepare a collaborative practice-ready health and social care professionals through IPE.

What does the article attempt to achieve?

The purpose of this article is to raise the awareness of IPE in Turkey and initiate collaborative learning opportunities at all health and social care education. The study aims to promote that IPE prepares students to become professionals who can competently, professionally deliver high quality care either at clinical and community settings. The article concentrates on interprofessional learning, it is important to confirm that there is always a need for uni-professional learning that is distinctive and unique for each profession and that cannot be substituted by interprofessional learning. This is because IPE is not having all health and social care professionals carrying out the same tasks and skills, but is rather enabling each professional team member to make best use of their own professional skill sets. However, although health and social care professionals share common core values, traditionally education programmes have been conducted separately, with students in one programme rarely meeting those in other programmes before they graduate. In the Western Universities, investing in the IPE programmes at the Higher Education level enabled health and social care workforce to tackle more demands in the care services. Consequently, the ultimate aim is to work successfully together with the others to maximize the patient-focused care and increase the quality of life of the patients. This will be achieved by establishing each professional identity and unique sets of competence is for successful team formation and training in IPE.

IPE generally includes teamwork and collaboration and provides opportunities for students in different disciplines to study shared content together. IPE covers group assistance/learning, group activities, interactions across disciplines, such as seminars and workshops, meetings with tutors, special-interest groups and web-based discussion groups; and

the provision of a variety of instructional resources that can be adapted by students to suit their subject and to ensure ownership of ideas and strategies. There are benefits of IPE which would produce more cost effective care in a range of settings from primary care to acute hospital care, reablement and community based mental health services, reduced duplication of work, shorter length of patient stays, improved staff retention and higher quality of patient care (Domac and Dokuztug-Ucsular, 2011). These studies above simply examples of where people worked well together collaboratively and demonstrate that IPE matters to health and social care outcomes. In addition, collaboration between health and social care preserved and enforced in law and public policies in many countries (such as Denmark, Belgium, America, Canada, Norway, the United Kingdom and Japan) to prevent the exclusion of people with social and physical disabilities, mental health problems and older people. The traditional professional education have created artificial professional silos, leading to subjective forms of distance and obstacles between health and social care professionals which created mistrust and a lack of collegiality

International Experience of Interprofessional Teaching

IPE was first introduced into the health and social care sectors over four decades ago through sporadic initiatives first implemented in North America and later in Europe. The first statement recorded as a concept of IPE has been credited to Dr. John F. McCreary, Dean of Medicine at the University of British Columbia (UBC), who published an article in the Canadian Medical Association Journal (CMAJ) in 1964 and stated, ‘All of these diverse members of the health team should be brought together during their undergraduate years, taught by the same teachers, in the same classrooms, and on the same patients’ (McCreary, 1964; Inuwa, 2012). Early examples of interprofessional approaches to education and collaborative care of medical schools with distinct programmes started in Canada and Linköping in Sweden. These initiatives initially took place between 1975 and 1980. As a summary of these experiences, and to establish the underlying philosophy of IPE, a WHO working group followed up with a publication on the topic, called ‘Learning Together to Work Together for Health’(WHO, 1988). This gave

the impetus to promote IPE programmes and collaborative practices in many national and international organisations, including the Australasian Interprofessional Practice and Education Network (AIPPEN), the Canadian Interprofessional Health Collaborative (CIHC), the European Interprofessional Education Network (EIPEN), and the UK Centre for the Advancement of Interprofessional Education (CAIPE). Barr (2000) has described the continuing importance of IPE developments in Scandinavia, exemplified by the Karolinska Institute, University of Stockholm. In 2004 the European Interprofessional Education Network was founded with the purpose of sharing and developing effective IPE curricula, methods and materials to improve collaborative working (EIPEN). The organisation is supported by funding from the European Commission. The literature reveals that IPE is emerging and developing in several countries (e.g., Australia, Canada, Sweden, UK and USA) while a serious of reviews of conferences and regional IPE networks indicate many others (e.g., Belgium, Norway, Denmark, Sweden, Finland, Hungary, Spain, Ireland, Japan, New Zealand, Poland, Slovenia and South Africa). A study from Israel signifies a pioneering approach where the potential assessment tools for interprofessional learning produced during the selection of medical students in a simulation based assessment centre (Stone, 2010). In Sweden at Linköping University has allocated twelve weeks of the circula for IPE between educational programmes for physicians, nurses, physiotherapists, occupational therapists, speech and language therapists and medical biologists since 1986. IPE is regulated and is a requirement by law for higher education programmes in Denmark. There are also work based projects where Danish interprofessional unit provides in-depth learning programmes. In Finland, there are new schemes where exchange students from Belgium, Hungary and Lithuania studying Applied Sciences under the IPE umbrella. In Belgium, since 2003 an IPE was introduced at the Brussels University, the Ghent University Association has the greatest history of IPE which involves one university and three colleges as separate higher education institutions. It was the active involvement of these organisations that culminated in the publication by the WHO in 2010 of the Framework for Action on Interprofessional Education and Collaborative Practice, which serves as a proposal for developing IPE and collaborative practice in health care.

