Original Research

Development and Testing of a Scale to Assess Interprofessional Education (IPE) Facilitation Skills

Joan Sargeant, PhD; Tanya Hill, MSc; Lynn Breau, PhD

Introduction: *Interprofessional education (IPE) is interactive and constructivist in nature and requires specific facilitation skills to engage participants in a unique body of content, interpersonal interaction, and learning from each other. This article describes the development and testing of a scale, the Interprofessional Facilitation Scale (IPFS), to assess educators' skills in facilitating IPE.*

Methods: *Following participation in an Interprofessional Facilitator Development Program, facilitators provided interprofessional workshops for health professionals caring for patients with cancer. Workshop participants (311 community health professionals) assessed IPE facilitation skills with the use of the IPFS.*

Results: *Psychometric testing of the scale demonstrated high reliability and strong construct and content validity. Factor analysis produced a 2-factor solution that explained 62.1% of the scale variance. The factors "Encouraging IP interaction" and "Contextualizing IPE" were psychometrically rigorous and supported by the literature as being critical to facilitating successful IPE.*

Discussion: *The IPFS can be used in facilitator development as a concise guide to IPE facilitation skills and for assessment and further enhancement of IP facilitation competencies. Further study is required to assess the scale in diverse settings, with preservice learners, and over the longer term.*

Key Words: *interprofessional education, faculty development, interprofessional facilitation skills, scale construction, psychometrics, competency assessment*

Introduction

Interprofessional education (IPE) is interactive learning and occurs when "individuals from two or more health professions learn with, from and about each other to improve collaboration and the quality of care."[1] Although health professionals often learn *with* each other in structured activities such as clinical education rounds, IPE emphasizes learning *from* each other as members of different professions and *about* each other's roles and responsibilities with the goal of enhancing collaborative practice and patient care.[2] The focus on interaction and shared learning necessitates the use of specific skills in the facilitation of IPE.[3,4]

The process of learning from each other requires attention to the interpersonal process and how learners interact to accomplish their goals.[5] Conceptually, IPE is constructivist in nature.[6] Learning occurs through interactions with each other and learners construct and "make their own meaning."[7] For many educators, shifting from the more didactic teacher role to the more interactive facilitator of learning role requires effort and skill acquisition.[8] Particular skills for IPE facilitation include creating supportive learning environments, explicitly valuing IPE, showing appreciation for the roles of diverse health professionals, and promoting team formation and conflict resolution.[5,9–14] Faculty development can foster these skills.[15]

Several theoretical perspectives inform the facilitation of IPE in continuing education.[16] Two particularly helpful ones are social learning theory, specifically as represented through communities of practice,[17] and social identity and professionalism theories.[18,19] Communities of practice are groups of individuals who share expertise and passion for a joint goal; for example, an interprofessional team caring for patients with specific health needs. As they work together, they create experiential knowledge and learn together; learning is not separate from work.[17] Understanding how communities

Disclosures: The authors report none.

Dr. Sargeant: Director of Research, Continuing Medical Education, Dalhousie University; *Ms. Hill:* Research Associate, Continuing Medical Education, Dalhousie University; *Dr. Breau:* Pediatric Pain Research, IWK Health Centre.

Correspondence: Joan Sargeant, Continuing Medical Education, Dalhousie University, C106-5849 University Avenue, Halifax, Nova Scotia, B3H 4H7, Canada; e-mail: Joan.Sargeant@dal.ca.

of practice work and learn together contributes to the content and process of IPE and its facilitation in continuing education.

Social identity and professionalism theories inform the sensitivities and challenges that occur when individuals from diverse professions are expected to collaborate and learn from each other. Social identity arises from a sense of belonging to a particular group.[18] Professions are highly socialized groups with strong structures, social identities, and values.[19] Asking individuals to work interprofessionally can evoke a fear of losing one's professional identity. This fear and competing professional values can impede participation in IPE and collaborative practice, and leads to a need for skilled facilitation that enables learners to appreciate and respect others' professional identities and communicate effectively.

