Reducing barriers to interprofessional training: Promoting interprofessional cultural competence

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Abstract
The need to train health professionals who can work across disciplines is essential for effective, competent, and culturally sensitive health care delivery. By its very nature, the provision of health service requires communication and coordination between practitioners. However, preparation for interdisciplinary practice within the health care setting is rare. The authors argue that the primary reason students are not trained across disciplines is related to the diverse cultural structures that guide and moderate health education environments. It is further argued that this profession specific “cultural frame” must be addressed if there is any hope of having interprofessional education accepted as a valued and fully integrated dimension of our curriculum. Each health discipline possess its own professional culture that shapes the educational experience; determines curriculum content, core values, customs, dress, salience of symbols, the meaning, attribution, and etiology of symptoms; as well as defines what constitutes health, wellness and treatment success. Most importantly, professional culture defines the means for distributing power; determines how training should proceed within the clinical setting; and the level and nature of inter-profession communication, resolution of conflicts and management of relationships between team members and constituents. It might be said that one factor limiting interdisciplinary training is profession-centrism. If we are to achieve effective and fully integrated interdisciplinary education, we must decrease profession-centrism by crafting curriculum that promotes interprofessional cultural competence. The article explores how to promote interprofessional cultural competence within the health education setting.

Keywords: Barriers to interprofessional training, interprofessional cultural competence

Introduction
The notion of collaborative, interprofessional education and service provision is far from novel (Lavin et al., 2001). Baldwin (1993) notes that interprofessional teams were utilized as early as the 1960s where collaboration at the level of the community health center provided comprehensive care to underserved populations. As far back as the 1970s the World Health Organization (WHO) began promoting interprofessional education (IPE). Following their lead, some countries established organizations dedicated to IPE. For example, the Interdisciplinary Professional Education Collaborative (IPEC) was established in the United States. The United Kingdom developed the Center for Advancement of Professional Education (CAIPE), while a similar program known as the Center for Professional...
Education Advancement was organized in Australia. Since this time, practitioners, legislators, and policy makers have continued to emphasize the importance of interdisciplinary training and practice.

The need to train health professionals to work across disciplines is essential for effective, competent, and culturally sensitive health care delivery; however, the promotion of effective interdisciplinary practice within the health care setting is rare (Davidson & Waddell, 2005). This is particularly troubling since there is increasing evidence that interdisciplinary practice improves health outcomes (Institute of Medicine, 2001). In fact, this Institute of Medicine report supports the development of health care practice built upon collaboration and interdisciplinary practice. The promise and utility of interdisciplinary practice has been increasingly documented within a wide array of settings and populations including: community and academic partnerships (Bloomer, 1995), community-based education (Duerst, 1997), care of the elderly (Bevil et al., 1988; Sommers et al., 2000), obstetrics (Bryson et al., 1997), rehabilitation (Campbell et al., 1992), pediatrics (Ribby & Cox, 1997), substance abuse treatment (Marcus, 2000), teaching health care ethics (Browne et al., 1995), health education (Childers & Guyton, 1985), distance learning (Sweeney & Schuster, 2000), faculty development (Kirchhoff & Haase, 1995; Larson, 1995), diabetic control (Aubert et al., 1998), management of asthma (Delaronde, 2002), and others. In addition, interprofessional training reduces stereotypes associated with professional groups, while enhancing teamwork and clarifying roles within the helping relationship (Lefebvre et al., 2007; Cooper et al., 2001).

Despite the growing evidence and support within policy arenas, training programs remain reluctant to operationalize and institutionalize interprofessional education (IPE). Cooper et al. (2001) found that the professions often avoid interprofessional education because of cost, labor, lack of faculty support, and inter-school scheduling difficulties. In addition, not all health problems require an interdisciplinary team. For example, it makes little sense to mobilize a cadre of health professionals to assist a child who is having a tonsillectomy. Conversely, addressing problems such as teen pregnancy, childhood obesity, diabetes, asthma, drug abuse, domestic violence and other problems moderated by psychological and social variables demand consideration of interdisciplinary collaboration.

