**Interprofessional Learning Interventions: Championing a lost cause?**

Reflecting on this editorial, I think I am possibly making myself redundant as the associate professor for interprofessional learning. However, as a clinician and an academic I have a duty of care to truthful present evidence, eradicate and change practice that is based on personal values and preferences. Most papers written about interprofessional learning (IPE) and practice can be traced to researchers who have a personal or professional bias to promote IPE e.g. are employed to teach interprofessional learning and or to promote it within their own professional fields.

As a champion of IPE, 2017 was a challenging year in which I had to convince nursing and allied health professional’s academics to sign up to the principles of collaborative learning and teaching. A systematic review exploring students’ experiences of IPE found tensions between student groups were exacerbated by academic attitudes and those conversations created hierarchies in relation to a student’s ‘pecking order’ within the health care team/ (Butcher et al 2017).

Whilst IPE is supported in theory, it is rarely implemented in professional practice and this could be why it is difficult to implement within academic institutions. The literature is thwart with challenges and successes with new evidence emerging from countries just adopting IPE e.g. *Impact of the first interprofessional education programme in Spain* (González-Pascual et al 2017). The question for me, is why adopt an intervention that may itself be associated with aggravating rather than encouraging interprofessional collaboration? There appears to be a blanket assumption that inter-professional teams are good for all types of patients yet the evidence to support these claims is remarkably slim. In some instances, the language is puzzling. For example, Reeves (2016: p 656) after reviewing the evidence on the effects IPE writes ‘*There is more limited, but growing, evidence related to changes in behaviour, organizational practice, and benefits to patients/clients’*.

Most health care professions now have elements of IPE within their pre-registration curricula and this is most prevalent in nursing (Herath et al 2017). But delivering this IPE is challenging. Why is this? Does this reflect the reality of clinical practice? Most health care professionals understand the importance of teamwork in health and social care but effective partnership between health and social care remains elusive? A review of serious case reviews involving children found that most failings were due to poor inter-professional communication, inter-professional disagreement, inter-professional conflict, power differences in teams, documentation, not speaking and or sharing information and poor or inadequate interagency communication (Social Care Institute for Excellence 2016). A systematic review examining midwives and nurses’ collaborative experience found negative experiences might be influenced by distrust, unclear roles, or a lack of professionalism or consideration (Macdonald et al 2015). Inter-professional working in both the clinical and academic settings requires competence, commitment and the desire and will to cooperate. In addition, the success of such teamwork is dependent on individual professional’s skills and a detailed understanding of the different health and social care agencies as well as a willingness to remove protected boundaries and roles.

The rhetoric supporting IPE is that it can both fix and prevent human, system and organisational failures. In reality, this is not the case. There is no magic pill or instant solution to improve interprofessional collaboration. To understand the problem, it is essential to examine interventions used to promote co-operation between different professionals. IPE strategies are often viewed as the ‘medication’ needed to achieve an integrated workforce. IPE concepts appear to be based on sound philosophy which in ingrained within the culture of the professions rather than actual evidence. Does IPE influence outcomes in professional practice? Who benefits from IPE? There is an assumption that the beneficiaries of IPE are service users, although Herath et al (2017) suggest that it is actually academics

There is an absence of quality research exploring the benefits of IPE. A systematic review investigating the state of IPE in nursing concluded it was not possible to identify the best methodology for implementing it, particularly in relation to simulation and teaching methodologies (Rutherford-Hemming and Lioce 2018). Another systematic review to evaluate whether IPE interventions increased practitioners understanding of dementia concluded there was poor quality evidence to make any such associations (Jackson et al 2016). In addition, there is an absence of research on economic benefit as well as the effect on service users. The Society for Cost and Value in Health Professions Education (Prato Statement) emphasises the need for an economic analysis of IPE to ensure it delivers maximum value for a given spend (Maloney et al 2017).

Given the issues outlined above, is there an urgent need for a rethink IPE? In curricula where numerous subjects are competing for time, what should the IPE content look like? Evidence from students suggests the most memorable IPE experiences occur in clinical placement settings but that there is a perception that these learning opportunities are often missed, as they are not structured (Gilligan 2014). A systematic review of health care professionals’ experience of teamwork education recommended that IPE should be both practical and be relevant to practise to foster positive debriefing and reflection. Thus, there is a need to move IPE away from the classroom into clinical practice.

There is also a need to modernise IPE in relation to service user involvement. The only way to tackle better team working is to ensure organisational practitioners and managers focus on the service user. However, the service user voice is neglected within the IPE literature. There is a need to refocus the training of professionals to become more flexible and fluid (i.e. to accept role blurring as part of professional practise to enhance patient care). The care provided should focus on the needs of the service user rather than professional needs. In summary, the editorial has highlighted that despite limited evidence to support IPE we continue with a concept that remains unproven. There is a need for further research to evidence clearly, whether IPE does enhance patient outcomes and a need to rethink how it is delivered. Could service users lead IPE? In the meanwhile, let us continue the debate.

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