Through a Health Canada initiative, Interprofessional Education for Collaborative Patient-Centred Practice, the "Partners for Interprofessional Cancer Education" (PICE) project, led by Cancer Care Nova Scotia, implemented an extensive continuing education program in interprofessional cancer care education. The program built on a series of workshops for community health professionals (eg, chemotherapy, pain management) to enhance their interprofessional content and focus.[20] Facilitators prepared for the IPE sessions by participating in an interprofessional Facilitator Development Program based on identified competencies for IP facilitation.[21] A review of the literature revealed the absence of a scale to assess IPE facilitation skills. To evaluate facilitation skills and competencies, we developed the Interprofessional Facilitation Scale (IPFS). This article describes the development and psychometric testing of the IPFS.

Methods

We developed and validated the scale in 3 phases (see EXHIBIT 1): (1) development of the Interprofessional Facilitation Scale (IPFS); (2) participation in the Interprofessional Facilitator Development Program, provision of workshops, and IPFS administration; and (3) psychometric testing of the IPFS. The study was approved by the Dalhousie University Research Ethics Board.

Phase 1: Development of IPFS (EXHIBIT 2)

Interprofessional (IP) facilitation competencies had been identified and validated through an extensive process, including literature search and validity and feasibility testing through expert and health practitioner assessment.[21] The first overarching IP facilitation competency theme was "interprofessional facilitation," wherein "the facilitator supports the interaction between two or more health professionals to improve collaboration . . . for patient care."[21] This theme included 7 competencies (eg, "Demonstrates positive role modeling," "Demonstrates confidence and flexibility in using professional differences creatively within groups," "Possesses an understanding of interactive learning methods and exhibits confidence in their application"). The second theme was "Collaborative patient-centered practice," defined as "the facilitator role models and develops others' ability to constructively explore their differences and search for solutions to synergistically achieve patient and family centered goals." This theme included 9 competencies (eg, "Tolerates differences of and misunderstandings between other health professions," "Works with other health professionals to resolve conflict," "Describes one's roles and responsibilities and scope of practice clearly to other professionals/patients"). For a complete discussion of the identification of IP facilitation competencies, please see Banfield and Lackie (2009).[21]

Using these competencies, we compiled an initial scale of 27 facilitator activities that were observable and would most effectively promote interprofessional learning in a workshop setting. Local and national IPE experts reviewed the items for content validity, clarity, and feasibility. Redundant and general facilitation items were removed to generate a final scale of 18 items.

EXHIBIT 1. Three Phases of IPFS Development and Testing

Phase 1. Identify competencies, develop IPFS items
Phase 2. Facilitator development, provision of workshops, IPFS administration
Phase 3. Psychometric analysis

Phase 2: Facilitator Development, Provision of Workshops, IPFS Administration (EXHIBIT 3)

Health professionals skilled in cancer care volunteered as workshop facilitators. A total of 34 volunteer facilitators, including nurses, physicians, radiation oncologists, radiation therapists, social workers, pharmacists, psychiatrists, health policy analysts, and First Nations patient interpreters, participated in a 5-day, interactive, competency-based interprofessional Facilitator Development Program. Not all interprofessional facilitators were able to participate in the Interprofessional Facilitator Development Program, because of facilitator and project constraints. Accordingly, workshops were provided by teams of 2–4 facilitators in which 50% or more of the facilitators had participated in the facilitator development program. Facilitators not participating in the development program received instruc-

EXHIBIT 2. Phase 1: Development of the IPFS

Identify IP facilitation competencies using literature search, content expert, and HP input[21]
Content experts review items
Revise to 18-item IPFS

DOI: 10.1002/chp

EXHIBIT 3. Phase 2: Facilitator Development, Provision of Workshops, IPFS Administration

Thirty-four HPs complete a 5-day IPE facilitator development workshop
Trained IPE facilitators provide 24 workshops to 437 HP learners
Three hundred eleven learners assessed IPE facilitators using the IPFS
Trained observer attends 12 workshops to validate IPFS items

tional materials in facilitating IPE and mentoring from the Cancer Care Nova Scotia education coordinators.

From September 2007 to March 2008, participants in 24 community IPE workshops used the IPFS to assess the interprofessional facilitation skills of their facilitator teams. Participants rated facilitators' skill with the use of a 4-point Likert scale, where 1 = *poor*, 2 = *fair*, 3 = *good*, and 4 = *excellent*. Of note, we found no statistically significant difference between participant mean IPFS scores for completely trained versus partially trained facilitator teams, supporting the inclusion of participants' IPFS data from workshops facilitated by partially trained facilitator teams in our psychometric testing of the scale.

