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THE MAKING OF THE INTERPROFESSIONAL ARENA IN THE UNITED KINGDOM: A SOCIAL AND POLITICAL HISTORY

ABSTRACT

This article offers a critical sociological rendering of the making of the interprofessional arena in the United Kingdom. It offers an interpretation of the conditions that led to the formation, expansion and development of the interprofessional arena using a social worlds/arenas lens of secondary data. I propose that the making of the interprofessional arena has been achieved in three historiographical phases. First, the "recognition of the professionalisation conundrum" that led to the intuitive assumption that interprofessional education (IPE) could lead to improved collaboration in practice and improved outcomes. Second, the "legitimisation" of the interprofessional assumption through the development of networks, building consensus, nurturing an evidence base and negotiating with policymakers. Third, "Talking up and acting up" the interprofessional agenda by developing global communities of practice, pandering to a neoliberal agenda, disseminating exemplars of good practice and encouraging practical changes within diverse settings. Articulating these historical 'moments' may allow us insights into the conditions that have created the contemporary interprofessional arena and offer us ways of considering how present conditions may re-shape the discourses that constitute the interprofessional arena of the future.

INTRODUCTION

In historicising developments in interprofessional education (IPE) specifically, Hugh Barr and colleagues have constructed a detailed record of major historical milestones and themes in a succession of accessible and comprehensive publications (Barr, 2002; Barr, 2007; Barr, Helme & D'Avray, 2011). Fifty years on from the embryonic initiatives of the 1960s, bustling social and political discourses now colour the contemporary interprofessional arena in the United Kingdom (UK). In this article I aim to explore the conditions that have contributed to creating the interprofessional arena in the UK, representing its emergence and evolution as a sociological event. An emphasis on policy represents the reciprocal relationship between the making of the interprofessional arena and political developments in the UK that were occurring at the same time. By treating policy, published empirical work, expert commentaries and conference presentations as "data", a historiography of the interprofessional is presented.

A social worlds/arenas lens (e.g. Strauss, 1991; Clarke, 2005) informs my approach. The term "arena" implies both "territory" and "contest" – concepts well-suited to considering interprofessional matters. This paper serves to deliver what Park (1952) calls "the big picture" with the inevitable consequence that only some of what has happened is represented here. It also minimises the distinction between structures and processes, to focus on the collective construction and formation of "facts" and definitions. This assumes that structure and process are co-constitutive, following Foucault's (1991) emphasis that "regimes of practice" are sustained not by governing institutions or structures but by negotiated social interactions that create the taken-for granted social practices.

RECOGNISING THE PROFESSIONALISATION CONUNDRUM

Professionalisation seeded within medieval craft guilds manufactured the master-apprentice relationship; emphasised differences in definition based upon distinct knowledge and skills and claimed territories of autonomy. These early characteristics were, according to Barr (2007, p.11), reinforced over centuries to create guilds accentuated by "collective self-protectionism rather than the public good". Projects of defining the professions and their collective values were also the proclivity of early sociological work in the early to mid-twentieth century (e.g. Carr-Saunders & Wilson, 1933; Greenwood, 1957).

Through the mid to late twentieth century, sociological perspectives on the professions became more complex, moving beyond simplistic descriptive definitions to more comprehensive analyses of processes of professionalisation. Commentators recognised the power that professions held in terms of occupational and market control (Johnson, 1972; Larson, 1977; Freidson, 1994). Theorising the professions as powerful entities in public life, the rise of managerialism in health and social care, an uneasy alliance between the medical profession and the welfare state, the proliferation of specialisms amongst the health professions and changes in educational practices seeded the "conditions of possibility" (Foucault, 1975) from which the interprofessional arena might emerge.

Theorising professionalisation

Studies of processes of professionalisation emerged and proliferated through the latter part of the twentieth century. Evetts (1999) categorises these studies as historical – the formation and development of a professional group within a socio-temporal context; comparative – the differences between professionalisation of professional groups in different contexts; and conceptual – the development of descriptive and explanatory models of professionalization. Examples of professional socialisation were reported in the development of several care professions, as repertoires of behaviours and routines embedded through social learning (e.g. Becker, Geer, Hughes & Strauss., 1961; Dingwall, 1979; Melia, 1987;). The professionalisation process became conceptualised as a largely linear process regulated by ordered and sequential events.