Interprofessional Education and the way forward at Turkish Universities

The extend of IPE at Turkish Universities amongst health and social care students is an unknown quantity and there might be some IPE related programmes being delivered but this was not been formalised by the Higher Education (Domac and Dokuztug-Ucsular, 2011). This is despite the fact that the current approach to health and social care education in many institutions is to produce professionals who are good communicators as well as adaptable, flexible team players who can collaborate with and share the same goals as other health and social care professionals (Parsell, Spalding and Bligh, 1998). There is an assumption that this will happen automatically in the workplace, although structural, organisational and attitudinal factors may inhibit team development and working collaboratively. Structural and organisational barriers could be difficult to overcome and may reflect in large part the attitudes of individuals within such organisations. Ultimately, IPE helps to change attitudes by increasing knowledge and understanding of other professionals' potential contributions towards patient care. Such understanding can improve relationships, increase trust and dispel stereotypes between the professionals and enhance the partnership work (Barr, 2002).

IPE is the way forward for sharing the hierarchical power in health care and raising awareness and understanding of each professional roles and preparing students to enter into interdependent relationships in the work life. IPE is the only way of developing more team work approaches to the multi-faceted health and social care problems that patients experience. IPE must be understood by educators in health professional schools because interprofessional care is the only integrated model of care for many vulnerable groups (for example, frail elderly people, palliative care patients, long term neurological disorders) who require co-coordinated care (Zwarenstein, Reeves, Perrier, 2005). Initially, the article suggests that commonly agreed interprofessional competencies should be agreed across the teaching institutions for health and social care in Turkey. Providing common modules on issues such as communication skills is relatively manageable, but supporting the more radical changes is a substantial challenge, involving major curriculum redesign and possibly an overhaul of programme provision. In addition, a strong cultural shift required which internally consistent and is widely shared and makes it

clear what it expects and how it wishes students and educators to behave and show mutual respects and understanding in order to set IPE in Turkey. There is a vast amount of competency based education literature available and the curriculum developers at Universities of Turkey must familiarize themselves with these common competencies where the students in health and social care professions must have the joint learning which will lead to the collaborative practices in future (Domac and Anderson, 2012). It is logical to assume that some professionals complement each other's work by sharing a similar goal of achieving good service user care.

Interprofessional Education and some of the relevant Learning Theories

Numerous educational theories inform the practice of IPE including theories of adult learning (Knowles, 1980) the 'reflective practitioner', and social group behaviour (Bandura, 1986). Each of these theoretical approaches underpin and inform the practice of IPE. Students from medical, nursing, and allied health sciences (physiotherapy, speech and language therapy, occupational therapy), social work, programs spend years developing attitudes, beliefs, and insights that conform to their respective professions. However, students often complete these programmes with insufficient knowledge of the skills that facilitate working with other professional groups. As a result, many students enter the workforce poorly prepared for the challenges associated with interprofessional working social modelling and supportive environments based on Bandura's Social Cognitive Theory (Bandura, 1989) and is inspired by Paolo Freire's empowering education philosophy.

Literature has suggested that the way to improve team work and the quality of patient care is to develop shared learning programmes at undergraduate level (Kyrkjebo and Brattebo, 2006). The educational system has a major impact on collaborative practice because it is during professional training that such values are instilled in students (San Martin-Rodriguez et al., 2005). Previous studies indicated that in some settings medical students enter educational programmes perceiving nurses as less competent and academically weaker than doctors, and with lower social status. Such attitudes and perceptions have been identified as influential factors in determining the success of IPE and how both groups interact with each other in practice (Hall, 2005; Rudland and Mires, 2005).