IPE has been criticized for its lack of methodological rigor and poorly developed outcome measures (Cooper et al., 2001). Problems include the limited number of studies, single site evaluations lacking comparison groups, omission of long term follow up, small numbers of participants, and neglect to document patient outcomes or costs of care (AACN, 1995, as cited in Brashers et al., 2001).

Barr’s (1999) systematic review of the international IPE evidence-based literature did not identify even one article that met the standards of the Cochrane Systematic Review system. Skeptical of any substantial increase in the number of reviews fitting the Cochrane criteria in the near future, the authors determined that an alternative systematic review could help in the evaluation of IPE. Cooper et al. (2001) support this position by suggesting “other types of evidence should be considered when evaluating the impact of IPE, including both quantitative and qualitative evaluations” (p. 229). Others suggest that “inadequate research” (McPherson, Headrick, & Moss, 2001, p. iii47) should not be interpreted as evidence that the programs themselves don’t work, but rather how advances need to be made in methods to evaluate IPE programs (McPherson, Headrick, & Moss, 2001).

Limited systematic knowledge on the topic may at least be partially explained by the lack of clarity concerning the terms defining this type of learning (Cooper et al., 2001), as the literature is replete with various terms used to describe interprofessional learning. Given this, it is important to explore the differences among these terms.
Much is written about the differences between multidisciplinary and interdisciplinary practice within the health care setting (Melvin, 1980; Ducanis & Golin, 1979; PEW Health Professions, 1993; Larson, 1995; Helm, 2001; and others). “Different prefixes – multi, inter, cross, joint, and shared – are attached to different adjectives – disciplinary and professional – which are in turn attached to different nouns such as education, training, learning, and study (Leathard, 1994; Rawson, 1994, as cited in Barr, 1999). Terms such as shared learning, collaborative, interprofessional, and multiprofessional are used interchangeably and without general agreement to meanings (Hammick, 1998, as cited in Cooper et al., 2001).

**Multidisciplinary practice**

Much of health care delivery within the United States utilizes a multidisciplinary approach, which occurs when several disciplines work with client systems in parallel. Within this model, communication between practitioners or disciplines is loosely coupled as providers work independently and may or may not share information formally. The communication process is typically embedded within a prescribed leadership hierarchy. In practice, each professional independently conducts patient assessments, with health concerns divided along biological and psychosocial systems (Zeiss & Steffer, 1996). Ultimately, each discipline implements its own treatment plan and evaluates its effectiveness, based on discipline specific outcome expectancies. Although treatment team members may share assessment information there is no expectation that a consensus be reached between disciplines in terms of treatment goals and approaches. Within this model of care, team members are only responsible for the activities related to their discipline. As expected, there is little sense of shared responsibility for patient outcomes or team development.

**Interdisciplinary practice**

Conversely, interdisciplinary training incorporates a collaborative and integrated program of care that celebrates and utilizes the interdependent knowledge, skills, attitudes, values and methods each professional brings to the health care system (AUCD, 2001). The Association of University Centers on Disabilities (AUCD) suggest that the fundamental objectives of interdisciplinary training are to assist students to: (i) identify the common and unique skill set and knowledge base of health care team members, (ii) understand the need for cooperation and the inherent interdependence between professions in the provision of comprehensive health care services, and (iii) understand the contribution and roles of family members, community providers, and advocates as team members. Drinka and Clark (2000) define the interdisciplinary health care team as a group of individuals with diverse training who work together as a unit. Similar to multidiscipline approaches, a health professional may conduct patient assessment independently. However, assessments are systematically codified, shared, discussed, coordinated, and implemented via the treatment team process. In addition, leadership is not hierarchical but instead shared, depending on the problem and expertise in demand. Drinka and Clark (2000) add that team members practice collaboratively to solve patient problems beyond the scope and skill of any specific health discipline. In this sense, the sum or dynamic of the interaction between team members is greater than contributions made by individual assessments offered outside the team. Characteristics of true interdisciplinary practice include an understanding and appreciation of the roles and contributions that each discipline brings to the helping process and incorporates the notion of team decision making, planning, and goal setting, within regularly
scheduled meetings. As the interdisciplinary team evolves, there is mutual appreciation and respect between participants for both their unique and common contributions. Through this process of group development, the team is able to address an array of biological, psychological, and social factors impacting a patient’s illness.