Freidson's (1970a; 1988) concept of professional dominance emphasised a move towards power differentials. In Freidson's view the professional maintains control and authority over interactions. Others attempted to confirm professional dominance in empirical observations of interaction (Illich, 1976). Larson (1977) developed the notion of the "professional project", a social process whereby a privileged position is achieved through the assemblage and manipulation of organisational and cultural capital. The concepts of "jurisdictional competition" (Abbott, 1988) and "social/occupational/patriarchal closure" (Witz, 1992) exposing the strategies of negotiation, defence and monopoly that professions use to maintain their own boundaries and exclude others were also significant. These conceptual schemes shared a central condition of professional empowerment that promoted regulatory, economic and political autonomy.

Regulatory bargaining and the market share

Historical conditions facilitated the empowerment of the medical profession through bargaining with the state for regulatory and market control. There was resistance to regulation from those who saw it as an infringement of free individuals being able to sell their skills in a free market, however with regulation came the bargaining relationship with the state. Victorian middle-class society also demanded improved health care, and new techniques in medical and surgical interventions were required to deal with the "new" injuries and ailments of the working classes exposed to industrial health risks (Lupton, 2004).

In 1858, the Medical Registration Act was passed, amalgamating doctors under a single occupational banner, and represented increasing state involvement in health care where certain practising appointments were restricted to registrants only. At the same time, nursing was emerging as a recognised profession in hospital settings. Reformers such as Florence Nightingale instituted new forms of discipline, recruited educated women and established the first school of nursing in London. The role of the nurse became redefined as one of mediator between doctor and "patient", committed to, and expert in, care. State registration, initiated in 1919 with the publication of the Nurses Registration Act, followed the establishment of the College of Nursing in 1916. Regulation implied professional status; however nursing was not able to follow the linear trajectory of dominance that had privileged the medical profession. Its development under the medical umbrella veiled its distinctive body of knowledge and denied it a robust market status until much later. In comparison, later emergent professions – in therapy and social work for example – were able to

claim a distinct knowledge base and separate divisions of labour that allowed them a market share.

Modern developments in the welfare state

The creation of the National Health Service (NHS) in 1948 was not without resistance from the medical establishment who attempted to preserve the status of general practitioners as independent contractors and the control of working conditions by hospital consultants (Porter, 1997). The regulative bargain allowed the medical profession to retain hierarchical dominance in a command and control healthcare system, privileging medical definitions of clinical need. This regulative bargain came under scrutiny when the Conservative government of the 1980s instituted managerial and structural reform of health and social care services. The previously demarcated terrains of management and professions became blurred, and restructuring led to the redistribution of responsibilities that destabilised established roles and relationships and threatened the autonomy and dominance of the medical profession (Engel & Gursky, 2003).

Specialisation and diversification in health-related arenas allowed professions allied to health to proliferate and divisions of labour became confused and fragmented. Nursing, too, was gaining more ground as an established profession, its professional project driven by the illumination of its distinctive knowledge base, market monopoly and theoretical relevance. Metaphors of territories, boundaries (Fournier, 2000; Nancarrow & Borthwick, 2005) and tribes (Atkins, 1998) became commonplace in research and commentaries on the professions as processes of professionalisation

that were distinct to historical, social and cultural contexts became increasingly recognised.

Re-theorising professionalisation

Increasing regulation, through the reorganisation of specifically *regulatory* bodies for the protection of the public, and a growing political concern relating to accountability and quality combined with workforce development demands for interdependence, flexibility and substitution demonstrated the need for situated theorising. Dent and Whitehead (2002: 2) suggest that the "professional" has been reconfigured, shifting away from notions of competition, exclusivity and autonomy towards a "culture of performativity". Whilst there is limited conceptual description of contemporary changes in the health care workforce, some attempt has been made to address recent trends using the related concepts of proletarianisation – the Marxist concept that professions cannot maintain power and autonomy; de-professionalisation – the loss of cultural legitimacy through consumerist ideals of user empowerment and evidence-based practice (Fook, 2002); and post-professionalism – loss of exclusivity by relocating professions within corporate and institutional structures that emphasise performativity against political benchmarks causing some to prophesy "the end of the professions" (Dent & Whitehead, 2002; Broadbent, Dietrich & Roberts 1997).

