INTERPROFESSIONAL LEARNING IMPACTS ON PROFESSIONAL DYNAMICS AMONG HEALTH PROFESSIONALS IN SOUTHEASTERN NIGERIA.

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ABSTRACT

Assessment of the impact of interprofessional learning (IPL) on professional dynamics among healthcare professionals is very important for quality patient care management. The research design was a prospective cross-sectional descriptive study. It was conducted in various healthcare departments at Federal Medical Centres and Federal Teaching Hospitals in South-East Nigeria having a sample size of 386 healthcare professionals. Validated questionnaire "Interprofessional Learning Dynamic Scale (IPLDS)" was used for this study. It contained 63 items with 2-sections: A and B. 'A' for socio-demographic data and 'B' for professionals' relationship, knowledge, readiness, perception and attitude towards IPL. Data was collected through simple random sampling and analysed descriptively using Spearman rank correlation. Previous IPL experience showed significant positive relationship with radiographers' ability to accommodate, collaborate, form teamwork, resolve conflict and communicate effectively with other healthcare professionals. This study reveals that previous interprofessional learning experience promotes positive group dynamics between radiographers and other healthcare professionals, promotes better understanding of one's own and others' roles. Level of education had negative significance with knowledge (rs = -0.192; p = 0.000), readiness, perception and attitude towards IPL (rs = -0.299; p = 0.000). Level of education were of great influence on radiographers' relationship with other healthcare professionals. This study affirm that IPL experience proves to have more positive chances to strengthen team dynamics and prevent the transfer of disciplines negative stereotypes into the workforce.

INTRODUCTION

The healthcare system is fast and progressively becoming complex with the high technology innovations which demands a push for greater focus on quality and safety of patients. In response to the growing demands for efficiency and flexibility, healthcare environment is shifting to team based structures. Henderson *et al.*, (2010) reported that there was much to be gained in working as a team and recommended that interprofessional learning (IPL) occurs from the foundation of clinical settings both within medical, nursing, and allied health programs as well as across these professions. These include a stronger sense of professional autonomy and competence, an enhanced sense of clinical self-confidence, and an improved understanding of other professions scope of practice (Pinto *et al.,* 2012). It is imperative to note that these positive changes have been found to strengthen team dynamics and prevent the transfer of negative stereotypes into the workforce (Coster *et al.,* 2008).

Although in clinical settings healthcare professionals maybe co-located with other professionals, there is usually little cross-disciplinary interaction during clinical activities (McGettigan and McKendree, 2015). Pinto *et al.,* (2012) reported also that the amount of teamwork that exists in traditional clinical placement varies across professions as others are more isolated. Improved healthcare through interprofessional collaborative learning in practice is the essence of IPL which ensures that future healthcare givers in radiography and other health professions embed and maintain best practice in their career. The best way of learning to work together is by doing it: taking an active part in a project with agreed joint and realistic objectives to develop a joint system, (Hammick *et al.,* 2007).

The World Health Organization acknowledged in 2010 that IPL, an adjunct of interprofessional education (IPE), is a necessary step in preparing a "collaborative practice-ready" health workforce to respond to health needs, as likely the interaction of students in an interprofessional education curriculum may differ from the interaction of different healthcare professions in the clinical situation (Yu-Chi Lin *et al.,* 2013). Medical cost and readmission seem to reduce when healthcare professionals with versed skills work together and understand where their scope ends, and other professionals begins care needs of patients. Seaman *et al.,* (2016) reported that this improves appropriate patient's referral processes and collaborative care among healthcare professions.

There is evidence to suggest that interprofessional learning improve patient outcomes as well as professional satisfaction (Olson and Bialocerkowski, 2014). Although doctors, nurses, pharmacist and allied healthcare professionals share a common commitment to quality patient management, most professional disciplines largely work in isolation in clinical settings (Booysen *et al.,* 2012). It can be difficult therefore for scholars to reconcile a theoretical knowledge with their clinical experiences of healthcare delivery if such understandings are not fully grounded in the reality of everyday clinical practice (Henderson *et al.*, 2010). Under this pressure, IPL is required to produce its own evidence based best practices within our locality.