**The avoidance of interprofessional education**

Perhaps the most commonly accepted definition of interprofessional education is “...when healthcare professionals learn together, learn from each other, and/or learn about each other’s roles in order to facilitate collaboration” (CAIPE, 1997, as cited in Mcpherson, Headrick, & Moss, 2001, p. ii47). Bruder (2000) suggests that if we want students to develop cooperative working relationships across disciplines, we must educate and socialize them within interprofessional environments. Although most health professionals and policy makers acknowledge the utility of interdisciplinary practice, few models exist that are accepted by the academic community and successfully operationalized within the classroom (McCallin, 2003). Thus, it is difficult to prepare health professionals to work across disciplines when most, if not all, profession specific education discourages cooperation between professionals.

Clearly, cost and coordination are realities that challenge the implementation of interprofessional training. However, the primary reason that training students across disciplines is avoided is the diverse cultural structures that guide and moderate health education environments. This profession specific “cultural frame” must be addressed if there is any hope of having interprofessional education accepted as a valuable dimension of our curriculum.

Each health discipline possesses its own *professional culture* that shapes the educational experience; determines the salience of curriculum content, core values, customs, dress, salience of symbols, the meaning, attribution, and etiology of symptoms, as well as what constitutes health, wellness and treatment success. Most educators who attempt course offerings that reach across disciplines (e.g., medicine, social work, nursing, pharmacy etc.) quickly realize that even simple differences, such as semester length and grading requirements, create barriers that discourage students from participating in joint classroom activities.

Most importantly, professional culture defines the means for distributing power within the work environment, how training should proceed within the clinical setting, the level, and nature of inter-profession communication, resolution of conflicts and management of relationships between team members and constituents. It might be said that one factor limiting interdisciplinary training is *profession-centrism*.

**Profession-centrism**

Similar to ethnocentrism, *profession-centrism* (professional centric thinking) is a constructed and preferred view of the world held by a particular professional group developed and reinforced through their training experiences. The concept of profession-centrism is orthogonal to ethnocentrism as originally coined by American Sociologist William Graham Sumner in his book *Folkways* (Sumner, 1906). By definition, ethnocentrism is the proclivity to view the world from the perspective of ones own culture. Sumner states, “Each group nourishes its own pride and vanity, boasts itself superior, exalts its own divinities and looks with contempt on outsiders” (pp. 12–13). Within this narrowed perceptual field one judges the worth, value, and utility of aspects of their environment. Accordingly, human interaction
is organized within groups that go to great lengths to differentiate between legitimized participants and others. In addition, Summner’s notion of ethnocentrism suggests that strong group affiliation is positively associated with negative attitudes towards out group members. In this way ethnocentrism typically results in stereotypic images of the outgroup (LeVine & Campbell, 1972). There is an inherent sense that one’s view of the world is more carefully constructed and reflective of reality than those living in other cultural groups. Profession-centrism is similar. However, the “narrowed view of the world” is now applied to the cultures of health professions. By the very nature of our professional training, we are encouraged to abandon or at least minimize an appreciation of diversity across health disciplines. Even the word professionalism is socially constructed and denotes difference, being special and possessing knowledge or skills unknown and unavailable to others. The construct of professionalism promotes competition rather than collaboration between health care providers. In addition, professional training takes place with mentors and role models that often promote isolation, elitism, and territorialism (Brand, 2003). Although most health professions espouse the importance of collaboration between the health care team, a variety of studies have found that most health care professionals can not even agree on what constitutes effective teamwork (Makary et al., 2006; Thomas et al., 2003).

It seems clear, that if we are to be successful in promoting interprofessional education, we need to develop ways to challenge and dispel the notion of profession-centrism. Reaching this goal will allow us to understand and embrace the professional cultures of our colleagues, and reduce barriers to interprofessional training. To achieve this goal students and faculty must develop Interprofessional Cultural Competence. Although interprofessional cultural competence is related to the process of interdisciplinary training, this concept goes well beyond teaching the skills and strategies of interdisciplinary practice. In fact, interprofessional cultural competence places interdisciplinary practice within the context of the overall health educational system, and within each disciplines specific culture.

