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Qualifying for Teamwork in Health and Social Services

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Abstract

Teamwork has become increasingly important within health and social services, as the specialization and fragmentation the last decades have become obvious features of the services. One of the educational challenges is to prepare students for future teamwork. Since 1995 the curriculum of the various study programmes within health and social education in Norway has a common part, aiming at improving the quality of care, by developing collaborative skills and understanding of other professionals' characteristics and roles, as well as emphasizing the common ethical and scientific foundation for professional practice.

At Oslo University College the study programmes for health and social work professionals are organized within three different departments: the Faculty of Health Sciences with eight professional programmes,[1] the Faculty of Nursing with a programme of nursing and the Faculty of Business, Public Administration and Social Work with two programmes: Social Work and Child Care and Welfare. This organizational structure forms different conditions for study programmes aiming at developing skills for working together in the health and social services. At the Faculty of Health Sciences an inter-professional unit of 30 credits has been offered for the eight different study programmes, referring to WHO's slogan "Learning together to Work together for Health" (1988). For the two other faculties offering health and social work study programmes, similar contents are given in uni-professional study programmes.

This paper discusses the foundations, conditions and different ways of qualifying for the challenges of collaboration within health and social services. How can educational study programmes best prepare students for inter-professional collaboration? To what extent is inter-professional education needed? Referring to a text-analysis of the curriculum for 11 different study programmes of Bachelor Degrees within health and social work offered at Oslo University College, this paper discusses some central questions connected to developing collaborative competency.

Introduction

The expansion of health and social services offered in an increasing specialized sector, creates a need for coordination and cooperation between professionals. From the patient's or the user's perspective, dealing with a fragmented health service is a challenge when it comes to obtaining the help needed. Today inter-professional collaboration is considered as an essential feature of professional practice for effective health care. In Norway, this is even regulated by law: *"..If the patient's need is such, cooperation and interaction between professionals should happen"...* (Lov om helsepersonell, 2000, § 4) Promoting coordinated health services, teamwork, cooperation, collaboration and interaction, inter-professional approaches and shared learning has been brought into health education worldwide.

[1] The following Bachelor studies are the portfolio of educations at the Faculty of Health Sciences: Bachelors in Biomedical Laboratory Sciences, Dental Technology, Occupational Therapy, Pharmacy, Physiotherapy, Physiotherapy Mensendieck, Prosthetics and Orthotics, and Radiography.

Traditionally, health education consists of a variety of uni-professional studies, with hardly any connections and with strong boundaries around each one. Inter-professional education therefore, means a huge step in the direction of boundary crossing. In Norway, inter-professional education has, to some extent, been established on an advanced level. On the undergraduate level uni-professional education is still the main educational model.[2] A proposition of inter-professional approaches were introduced in the early 70's, but was resisted by the professions.[3]

This paper discusses some of the challenges linked to the construction of educational programmes with the intention of developing collaborative competences:

- The foundation for collaboration, cooperation and teamwork
- The antagonism between professionalism and inter-professionalism
- Curriculum development and the choice of different educational approaches.

With references to the contextual background for focusing on coordination and collaboration within health and social services, the underlying questions will be: If qualification for teamwork is going to be the outcome of professional training, how can the learning process prepare for this? To which extent is inter-professional education needed in order to qualify for future teamwork between different professionals?

The Empirical Basis and Methodological Approaches

The empirical basis for the discussion brought forward in this paper, is an analysis of the curriculum for health and social education. By a revision of the General Plans in 1995 the Norwegian Ministry of Education gave instructions for a common part, focusing on common goals, common contents and common learning approaches for health and social work study programmes at the college level. This part of the General Plans is here being analyzed and compared to the curriculum documents of some chosen health and social study programmes, with the study programmes at Oslo University College as an example.

Half of the altogether 22 original Bachelor Degree's study programmes at Oslo University College,[4] Norway's largest state university college**,** are aimed at professional trainings for health and social work. These study programmes are organized within three faculties, which in return represent different conditions for cooperation across their borders. The Faculty of Health Sciences has actively chosen an inter-professional module within the common curriculum, for their eight otherwise different uni-professional study programmes, while the Faculty of Nursing has only one Bachelor Degree course (nursing) and the Faculty of Business, Public Administration and Social Work two study programmes (social work and child care and welfare).