LITERATURE REVIEW

Interprofessional learning has been documented to improve teamwork, enhanced quality care, encouraged patient participation, and improves patient outcomes (McGettigan and Mckendree, 2015). Henderson *et al.*, (2010) suggested two goals for much to be gained from IPL: firstly, that the key objectives of IPL should be defined to allow a coordinated response to policy and delivery model development, which should be actively promoted in the work place to clearly delineate what can be achieved from IPL, so not be seen as an 'all encompassing' end in itself or driver of particular healthcare agendas; secondly, IPL should be supported by authentic clinical activities to ensure alignment between learning objectives and clinical learning experiences. Pinto *et al.,* (2012) revealed in their study the acceptability of IPL as participants affirmed having a better understanding of the need to collaborate to attend a common goal and achieve optimal patient outcomes. Education Management Solutions (2017), affirm that Interprofessional collaboration begins with interprofessional learning. Providing training to the medical and healthcare scholars on how to effectively work as a team across disciplines will yield well-informed professionals to cooperate with each other in the workplace (Education Management Solutions, 2017). Reeves and Freeth (2006) applied the 3-P (Presage, Process and Product) model to the evaluation of an interprofessional initiative in mental health. They found that the model was useful in helping to untangle the complex web of factors that promoted and inhibited success in this initiative. In particular, the model proved effective in yielding new insights, making connections clearer and highlighting the key importance of presage in relation to process and product. Maharajan *et al.,* (2017) report that attitudes and readiness towards interprofessional learning showed significant differences among students of various healthcare professions; these differences also depended on the students' year of study. Interprofessional learning should be incorporated in the curriculum of all healthcare professional programme, which may foster students to become competent healthcare providers and understand each profession's role. Yu-Chih Lin *et al.,* (2013) stated that different professions may see problems differently and may hold values or perspectives that are unique to their own profession which may result having more than one single solution that would be good for a specific clinical ethic situation. Yu-Chih Lin *et al.,* (2013) reported that IPL will lead to positive impacts on students' attitudes and confidence of interprofessional collaboration in clinical practice. McGettigan and McKendree (2015) concluded that interprofessional training placements can be delivered in a clinical setting without detriment to care and with benefits to patients and healthcare personnel. Booysen *et al,* (2012) reported increase in understanding of the scope of practice of allied health sciences and the more advanced the years of experience, the less comfortable participants

were to assume some of the roles of another discipline. Their research revealed a general increase in knowledge and a positive change in the attitudes and perceptions of healthcare students and professionals in accordance with years of experience.

MATERIALS AND METHODS

Research Design

The research design was a prospective cross-sectional descriptive study.

Study Areas

The research was conducted in various healthcare departments at Federal Medical Centres and Federal Teaching Hospitals in South-east geopolitical zone in Nigeria. Three Federal Teaching Hospitals [University of Nigeria Teaching Hospital Enugu (UNTH), Nnamdi Azikiwe Teaching Hospital Anambra (NAUTH) and Federal Teaching Hospitals Abakaliki (FETHA)] and two Federal Medical Centres (Owerri & Umuahia) were the study sites. The departments include Accident and Emergency, Orthopedic, Intensive Care Units, Theater, Pharmacy, Nursing, Radiology, Physiotherapy, Medical Laboratory, Dietetics, and Dental Laboratory were surveyed. These study sites were chosen due to its representative of each geographical area in South-east of Nigeria, the greater opportunity for institutions multidisciplinary team support, availability of resources for multidisciplinary collaborative practice, availability of large number of various healthcare professionals, interdisciplinary specialist care, autonomy of departmental healthcare delivery plans, in-patients' and out-patients' referral services.

Study Population

The population size of healthcare professionals working at Federal Medical Centres and Federal Teaching Hospitals in South-east geopolitical zone of Nigeria was estimated. The estimated population number of healthcare professionals in NAUTH, UNTH, FETHA, FMCO and FMCU was 11370.

Sample Size

The sample size was determined using Yaro Yamane's formula as adopted by Ugwu, Elugwu, and Onyegbule, (2016) in a similar work:

$n = \frac{N}{1+N(e)^2}$ $n = \frac{11370}{1+11370(0.05)^2}$ = 386 healthcare professionals.

Sampling Technique

A simple random sampling method was used to enlist participants.

