Faculty perceptions of key factors in interprofessional education

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Abstract
Embedding interprofessional education (IPE) into academic programs presents structural, curricular and human factor challenges. Nurses and physicians comprise the dominant dyad in healthcare, and therefore nursing and medical faculty are key in guiding future IPE approaches. However, faculty experiences with IPE are rarely reported. This paper presents perceptions of medical and nursing faculty about key factors related to IPE for pre-licensure medical and nursing students. Semi-structured interviews with 32 faculty from three Midwest universities were analyzed thematically in this phenomenological study based on collaboration and cooperation theories. Findings clustered into six categories. Specific subthemes little discussed in the literature are addressed in detail. Study participants felt the most powerful interprofessional student experiences were authentic and faculty-facilitated, that constructive clinical environments were crucial, that curriculum design challenges included disparities between undergraduate and graduate education, and that leadership commitment to full-time and adjunct faculty engagement and development was imperative.

Introduction
Interprofessional collaboration has been associated with improved team behavior and reduced potential for medical error (Interprofessional Education Collaborative Expert Panel, 2011; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). Consequently, nursing and medical education programs are encouraged to embed interprofessional education (IPE) into curricula (Greiner & Knebel, 2003; World Health Organization, 2010).

Interprofessional education research has focused on learners’ attitudes, perceptions, knowledge, skills, behavior change (Barr, Koppel, Reeves, Hammick, & Freeth, 2005); practice and service improvements (Hammick, Freeth, Koppel, Reeves, & Barr, 2007; Reeves, Tassone, Parker, Wagner, & Simmons, 2012); cross-professions collaboration, IPE delivery and facilitation (Reeves et al., 2012), and relationships (Baker, Egan-Lee, Martimianakis, & Reeves, 2011). The continuing education of practicing professionals has received more attention than students (Reeves et al., 2012), and faculty perspectives even less (Lapkin, Levett-Jones, & Gilligan, 2013). Two studies explore IPE exclusively from faculty/facilitator perspectives. Lindqvist and Reeves (2007) found effective facilitation of even small interprofessional student groups was complex, required multiple attributes, and benefitted from peer support and debriefing. Bennett et al. (2010) found that faculty felt positively about IPE, but identified barriers: the need for executive level commitment, disparity in discipline-specific accreditation and regulation requirements, and lack of an evidence base. This study aimed to improve our understanding of faculty perceptions, by exploring the experiences of medical and nursing faculty helping pre-licensure students learn to collaborate inter-professionally and prepare for teamwork. Nursing and medical faculty comprise the sample because nurses and physicians form the central healthcare team dyad, but report conflicting perspectives on physician–nurse collaboration (Thomas, Sexton, & Helmreich, 2003; Thompson, 2007). Also, because including additional health professions would have made the sample size unwieldy.

Methods
The central research question was: which pedagogical and environmental factors do faculty use to help students learn interprofessional teamwork and collaboration, and what did they think about the experience? A constructivist epistemology which holds that human beings construct their own perceptions of the world (Patton, 2002) guided the study. A phenomenological method was used, which seeks to understand and interpret experience as described by the participant (Patton, 2002). Realities of the two faculty groups were explored, compared and analyzed for common themes.

Collaboration and cooperation theories guided construction of research questions, a semi-structured interview guide and data analysis. Collaboration is both a concept and dynamic theory, necessary for collective action (D’Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005; Rosen, 2007). Core elements include motivation based on shared goals and vision, competency,
knowledge-sharing, engagement and trust (D’Amour, Goulet, Labadie, San Martin-Rodriguez, & Pineault, 2008). Mutual benefit may also be accomplished when interpersonal dynamics are not ideal; cooperation theory explains these complex dynamics (Axelrod, 1997, 2006). Semi-structured interviewing allowed emphasis on participant perspectives and interests, while enabling the interviewer to probe and clarify meaning (Horton, Macve, & Stuyven, 2004; Patton, 2002).

Participants reflected on their experiences creating interprofessional learning environments to prepare students for collaborative teamwork. They were asked to describe: (1) experiences devising curriculum and pedagogy to help students learn to work collaboratively in interprofessional teams; (2) perceptions of how students gained a command of interprofessional collaboration; (3) experience with factors hindering IPE; and (4) experiences removing barriers to IPE. Interprofessional learning is defined in this study as occasions “when two or more professions learn with, from and about each other in order to improve collaboration and the quality of care” (Centre for the Advancement of Interprofessional Education, 2002).