The emergence of the "interprofessional"

Whilst the political developments of the twentieth century created conditions that placed the professions, to some extent, in crisis, a mutual set of conditions were under construction that enabled the emergence of the "interprofessional" as a discrete concept. With the rise of consumerism came increased public expectations

of the professions, answerable to the populations they served; populations that were more informed through instant access to health information and media coverage that highlighted deficiencies in service delivery.

Notional recommendations for improved team working and collaboration in health and social care services had been proposed as early as Dawson's (1920) influential report that proposed a single system of health care constituted by different disciplines services through primary and secondary health centres. This proposal, shelved at the time of publication, later became a cornerstone for the founding of the National Health Service (Webster, 1993). Subsequent government reports emphasised integration of services but not professional education (e.g. Younghusband, 1959; Cumberlege, 1986).

Over the same period, the way that health and social care professions were educated was also evolving. Amalgamation of professional training schools with universities and polytechnics brought professions allied to medicine, therapists, nurses and midwives into the higher education arena and furthered their professional projects from "semi-professions", to emergent professions with developing market and knowledge monopolies (Shipman & Shipman, 2006). The modularisation of learning materials may have fragmented curricula, but also facilitated heterogeneity of participants and lent itself to mixed groups of professions. Whilst traditionalist approaches to education through the transmission of knowledge from expert to novice still prevailed, progressive focus towards critical thinking and problem-solving were becoming increasingly fashionable.

LEGITIMISING THE "INTERPROFESSIONAL"

Problematising professional socialisation as *silo*isation, along with changes in the social, political and educational landscape, enabled the legitimising of interprofessional endeavours. The potential financial, organisational and health benefits of IPE and improved collaborative practices were, however, more speculated upon than grounded in empirical evidence. Since the 1980s, a concerted effort was made to draw together shared dedication and advance the interprofessional imperative. This took shape through networking of committed individuals and groups who sought to manufacture consensus, influence policy and practice, garner support and develop an evidence base for their assertions.

From diversity to commonality: building networks and definitions

Pioneering initiatives were diverse in their remit. Most notable amongst these, for its breadth of membership and subsequent longevity and influence, was CAIPE (the Centre for the Advancement of Interprofessional Education) launched in 1987. Under the neutral auspices of CAIPE, diverse committed individuals could congregate and share knowledge and, independent of government control, co-ordinate interprofessional activities, lobby regulators, and exchange experiences.

These activities were central to creating commonality amongst a diversity of professions and organisations. They created legitimacy for the interprofessional movement in the UK and furthered its influence in health and social policy. The World Health Organisation (1988) highlighted the importance it attributed to developing attitudes that fostered effective interprofessional working relations and teamwork. The extent to which this report influenced later developments in UK

government policy is tenuous, however many subsequent policy documents contained more explicit inflections towards collaboration at both an individual and organisational level to support the increasingly-recognised complex needs of an aging population (e.g. Department of Health, 1990; 2000).

Whilst developments in the interprofessional arena had concentrated upon enhancing mutual relations between professions, a government report by Schofield (1996) constructed through consultation with health service managers offered an alternative perspective. Recommendations for a multi-skilled generic workforce that allowed flexible substitution between professional groups with common core training were posited. As a management strategy this would facilitate efficiency and cost-effectiveness, and IPE was touted as a means of overcoming "inflexibility" and reforming the workforce. Pittiloe and Ross (1998) suggested that Schofield's recommendations were divisive and enforced resistance to the interprofessional agenda. By framing IPE as a means of engineering the professions to the mores of management, Schofield had threatened their integrity, re-conceptualising the interprofessional as a substitutive rather than collaborative phenomenon. From this re-conceptualisation sprouted the need for clarity of definition about which there could be consensus on what it means to be "interprofessional".