[2] This is in accordance with findings of studies abroad. (Harden, 1998)
[3] A Royal Commission – NOU 1972:23 - presented an organizational plan for health and social educations, proposing a common first year, before specialization into various professional study programmes. After intense arguing for the need of identity building before common learning programmes, the professions won the battle, and the Parliament refused most of the proposal.
[4] The total number is now increasing, as new Bachelor Degree studies are coming up.

The texts being used are health and educational policy documents, propositions from Royal Commissions as well as the actual General Plans and curriculum documents, including, to a certain extent, also teaching plans for each one of the study programmes. The texts chosen are discussed in view of modern educational theory.

From the common part of the General Plans this study points out main elements of the strategies for the development of future health services. With these main elements as a background each one of the curriculum is analyzed in order to describe different ways of carrying out the intentions of qualifying health and social workers for teamwork.

This paper presents a preliminary examination and description of how plans and curriculum express intentions of policy strategies, how these are being implemented or how innovations take place. A follow-up study should be a more in-depth investigation of elements of the implementation of a new direction or even a paradigm shift in health and social work educations.

Background

Collaboration as a Quality in Health and Social services

A Royal Commission on health and social systems in Norway described in 1986 lack of coordination of the sectors, lack of cooperation between professionals and also professionals' lack of basic communication skills and knowledge about the health and social system. (NOU 1986:4) The answer to this critical proposition was new directions for the organisation of the services, and national directives for the curriculum of the educations for health and social work. (St. meld. nr. 41 (1987-88). At the same time major reforms took place in higher education, which in turn also effected health and social work educations. (St. meld. nr. 40 (1990-91), NOU 2000: 14, St. meld. nr. 27 (2000-2001), Kyvik, 2002)

The features of the health and social services, as described in the eighties, are understandably an effect of the expansion and specialization within the field. The different professionals working in health and social services have, after World War II increased from app 30 to more than 100. Patients' narratives tell about situations where they are being sent from one specialist to another, or they, themselves, have to trace down where to seek appropriate help. Patients' stories of being failed by professionals have been too many. In some institutions also conflicts between different professional groups have become apparent, and known to the public as well.

This scene is not particular for Norway. Poor communication, conflicting power relations and role confusion are reported as characteristics of tendencies within health and social services in many countries. (Rawson, 1994) To meet and change these features health policies today emphasize partnership between professional groups, as well as with users. Coordination or integration of services is expressed as a goal, and inter-professional, inter-sectoral and professional-user collaboration are endeavoured. (Schmitt, 2001, Rolls, Davis and Coupland, 2002). In Norway the growth of community-based health services has utterly emphasized the need of coordination and collaboration. This new structure based on many different professional groups working together in new settings, has revealed the need for an integrated service, as much as integration between health and social services.

With the assumption that coordination and collaboration will result in improved health and social services, focus has been placed upon teamwork and shared learning within professional education.

Curriculum changes in the educations for health and social work

Norwegian Bachelor Degrees within health and social work are traditionally uni-professional, and focus has scarcely been explicitly placed upon preparations for cooperation in the health and social services. The first college to focus on inter-professional undergraduate education was Tromsø College, inspired by the University of Linkøping, Sweden. In 1991 an inter-professional module was created, in cooperation with the University of Tromsø. The professional study programmes included were medicine, pharmacy, psychology, nursing, physiotherapy, radiography and biomedical laboratory sciences. Over the years changes have been made, and some of the participating professions have withdrawn. The idealism of cooperation within educations, has been challenged.

On a national level, the curriculum of health and social work education have, over the last decades, more or less continually been through revisions. In the eighties new General Plans for each one of the professional trainings were revised as a part of integrating health and social work education into the system of higher education. Through this revision it became clear that parts of the curriculum for various health professional educations seemed similar.

After restructuring the governmental councils for health and social work education into one common council at the beginning of the nineties, a new revision of the General Plans took place. This new organizational structure made way for identifying and describing the common contents of the closely related professions. The common part for health and social work study programmes on the college level was proposed and finally decided in 1995. The topics included were

- scientific theory and research methods
- ethics,
- communication, collaboration and conflict-solving
- political science, health and social politics.

Through studying these themes, the outcome expected were developing collaborative skills, understanding the different health and social worker's roles, as well as strengthening a reflective way of dealing with own professional roles, especially to emphasize the user's perspective and understanding of the patients needs in health and social services.