To assess content validity of scale items further, we prepared an independent educator experienced in IPE facilitation to observe the workshops, use the IPFS to rate the facilitator teams, and provide commentary on item usefulness and completeness. We pilot tested the IPFS in 2 workshops. The observer and 2 researchers experienced in IPE attended the workshops, used the IPFS to independently rate the facilitator team and record observations pertinent to each item, and then discussed ratings and observations. We found agreement in scores assigned and item interpretation.

Phase 3: Psychometric Testing (EXHIBIT 4)

We conducted an exploratory factor analysis and assessments of reliability and validity of the IPFS.[22] We chose exploratory factor analysis and not confirmatory factor analysis because this is the first study to test the psychometric properties of an interprofessional facilitation scale. To evaluate the structure of the scale and construct validity, a maximum-likelihood factor analysis with direct oblimin rotation was conducted on participant IPFS scores. Although oblimin rotation is not the standard rotation method, we feel that oblimin (ie, oblique) rotation presents a more accurate reflection of reality (ie, IP facilitation) by allowing factors to be correlated. This may facilitate the interpretation of the factor structure. Note, statistical criteria were selected a priori. Eigenvalues ≥ 1.0 were used to select factors and factor loadings ≥ .40 were used to interpret factors. Reliability of the scale and the factors was assessed with Cronbach's alpha and corrected item–total correlations were used to assess the contribution of each item. To establish scale validity further, IPE facilitators individually rated scale items for understandability and relevance, and the trained independent observer attended 12 workshops.

EXHIBIT 4. Phase 3: Psychometric Testing

Data cleaning (eg, missing data analysis)
Compute item correlations, scale reliability
Conduct factor analysis
Identify factors and interpret meaning
Determine scale reliability and validity

Results

Phase 3: Psychometric Testing

The IPFS was completed by 311 (71%) of 437 workshop participants. Participants represented over 15 different professions, the largest proportion being nurses (58%), pharmacists (18%), and physicians (13%).

Missing data analysis and data cleaning. Participant response rates for each item were high (RR = 94–100%), except for 3 items (items 16, 17, 18; TABLE 1) regarding facilitators' skill in managing conflict among health professionals (RR = 66–74%). In qualitative feedback, the observer also reported the absence of 1 or more of these items in all workshops attended (n = 12) and commented that the opportunity to use and assess conflict management skills arose infrequently in the workshops. Hence, these items were removed from subsequent analyses.

Psychometric testing. Overall mean item scores (see TABLE 1) indicated that participants' evaluation of educators' interprofessional facilitation skills was high.

The interitem correlations for the overall scale were good, ranging from .23 to .67 and the item–total correlations ranged from .56 to .75, indicating all items were relevant and none appeared redundant. The reliability analysis did not indicate the need to omit any items from the scale. The Kaiser–Meyer–Olkin statistic for the scale was excellent (KMO = .94) which supported the use of factor analysis to reduce scale items into factors.

The factor analysis produced a 2-factor solution that explained 62.1% of the scale variance. Item communalities (.51–.60) indicated item variances were well accounted for by the two factors. All items had factor loadings ≥ .40 and no items had factor loadings ≥ .40 on both factors.

Reliability. The internal consistency of the 15-item scale was excellent (Cronbach's alpha = .94). Internal consistency values for each factor were also excellent (see TABLE 1).

Validity. We recomputed interitem and item–total correlations for the factors to establish construct validity and found further support for the scale structure. For Factor 1, inter-

DOI: 10.1002/chp

TABLE 1. IPFS Rotated Factor Loadings, Mean Scores, and Standard Deviations (SDs) (α = .94) (N = 289)

