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PERCEPTIONS OF ACADEMIA OF DIFFERENT HEALTH PROFESSIONS TOWARDS INTER PROFESSIONAL EDUCATION

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ABSTRACT

Interprofessional education is an approach to educating and training students and practitioners from different professions to work in a collaborative manner. The purpose of this research was to examine attitudes towards interprofessional in readiness for interprofessional learning scale was measured with respect to how their influence in clinical situations in Sri Lanka. The questionnaires were sent though post and emails to the consenting participants as per their suggestions of most convenient ways during January 2018 to academics in Sri Lanka representing all faculties in the country including medicine, nursing and physical therapy educational programmes. There were 46% replied and hundred percent of respondents agreed that it was important to patients would ultimately benefit by provide interdisciplinary learning opportunities. The results of this study suggest that a favorable perception of both interprofessional teamwork and interprofessional education exists amongst academic administrators of Sri Lankan health professional education programs.

Keywords: Attitudes, interprofessional education, interprofessional relations

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INTRODUCTION

The delivery of high-quality patient care demands collaborative practice among multiple health professionals (Mu'taman Jarrar & Don, 2016; Mu'taman Jarrar, Sebiany & AbuMadini, 2018). Collaborative practice occurs when health care workers from different professional backgrounds work effectively in a team, communicate productively, and understand each other's roles (Lindqvist & Educaton, 2010; Norwegian Education, 2015). There is an abundance of evidence in international literature supporting collaborative practice. Yet owing to the traditional training of individual health professions, establishment of it has been problematic. Thus, Inter Professional Education (IPE) was introduced with prospects of enhancing the quality of patient care by preparing a "collaborative practice-ready" health workforce. According to World Health Organization (WHO) "inter professional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (Lindqvist & Educaton, 2010; Zechariah et al., 2019; Bridges et al., 2011; Buring et al., 2009).

The importance of IPE was first recognized in late 1970s. WHO was the pioneer to acknowledge IPE as an important aspect of healthcare in 1978 and noted that there is an increased trend towards multi-professional teamwork in healthcare supported by an increasing body of evidence (WHO, 1988). Following this, the Center for the Advancement of Interprofessional Professional Education (CAIPE) was established in 1987 in the United Kingdom (CAIPE, 1997; Zeer, Tretyakova & Miroshnichenko, 2019). At present the introduction of IPE into the training curricula of healthcare professions has become an important objective for governments and universities internationally. In the UK, the government supports interprofessional education in both post-qualification and undergraduate settings (Department of Health, 2001; Merriman et al., 2020).

A Bridge to Quality" summit report "All health professionals should be educated to deliver patient-centered care as members of an interprofessional team, emphasizing evidence-based practice, quality improvement approaches, and informatics" (Hinrichs et al., 2019; Gilbert, 2005; Coster et al., 2008). Apart from lack of infrastructure and commitment at the administrative level, the attitudinal difference among faculty members have been identified as a major barrier in incorporating IPE into the health profession curricula. Therefore, it is very much important for the faculty members to appreciate the advantages of IPE so that they can be fully engaged in implementing the change. To date this has been challenging in part due to increased workload and partly because of lack of time. Therefore, the present study is designed to investigate the perceptions towards Interprofessional Learning amongst academia in different health professions in Sri Lanka.

METHOD

Study Design and Study Population

Cross sectional descriptive study will be done representation of all Medical and Allied health faculties in Sri Lanka. The academic staff of Medicine, Physiotherapy and Nursing of above representation from all faculties in Sri Lanka. Sample size a total of 56 academic members were included. The whole cohort of academic staff members in the mentioned study settings will be invited to complete the questionnaire.

Study Instruments

Data will be collected using a self-administered questionnaire. The questionnaires, consent forms and information sheet will be provided in English language only since the academic staff members are proficient at speaking and writing in English.

Readiness for Inter-Professional Learning Scale (RIPLS)

RIPLS is a simple, self-administered questionnaire which has been originally developed in 1999 by Parsel and Bligh (Parsell & Bligh, 1999). This 19 ties scale examines the attitude of health and social care students and professionals towards inter professional learning. Using a five-point Likert type scale, it assesses the attitudinal differences with open ended questions for IPE.

Data Collection

Ethical clearance was obtained from Ethics Review Committee, Faculty of Medicine, General Sir John Kotelwala Defence University. After obtaining ethical clearance, Heads of the relevant institutions will be contacted over the phone/ met in person and informed about the study. Their permissions were obtained prior to the data collection. The questionnaires were sent though post or emails to the consenting participants as per their suggestions of most convenient ways.