This new part of the General Plans gives direction for common contents, signals the possibilities of inter-professional encounters for students, suggest teaching and learning approaches that will promote collaboration, but gives no explicit directions concerning inter-professional or shared learning. This means that each one of the college study programmes can choose their own way of interpreting the guidelines given, as well as educational design and learning approaches.

Theoretical pillars

A literature review of North American articles on interdisciplinary education and teamwork in health care concludes that there is a need for specialized health professionals, and a need for these professionals to collaborate. However, the literature shows that questions about when, who and how to educate for collaborative qualities are not yet answered. (Hall & Weaver, 2001).

Caldwell and Atwal (2003) points out that the problems of inter-professional healthcare practice in hospitals are characterized by fundamental ideological differences between health care professions, unequal power relations between the members of the hospital teams, complex and ineffective communication within and between health care professionals and role overlap and confusion.

In order for the inter-professional team to work effectively, Caldwell and Atwal (ibid.) suggest a need for addressing the structure as well as the process on different levels: development of an explicit and shared philosophy, ability to recognize and value the contribution that all bring to the team, and guidance in setting up, developing and sustaining inter-professional teams. Shared learning in the undergraduate curriculum is seen as one way of building the foundation for better teamwork.

Definitions

A variety of terms are being used, concerning "learning together to work together": 'multi-disciplinary', 'multi-professional', 'inter-disciplinary', 'inter-professional', 'trans-professional', or bare 'shared learning'. To make it short, Leathard (1994) suggests that 'multi' means "many", 'inter' means "between" and 'trans' means "across". Parcel and Bligh (1998) interprets, though, 'inter-professional education' as between two professional groups. Harden (1998) defines 'multi-professional education' as shared learning where each professional group looks at the themes from their own view, and 'inter-professional' when they look at the subject from the perspective of their own and other professions.

WHO has favoured the term 'multi-professional education', and defines this thus:

> *the process by which a group of students (or workers) from the health-related occupations with different educational backgrounds learn together during certain periods of their education, with interaction as an important goal, to collaborate in providing promotive, preventive, curative, rehabilitative and other health-related services.* *(WHO 1988)*

Leathard (1994:6) discusses the different terms being used, and clarifies the confusion between "disciplinary" and "professional" education in this way:

> *In academic parlance, multi-disciplinary work usually refers to the coming together and contribution of different academic disciplines. Meanwhile, multi-professional and inter-professional study programmes are often both used to express the coming together of a wide range of health and welfare professionals to further their studies in a shared context.*

Barr (1994) makes another distinction: that inter-professional work relies on interactive learning.

'Shared learning' might, though, mean that students are being taught together, not necessarily that this might be interactive learning processes. Harden (1998) mentions that some of the advantages of students learning alongside each other, can also be gained just by having teachers or staff from other professions.

Collaborative learning or learning to collaborate

The prevailing modern theories of teaching and learning focus on socio-cultural and social constructive perspectives. The principles of dialogue, as described by Bahktin and Vygotskij (Dysthe 2000, Lave and Wenger, 1991), emphasize that learning is not merely an individual activity, but is a social process: learning takes place in interplay between individuals and between individuals and the social context as well as with written texts.

These perspectives still focus on the learning process and the competence the learners are building up. The learning outcomes wanted might not necessarily be those of collaboration. In this way there might be a distinction between collaborative learning as a way of learning and the collaboration that might be the goal for a learning process. The link between these two is collaborative learning where collaborative skills are the explicit wanted outcome.

Collaborative or generic skills

Another distinction might be between the goals of developing collaboration or generic skills. Freeth and Reeves (2004: 43-44) describes the collaborative competences wanted for inter-professional health care as

- *Describing one's role and responsibilities to other professions*
- *Recognising and respecting the roles, responsibilities and competence of other professions*
- *Coping with uncertainty and ambiguity*
- *Facilitating inter-professional case conference and meetings*
- *Handling conflict with other professions*
- *Working with other professions to assess, plan and provide care*

These qualities might be of a general character, but are still related to different professional groups. The generic, or transferable skills, required for today's students, as described by Birenbaum (in Tait and Godfrey, 1999: 246), is of a similar character, but does not necessarily relate to different professions:

- *Cognitive competencies, such as problem solving, critical thinking, formulating questions, searching for relevant information, making informed judgements, efficient use of information, conducting observations, investigations inventing and creating new things, analysing data, presenting data communicatively, oral, written or self-evaluation;*
- *Meta-cognitive competencies, such as self-reflection or self-evaluation*
- *Social competencies, such as leading discussions and conversations, persuading, cooperating, working in groups;*
- *Affective dispositions; such as perseverance, internal motivation, initiative, responsibility, self-efficacy, independence, flexibility.*

These are qualities certainly needed for working in health and social services, but do not cover the cooperative and collaborative skills needed.