Item	Factor		
	Encourage IP Interaction	Contextualize IPE	Mean (SD)
1. Described why interprofessional education is important.		−.67	3.55 (.52)
2. Explained how interprofessional collaboration can enhance patient-centered practice.		−.93	3.56 (.52)
3. Role-modeled positive interactions with other health professionals and how professionals can work together, for example, by working collaboratively with the cofacilitator.		−.43	3.57 (.55)
4. Created a learning environment in which the principles of interprofessional education were demonstrated or clearly explained (eg, did not focus on 1 provider group; acknowledged all professionals' contributions; acknowledged, respected, celebrated diversity in group).	.63		3.60 (.53)
5. Openly encouraged participants to learn from other health providers' views, opinions, and experiences (eg, asked questions that generated free exchange of ideas, openness, and sharing among all professions).	.70		3.59 (.57)
6. Used learning and facilitation methods that encouraged participants from different professions to learn with, from, and about each other (eg, icebreaker games, case studies, group discussions).	.74		3.54 (.58)
7. Invited other professions to comment and share their experiences/perspectives as questions or comments were made in the large group.	.79		3.53 (.60)
8. Used appropriate facilitator skills to keep discussion topics on track.	.63		3.54 (.53)
9. Acknowledged and respected others' experiences and perceptions.	.65		3.65 (.50)
10. Encouraged members of all professions to contribute to decisions and seek opinions from others in the group during case or patient discussions and decision-making activities.	.69		3.58 (.53)
11. Asked participants to share their professional opinions, perspectives, and values relative to patient care and collaborative practice.	.83		3.53 (.57)
12. Identified professional differences in a positive manner as participants offered their professional experiences and perceptions.	.78		3.55 (.53)
13. Asked health professionals to indicate their profession and discuss each other's roles and responsibilities in the delivery of patient care.	.79		3.50 (.59)
14. Listened to and acknowledged participants' ideas without judgment or criticism.	.73		3.69 (.47)
15. Asked questions to encourage participants to consider how they might use each others' professional skills, knowledge, and experiences.	.68		3.52 (.57)
16. Helped participants work through differences in a spirit of openness and collaboration when differing opinions arose (eg, led the discussion and ensured that all participants had an opportunity to express their views openly).[a]	—	—	3.52 (.56)
17. Used effective communication skills to clarify and resolve misunderstanding and conflict, if applicable.[a]	—	—	3.63 (.52)
18. Discussed issues related to hidden power structures, hierarchies, and stereotypes that may exist among different health professionals.[a]	—	—	3.37 (.74)
Eigenvalue	7.52	4.53	
Percent variance explained	54.3%	7.8%	
Cronbach's alpha	.94	.80	

[a]Scale: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *excellent*. Items 16–18 were removed from the analysis because of high rates of nonresponse.

item correlations ranged from .42 to .64 and item–total correlations ranged from .58 to .74. For Factor 2, interitem correlations ranged from .47 to .66 and item–total correlations ranged from .58 to .74. In addition, facilitators (n = 25) confirmed the content validity of the 15-item IPFS as 96% (23/25) facilitators agreed that all items were "understandable" and "relevant." Note, 1 facilitator did not feel that item 7, "Invited other professions to comment and share their experiences/perspectives as questions or comments were made in the large group," was relevant to his or her workshop. Another facilitator did not feel that item 11, "Asked participants to share their professional opinions, perspectives, and values relative to patient care and collaborative practice," was relevant in his or her workshop. However, other facilitators from the same workshops felt that these items were relevant, and workshop participants' response

DOI: 10.1002/chp

rates on these items also supported the inclusion of these items. Observer workshop ratings ($n = 12$) and comments confirmed that the IPE facilitation skills as presented in the 15-item IPFS were observable.

Description of Factors

Factor 1, labeled "Encourage IP Interaction," accounted for 54.3% of the variance. Nine of the 12 items addressed specific activities to encourage interaction among participants; 3 items represented skill in creating an environment amenable to workshop participants' interacting. The item with the highest factor loading was "asked participants to share their professional opinions, perspectives and values relative to patient care and collaborative practice," which had a loading of 0.83.

Factor 2, labeled "Contextualize IPE," accounted for an additional 7.8% of the variance. These 3 items addressed positioning IPE for learners; that is, ability to explain its benefits and demonstrate positive aspects. The item with the highest factor loading on this subscale was "explained how interprofessional collaboration can enhance patient-centered practice," which had a loading of 0.93.

Discussion and Conclusions

This paper described the development and testing of the Interprofessional Facilitation Scale in continuing education workshop settings. The IPFS was developed from a validated framework of competencies for interprofessional facilitation.[21] The scale demonstrated high internal consistency and 2 factors were identified, explaining 62% of the scale variance. The first factor, "Encouraging interprofessional interaction," confirms the centrality of interaction to successful IPE.[12–14] Fostering interaction among learners of different professions is essential for them to learn about their respective roles, experiences, responsibilities, and equally important, their opinions and values.[2–4,7,16,17] Essential to a willingness to learn from each other is the creation of a learning environment characterized by mutual respect and acknowledgment of the contributions of all.[23,24] Items depicting these facilitator activities comprise the first factor.