Ethical Consideration

Ethical clearance was obtained from Nnamdi Azikiwe University Faculty of Health Science and Technology Ethical Committee. Informed consent was obtained from participants.

Instruments for Data Collection.

The Interprofessional Learning Dynamic Scale (IPLDS) contained a total of 63 questions consisting of 62 close ended questions and 1 open ended question, divided into 2 sections: section A and B. Section A contained 11 questions on the socio-demographic data of the respondents and section B contained 52 questions aimed at assessing the respondents' relationship, knowledge, readiness, perception and attitude towards interprofessional learning. The closed ended questions consisted of multiple-choiced questions and a 5-point Likert interval scale.

Validation of Instrument.

The Education Foundation Department at Nnamdi Azikiwe University Awka assessed the clarity of the questions, as well as to streamline all data collection procedures. The face validity of the questionnaire was performed by the supervisors. The pilot study was carried out at Chukwuemeka Odumegwu Ojukwu University Teaching Hospital Anambra. Forty-five adapted questionnaires were administered and completed by appropriate healthcare professionals. All the questionnaires were returned. Data was analysed using SPSS version 25 via scale reliability test component of it. The test reliability was carried out using Cronbach's alpha method:

The statements on radiographers' relationships with other profession had reliability co-efficient of 0.734, which means that it has 73.4% reliable score.

The statements on knowledge of interprofessional practice had reliability co-efficient of 0.857.

The statements on readiness for interprofessional learning had reliability co-efficient of 0.835, which means that it has 83.5% reliable score.

The statements on perception and attitude towards interprofessional learning had reliability co-efficient of 0.782.

Method of Data Collection

Data were collected using 'Interprofessional Learning Dynamic Scale (IPLDS)', distributed amongst healthcare professionals who work at Federal Medical Centres and Teaching hospitals in South-east geopolitical zone of Nigeria.

Method of data analysis

The data collected from the questionnaires were analysed using Statistical Package for Social Science (SPSS) version 25. Impacts of interprofessional learning on professional dynamics among healthcare professionals were assessed using Spearman rank correlation. A p-value of 0.05 was adopted as a criterion for the level of significance.

RESULTS

Table 1 showed that previous experience of interprofessional learning has a positive group dynamic among radiographers and other healthcare professionals (rs= 0.207; p= 0.000). Gender had a positive significance (rs= 0.150; p= 0.003) and educational level had a significant negative relationship (rs= -0.192; p=0.000) with knowledge of interprofessional practice. Level of education had a negative significance (rs= -0.284; p= 0.000) while previous experience of interprofessional teaching had a positive relationship (rs= 0.108; p= 0.034) with readiness for interperofessional learning. Level of educational had a negative significance (rs= -0.299; p= 0.000) while discipline and previous experience of interprofessional learning had a significant positive relationship (rs= 0.130; p= 0.011) and (rs= 0.183; p= 0.000) respectively with perception and attitude towards interprofessional learning.

Table 1. IPL impacts on professional dynamics among healthcare professionals.

IPL dimension		Gender	Highest level of education	Discipline	Years of professional practice	Previous IPL experience
Radiographers' relationship with other health professionals.	Rs	0.059	-0.006	-0.068	-0.033	0.207**
	P-value	0.249	0.914	0.183	0.517	0.000
Knowledge of interprofessional practice.	Rs	0.150**	-0.192**	0.065	-0.066	0.012
	P-value	0.003	0.000	0.206	0.198	0.819
Readiness for interprofessional learning.	Rs	0.075	-0.284**	0.076	0.008	0.108*
	P-value	0.139	0.000	0.135	0.868	0.034
Perception and attitude towards interprofessional learning.	Rs	0.025	-0.299**	0.130*	-0.009	0.183**
	P-value	0.624	0.000	0.011	0.860	0.000

