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Stereotyping as a barrier to collaboration: Does interprofessional education make a difference?

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SUMMARY

This research was part of a Health Canada funded initiative developed to provide evidence about the effectiveness of interprofessional education (IPE) interventions to promote collaborative patient-centred care. Health professional students' ratings of health professions and the effect of IPE on those ratings were examined. Participants were divided into three groups (N = 51); control, education, and practice site immersion. Utilizing the Student Stereotypes Rating Questionnaire (SSRQ) which consists of a five point Likert-type scale each group rated health professionals on nine characteristics: academic ability, interpersonal skills, professional competence, leadership, practical skills, independence, confidence, decision-making, and being a team player (Hean, Macleod-Clark, Adams, and Humphris, 2006). Data were collected at four time points; prior to an IPE classroom intervention, following an IPE classroom intervention, following the IPE immersion experience, and four months post IPE immersion experience. Overall, perceptions of other health professions were more positive following the 2.5 day interprofessional education session and immersion experience. Student ratings of the seven professions among the nine characteristics will be presented, highlighting similarities and differences across professional groups. Findings support the incorporation of IPE curricula that address the role and functions of other health care professions to facilitate the development collaborative patient-centred care health care teams.

Introduction

Increasingly, interprofessional collaborative practice in health care is being viewed as essential for the provision of patient-centred, responsive and high-quality care. There is growing awareness and developing momentum to improve the quality of patient care, patient safety, the retention of health-human resources, and cost efficiencies within the health care system. This momentum is the driving force behind initiatives such as Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) and the Canadian Interprofessional Health Collaborative (CIHC) sponsored by Health Canada, the Institute for Healthcare Improvement (IHI) Open School for Health Professions in the United States, and the Centre for Advancement of Interprofessional Education (CAIPE) in the United Kingdom. Internationally, such initiatives for improved patient care began as early as 1973 with recommendations from the World Health Organization, and the movement continues (Carpenter and Dickinson, 2008; Curran, 2004; Oandasan et al., 2004).

Recent studies have examined the benefits of interprofessional interventions on health care providers' satisfaction. Increases in job satisfaction were reported among nurses and physicians in an emergency department as a result of reduced workloads after adding nurse practitioners to the staff mix (Searle, 2008). An interprofessional education intervention in primary care helped practitioners in their approach to difficult issues with clients and their ability to recognize the availability of other resources (Larivaara and Taanila,

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2004). Whether discipline-specific to a health profession or broadly health professional, the IECPCP movement is advancing in many ways, including stressing the need for core competencies (Curran, 2004; CIHC, 2010; University of British Columbia College of Health Disciplines, 2008), developing IPE curricula, and establishing guiding principles, standards, and evidence for accreditation (AIPHE, 2009). It is well recognized that exposing, confronting, and dispelling stereotypes is a key step within the movement (Oandasan and Reeves, 2005).

A number of factors are known to affect the formation of collaborations and their effectiveness, including perceptions and an understanding of one's own and others' professions. Typically, students in health profession education programs learn with little or no exposure to, or experience learning with, students in other health profession programs. This has been our experience at the University of Manitoba. In a review of interprofessional initiatives, Hammick et al. (2007) noted that the majority of such initiatives directed at pre-licensure students involved voluntary rather than mandatory participation. Students may complete their programs and begin careers with certain perceptions or understandings of other professions that may or may not be accurate, and that persist as unchallenged ideas in part because they do not have opportunities for direct interactions with students from other professions. These perceptions may be profession-specific stereotypes, which are described by Turner (1999) as social, categorical judgments of people who are members of groups. In reality, not all stereotypes are negative. For example, nurses are often viewed as caring and trustworthy, which are important traits for their roles and activities in providing holistic care to patients and their families. In 2008 nurses were voted "the most trusted profession" in America for a seventh consecutive year (American Nurses Association, 2008). However, other stereotypes of nurses are negative, overly traditional and/or hierarchical in nature and do not reflect current realities and scope of practice. Those negative stereotypes can be expected to have negative effects on other professionals' interactions with nurses, and also contribute to nurses' views of themselves and their satisfaction with their roles. Takase et al. (2002) report that nurses' individual self-concept, job satisfaction, and self-esteem as a profession, are related to the extant stereotypes about the nursing profession. Effective working relationships within multidisciplinary health care teams are influenced by stereotyping (Carpenter, 1995a). Traditional stereotyping of health professionals is reported by students at the beginning (Hean et al., 2006) and end (Carpenter, 1995a,b) of their educational programs. It is reasonable to expect that stereotypical views of various professions held by members of the public would be shared by students in health care professions unless they have an opportunity to learn or experience otherwise. Findings from an interprofessional learning program in the United Kingdom for first-year health profession students demonstrate that students in an interprofessional intervention group viewed the participating health professions as more "caring" and "less subservient" than those students in the control group who did not complete the interprofessional learning activities (Lindqvist et al., 2005). These findings indicate that health professional students hold such stereotypes of health professions as they begin health education programs.