Research sites and sampling
Faculty from three Midwestern universities with both prelicensure baccalaureate nursing and medical education programs participated. Two universities were public and one private, enrolling 10,000 to 40,000 students. Medical and nursing schools were of comparable size, affiliated with academic medical centers. Website information, faculty publications or grant partnerships showed faculty interest in IPE at the sites. A purposive sampling strategy was used seeking faculty with a minimum of five years relevant teaching experience, including direct responsibility for courses or experiences involving interaction with students from the other health profession. After identifying appropriate faculty through nursing school deans, websites listing medical school curriculum committees or collegial recommendation, faculty were contacted by one author. All 17 nursing faculty were female, and of the 15 medical faculty, 4 were female. Their mean ages were: nursing faculty, 51.3 years, and medical faculty, 54.5 years. Their mean years of teaching was 22 years (nursing) and 23.6 years (medicine).

Table I. Student centered themes (shading indicates discussion).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Cluster</th>
<th>Sub-theme</th>
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| Curriculum                  | Authentic experiential learning | • Authentic experience  
|                             |                        | • Spontaneous teachable moments  
|                             |                        | • Exemplars of authenticity  
| Faculty facilitated pedagogies |                        | • Mentoring/role modeling  
|                             |                        | • Debriefing  
|                             |                        | • Narrative reflection  
| Structured methods          |                        | • Evaluating student competency  
|                             |                        | • Simulated learning experiences  
|                             |                        | • Teaching communication  
| Collaborative methods       |                        | • Collaboration around common ground  
|                             |                        | • Peer learning  
|                             |                        | • Engaging other profession with students  
| Clinical Environments       | Positive influence on students | • Culture values quality, safety, collaboration  
|                             |                        | • Specialized, stable teams  
|                             | Negative influences on students | • Civility issues/conflict  
|                             |                        | • Poor role examples  
|                             |                        | • Students fearful of/intimidated by other profession  
| Student Roles & Role Understanding |                        | • Student role identity & comfort  
|                             |                        | • Student understanding/expectations other professions’ roles  
|                             |                        | • Team building in medical/nursing students  

Data collection
Five faculty from each nursing and medical school participated, plus two nursing faculty from one branch campus. All participants understood the definition of IPE, participated voluntarily, and gave informed consent. Individual interviews lasting 45–90 min were conducted by the co-investigator, were audio-recorded, and yielded 850 pages of transcription. The interviewer kept field notes to record environmental context, participant nonverbal behavior and reflections on participant stories. Participants were aware of the researcher’s stance and her background as a nursing faculty. The interviewer also kept a reflexive journal, and debriefed with the primary investigator and a research colleague.

Two methods of triangulation were used. Participants were sent individual transcripts, with requests to verify accuracy or modify. Documents were analyzed to verify participant mention of IPE in records, such as strategic plans, grant documents, curriculum plans, meeting minutes, program/graduation objectives, core competencies, syllabi or competency evaluation tools. Documents were provided by participants, or located on the university’s website.

Analysis
Data were analyzed thematically (Ayres, 2008), which permitted both attention to individual participant voices, and clustering of common experience. Data reduction was consistent with Miles and Huberman (1994) process of selecting, simplifying, abstracting and transforming data. NVivo 9 (QSR International, 2012), a qualitative data analysis software program, was utilized. Following three rounds of coding and data reduction, 44 codes were identified. These were grouped into six primary themes, then separated into two categories: student-centered (Table I), and environments and cultures (Table II). Associated subthemes (right column) were clustered (center column), and appear in order of frequency as discussed by participants. Thematic clusters and subthemes highlighted in gray are selected for discussion here because they are sparsely addressed in the literature from the faculty perspective. Each category is discussed separately below.
Faculty perceptions of IPE