Learning approaches

Some teaching and learning approaches are more appropriate than others to promote collaborative skills. Learning to communicate and to relate to each other are skills that needs to be integrated in behaviours, attitudes as well as considerate actions, it is not a mere intellectual activity. Such relation skills has to be learnt in a real, living way, as realistic as possible. These skills cannot be learnt through reading and writing. Encounters between persons are needed. Barr (1994:105) emphasizes that inter-professional education should be of an interactive character:

> *Lumping students together across professions is one thing; enabling them to learn from and about each other is another. It relies on interactive learning across the professions.*

Small-group work, esp. with problem-solving tasks, is a well known learning approach to prepare for teamwork. The rationale for such learning concepts is an aim of developing collaboration skills. Special learning facilities, such as clinical skills laboratories have also been developed to offer experiences of a collaborative character. The question here is whether students from different professional studies actually are brought together, and what kind of tasks they are given.

The main differences between learning approaches might be to which extent collaboration actually and consciously is focused, and to which degree the instructional design favour individualism or competition. Lecture-oriented designs might not require students' cooperation, and individual assessment methods might not either.

Teamwork for quality of care

Teamwork has become a central feature within business and industry, based on the notion that working in teams improves the quality and productivity. Belbin (1998) quotes Toyota Motor Manufacturing Company, where it is believed that *"a well coordinated group can accomplish far more than the sum of individual efforts"* (p.94). "A well coordinated group", defined as a team, differs from a group as such. Belbin describes some of the crucial characteristics of teams as having a limited size (4-6 members), with a shared, rotating leadership, mutual knowledge and understanding, with different roles which are coordinated and with dynamic interaction. Team roles are essential, to contribute to the effectiveness of the team

Hjort (2001) describes the distinction between inter-disciplinary and teamwork. He points out that there might be teamwork that is not inter-disciplinary and vice versa.

WHO (1988:6) suggests teamwork as a mean of improving the quality of care. Teamwork is here defined as

> *Coordinated action, carried out by two or more individuals jointly, concurrently or sequentially. It implies commonly agreed goals; a clear awareness of, and respect for, others' roles and functions on the part of each member of the team: adequate human and material resources; supportive cooperative relationships and mutual trust; effective leadership; open, honest and sensitive communications; and provision for evaluation.*

Nevertheless, it has been pointed out that research has still not proved that collaboration makes a difference and really improves the quality of care. (Schmitt, 2001). However, this could also be a question of the quality of the collaboration or the teamwork.

Foundations for inter-professional education

One of the main theoretical foundations for inter-professional education seems to be related to the contact hypothesis. The arguments behind the expression 'learning together to work together' are based on theories from social psychology, namely the 'contact hypothesis'. (Hewstone and Brown, 1986) The main idea is that in order to improve the relation between competing or even hostile groups, contact needs to be made. Interaction can reduce tensions and prejudices between groups. Through contact and interaction individuals can discover similarities, both in attitudes and values. In this way negative beliefs can be neutralized.

Another main question is how stereotyped believes about other professional groups are being developed. Such views are considered a barrier for genuine collaboration, and have raised the debate on when and how to introduce inter-professional education for health workers. (Harden, 1998, Horder, 1996)

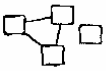
A study at Kingston University, UK, in 1996, showed that students arrive at the university with stereotyped views on each other, and that these views become exaggerated during a common foundation programme. This study also tells that student whose parents worked as health care professionals, held stronger stereotyped views than students from other family backgrounds. (Tunstall-Pedoe et al, 2003). The main question, or challenge, seems therefore not to be to avoid stereotypes to be developed, but rather how to break down stereotypes, and thereby to enable professionals to work effectively together.

From uni-professional to trans-professional education

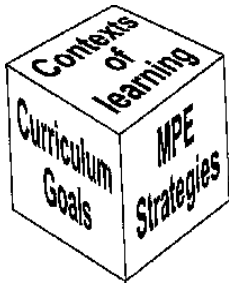
Harden (1998:405) describes 11 steps of multi-professional education[5] as a continuum with uni-professional education at one end, and trans-professional education at the other. Uni-professional education is discipline or subject-based, while trans-professional education is integrated or multi-disciplinary.