DISCUSSION

Previous IPL experience had significant positive relationship with radiographers' ability to accommodate, collaborate, form teamwork, resolve conflict and communicate effectively with other health professionals. This agrees with Olson and Bialocerkowski (2014) report that IPL can influence healthcare professional's view about others and provides solutions relating to differences in 'interdisciplinary' practice. This study affirm that previous IPL experience proves to have more positive chances to strengthen team dynamics and prevent the transfer of disciplines negative stereotypes into the workforce. Professionals with previous interprofessional learning experiences are accommodating for collaborative clinical practices. This study also agrees with Education Management Solutions (2017), as patients and clients are not the only ones who benefit from interprofessional learning as it promotes team mentality, satisfaction and healthcare professionals' continuity in clinical services. Shared learning with other healthcare professional through IPL opportunity might increase the ability to understand clinical problems, communicate better with patients and other professionals which agrees with previous studies (Coster *et al.*, 2008; Maharajan *et al.,* 2017). Interprofessional learning prepares and provides opportunities to develop good communication skills as independent working could lead to

overlooked symptoms or misdiagnosis which may result to readmission at a high cost both to the patient and the medical facility. Education Management Solutions, (2017) and Yu-Chi Lin *et al.,* (2013) also reported similar findings.

This study reveals that previous interprofessional learning experience promotes positive group dynamics between radiographers and other healthcare professionals. This evidence agreed with previous studies that learners with previous IPL experience demonstrate greater understanding of one's own and others' roles and the types of experience shapes participants perception relative to one another (Booysen *et al.,* 2012; Maharajan *et al.,* 2017; McGettigan and McKendree, 2015; Pinto *et al.,* 2012; Yu-Chi Lin *et al.,* 2013). This agrees with the assertion made by Seaman *et al.,* (2016) and WHO (2010) that interprofessional learning creates awareness and respect for other healthcare professionals' roles and responsibilities. This may improve appropriate patient referral among healthcare professionals and reduce medical cost and patients' readmission rate. It might increase healthcare professionals' job satisfaction and reduces disengagement from public clinical services thereby improving general patient care management. Healthcare professionals with previous interprofessional learning experience showed readiness for interperofessional learning. This study agrees with previous report by Booysen *et al.,* (2012) that the more mature and experienced learners are, the more favorably dispose they are towards IPL than the younger and less experienced learners. Participants who are more experienced in interactive learning were more disposed towards IPL.

Nevertheless, this study noted that respondents' level of education had a significant negative relationship with their knowledge of and readiness for and perception and attitude towards interprofessional learning. This proves that professions culture and stereotype in healthcare setting increases as one engages more in core discipline courses. This may imply that the more healthcare professionals' progresses in their discipline-specific academic awards the more stereotypes they become and less ready for interprofessional interaction. This noted that only scholars interested in learning about the other professions mostly utilize informal learning opportunities other than academic processes for core profession awardment. Awareness of this beacon on academic and clinical institutions for the need to incorporate IPL into continue professional progamme rather than only core professional courses as previous studies reported similar findings (Maharajan *et al.,* 2017; Pinto *et al.,* 2012; Reeves and Freeth, 2006). Generally, this study revealed that participants had a positive perception and attitude towards IPL which agrees with Booysen *et al.,* (2012) and Pinto *et al.,* (2012). This maybe as a result of differences in location of studies and research methodology. This study agrees Hammick *et al.,* (2007) that each profession has a varied expectation from IPL, revealing the differences in willingness to participate in IPL programme. This could be a contributing factor resulting from various models of IPL co-existing with each profession.

Summary of findings

Previous IPL experience showed significant positive relationship with radiographers' ability to accommodate, collaborate, form teamwork, resolve conflict and communicate effectively with other health professionals. Level of education had a negative significance with knowledge of ($r_s = -0.192$; $p = 0.000$), readiness for, perception and attitude towards IPL ($r_s = -0.299$; $p = 0.000$). In general, this implied noted increase in knowledge of interprofessional practice among healthcare professional in South-eastern Nigeria which may have had direct positive impact on professionals' readiness, perception and attitude towards interprofessional learning.

Conclusion

Level of education were of great influence on radiographers' relationship with other healthcare professionals which may have led to the observed differences in knowledge, readiness, perception, and attitude towards interprofessional learning among healthcare professions. There was evidence of ongoing interprofessional learning activity which may have led to the participants' good knowledge of, ready for, and positive perception and attitude towards IPL in this locality. Nevertheless, this study noted increase in knowledge of interprofessional practice among healthcare professionals. IPL may provide a solution relating to differences towards 'interdisciplinary' practice, creating path for socialization and improved knowledge towards interprofessional collaboration. These outcomes justify that there are much to be gained through interprofessional learning.

Recommendation.