Health professionals and their cultures

If we define culture as a body of learned behavior common to a given group shaping patterns of thinking, feeling and behaving, then health professions and their training environments are steeped in professional culture. These preferred ways of perceiving, understanding, and interacting with the world become an internalized template for cultural bias transmitted to students that shape evolving practice attitudes, perceptions and behaviors. Most training environments unwittingly encourage the development of this unfortunate outcome by teaching their unique view of professionalism which is seamlessly embedded within their curriculum. Much of this biased thinking emanates from specific health discipline stereotypes and prejudice reinforced by history, classroom experiences and practice environments. For example, social workers know how they are better prepared to promote sensitive communication with their patients when compared to the “cold and removed” physician, who is only interested in treatment outcome. Likewise, most physicians know how social workers “talk about an issue endlessly” rather than taking action; the latter, (for the physician) being the hallmark of effective and efficient health care management. Prejudice such as this is no different from the stereotypes we observe between ethnic, racial or cultural groups within our communities. Because of this type of profession-centric thinking, it is not surprising that most health disciplines do not acquire interprofessional cultural competence and avoid cooperative training opportunities within the classroom or clinical setting. Thus, an important educational goal should be to train health care providers to transcend their professional biases that limit integrated and comprehensive patient care.
It seems reasonable, that if we are to achieve effective interdisciplinary education we must craft curriculum that promotes *interprofessional cultural competence.*

**Profession centrism and Social Identity Theory**

Social Identity Theory (Tajfel, 1981) helps to explain how the concept of profession-centrism negatively impacts on IPE. The theory suggests that our self-concept and identity is derived chiefly from our unique group affiliations. Through this process of identification we develop an understanding of how to act within our social world. Tajfel (1982) suggests that social identity is constructed from experiences with members of various groups that are salient to the individual. This is similar to G.H. Mead’s (1934) notion of the self-concept as being derived through social interaction. One cannot fully understand a person’s self-concept without also considering the social context of agency. As Miller & Prentice (1994) suggest, Social Identity Theory is interested in how the group is expressed within the individual rather than how a person acts within the group. In this sense a persons’ self-esteem is intimately tied to the group process. Once inoculated with the culture of the group, members will attempt to maintain their self-esteem by defending and preserving the ascribed values (Abrams & Hogg, 1990). Some have described the source of this motive as the quest for positive social identity (Sedikides & Strube, 1997). According to this notion, individuals attempt to see their group affiliations in a positive light. Thus, it is understandable how stereotypes can be used to preserve the group by providing members with an interpretive frame for evaluating information, and formulating impressions and courses of action that preserve the preferred status quo. This cognitive frame of stereotypes manages group culture by both constructing reality and solidifying perceptions of self-concept. Although efficient, these stereotypes become overly simplistic, bias judgment and action. A second social identity motive associated with this theory and relevant to our present discussion is Uncertainty Reduction (Hogg, 2000). It is of no surprise that we prefer to know what is expected of us and others in any particular social situation. Uncertainty about these interactions and social relationships promote anxiety. Reducing this subjective sense of uncertainty within in our important social interactions promotes predictability and control. One way to reduce uncertainty is to utilize stereotypes; simplistic prejudicial thinking that prescribes prototypes of how we and others should act in any given situation. These biased, but easily available templates or prototypes provide a roadmap for behavior within these social situations, and thus reduce uncertainty.

**Interprofessional cultural competence**

Interprofessional cultural competence is similar to the general notion of cultural competence. It is widely accepted that cultural competence involves a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables the system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al., 1989; Isaacs & Benjamin, 1991). The goal of creating interprofessional cultural competency is consistent with this definition. Health care professionals need to be comfortable and skilled in working across professions. Unfortunately, training health care providers in isolation creates *profession-centric* practitioners with limited interprofessional cultural competence. For example, health care disciplines rarely create clinical training opportunities that explore the roles of its health care team members. Thus, following graduation health professionals often become either defensive or confused when considering how their team members address a clinical
problem. This reality becomes even more interesting when we remind ourselves how each health professional is expected to possess the component skills and attitudes necessary for integrated service delivery and cooperation between the professions upon graduation. At best, these skills are learned by trial and error, post graduation, and within the work environment. At worst and perhaps more common, health practitioners avoid effective communication and diminish the benefits of integrated health care delivery by perpetuating their discipline centric beliefs. Thus, successful health care delivery is predicated on the development of innovative curriculum that creates opportunities for interprofessional training.