[5] WHO (World Health Organization) uses the term 'multi-professional education', but in most of the international literature of to-day the term 'inter-professional education' is more common. Although Harden, in his model, makes a distinction between those two, we lean on the term 'inter-professional'.

Table 2. The steps in multiprofessional education.

(1) Isolation		Each profession organizes its own teaching and is unaware of what is taught or learned in other professions
(2) Awareness		Teachers are aware of what is covered by other professions but no formal contact with regard to conceptualization, planning or implementation of teaching programme
(3) Consultation		Consultation about the teaching programmes between teachers from different professions
(4) Nesting		Aspects relating to the work of other professions are included in otherwise uniprofessional courses
(5) Temporal Co-ordination		Timetable arranged so that two or more professions can be scheduled for the same learning experience, e.g. a lecture but little formal interaction during the session
(6) Sharing		Two professions plan and implement joint teaching, with interaction between the professions in one part of a course. The remainder of the course has a uniprofessional focus
(7) Correlation		Sessions are scheduled in the programme for multiprofessional consideration of topics in an otherwise uniprofessional course
(8) Complimentary programme (*mixed programme*)		Multiprofessional teaching runs alongside uni-professional teaching
(9) Multiprofessional		The emphasis in the course is on multiprofessional education. Each profession looks at themes from the perspective of its own profession
(10) Interprofessional		Each profession looks at the subject from the perspective of its own and other professions
(11) Transprofessional		The multiprofessional education is based on the experience of the real world which provides a filter for the students' learning

The different stages illustrated here, represent different learning situations, where students from different professions are taught together or separately. Harden's point is that the model chosen will inter-relate with the curriculum goals and the contexts of learning. (Harden, 1998:403):



"The context of learning" will in Harden's terms include 1, the phase or stage of education in which multi-professional education takes place, 2, the category of students, 3, the setting for multi-professional education (within institutions, in community care, on campus), 4, the topics or the subject to be covered (ex. ethics, learning disability, palliative care etc), 5, the learning

approaches: small group work, lectures, distance learning or problem-based learning. Harden (1998: 403) defines the goals of multi-professional education as

1. *core competences common to the different professions. These may relate to knowledge, skills, attitudes and to a better understanding of more complex health problems*
2. *the development of a multi-skilled workforce able to take on other professions' work with a breakdown in professional boundaries and demarcations*
3. *the development of a familiarization and understanding of professional roles and an appreciation of healthcare from the perspective of different professions*
4. *skills relating to teamwork, collaboration and communication which will facilitate the different professions working together in the healthcare teams.*

A Norwegian Example

We will here draw some examples, from a Norwegian context, of how educational programmes are being planned and implemented in order to prepare students for future collaboration and teamwork within the health and social services.

National Guidelines for Health and Social Work Education

The revision of the General Plans for college education for health and social work in 1995, introducing a common component within the national guidelines, represented in many ways a paradigm shift. For degrees in child care and welfare work, occupational therapy, physiotherapy, radiography, social work and nursing, this component was given a volume of 30 ECTS credits, out of a total of 180 credits for the whole professional training. For degrees in audiography, biomedical laboratory sciences and prosthetics/orthotics the component was decided less, 15 credits.[6]

The new General Plans were developed through a long process characterized by discussions in the planning groups and with resistance from the professions' interests. The resistance towards common contents was strongest within the technical oriented professions, and arguments that this would "steel" valuable teaching time from more particular professional contents were expressed. For some of the social oriented professions (therapy, nursing and social work), the suggested common contents meant a reorganizing of curriculum that were already there.

The main intentions of the common component is expressed as

> *"to educate competent professionals who place human beings in the middle, and who can plan and organize actions in collaboration with clients and other service providers. The aim of the shared component is to assist students in acquiring the necessary knowledge and understanding within a mutual health service and to form a basis for a professional framework for the development of shared attitudes and some shared skills."*

[6] The study programmes for pharmacists and dental technicians at the Oslo University College is also of 15 credits.