Factor 2, "Contextualizing IPE," was itself unexpected as a distinct factor. In reflecting upon its emergence, it may be indicative of the CME and professional context within which IPE is being implemented; that is, of IPE being perceived as an innovation in a relatively early stage of development toward becoming an established field. As for any innovation, sharing with participants its relevance and importance is a recognized strategy for developing engagement and acceptance. As the field matures, the need for "contextualizing IPE" may decrease, and further testing of IP facilitation competencies and related scales will be required to determine if this is the case.

Seen through the lens of social learning theory, these factors and the activities included within each enhance understanding of conditions that promote interprofessional (ie, social) learning from one another. From the perspective of social identity theory, they help us to understand approaches that may allay concerns regarding fear of loss of one's professional identity. Both are goals of IPE and specific facilitation skills and creating an environment of trust appear central to success.

Of interest, the 3 items on the original 18-item scale addressing the resolution of differing opinions, conflict, and hidden power structures received low rates of response from workshop participants. The observer comments were used to confirm this finding. From the literature, resolving differences and conflict resolution are recommended topics for inclusion in IPE curricula, as lack of understanding about the roles of others can lead to difficulty in resolving differences.[23–25] The fact that these were relatively short workshops (ie, 3 h) may have minimized the expression of strong differences among participants. We recommend testing these items in other settings and with groups that are learning together over a longer period of time.

Although construct validity of the scale and its 2 factors was confirmed through factor analysis, we confirmed content validity, clarity, and feasibility in several ways. The scale was developed from validated IP facilitation competencies and subsequently revised by IPE experts. Participant scores and feedback from IPE facilitators and the trained observer confirmed the relevance and practicality of the scale.

Limitations of this study include limiting testing to a population of health professionals caring for patients with cancer, and health professions not equally represented by workshop participants. Study with more balanced groups of health professionals will further inform the characteristics of the scale. Further validation testing (ie, concurrent validity) will also strengthen it. Additionally, it should be recognized that any scale ratings may be based on a range of impressions other than those contained in the scale. Testing of the IPFS revealed that the factor structure accounted for 62% of the variance. Therefore, 38% of scale variance remains unexplained.

We believe that the validation of the IPFS can contribute to the field of IPE through both practice and research. Practically, the IPFS is useful in the development of IPE facilitators for continuing education. It is a concise summary of skills required for IPE facilitation and sharing it with facilitators can inform their self-development as IPE facilitators. Workshop participants can evaluate educators' IPE facilitation skills with the use of the IPFS, and these results can be shared confidentially with facilitators to inform their strengths and potential areas for development further. Facilitators could use the scale as a self-assessment measure to assess their own IPE facilitation skills, and if they wished, compare their own ratings with those of participants. Activities such as these could be incorporated into IPE facilitator development programs, in a safe and confidential manner, to stimulate self-development and group discussion about developing skills as a facilitator.

DOI: 10.1002/chp

Lessons for Practice

- Interprofessional education requires educators having specific facilitation skills.
- The Interprofessional Facilitation Scale is a reliable and valid tool to assess IPE facilitation skills.
- Encouraging interprofessional interaction and describing the benefits of IPE are key components of effective IPE facilitation.
- The Interprofessional Facilitation Scale might prove helpful in faculty development and in self-assessment and self-directed learning preparation.

For IPE research, further testing of the scale with health professionals in diverse fields of patient care will better inform its use. Testing with facilitators of IPE in clinical settings and in programs extending over longer time periods is also warranted. Might different factors emerge, or might different items be of less importance? Through such initiatives the more general usefulness of the IPFS will be determined.

Acknowledgments

We acknowledge the Partners for Interprofessional Cancer Education and their contributions: Cancer Care Nova Scotia, Registered Nurses Professional Development Centre, Dalhousie University Continuing Medical Education, Dalhousie University College of Pharmacy–Division of Continuing Pharmacy Education, St. Francis Xavier University School of Nursing, District Health Authorities in Nova Scotia, Prince Edward Island Department of Health, Union of Nova Scotia Indians, Confederacy of Mainland Mi'kmaq, IWK Health Centre, and Nova Scotia Department of Seniors.