Processing and Analysis of Data

Analysis of data will be done using (SPSS version 20). The data will be initially analyzed using descriptive statistics. Analytical statistical methods were used to compare responses of different groups. The free comments will be content analyzed.

Ethical Clearance

They were informed about the study and given time to clarify doubts. The voluntary participation was reassured. Informed consent was obtained from each participant after providing information. The written information sheets were provided to the participants. The completed consent form was ensured that subjects have understood the information provided. The participants were informed about their right to not to participate and that they will not be penalized for doing so.

Confidentiality

The questionnaire is anonymous and identified only by a unique identifier. Such information will not be published. All soft copies are password protected and hard copies will be kept in a locked cabinet. The data will be disposed after 7 years of the research study. These data will never be used in such a way that you could be identified in any way in any public presentation or publication without your express permission.

FINDINGS

Participants were also asked to indicate their level of agreement or disagreement with a series of attitudinal items related to interdisciplinary education

Table 1. Attitudes Towards Interdisciplinary Learning

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree		Total
	N	%	n	%	n	%	n	%	n	%	
Learning with other students more effective member of a health care team					1	1.8	22	39.3	33	58.9	56
Patients would ultimately benefit if health students / professionals worked together							13	23.6	42	76.4	55
Shared learning with other health students increase my ability to understand clinical problems					3	5.5	19	34.5	33	60.0	55
Communications skills should be learned with other health students / professionals			1	1.9	2	3.7	23	42.6	28	51.9	54
Team-working skills are vital for all health students / professionals to learn					1	1.8	12	21.4	43	76.8	56
Shared learning will help me to understand my own professional limitations			1	1.8	3	5.4	21	37.5	31	55.4	56
For small group learning to work, students / professionals need to respect and trust each other					3	5.4	19	33.9	34	60.7	56
I don't want to waste time learning with other health students / professionals	26	46.4	26	46.4	2	3.6	1	1.8	1	1.8	56
Shared learning with other health care professionals will help me to communicate better			2	3.6	3	5.4	27	48.2	24	42.9	56
Opportunity to work on small group projects with other health care students			1	1.8	4	1.5	28	50.9	22	40	55
Opportunity to share some generic lectures, tutorials or workshops with other health care students / professionals			1	1.8	4	7.3	31	56.4	19	34.5	55
Shared learning and practice will help me clarify the nature of patients' or clients' problems					4	7.3	23	41.8	28	50.9	55

(Table 1). In terms of items which received the largest support, 100% of respondents agreed that it was important Patients would ultimately benefit if health students professionals worked together for academic health center campuses to provide interdisciplinary learning opportunities, 98.2% agreed that Learning with other students / professionals will make me a more effective member of a health care team and Team-working skills are vital for all health students / professionals to learn in interdisciplinary courses, 94.5% agreed that interdisciplinary efforts require support from Shared learning with other health students / professionals will increase my ability to understand clinical problems and Communications skills should be learned with other health students / professionals and For small-group learning to work, students / professionals need to respect and trust each other.

Table 2. Potential Barriers to the Implementation of Interdisciplinary Learning in Clinical Situation

	Minimally important		Somewhat important		Very important		Essential		Total
	n	%	n	%	N	%	n	%	
Management of acute situations e.g. Cardiopulmonary Resuscitation, trauma, burns, seizures, unconscious patient, poisoning			6	10.9	15	27.3	34	61.8	55
Clinical decision making e.g. long-term care planning, discharge planning	2	3.6	7	12.7	20	36.4	26	47.3	55
Performing procedures e.g. lumbar puncture, blood culture, taking a biopsy, ascitic tap	4	7.3	14	25.5	18	32.7	19	34.5	55
Work in the theatre e.g. surgery, anesthesia, post-operative care	3	5.5	4	7.3	17	30.9	31	56.4	55
Work in the labor room including neonatal care	1	1.9	8	14.8	14	25.9	31	57.4	54
Work in the hospital clinic e.g. referrals	1	1.8	12	21.8	23	41.8	19	34.5	55

Table 2 presents results related to potential barriers to the implementation of interdisciplinary education in clinical situations. In terms of ranking the highest rate was given to in hospital rehabilitate care which was 90.7%, and all most all the clinic setting all discipline gave the above 76% other than the performing procedures e.g. lumbar puncture, blood culture, taking a

biopsy, ascitic tap which is the lowest such as 67.2%. The all the disciplines and no potential barriers in setting up interdisciplinary education in the clinical setup.