The "shared attitudes" and "shared skills", mentioned, are probably those described in the Royal Commission of 1986 as "communicative and collaborative skills". The aims of the common component in the General Plans are now defined in concrete terms:

To educate professional health workers who

- *consider clients' needs as the starting point for their work, and are able to plan and organize actions in collaboration with people concerned*
- *are able to evaluate and justify their professional activities in relation to overlying professional and ethical perspectives, and see their professional roles in a critical light*
- *can take responsibility of giving feedback to professional and political authorities for the basis of help needed and for public actions to be taken*
- *can contribute to ensure that those who need help from the health and social services are receiving appropriate help*
- *know the role of the health and social services in society and of their own role in this organisation*
- *know other professional groups, and are able to evaluate their own and others' competence in actual collaboration*

The main intentions of the qualification needed, as expressed in the Royal Commission of 1986, have been modified. To some extent, this ten years process can be understood as a negotiation period, which has resulted in a common part in the general plan. However, the intentions of focusing on similarities and the mutual basis for working together seem to have been set aside, which makes it possible still to focus more on particularities than on similarities. Common contents are expressed, and learning approaches that promote collaborative competences are suggested, but is not instructed. It is possible to choose learning designs without students actually meeting students from other professional groups. This means that collaborative skills are understood as generic skills, which can be learnt in a uni-professional context and are transferable into inter-professional work situations.

This discrepancy between the original intentions and the guidelines given in the General Plans, gave way for interpretations of different educational approaches. To which extent the new guidelines, which in fact might mean new directions, or even a paradigm shift within the professional programmes, have been followed, is a question that needs investigation. One can question whether the new guidelines are actively used, or whether the General Plans are mere documents that have been stored away and ignored.

In the following we will take a look at the different ways the common parts of the national General Plans have been taken into the curriculum and teaching plans, at the health and social educations at the Oslo University College.

The Common Curriculum – as carried out at Oslo University College

If we consider learning to collaborate, or developing teamwork skills, as one of the main intentions of the new guidelines for health and social educations, the organizational structure offers different conditions for different professional study programmes at the Oslo University College. In fact, the organization of three different faculties for educations for health and social work within the college forms some of the conditions:

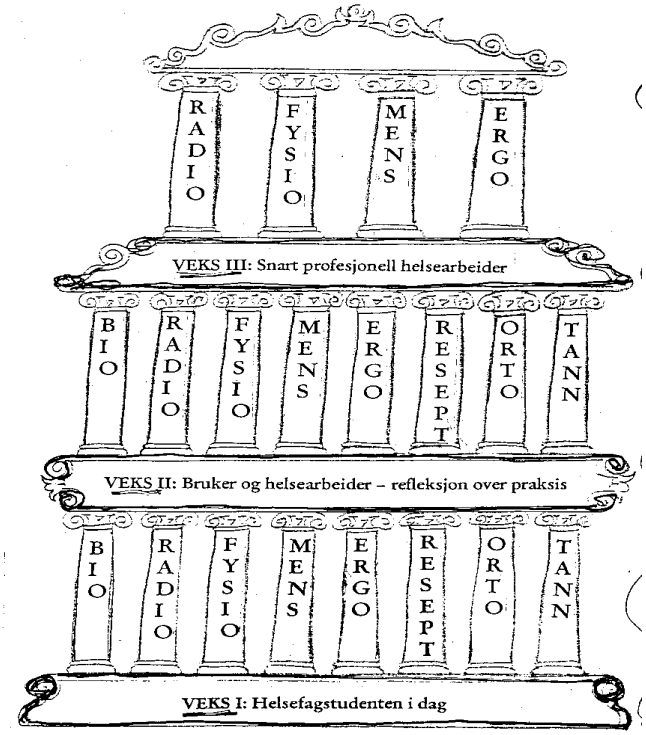
- eight different study programmes for health professionals are organised within the Faculty of Health Sciences, with a total of app 1100 students
- the nursing course is taught in a separate faculty, with app 1200 students.
- the social work and child care and welfare programmes are organized within one faculty, with a total of app 800 students (???)

If bringing students from different professional programmes together, to learn about similarities and differences and to experience working together, is essential to prepare for future teamwork, the organisational college structure already gives some restrictions. To meet the intentions of learning to collaborate for students across the faculty borders, the established patterns of teaching traditions will be challenged. Another, more practical complication, would be the logistics when organizing groups of a great number of students.

In the following we will describe how each one of these faculties has chosen to meet the challenges of the common contents of the General Plans.