Promoting interprofessional cultural competence

Like most learning, developing interprofessional cultural competence is a process. The skills and associated attitudes need to be initiated at the earliest stages of training. Some students will be better prepared to understand these concepts while others will require more ongoing supervision of their interaction with the health care team. In general, this curriculum should help students get the IDEA of how to work competently across disciplines where “I” stands for Interaction, “D” stands for Data, “E” stands for Expertise and “A” stands for Attention.

Interaction is the process during which the student has the opportunity to work or learn directly with individuals from other health disciplines. These face-to-face interactions with other health professionals will inform and challenge existing beliefs about a professional groups’ culture and prevent stereotyping. Familiarity with other disciplines promotes understanding and an appreciation for the intricacies and complexities of both their training and methods of patient care. There is some data that suggests that the earlier students are exposed to interdisciplinary practice within the curriculum; the more likely they are to practice within an interdisciplinary model following graduation (Cooper et al., 2001).

Data involve obtaining accurate information about other health professions. These data include not only information related to professional training and roles within the clinical setting, but also information about the person within that professional role. To accomplish the first goal the health care students must be able to understand how colleagues are trained, what is covered in their curriculum, and what skills and competencies are associated with their clinical roles. Students should strive to understand and compare how other professional cultures define health, illness, the etiology of important health concerns, the role of biology, psychology, and social factors influencing these beliefs, the notion of cure or how change occurs, as well as the values and ethics that guide and direct their decision making and clinical practice. To accomplish this goal, instructors within these settings must use examples and information from a variety of health disciplines to illustrate key concepts and theories being discussed within the classroom. In addition, attention should be paid to how knowledge within a particular discipline has been constructed over time. Tradition, along with assumptions, perspectives, and biases within a professional culture, clearly impact on practice beliefs.

The second source of data consists of developing both insight and understanding about the person that one is working with. Learning to see a colleague as a person with needs, vulnerabilities, and strengths both within their professional role as well as in other areas of their life, promotes empathy, role taking, quelling of stereotypes, and ultimately a growing comfort with the complexities that influence this collaborative relationship. A person is more than a social worker, physician or nurse. Developing true interprofessional cultural competence requires time spent in both classroom and social activities; seeing others not only as professionals but also as people.
Expertise is the ability to communicate clearly, and effectively with other disciplines concerning the values and processes of patient care associated with one's own profession. Perhaps the first and most important step in developing interprofessional cultural competence is a willingness to enter into a dialogue with another professional. Within this conversation, students have the opportunity to explain their perceptions of assessment and treatment of a shared patient/client. Simultaneously, a culturally competent professional is able to be open to the views and approaches of their colleagues; altering their perceptions via the discussion when appropriate. Ultimately, the goal of interprofessional care is to do what is in the best interest of the patient/client. Within the interdisciplinary setting, this often requires compromise, embracing the others perspective and rethinking your initial formulation. Students who are exposed to this type of interaction early in their training will be both skilled and more willing to carry this set of attitudes and behaviors into the practice environment post graduation.

Attention involves the in-depth exploration of one’s personal and professional, cultural background while simultaneously recognizing one’s biases, prejudices, and assumptions about individuals who are trained in different health care professions. Students need to understand the centrality of professional culture and how this moderates successful treatment. Similar to their professional role with patients, the health student must have a commitment to professional self-reflection. Each student should be encouraged to become aware of their professions culture, its history, present trends, and the social and economic factors that have helped shape this professional culture. As the professional group constructs culture, it is important that trainees understand this phenomenon and its implications for practice. In order to accomplish this goal, students need to have knowledge and appreciation of the specific values, customs, beliefs, and practices of the other professionals. Specific roles and training backgrounds of relevant professions should be defined, discussed, and incorporated into comprehensive training schemata. Students from various disciplines need time to discuss these important differences and similarities related to their approach to assessment and treatment. Thus, specific curriculum activities of interdisciplinary training programs should be dedicated to the process of understanding and evaluating attitudes and values as they apply to one's own profession and to the profession of others. In addition, there should be a focus on not just developing knowledge about a particular discipline but also developing a set of generalized investigative skills to promote communication and an appreciation of how any health discipline understands and defines its approach to client/patient care. Students should understand that all health professions possess culture that is real, ongoing, and evolving.