Institutions should create harnessed opportunities to give healthcare professionals' further interprofessional training they need for authentic, customized and effective patient care management as a team.

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Appendix 1

INTERPROFESSIONAL LEARNING DYNAMIC SCALE (IPLDS)
BY
CHUKWUEMEKA HENRY ELUGWU

All the information provided here will be considered confidential and will only be used for the purpose of the study. Your name is not required; kindly give your sincere opinion by ticking in the appropriate box [√].

SECTION A (Socio-demographic data)

1. What age group do you belong to? (a) 20-29 [ ] (b) 30-39 [ ] (c) 40-49 [ ] (d) 50-59 [ ] (e) 60 & above.
2. Gender. (a) Male [ ] b) Female [ ] c) Others specify [……]
3. Which is your highest level of formal education? a) B.Sc / B.NSc / B.MLS / B.PT / B.Pharm / PharmD [ ] (b) MBBS [ ] (c) M.Sc / M.PT / M.Pharm [ ] (d) Residency [ ] (e) Ph.D [ ] (f) Consultant [ ].
4. Your discipline? (a) Dental Laboratory [ ] (b) Dietetics [ ] (c) Medical Laboratory [ ] (d) Medicine [ ] (e) Nursing [ ] (f) Pharmacy [ ] (g) Physiotherapy [ ] (h) Radiography [ ]
5. Name of your place of work …….
6. Total years of professional practice. (a) < 1[ ] (b) 1-5 [ ] (c) 6-10 [ ] (d) 11-15 [ ] (e) 16-20 [ ] (f) >20 [ ]
7. Which religion do you profess?
(a) African traditional religion [ ] (b) Christianity [ ] (c) Muslim [ ] (d) others specify […….....]
8. Marital status? (a) Single [ ] (b) Married [ ] (c) Separated [ ]
9. Have you had previous experience of interprofessional learning? Yes [ ] No [ ]

If you answered YES to question number (9), then answer (10) & (11):

10. When? (a) As a student [ ]. (b) As a staff [ ]
11. How often? (a) Occasionally [ ]. (b) Frequently [ ]. (c) Consistently [ ].

SECTION B (Relationships, Knowledge, Readiness, Perceptions and Attitude)

Please indicate your level of agreement with each of the following statements
Use the scale SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree.

STATEMENT:	**SD**	**D**	**N**	**A**	**SA**
Radiographers relationships with other health professionals					
1. Radiographers have a good understanding about our roles/responsibilities.					
2. Radiographers are usually willing to take into account our convenience when planning their work.					
3. Radiographers cooperate with the way we organize our health care plans.					
4. Radiographers do not usually ask for our opinion.					
5. Disagreement with radiographers often remains unresolved.					
6. Radiographers think their work is more important than the work of other health staffs.					
7. I feel that patient treatment and care are not adequately discussed among health professionals.					
Knowledge of interprofessional practice	**SD**	**D**	**N**	**A**	**SA**
1. I do place the interests of patients at the centre of interprofessional healthcare delivery					
2. I do respect the unique cultures, values, roles/responsibilities, and expertise of other healthcare professions.					
3. I do act with honesty and integrity in relationships with patients, families, and other team members.					
4. I do communicate effectively my roles and responsibilities clearly to patients, families, and other professionals.					
5. I do engage in continuous professional and interprofessional development programmes.					
6. I do avoid discipline-specific terminology when possible					
7. I do listen actively, and encourage ideas and opinions of other team members.					
8. I do share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care					
9. I do reflect on my individual performance for my improvement.					
10. I do maintain competence in my own profession appropriate to my scope of practice.					
Readiness for interprofessional learning	**SD**	**D**	**N**	**A**	**SA**
1. Learning with other professionals will make me a more effective member of a health care team.					
2. Patients would ultimately benefit if healthcare professionals worked together.					
3. Shared learning with other health care professionals will increase my ability to understand clinica problems.					
4. Communications skills should be learned with other healthcare professionals.					
5. Team-working skills are vital for all healthcare professionals.					
6. Shared learning will help me to understand my own professional limitations.					
7. Shared learning will help me think positively about other healthcare professionals.					
8. For small group learning to work, professionals need to respect and trust each other.					
9. I don't want to waste time learning with other health care professionals.					