Table II. Environment and cultures themes (shading indicates discussion).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Cluster</th>
<th>Sub-theme</th>
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| Educational Program Structures & Cultures | Academic medical center structures & logistics | • Programs in silos  
• Minimal opportunity for student connection  
• Scheduling  
• Competition for scarce resources  
• Saturated curriculum  
• Expansive class size |
| Structural curriculum design challenges |                       | • Interprofessional content in formal curriculum (there or not)  
• Curricular change (see below)  
• Pedagogical challenges  
• Matching student mastery levels  
• Matching student maturity levels |
| Organizational culture |                               | • Organizational culture and inertia  
• Perceived value of “soft” content |
| Faculty Engagement, Competency & Development Faculty Engagement | | • Building inter-faculty communication/relationships  
• Faculty engagement & development  
• Faculty perceptions of interprofessional education value |
| Resources |                                         | • Faculty workload/reimbursement  
• Creating faculty incentives  
• Accreditation standards  
• Funding vehicles  
• External press  
• Curricular reform  
• National models  
• Value of leadership “champion”  
• Align with department/university strategies  
• Involve ‘‘critical mass’’ of faculty colleagues |
| Curricular Change Considerations External Drivers | | • External Drivers |
| Strategies for success |                                               | • Involve ‘‘critical mass’’ of faculty colleagues |

Ethical considerations
The research protocol was approved by The Ohio State University Office of Responsible Research Practice.

Findings

Student centered themes/clusters

Twenty-two student-centered (sub)themes emerged, organized first into six clusters, then three major themes: curriculum, clinical environments, and student roles and role understanding. Major themes and clusters are discussed, with exemplars drawn from subthemes. Quotes are designated “N” for nursing and “M” for medical faculty.

Curriculum

Faculty described curricular successes and challenges. The first two clusters (Table I), authentic experiential learning and faculty facilitated pedagogies, were dominant and most frequently discussed overall.

Faculty said authentic experiences were the most powerful drivers of interprofessional learning. Although faculty valued simulation experiences, they differentiated authentic experiences as “‘real’”, non-contrived and requiring team collaboration to solve patient problems. Faculty attributed the power of authentic experience to associated patient outcomes and potential risk; students resolved to make meaningful contributions to team work because failure had tangible patient consequences. Faculty noted that embedding authentic collaborative experiences into pre-licensure education allows students to deepen understanding, and assures access to faculty-mentors:

I seek as much as possible to have experiential environments where there is authentic experience, where the student is doing the work themselves and where we’ve got their back. As opposed to the traditional way of following us around until you can actually do it. Then you look around and nobody’s there to help you. [Authentic experience provides] a way to learn the lessons at the depth they need to be learned…learning is not an intellectual exercise. Not when you’re going to be a care taker… (M-2).

Faculty took advantage of spontaneous teachable moments to engage students with the “other” profession. Faculty opportunistically prompted dialogue between students and other health professionals to reduce fear and increase confidence. Nursing students were encouraged to ask physicians patient questions; medical students were sent to nursing staff on patient fact-finding missions. One nursing faculty called it an:

…opportunity…Not that every time they see somebody they’re going to talk to them, but it’s that,…fear of talking to doctors, that they’re not going to bite their head off. (N-3).

Exemplars of authenticity included shadowing, international experiences, service learning and vulnerable populations care. Medical students shadowed nurses or medical assistants to better understand non-physician roles. International experiences, which took students out of their comfort zones, were unique because students and faculty shared a common mission, regulatory restrictions constraining roles were minimal or absent in developing countries, and close living/learning circumstances created community, often resulting in lasting professional relationships:

These groups…work very closely together…it’s really the only chance for physician attendings to work closely with nursing students, because many of the rules are different [internationally]…the opportunity for disciplines to separate themselves…is gone…so it’s all about the patient…(M-3).

Students involved in US-based interprofessional service learning, or care of vulnerable populations, were also displaced from their comfort zones. These experiences also built community, civic engagement and interprofessional relationships.
The cluster faculty facilitated pedagogies, illuminated faculty methods for helping students experiment with, and process, interprofessional collaboration. Three required particularly skilled faculty facilitation: mentoring and role modeling, debriefing, and narrative reflection. All discussed mentoring and role modeling as exceptional methods for helping students appreciate collaboration. Faculty mentored students through challenging interprofessional clinical situations, and modeled respectful communication focused on information-sharing, problem solving and goal attainment:

When I have learners . . . it is a constant non-stop interprofessional experience . . . they just see how I’m working with all these other professions. I try to model respectful communication and . . . emphasize how these people are helping me as the day goes on. That I think is as valuable as anything that I could do for the students. (M-5).