References

1. Centre for the Advancement of Interprofessional Education (CAIPE). http://www.caipe.org.uk/about-us/defining-ipe/. Accessed September 21, 2009.
2. Parsell G, Bligh J. The development of a questionnaire to assess the readiness of health care students for interprofessional learning (RIPLS). *Med Educ*. 1999;33(2):95–100.
3. Freeth D, Hammick M, Reeves S, Koppel I, Barr H. *Effective Interprofessional Education: Development, Delivery and Evaluation*. Oxford, England: Blackwell Publishing; 2005.
4. Kwan D, Barker KK, Austin Z, et al. Effectiveness of a faculty development program on interprofessional education: a randomized controlled trial. *J Interprof Care*. 2006;20(3):314–316.
5. Anderson ES, Cox D, Thorpe LN. Preparation of educators involved in interprofessional education. *J Interprof Care*. 2009;23(1):81–94.
6. Merriam SB, Caffarella RS, Baumgartner LM. *Learning in Adulthood: A Comprehensive Guide*. San Francisco, CA: Jossey-Bass; 2006.
7. Barr H. *Interprofessional Education Today, Yesterday and Tomorrow*. London, England: Centre for the Advancement of Interprofessional Education (CAIPE); 2002. Centre for Health Sciences and Practice, Occasional Paper No. 1.
8. Westberg J, Hilliard J. *Fostering Learning in Small Groups*. New York, NY: Springer; 1996.
9. Steinert Y. Learning together to teach together: interprofessional education and faculty development. *J Interprof Care*. 2005;19(1):60–75.
10. Crow J, Smith L. Using co-teaching as a means of facilitating interprofessional collaboration in health and social care. *J Interprof Care*. 2003;17(1):45–55.
11. Lindqvist SM, Reeves S. Facilitators' perceptions of delivering interprofessional education: a qualitative study. *Med Teach*. 2007;29(4):403–405.
12. Barker KK, Bosco C, Oandasan IF. Factors in implementing interprofessional education and collaborative practice initiatives: findings from key informant interviews. *J Interprof Care*. 2005;19(1):166–176.
13. Oandasan I, Reeves S. Key elements for interprofessional education. Part 1: the learner, the educator and the learning context. *J Interprof Care*. 2005;19(1):21–38.
14. Reeves S, Goldman J, Oandasan I. Key factors in planning and implementing interprofessional education in health care settings. *J Allied Health* 2007;36(4):231–235.
15. Silver IL, Leslie K. Faculty development for continuing interprofessional education and collaborative practice. *J Contin Educ Health Prof*. 2009;29(3):172–177.
16. Sargeant J. We're now in a different place: theories to aid understanding and implementation of interprofessional education. *J Contin Educ Health Prof*. 2009;29(3):178–184.
17. Wenger E, McDermott RA, Snyder W. *Cultivating Communities of Practice: A Guide to Managing Knowledge*. Boston, MA: Harvard Business School Press; 2002.
18. Tajfel H. *Human Groupings and Social Categories*. Cambridge, England: Cambridge University Press; 1981.
19. Freidson E. *Professionalism Reborn: Theory, Prophecy, and Policy*. Chicago, IL: University of Chicago Press; 1994.
20. Mann KV, Sargeant J, Hill T. Knowledge translation in interprofessional education: what difference does IPE make to practice? *Learn Health Soc Care*. 2009;8(3):154–164.
21. Banfield V, Lackie K. Performance-based competencies for culturally responsive interprofessional collaborative practice. *J Interprof Care*. 2009;23(6):611–620.
22. Streiner DL, Norman GR. *Health Measurement Scales: A Practical Guide to Their Development and Use*. 2nd ed. Oxford, England: Oxford University Press; 2001.
23. D'Amour D, Goulet L, Labadie J, Martin-Rodriguez L, Pineault R. A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Serv Res*. 2008;8(1):188.
24. Kearney AJ. Facilitating interprofessional education and practice. *Can Nurse*. 2008;104(3):22–26.
25. Curran V, Orchard C. *Interprofessional Education and Core Competencies: Literature Review*. (Canadian Interprofessional Health Collaborative, Health Canada) http://www.cihc.ca/files/publications/CIHC_IPE-LitReview_May07.pdf. Accessed September 21, 2009.

DOI: 10.1002/chp