Ubiquity in definitions, confusion of terminology and the potential for misinterpretation led CAIPE (1997) to publish a definition of IPE as "occasions when two or more professions learn together with the object of cultivating collaborative practice", and subsequently (CAIPE, 2006): "occasions when two or more professions learn with, from and about each other to improve collaboration and the

quality of care". The definitions aim to be as inclusive as possible, but the additions of the dictum "with, from and about" and the outcome "improve…quality of care" delineate a clear process and outcome First, there is an implicit assumption that IPE leads to improved collaboration and, by extension, improved care. This makes it very difficult to argue against. Second, the addition of "with, from and about" intimates that certain educational processes that might have been labelled "interprofessional" do not fit the modified definition. These definitions, now widely adopted, are carefully crafted to retain the essence, autonomy and integrity of individual professions and repudiate Schofield's (1996) call for a generic health care workforce.

Garnering support

With the pioneers of the interprofessional movement coming from a range of professions it was only a matter of time before professional institutions became involved in interprofessional matters. Medicine, so often labelled as powerful and dominant, had taken a lead in some of the early interprofessional initiatives, especially in primary care. Barr (2009a) notes that the Royal College of General Practitioners developed a number of projects that advanced the interprofessional imperative amongst professions working in primary care (e.g. Billingham, Flynn & Weinstein, 1999). Professional and regulatory bodies, too, were beginning to become acquainted with the interprofessional movement. Located in positions that represented or regulated professions, these bodies negotiated a path between resistance and support vis-à-vis interprofessional matters. Collaboration was constructed as teamwork based on reciprocal regard for the integrity of professional roles for ensuring public safety.

The backing of interprofessional endeavours by regulatory, professional and political stakeholders would perhaps have been less intense had it not been for a series of incidents that highlighted the consequences of ineffective collaboration. Reports by Field-Fisher (1974), Ritchie, Dick and Lingham (1994); and Laming (2003; 2009) addressed high profile cases, each accentuating the disconnect between practitioners and agencies; recommending improvements be made in communication and collaboration. The consistency between each report's findings led to the accusation that previous reports had failed to sufficiently address policy and practice, and that professionals, organisations and agencies were incapable of learning from the lessons of the past (Parton, 2004).

Producing evidence

The logic of the intuitive assumption – that IPE leads to improved collaborative practice – had helped garner support from a variety of stakeholders and its relative absence noted when things went wrong embedded its presence further in government policy. The intuitive assumption, however, was not enough. Calls were made for more rigorous research to justify the assumption with sound evidence (Barr, 2000; Koppel, I., Barr, Reeves, Freeth & Hammick 2001). The pursuit of an evidence base became paramount, in the light of an expanding interprofessional movement that included diverse styles, foci, settings and participants. By now, notions of the "interprofessional" were being played out in both pre- and post-qualifying programmes and settings in formal and informal ways (Barr, 2002), but evidence of a causal relationship between IPE and collaborative practice was scarce and fragmented.

A number of evaluative reviews of IPE had been conducted (e.g. Barr, Hammick, Koppel & Reeves 1999; 2000), but securing the evidence of the "gold standard" systematic review was felt necessary to provide a convincing argument. A systematic review of the literature by Zwarenstein et al. (2001) used strict criteria of design in accordance with the Cochrane Collaboration to review evaluations of IPE between 1966 and 1999. Whilst many articles were found, none met the stringent inclusion criteria – though lack of evidence of a positive correlation was not necessarily evidence of a negative one. That many articles were found during the review suggested widespread activity in evaluating IPE. Their designs, whilst failing to satisfy the criteria for Cochrane review, provided sufficient analyses to illuminate the potential impacts of IPE. With less strict inclusion criteria Cooper, Carlisle, Gibbs and Watkins (2001) review of undergraduate IPE found changes in knowledge, skills, attitudes and beliefs in reported outcomes. Subsequent reviews using modified versions of Kirkpatrick's (1967) evaluative outcome criteria, were conducted by Freeth, Hammick, Koppel, Reeves and Barr (2002) and Barr, Koppell, Reeves, Hammick and Freeth (2005). Both offered more promise in the search for a causal correlation, but perhaps just as telling was the comparative work the review did in providing empirical evidence of the diversity of both approach and outcome amongst initiatives.