Debriefing was used by nursing and medical faculty following encounters with other health professionals, although approaches differed. Nursing students processed nurse–physician communication and the meaning of nursing’s contributions to teamwork. Medical faculty focused on the importance of extracting essential patient data from conversations with nurses:

We’ll say ‘‘why do you think there was a disconnect in the communication? . . . Was the nurse not clear in what she was trying to transmit to the physician? . . . Was she giving information that was really important to the patient’s care, or was this just . . . nice information but not . . . critically important . . . at that point in time?” (M-10).

Narrative reflection was used to help students explore complex interprofessional dynamics. Nursing faculty asked students to reflect on interactions with physicians, then used reflection to stimulate group discussion. The one medical faculty who talked about narrative reflection, emphasized its usefulness as both an instructional tool and opportunity to share voluntarily published student insights with the institution’s professional community to “bring forward issues of professionalism . . . empathy [and] . . . humanism . . . ” (M-8).

Clinical environments

The impact of clinical environments on students was the second strongest theme and a critical finding. More faculty discussed experiences in clinical environments with positive attributes than negative. However, the number of negative examples exceeded the number of positive (Table I).

Positive influence on student perceptions

Faculty identified clinical environments, where quality, safety and collaboration values were visibly practiced in the organizational culture, as the most critically influential. Students saw that patient care quality and safety trumped hierarchy and status, and collaborative behavior was the norm. They saw the effects of health care providers safely raising critical questions about care, stopping actions that potentially cause harm, and engaging in respectful and productive debate. Exposure to these environments helped students connect their academic learning about interprofessional collaboration to clinical applications. One faculty described the experience:

It’s trying to build the culture of question-asking, because . . . people get kind of defensive, so when . . . and I tell this to the students. If a nurse comes up to you and questions your order, you have to understand there could be one of a couple different things, and they’re all good. One is, you know, we all make mistakes. If the nurse says, ‘‘I think you’ve ordered the wrong dose here,’’ go back and check. If you look it up and say, ‘‘No, really, this is the prescribed dose,’’ that’s a good thing, because now the nurse has learned something. (M-2).

More than half the faculty discussed the attributes of specialized, stable teams and units, citing solid organ transplant, specialized pediatric, and palliative care units, operating rooms, or emergency departments as exemplars. Common characteristics emerged: (1) minimal staff turnover, allowing interprofessional relationships to develop; (2) a need for depth and breadth of expertise, producing close teamwork and flattened hierarchy; and (3) staff self-selection because they liked the work. One faculty described the benefits for students:

So what they [students] learned [was] expertise doesn’t live in a single discipline . . . They acquired some understanding of how their differences actually create capacity rather than their similarities . . . At first it’s just doing away with all stereotypes in the face of challenge. Then it’s working together—along the way, there’s usually some friction and disagreements. Then it’s really discovering capacity. (M-8).

Negative influences on student perceptions

More faculty expressed concern about student exposure to clinical environments enculturated by rigid hierarchies and power structures than other negative influences. Students appeared attentive to emotional subtexts and cultural norms, potentially cementing attitudes about interprofessional collaboration.

Incivility and open conflict in enculturated clinical settings was more disturbing, negatively influencing students and alarming faculty. Half the participants said students either witnessed, or were victims of incivility in clinical settings – incivility directed toward nurses by physicians, or incivility between nurses.

Faculty also identified the influence of poor role examples. Physicians or nurses occasionally behaved in ways that perpetuated the tension between medicine and nursing by acting unprofessionally during physician–nurse interactions, or undermining the other profession before a student audience. They did not cross an “incivility” threshold, but influenced student perceptions about the potential for healthy interprofessional collaboration.

Although faculty helped students reframe and cope with these occurrences, they expressed concern about the potential effects of unprofessional behavior on impressionable students:

Although a focus on medical and nursing students is valuable, an equally if not more valuable focus is on how . . . practicing physicians and nurses interact with one another. It’s the lived experience that the students observe in the clinical context, or even in the academic context, that is going to set the stage for what they do with one another. (M-6).

Fear of, or intimidation by, the other profession was mentioned as a problem for both nursing and medical students by six participants. Faculty said students from both groups were sometimes reluctant to approach the other profession, anticipating unpleasant encounters based on previous experience.