Interprofessional education involves opportunities for two or more professions to learn with, from and about each other (CAIPE, 1997). It allows students in the health professions to develop the knowledge and relationships required to work collaboratively in the best interests of the patient. Working in an effective and collaborative manner requires that all members of the health care team understand their own roles and those of the other members, and can work together in a respectful and inclusive environment. Although intuition would suggest this is the most logical way for health care teams to organize themselves and function, health profession educational programs generally do not prepare students to work collaboratively with other professions, a deficiency that is often, unfortunately, subsequently reflected in practice settings and in the presence of patients/clients. While there is evidence that interprofessional education, collaboration and patient-centred practice are essential for improving the quality of patient care and patient safety (Romanow, 2002; Kaufman et al., 2001), interprofessional learning initiatives and opportunities for students are not a consistent or widespread part of programming. However, there are many initiatives working to change the way health care professionals are educated and how they will subsequently practice. For example, in Canada, the University of British Columbia's College of Health Disciplines and the University of Toronto's Office for Interprofessional Education are examples of programs that coordinate student and faculty interprofessional activities for health professionals to promote collaborative patient-centred care (University of British Columbia, n.d.; University of Toronto, n.d.).

This paper describes a research initiative that involved exposing pre-licensure students (prior to becoming licensed professionals) in health care professional programs to an interprofessional education initiative. All aspects of the project, including design, implementation and evaluation, were planned using an interprofessional collaborative approach and informed by contact theory (Hewstone and Brown, 1986; Hewstone et al., 1994). Briefly, contact theory built upon Allport's work (1954) which proposed that to improve group relations participants should have equal status, common goals and both institutional and social support. Hewstone and Brown (1986) further emphasized that the understanding of both differences and similarities between groups contributes to decreasing prejudice between them. This study's overall purpose was to compare knowledge, attitudes, skills and values among groups of participants enrolled in one of seven pre-licensure health professional education programs (Anderson et al., 2009). Specifically, the research question addressed in this paper is whether the attributes of the seven health professions recorded at the time of initial assessment in the study were changed by interprofessional education and/or practice immersion experiences.

Methods

Study design

The study utilized a modified experimental pre-test, post-test design. Participants were students from four faculties (Dentistry, Medicine, Nursing, and Pharmacy) and two schools (Medical Rehabilitation and Dental Hygiene) at the University of Manitoba. The development of this project occurred in partnership with two service-provider organizations, the Winnipeg Regional Health Authority (WRHA) and the J.A. Hildes Northern Medical Unit (NMU) of the University of Manitoba. There were two types of interventions; first, in the classroom, where participants took part in sessions on collaboration, interprofessional group discussion, and second, in collaborative practice settings where small interprofessional groups of pre-licensure students were immersed in one of four settings in urban (Winnipeg, Manitoba), and rural and remote locations (Manitoba and Nunavut). This project was approved by the Human Research Ethics Board of the University of Manitoba (H2006:189).

Students from each faculty or department were invited to information sessions regarding the type of study, time commitment and compensation for participation. Detailed recruitment procedures are described elsewhere (Snow et al., 2009). Interested student participants identified the time commitment they could manage, as well as their ability to travel if needed, and were subsequently randomly assigned to one of three groups of interprofessional learners: a control group (C), an education-only intervention group (E) and an interprofessional immersion experience intervention group (I). Eighty-five percent (85%) of participants were randomly assigned to the groups. However, some self-selection did occur as some students agreed to participate only in certain groups due to time constraints. Participants received honoraria and living and/or travel expenses (to rural and northern sites) as a result of participation.

The project working group represented the seven health profession education programs (dental hygiene, dentistry, medicine, nursing, occupational therapy, pharmacy and physical therapy) and members