With evaluation of programmes being increasingly recognised as a necessity for providing evidence, numerous strategies were put forward to help those involved to undertake systematic evaluations. Guidance from Reeves, Koppel, Barr, Freeth and Hammick (2002), Freeth and Reeves (2004), and Freeth, Reeves, Koppel, Hammick

and Barr (2005) built upon Shaw's (1994) earlier foundations. Particular attention was given to combining the Kirkpatrick outcomes model with Biggs' (1993a) presage-process-product (3P) model as an accessible and comprehensive tool for dissecting the important components required for successful evaluation and planning of IPE. Later reviews by Barr et al. (2005) and Hammick, Freeth, Koppel, Reeves and Barr (2007) identified a wide range of positive outcomes associated with IPE. The review by Hammick et al. (2007: p.54) is particularly forceful in drawing links between process (evidence informed interprofessional education, practice and policy-making) and outcome (learner satisfaction, enhanced patient/client care and care service delivery) and recommends adoption of a common framework for evaluation as a means of enabling "more robust comparisons between individual studies". An updated review by Reeves, Perrier, Goldman, Freeth and Zwarenstein (2013) found 15 studies that met the Cochrane criteria. Whilst heterogeneity of design made meta-analysis impractical, a narrative discussion of the included studies marked the continuing emergence of an evidence base that accorded to the most exacting requirements of scientific rigour, whilst also adding to the expanding evidence from more inclusive reviews.

TALKING UP AND ACTING UP THE "COLLABORATIVE"

Elston (1991), when discussing the progressive principles of user empowerment and shared decision-making, so often lauded in policy, suggested that increased rhetoric was not necessarily a sign of changing practice. To avoid the same being said of IPE it became important for the positive influences of IPE to be collectively observed. The benefits needed to be seen and felt by policymakers, regulators, practitioners, educators, students, service users and the public at large. Whilst collaboration made

sense, personal stories of ineffectual care and public stories of avoidable tragedies suggested mismatches between policy and practice. Talking up and acting up the "collaborative" was needed, not to exaggerate claims of their potential, but to inform and demonstrate their requirement in contemporary health and social care.

Making the case

CAIPE took the lead: principles of IPE from which others could work were conceived and later refined (CAIPE, 1996; 2006) in line with the definition of IPE and the evolving evidence base. The principles called for "positive regard for difference, diversity and individuality". Refinements were made to take account of concepts becoming prevalent in political discourse such as "quality" and "user involvement", giving service users a more participatory role. The principles also possessed an egalitarian tone that emphasised mutual benefits for all stakeholders whilst respecting the integrity of each.

Meads (2003, p.133-4) detailed policy developments and organisational restructuring in health and social care and its reciprocal relationship with interprofessional issues. Specific emphasis was drawn to the neoliberal reforms of the New Labour government whose policies were prospective, "re-engineering both the structures and processes through which individual members of the professions undertake their professional roles". A political climate of modernisation characterised by progressive policy suited the requirements of the interprofessional movement, and opportunities were seized to influence policy. Finch (2000), however, noted the confusing lack of clarity from government regarding the objectives of IPE when analysing publications relating to the "new NHS" workforce. Meads, Ashcroft, Barr, Scoot and Wild (2005,

p.3) continued to “make the case” for interprofessional collaboration (literally in the title of their publication) embedded within policy, directing their work at “self-conscious beginners…in the early stages of their careers as health and social care professionals…managers and teachers”. This marked a clear progression in the promotion of the “collaborative”, encouraging those new to professional practice to gather a reflexive awareness of policy in their developing careers. It also situates collaboration as central to professional identity and development within complex organisational, political and social arenas.

The transition of IPE from impromptu and isolated initiatives in work-based settings to more structured, formal arrangements in higher education settings had made students of professional programmes the majority stakeholders. Whilst much research recognised that students considered collaboration important (e.g. Hind et al., 2003; Johnson, 2003; Baxter, 2004), few included students as partners in the development and leadership of interprofessional initiatives. CAIPE included a student member at Board level and, following Canada’s lead (Harris, Rosenfield & Hoffman, 2007), set about establishing a student network so that students could share experiences and have greater involvement in advancing the interprofessional agenda. A longer term aim was for students to become embedded partners in driving interprofessional policy and practice, as had been achieved with some success in Canada (Hoffman, Rosenfield, Gilbert & Oandasan, 2008).