Table 3. Potential Barriers to The Implementation of Interdisciplinary Learning in Their Skills

	Minimally		Somewhat		To a larger extent		Extremely		Total
	n	%	n	%	n	%	n	%	
Decision making skills	4	7.1	5	8.9	28	50.0	19	33.9	56
Respect for each other			3	5.4	18	32.1	35	62.5	56
Understanding how groups work	1	1.8	4	7.1	19	33.9	32	57.1	56
Communication skills	2	3.6	4	7.1	19	33.9	31	55.4	56
Teaching skills	1	1.8	13	23.6	24	43.6	17	30.9	55
Understanding professional roles and responsibilities	1	1.8	3	5.4	20	35.7	32	57.1	56
Recognizing limitations as a professional	3	5.4	5	8.9	19	33.9	29	51.8	56
Leadership skills	4	7.2	5	8.9	21	37.5	26	46.4	56

Table 3 reports results for responses concerning courses that lend themselves to interdisciplinary education in skills to be development (e.g., decision making skills). Respondents were asked to indicate the extent to which they extremely or minimally skilled to carry out the interdisciplinary education. Respect to each other was ranked highest (94.6%) and teaching skills were ranked the lowest such as 74.5%. All the skills such as decision-making skills, understanding how groups work, communication skills, understanding professional roles and responsibilities, recognizing limitations as a professional, and leadership skills ranked above 84% which is significant in this nature setup.

DISCUSSION AND CONCLUSION

Several barriers to the successful implementation of interdisciplinary education have been identified in the literature. Barriers related to the perceived loss of professional and disciplinary status, curricular and scheduling challenges, and lack of familiarity and comfort with interdisciplinary education among universities and departments have been described (Parsell & Bligh, 1999). In some instances, there may also be a certain level of ‘‘unwillingness’’ on the part of both students and teachers alike to experiment with new ways of teaching and learning (WHO. 1988). Parsell and Bligh (1999) classified barriers into categories including structural, curriculum/teaching, professional/disciplinary, and attitudinal. Issues surrounding timetabling and differences between the course characteristics of different health professional curricula present some of the most significant challenges for post-secondary education institutions

seeking to implement interdisciplinary education. As a result, there can be difficulties in coordinating the curricula of different professional groups so that the demands of interdisciplinary education can be met.

In a similar study to that reported in this paper, Gardner et al. (2002) concluded that senior administrators in health professional schools in the United States held overall positive attitudes towards interdisciplinary teams and interdisciplinary education (Gardner et al., 2002). The responses to the survey conducted for this paper suggest a high level of support amongst Canadian academic administrators towards the concept and principles of interdisciplinary health care teams, the efficiency and productivity of teamwork and the value of teamwork in the provision of patient-centered care. Respondents also held favorable attitudes towards interdisciplinary education in general. The results suggest that respondents hold a positive perception of the role of interdisciplinary education in fostering the development of teamwork skills amongst health professional students. The responses to Parsell and Bligh's scale suggest that respondents across all professions also have a positive perception of the influence of interdisciplinary education on the acquisition of individual professional identity.

The respondents identified several possible barriers to the implementation of interdisciplinary education in the didactic setting. The barriers which were rated the highest, in keeping with results from the Gardner et al. (2002) survey of US schools of health professional education, were problems with schedule/calendar, rigid curriculum, turf battles, and lack of perceived value. The results are that while respondents identified a number of barriers to interdisciplinary education, the majority indicated that ''interdisciplinary didactic courses'' were not logistically difficult (Gardner et al., 2002). This may reflect perspectives on the organization and coordination of ''common learning'' activities in which students from different professional education programs are brought together to learn together, commonly through didactic teaching methods such as lecturing. In comparison to interdisciplinary education activities which are based on clinically based experiential learning, common learning activities may present less logistical challenges. The respondents to this survey also represent only the views of academic administrators of Canadian degree-granting institutions or collaborative community college-university programs, serving primarily undergraduate students and graduate level students, and in some instances continuing professional education as well. Nonetheless, the survey results do provide a better understanding of the general attitudes of academic administrators of Canadian programs of health professional education. The results do suggest that these respondents support interdisciplinary teamwork and interdisciplinary education. Further investigation is required on the influence of faculty attitudes towards interdisciplinary teamwork and interdisciplinary education. Faculty members, as role models, have a major influence on the professional socialization process and the development of attitudes and value systems among health professional students. It is important to have a better understanding of the nature of faculty attitudes and the role of faculty development in promoting and fostering positive attitudes towards interdisciplinary education amongst faculty in health professional education.

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