Learning of Interprofessional Education

During professional education, students not only acquire specialist knowledge and skills but they also acquire the complex value system of their profession through informal social learning and work-based learning (Bandura, 1977). Through such learning, students are primed in the community's embodied knowledge: for example, they learn to speak its language, which enables them to become socialised as members of their own profession. In this way they develop their own set of norms and values. Dombeck (1997, p.11) calls this 'professional person hood', which she refers to as "the web of roles and relationships that are acquired and enacted in professional arenas". As a natural process, professional behaviour matures through a natural developmental process. It is a process that health care students integrate into other tacit processes and personal experiences, which occur throughout basic education until they gradually take on the role and actions of, for example, a doctor, nurse, therapist or social worker.

The practice curriculum is a key factor in students' professional socialisation. Students question or adopt the values, attitudes and behaviours of the professionals with whom they are working, thus practice educators have an influential role in their acquisition of a professional personhood. Through interaction with these role models, students are able to observe 'professionalism' in action. Professionalism involves a sense of identity and adoption of shared meanings, skills and practices. By observing several practice educators throughout different placements, students are able to compare these role models and formulate for themselves a 'professional personhood' with which they are comfortable (McAllister et al. 1997, p.81). Hager and Beckett (1998, p.225) describe "knowledge-in-practice" as work-based learning and define it as "informal learning that occurs as people perform their work" and they distinguish it from the formal "on-the-job training". It is often implicit or tacit so that health care students are frequently unaware of the extent of their learning as they participate in their professional work in the practice environment. Such situated knowledge needs to be reified (Wenger, 1998) so that, in both the practice and academic environments, it can be shared, discussed and given meaning. Interprofessional learning where the educator assists the progress of learning, paving the way for students to construct meaning through debate, discussion and shared reflection (Reeves, Goldman, Gilbert, Tepper, Silver, Suter, and Zwarenstein, 2011). IPE facilitators are

usually university academics or practitioners who teach in practice (also known as preceptors, mentors, clinical or practice teachers). Teachers from each specialty educate and instruct their students to develop profession-specific knowledge, skills, and attitudes. Concurrently, teachers transfer their opinions of other medical, social and therapy professions. As a result, subsequent difficulties in teamwork are often encountered due to a lack of awareness, understanding and respect of the roles or knowledge of other health and social care professionals. (McNair, Stone, Sims and Curtis, 2005; Inuwa, 2012).

Situated learning has traditionally been perceived as being spontaneous and unstructured, but it can be structured or it can be a combination of the two for which it requires a learning curriculum rather than a teaching curriculum. A learning curriculum involves all the participants in a community of practice: the students, the practitioners, the managers, the practice educators, and the academic educators. Such a work-based learning curriculum is a radical pedagogy as it acknowledges that the workplace as well as the university is a site of knowledge generation. The article will capture some of the relevant learning methods pertinent in the IPE.

Reflective and Transformative Learning and Learning from Experience

Schön's model (1987) for educating the "reflective practitioner" reminds us that health and social care professionals need to be well prepared in the science of their work but also in dealing with the "gray" areas where uncertainty and value conflicts are more commonplace. IPE can be one of those gray and value-driven areas, and being reflective and open to new learning through one's own experiences and interactions with others are desired characteristics.

Critically reflecting upon experience appears central to learning. It appears to function as a mediator between existing knowledge, skills, beliefs and values, and experience. But the process is often not explicit and it may be most useful when viewed as a learning strategy and often requires facilitation. Boud, Keough, and Walker (1985) describe a 3-step model of reflection as a way to learn from experience. The first step is returning to the experience, to clarify in one's mind the events, acknowledge feelings at the time, and consider different perspectives. The second is attending

to feelings, both positive and negative, and understanding how feelings influence response to the situation and subsequent actions. Attending to feelings related to an experience is critical to learning from it successfully. The third step is re-evaluating the experience. Often individuals skip steps 1 and 2 and hence operate at step 3 on false assumptions. Step 3 includes relating new data, integrating it, validating it, and finally making it one's own. Boud et al., (1985) stress that the steps of reflection can be taught, and that reflecting on one's own can often be ineffective; a knowledgeable facilitator is invaluable.