Study programmes within Health Sciences

At the Faculty of Health Sciences the common component of the General Plans is offered as an inter-professional module, as a shared learning programme for all eight professional study programmes. This module, named VEKS,[7] is organised in three parts, one for each year. The first part is common for all eight programmes, and is an introductory module. The second part, in the second year, is also common for all eight programmes, and focus is now on collaboration in the practice field, and reflective practice and a user's perspective. The third part, in the third year, is only for the therapeutic programmes and for radiography,[8] those with 30 credits module. The organisation of the three parts of this common module spread over three years, are illustrated in this way:



(Bjørke & Haavie, 2004)

[7] The name is put together by the initials of the main elements of the contents, see page 4
[8] These study programmes all have a 30 credits common contents

The design of the teaching programmes with a common module interwoven with the particular programmes, would in Harden's terms be that of a 'complementary programme': "*multi-professional teaching runs alongside uni-professional teaching*" (see page 5).

The teaching and learning approaches chosen are such as small group work within a problem- and project based learning. Lectures are given for introductions and overviews, and self studies and investigating learning approaches are central. With small group work and with the intentions of common problem solving, the students are learning collaboration through experience. In the introductory phase focus is laid upon group forming, as a fundament for future cooperation within the group. Through tasks given the students are exploring the work field of different professions, and thereby learning about each other's future work fields. Communication skills are being learnt as part of the group process, as well as through some of the themes of the cases the group deals with in their problem-based learning approach. As a conclusion of this first module, the groups do a small project together, which results in a written paper being presented for and being given feedback of a peer group. In part two and three group-projects are being used as the main approach.

A report from the first three introductory years of VEKS, documents and evaluates the experiences. (Bjørke and Haavie, 2004) Even though a lot of resistance towards this common module is openly expressed, the main attitudes among teachers as well as students are positive. The teachers involved discover the value of bringing students from different study programmes together. Meeting colleagues from related professions is valued of great importance for each one of the professional study programmes and the teaching staff. A mutual challenge for teachers is that of turning their own teaching role into a tutor role. The problem is the division between teachers who have earned experiences as tutors, being "inside" VEKS, and those who have had less contact with this module, being "outside".

After finishing third year the students who earlier might have been reluctant towards the module, become more appreciative and discover the value of learning together with other student groups. The students question the rationale of the composition of the groups, where students from all the different study programmes might be mingled, whether they are partners in the future health services or not.

Course of Nursing

The course of nursing is, as mentioned, a uni-professional one, equal to the first stage of Harden's model, shown at page 5: *"Each profession organizes its own teaching, and is unaware of what is being taught and learnt in other professions."*

This means that collaboration and teamwork skills have to be taught in a way, other than meeting with students from cooperating professions, as the case is at the Faculty of Health Sciences. The curriculum and teaching plans shows that interaction is a central theme, especially focusing on interaction with patients and their families, while inter-professional collaboration is mentioned only as a goal. The teaching plan does not tell in what way inter-professional collaboration is going to be learnt.

The curriculum for the nursing course seems to be of an individualistic character, focusing on the student's own learning process and the student's future interaction with patients and their families. It is, though, said that the course is planned for students to develop their

collaborative ability and ability to communicate. How this is going to happen, is not described.

Study programmes for Social Work and Child Care and Welfare

The two social work study programmes, that of social work and that of child care and welfare, are organized within the Faculty of Business, Public Administration and Social Work. The General Plans for these two study programmes show that these are professions which are closely related. In addition to the 30 credits common curriculum for all health and social professions, these two study programmes have another 30 credits in common.

Even though one third of the study programmes are the same, there is no shared learning within these study programmes. In the curriculum it is emphasized that

> *even though the topics are much the same, this does not mean that it is identical neither that the teaching is coordinated. The amount of common topics, though, is a possible precondition for more extensive cooperation and coordination, when this is considered appropriate*.

The curriculum for the child care and welfare study programmes emphasizes that the learning approaches focus on group work to develop interaction skills and relation skills. The goals express the importance of knowledge about other professionals, ability to consider own and others' competences and understanding for the value of inter-professional and inter-sector cooperation.

In the same way the curriculum for the social work study programmes expresses the importance of developing respect for cooperating professional groups, ability to consider own and others competences and understanding of the value of inter-professional and inter-sectional collaboration. Training of collaborative skills is arranged through general discussions, projects and reports. As a central part of social workers' role consists of relating to clients and families, communication and relationship skills are important, as well as handling group processes. This is emphasized in the curriculum and teaching plans. Within the subject matter the question is raised: "what promotes and what restrains cooperation across professional and sector borders?" This is the only textual expression that points at inter-professional co-operation. Training of collaborative skills is central as a learning approach, but seems to be performed in a general manner, or within the profession.