**Curriculum structures promoting interprofessional cultural competency**

*Early exposure to other disciplines*

Training with other disciplines should begin early and include both shared classroom experiences and clinical practicum (e.g., social workers and medical students and nursing students taking a clinical interviewing course together) (Wahlstrom et al., 1997). Barrington et al. (1998) found that interprofessional course work offered early in training prepared students to profit from later interdisciplinary activities. Cooper et al. (2001), in their systematic review of interdisciplinary education, found that students described their interdisciplinary training as “highly relevant and desirable”. As training progresses, additional opportunities for students to learn conjointly should be instituted (e.g., clinical pediatric rotations set up as teams, taking clinical classes together that lend themselves well to interdisciplinary practice). In addition, students should have the opportunity to spend time with other students from the various disciplines that are relevant to their chosen
specialty. For example, a social work student interested in autism should have the opportunity of learning with students from family medicine, psychiatry, psychology, nursing, pediatrics, occupational therapy, speech therapy, and physical therapy.

Common course offerings

Course development at the university level should have an interdisciplinary curriculum committee that promotes and oversees the attainment of interprofessional cultural competency. Thus, faculty need to rethink how students are trained within the health professions and to look for ways to break down the artificial walls that separate our training institutions and reinforce the “silos” effect (Rafter et al., 2006). There is much redundancy in health professional education that reinforces the “silos” phenomenon on most health campuses. For example, each medical school, nursing school and pharmacy school has its own biochemistry faculty often teaching similar content. Would it not be helpful to collapse these three courses into one and have them taught by an interdisciplinary team? Not only would this be more efficient and cost saving, but it would also provide students the opportunity to learn about other professions across a similar classroom topic. Policies such as these will also set into motion opportunities for students to challenge discriminatory statements about other professions, their training and process of patient care.

Interdisciplinary faculty teaching teams

There are certain skills that every health professional needs and could be taught conjointly by interprofessional teams. For example, each health care professional needs to know how to interview clients, build rapport, gather information for their assessment, present their findings or diagnosis, negotiate treatment, and provide feedback to clients about a variety of issues. Nursing teaches these skills. But so does social work, pharmacy, medicine, public health, dentistry etc. Why not let interdisciplinary faculty teach an interdisciplinary student group? Issues unique to a particular profession could be covered for the entire class; this would be instructive, as well as promote a more in-depth understanding of each profession’s role within the health care setting. Simple advances, such as promoting interprofessional rounds where each student and faculty member discuss their perceptions of the problem and course of treatment for clients, would go a long way in promoting interprofessional cultural competence. In addition, this committee could explore and develop course offerings and training experiences that could be offered across health professions.

Student involvement in curriculum design

Interprofessional cultural competence curricula may be evaluated on a regular basis and modified as needed. An important part of this ongoing quality improvement of interprofessional curricula is student involvement in curriculum design and evaluation. Thus, both faculty and students from each of the health professions should be represented and play a role in this process. In this fashion students, along with faculty, are encouraged to work on curriculum issues in an interprofessional manner.

Promotion of standards by accrediting bodies

Curriculum changes that promote interprofessional cultural competence should be required by each professions’ accrediting body. Most accrediting bodies have significant curriculum
requirements promoting cultural competence or interdisciplinary training when working with clients/patients but little if any emphasis on promoting interprofessional cultural competence. Only when Residency Review Commissions or the Council on Social Work Education require interprofessional cultural competence as part of a school’s continuing accreditation will health care institutions take this issue seriously.

Provosts and university presidents should also be interested in the process of promoting interdisciplinary training since the federally funded (USA) research environments are also moving in this direction. More and more federal grants will be looking for health campuses that put together interdisciplinary research teams that address a health problem from multiple perspectives. How can we expect these comprehensive research centers to be successful if students do not know how to work together?

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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