Transformative learning occurs when one cannot easily fit a new experience into their existing knowledge, views, or perspectives (Mezirow, 2000). Such a situation stimulates reflection. Critical reflection is a cognitive process by which individuals question existing knowledge and importantly, underlying beliefs and assumptions, including those related to power distribution, and strive to make sense of anew experience. Frequently this process elicits emotional responses. It is the re-examining of long-held beliefs and values that leads to transformative learning.

Social Theory of Learning

The focus of IPE reframed by Social Practice theory is practice (the workplace) and includes the development of tacit and personal knowledge as well as propositional knowledge for interprofessional practice. These three interdependent concepts form a region of interprofessional knowledge: knowledge of interprofessional practice. Learning model for this new epistemology for IPE (adapted from Wenger's social theory of learning). It takes the form of a conceptual framework for an integrated IPE curriculum thus it is a collaborative tool for use by educators. It could also run in parallel to and be integrated with the profession-specific curricula, which each occupational group will still require. The proposed learning framework recognises that independent attributes of interprofessional knowledge, skills and attitudes are integrated with, and embedded within, practice. Subsequently, all elements of the model need to be addressed in order to achieve a transformation to interprofessional practice.

The focus of the model is learning about health and social care. The surrounding components are the interconnected elements that are required to enable individuals to gain both an interprofessional identity as a health care professional and a professional identity as, for example, a

doctor, nurse or therapist. These components require social participation in communities of practice and use dialectical and dialogues learning strategies. The four components are:

Meaning: a way of talking about students' (changing) abilities, individually and collectively, to experience meaningful learning, in this example, in the field of rehabilitation. Through work/learning activities, discussions and using each other's language the interprofessional as well as the profession-specific experiences become meaningful.

Practice: a way of talking in both the practice and academic contexts about interprofessional practices and the mutual engagement of the students and other team members demanded by their roles, responsibilities and tasks.

Community: a way of talking about the social configurations of the team and, through legitimate peripheral participation, gaining competence as an individual member of the interprofessional team.

Identity: a way of talking about professional identities and becoming interprofessionally socialised as well as acquiring 'professional personhood' (Wenger 1998, p.5)

Today in health and social care it is common to combine performance examinations with written examinations. Miller has drawn attention to the need to assess what students know "Knows how", how this knowledge is applied, "Shows how", and the more challenging aspect of what students do with this learning when in practice "Does" (Miller, 1990).Learning activities should be designed to introduce learners to the competencies outcomes and objectives in such a way as to build on existing knowledge, create new knowledge, and facilitate movement through learning domains. These will be around cognitive/knowledge: thinking; psychomotor/skills; affective/attitude: feeling (Miller, 1990). The learning of interprofessional practice is moving into more competence and capability base where students have to demonstrate their knowledge, abilities, skills, relevant professional behavior and attitudes.

What are the Interprofessional Competences

Learning outcomes closely linked to the competences that students should obtain at the end of their IPE. These are identified as: working in a team, roles and responsibilities of other professionals, communication

skills, learning reflective and critical thinking, the patient safety, problem solving skills and ethical dilemmas, awareness of cultural differences, professional behaviour and attitudes. The learning activities associated with IPE curriculum will need to be integrated within the students' uni-professional (singular profession) curricula which can be established by each faculty/ department. There are four main competencies that are identified by international IPE group (WHO, 2010). The first domain is values/ethics for interprofessional practice. Interprofessional values and related to professional ethics that are part of crafting a professional identity. These values and ethics are patient centered with a community/population orientation, grounded in a sense of shared purpose to support the common good in health care, and reflect a shared commitment to creating safer, more efficient, and more effective systems of care. The second domain is about students to be interprofessional and develop an understanding of how other professional roles and responsibilities complement each other in patient-centered and community/population focused care. The third domain in interprofessional competency aspires students to develop basic communication, information sharing and gathering skills (for example interview skills, explaining complex issues) which are common areas for health and social professions education. Using professional jargon creates a barrier to effective interprofessional care. Presenting information that other team members and patients/families can understand contributes to safe and effective interprofessional care. Furthermore, considerable literature related to safe care now focuses on overcoming such communication patterns by placing responsibility on all team members to speak up in a respectful way when they have concerns about the quality or safety of care. This is linked to ownership and accountability of the future professionals that they put the service users in the centre of service design, service provision and service delivery. The fourth domain includes teams and team work. These are: team interaction; communication; service learning; information literacy; quality improvement; understanding diversity in society as a team; the impact of culture, ethnicity and religion on communication and the provision of services (Canadian Interprofesional Health Collaborative (CIHC) (2010). Within four domains there are cross sections where interprofessional collaboration covers areas such as providing clear and concise information to patients and their families, establishing relationships and networks, influencing and negotiating with relevant professionals, and gathering and processing information.