Summarizing

The examples from Oslo University College show different ways of implementing the common subject matter given in the General Plans for health and social educations. The main differences are between the study programmes at the Faculty of Health Sciences, where a common inter-professional module is offered, and the nursing and social work study programmes, where there are no meeting points for students across professional borders.

Even though the inter-professional module at the Faculty of Health Sciences do not deliberately focus on teamwork as a chosen topic, the group work and the learning approaches indirectly gives the students important skills training for future teamwork. The study programmes for social work focus on teamwork as a professional approach, but do not bring students from different professional studies together. The course for nursing focus, as mentioned, mainly on interaction related to patients and their families.

Discussion

The literature points out that social work and nursing rank teamwork and relationship building as core competencies and values of the profession, while medicine places greater emphasis on the clinical diagnosis and treatment of the individual patient and on the physician as a team leader. (Calleson & Seifer, 2004) These findings are not obvious in the curriculum plans at the Oslo University College. The curriculum of nursing focuses on interaction with patients and not on teamwork between professionals. Social work focuses on teamwork, but health professions are not explicitly mentioned as partners in these teams. At the Faculty of Health Sciences collaboration and teamwork are taught indirectly through small group activities. Teamwork as a topic is not taught explicitly, and the groups are arranged with students from all study programmes, whether they are future partners or not.

If teamwork is one of the goals for health and social work education, the main educational challenge is to choose learning concepts to develop teamwork skills. Are collaboration general skills, which can be learnt in different contexts, both in uni-professional units, and in inter- or multi-professional units? Or, to which degree is the WHO slogan "learning together to work together" a necessity?

If WHO's slogan describes a learning concept needed for an optimum preparation for future teamwork, there is still a long way to go before the study programmes of health and social studies at Oslo University College are on the target. Bringing those student groups together that will actually be partners in teams in the future, will challenge the organizational structure, or, rather, need a deliberate planning of cooperation across faculty borders.

Common contents – as foundation for health and social work

The common contents defined, are a result of discussions and negotiations, led by the council for health and social work educations. The common part in the General Plans gives a contextual rationale for the ideological and to a certain extent, philosophical foundation for the educations involved. Coming to the actual chosen subject-matter, the question is to which extent this is contextualised. One of the objections against common contents, on an early stage, has been the risk of generalizing or theorizing too much. (Jensen, 1995) In problem-solving learning formats such questions arise when choosing the tasks or cases to be worked with. Which cases would be of a common interest for which professional groups?

Another question is that of the curriculum format. The contents described in the General Plans are close to discipline-orientation. This might lead to an instrumental way of organizing the curriculum. The challenge is that of discussing the themes in relation to health questions. Focus on health, definitions on health, perspectives on health, which is common for all professions in the health services, are to a certain degree pointed at in the general plan and are less visible in the curriculum for each study programmes.

The guidelines for teacher education in Norway also consist of a general plan of two parts: one general part and another part for all the subjects being taught in school. A comparison of the two common parts for the General Plans for teacher education and health and social work education, show more direction given for teacher education, also on an ideological and

philosophical level, than for health and social work education. Does this mean that the professions for health and social services still are more linked to their biological scientific foundation, as medicine also is, and that the cultural, social, humanistic sides of these professional approaches still are not fully developed? In nursing one is aware of the educational or counselling role that is part of nurses' functional role. In technical oriented professions this part of the role is less obvious.

For therapeutic and caring professions, the interactions between persons involved, certainly have an important role.

Conclusions

One of the aims of the General Plans for study programmes preparing for work within health and social services, is to qualify future professionals for co-operation, collaboration and teamwork. The General Plans represent guidelines for the study programmes given, which mainly focus on common contents, not so much on the training of collaborative skills.

The traditions of the professional study programmes are individualistic oriented, and more focus is put on interaction with patient, which certainly is important, than on collaboration between health and social professionals. The individual foci are reinforced by learning approaches as well as by assessment forms. Even though group work is becoming more essential part of the learning approaches, lectures and individual production still plays a dominant part. Portfolio is becoming a popular way of documenting excellences, but still, traditional exams with an individual focus are the main way of the assessment being used.

The intentions of the General Plans, concerning preparing future professionals for teamwork are, in this way, still a challenge, and not yet fulfilled.

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