The more active role of service users in interprofessional endeavours has been driven in part by the NHS policy agenda of patient and public involvement (e.g. Department of Health, 2004) and is evident in the principles of IPE published by

CAIPE. Biggs (1993b) suggests that user involvement can take two forms: the democratic approach, whereby service users' voices contribute to the on-going transformation of services; and the market approach, whereby service users are constructed as consumers given a choice of alternative services. Whilst evidence of both is apparent in the complex arenas represented by education and practice, it could be argued that government policy has favoured the latter, whilst educators have favoured the former. Attempts to integrate service user perspectives into the planning, design and implementation of IPE and collaborative practice has met with moderate success (e.g. Barnes, Carpenter & Bailey, 2000; Cooper and Spencer-Dawe, 2006; Sitzia, Cotterell & Richardson, 2006).

From commonality to diversity: re-contextualising collaboration

CAIPE's position as an organisation committed to interprofessional endeavours in the UK was mirrored by similar entities in other countries and regions. Each possessed nuances of emphasis in their approach, but were united in advancing a common cause in diverse contexts. The publication of the *Framework for Action on Interprofessional Education and Collaborative Practice* by the World Health Organisation (WHO, 2010) brought together many of the key representatives from international organisations dedicated to IPE and collaborative practice. It builds on the earlier foundations of previous reports (WHO, 1988; 2006) reviewing the progress made globally, establishing the evidence base, making recommendations and developing an operational plan and policy brief for ministerial implementation. International conference series, notably *All Together Better Health* and *Collaborating Across Borders* emphasise the continuing global effort to embed IPE. Priorities within the contemporary interprofessional arena have focused upon further re-

contextualising processes characterised by the emergence of communities dedicated to knowledge transfer (e.g. Thistlethwaite et al., 2013) and embedding theory to guide interprofessional activities (e.g. Hean et al., 2013).

CONCLUDING COMMENTS

This paper has represented the evolutionary changes that created the conditions for early pioneers to recognise the problematic 'siloisation' of the professions and experiment with the practicalities of IPE in response to local need in the UK. These initiatives, primarily work-based, isolated and small-scale (Barr, 2002; Barr and Ross, 2006), grew in number and shared a collective assumption that bringing professions together to learn together could enhance collaborative practice and potentially improve user outcomes. Consequentially, an embryonic movement dedicated to IPE in the United Kingdom began to emerge. Building networks and garnering support allowed this assumption to become legitimised. The implications of legitimising the "interprofessional" are two-fold; firstly, the case for interprofessional education could now be made. Backed up with evidence and a strategy for developing and sustaining production of further evidence, government policy could be influenced beyond rhetorical and intuitive assumptions. Secondly, as a distinct movement with diverse advocates united by a single and consensual vision, the "interprofessional" possessed the potential capacity to become embedded throughout education and practice, as a systemic rather than isolated phenomenon.

Today, the rhetoric of the interprofessional infuses *most* policy and its action underpins *some* practice, hinting at the potential for sustainability. The concentrated influence on policy, a strategic move to embed the "collaborative" in actions as well

as words, is increasingly evidenced through emergent policy that seeks to practice what it preaches (e.g. National Collaboration for Integrated Care and Support, 2013). Empirical evidence, whilst promising, also suggests that traditional difficulties of professional identity (Wackerhausen, 2009; Copnell, 2010), organisational bureaucracy and workforce resistance (Meads, 2007) remain.

A conceptual progression proposed by Barr (2009b) suggests a triphasic transition model that documents the evolutionary embedment of IPE and collaborative practice into national culture. Barr suggests that historical phases can be categorised as organic, strategic and systemic; with the organic phase characterised by local, practice-driven initiatives, the strategic phase characterised by the thrust of regional and national policy, and the systemic phase characterised by consistent multilevel policy with protected funding and consensus of principles, priorities and rationale. In the systemic phase, IPE and collaborative practice are evidence-based, have shared and agreed outcomes and are embedded as a cultural norm within the complexity and diversity of professional education and practice. The UK stands, perhaps, at the entry threshold of the systemic phase, representing the conditions of possibility for the interprofessional arena of the future. We do not live in an unconditional present, and the "interprofessional" is no longer written on a blank page. Our collective endeavours are under-written by a "history of the present" (Foucault, 1973; 1975) and our contemporary actions represent the conditions that will form the history of the future interprofessional arena.

Declaration of interest

The author reports no conflict of interest. The author is responsible for the writing and content of this paper.

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