The competency framework linked to interprofessional learning should adjust itself as we involve patients' feedback and their expertise within the development process for the teamwork and ethical practice. All IPE learning events contain some involvement from patients and real case scenarios to prepare competent students for the reality.

Discussion and Recommendations

IPE has been encouraged throughout the world as it offers the value of interactive learning between health and social care students. As a first step, commonly agreed interprofessional competencies should be agreed across the teaching institutions for health and social care in Turkey. There are sufficient expertise, curriculum developers and literature available in health and social education in Turkey to implement such an innovative curriculum where the students can learn what the collaborative and partnership work would involve when they qualify. Providing common modules on issues such as communication, presentation, team working skills are reasonably manageable, but supporting the more essential changes is a significant challenge in terms of involving major curriculum redesign and possibly an renovation of existing programmes. In addition, moving from a traditional way of teaching to more interactive and reflective learning needed. Therefore, a strong cultural shift required which internally consistent and is widely shared and makes it clear what it expects and how it wishes students and educators to behave and show mutual respects and understanding in order to set IPE in Turkey. It is important to acknowledge that IPE is a growing phenomenon and the Universities in Turkey cannot afford to stay behind this innovative way of educating health and social care students in the modernising education. IPE has become synonymous with modernisation helping to breakdown traditional ways of teaching and ultimately modernising and empowering the future workforce to work more effectively. Teaching students about team working is the starting point for the IPE. This could be done on the selected health and social science faculties where this new way of teaching can be tested out on a smaller scale, for example, case analysis of patients with psychiatric problems can be assessed from the perspective of a multi-disciplinary team. The real challenge will be to see how interprofessional learning can be securely embedded in education programmes that students will continue to reflect and learn new concepts even after their graduation.

There is a role for the Turkish Higher Education that needs implementing IPE as a collaboration theme within an educational policy and investment for more joined up working as Denmark, Canada, Japan and Scandinavian countries have done. The higher education of European Union is planned to formulate a competitive and educated society which takes its energy from the education at Universities. "Bologna Process" higher education programs have been started to be recognized and curriculums were modernized in Turkey. Turkish Higher Education officially signed up for the Bologna process in 2001. The process aims to develop the skills and competencies of students' knowledge with student-centered educational approaches and moving away from the traditional methods of teaching. Besides a variety of knowledge that students need to learn, Bologna process drives students' skills and ability further so that they can demonstrate their learning (knowledge, skills, attitudes, professional behavior) at work when they qualify. Within the process, the innovative ways of teaching should be integrated with new ways of assessing where students should learn independently and accept their responsibility for learning, communication and social competence skills. This approach needs to focus on teaching cognitive (logical, intuitive and creative thinking) and practical (manual skills, methods, materials, tools to use) skills. In IPE, teaching of skills is different from teaching of the information in methods and practice. It is important to emphasize that in addition teaching cognitive and practical skills, students need to interact with other students to develop their organizational skills, preparing joint projects, developing professionalism, coping with mental, emotional aspects of life. Therefore the universities should be developing an innovative assessment of teaching and coaching skills where students will enhance their competences rather than purely receive knowledge from tutors. Universities currently provide intensive programmes that enable student to gain in knowledge; however, teaching students how to be self-learners so that they can gain skills and competencies will be better option in the longer run.

This paper suggests that educators need to begin by raising awareness in IPE and then development of small projects build upon European alliances (such as EIPEN and CAIPE) of learning from the research and development of IPE in Europe for the past two decades. IPE can barrow many learning theories and method from the educationists to enhance the collaborative learning in team settings. Learning is not a discrete activity separate from work and practice, it is integral to IPE and collaborative practice for life long learning. Generally speaking, this means a new way of thinking for educators. This will include recognition of a new type of knowledge and of a new format for learning opportunities which are not based on the traditional approaches. By introducing more innovative team teaching methods will equip students to tackle the future challenges as a team rather than as individual professionals in the changing demands of health and social care needs.

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