Faculty found it challenging to manage student reactions to negative clinical environments, and contemplated changes needed
in some clinical settings. One faculty speculated that leverage will come from students:

I think our students may quickly get to the point where they go, ‘we’re creating an interprofessional culture here [the academic setting] that’s not mirrored in the clinical years, so what’s up?’…students are actually pushing us to make changes in the competencies, and I’m hopeful that our students would push us to make changes in culture… I think our students will demand it if we don’t. (M-9).

Environment and culture themes/clusters
Table II presents Environment and Cultures themes. Two clusters, structural curriculum design challenges (in the theme ‘Educational Program Structures & Cultures’) and faculty engagement (in the theme ‘Faculty Engagement’) are highlighted. These clusters revealed elements faculty perceived as central to the development of successful IPE.

Structural curriculum design challenges
These factors were associated with actualizing an interprofessional curriculum within and across departments. These included faculty-wide awareness of the presence or absence of IPE in the formal curriculum, interdepartmental curriculum development, pedagogical challenges and issues matching student abilities. Faculty said these challenges are associated with typical silo structures in academic medical centers.

Particularly notable was the inconsistency in faculty awareness about the presence of IPE content in the formal curriculum. Participants in leadership positions or members of relevant committees were clearer about the formal presence of IPE; others were less certain. Nursing faculty were familiar with inclusion of relevant competencies required by accreditation standards. Medical faculty clarity about education competencies was more variable, because accreditation competencies are less specific. IPE content was generally elective rather than required, more often simulation-related, or grant-funded. Broad curricular changes, underway in two institutions, presented opportunities for integrating IPE. The most daunting pedagogical challenges described by faculty involved comprehensive IPE curricular integration. Faculty used terms such as ‘consistency’ and ‘critical mass’ to illustrate the dilemma:

So I think [the] challenge is… How does that [IPE experience] touch them to the extent that they actually learn what you think they should be learning?… So if they have a simulation here, and… another… over here, what happens in the middle?… what’s connecting these two experiences, if anything?… if we can’t figure out a way to build on that, [nothing’s] gonna help us because no one student will ever get enough of it to make that transition from ‘That’s interesting’ to ‘Oh, I know how to do that’. (N-9).

Two sub-themes, matching student mastery levels and matching student maturity levels revealed faculty perspectives on fundamental differences between pre-licensure undergraduate nursing students and graduate medical students. Faculty described student mastery as profession-specific knowledge and skill sets. Faculty noted that medical students are strong in graduate level sciences. However, nursing students, who are exposed concurrently to sciences, nursing content, and clinical skills early, had the edge in clinical applications. The differences became apparent during simulation experiences:

Figuring out the right match; what level of nursing student fits with what level of medical student and… the content, that they have been exposed to… We have to make sure they have the skill set to be successful in some of these interactions… (N-12).

Both medical and nursing faculty differentiated student maturity from mastery, particularly that differences in age and life experience affected student comfort with cross-profession communication.

Faculty engagement
This factor was perceived as essential for effective IPE implementation. Three subthemes emerged from this cluster. First, successful faculty sought joint grant/research opportunities, committee memberships or international experience which often segued into teaching partnerships, later developing into durable interprofessional relationships. Second, participants discussed faculty engagement and development in terms of commitment to curricular IPE, openness to interdepartmental relationships, and competency to engage in IPE. Barriers were identified: (1) among curricular priorities, IPE ranks low and faculty allocate energy accordingly; (2) colleagues with less exposure to collaborative cultures were harder to convince about IPE; (3) programs depend on large cadres of adjunct/clinical faculty, practicing physicians and nurses in roles limited to clinical teaching; and (4) IPE faculty development efforts are undermined by competing time commitments and budget constraints. The adjunct issue appeared critical:

I think our biggest problem is the massive use of adjunct faculty… They don’t come to the meetings. They don’t have to, so it’s hard to set a tone… When you have 700 students… you have to use adjuncts… I feel like that’s a real drawback… (N-6).

Finally, faculty perceptions of IPE value were most affected by competing curricular and time elements, the complexities of sharing resources interdepartmentally, and the need for parallel and comprehensive changes in both schools’ curricula:

I don’t think you can do this piece by piece… I think the resistance comes from the acknowledgement that two schools at the least would have to significantly change their curricula in order to accommodate it at the level it needs to be done. Maybe that’s just too daunting. (N-2);

And

We just haven’t put the time and money in the effort to sitting together to coordinate that. (M-10).

Discussion
The task of preparing health profession students for interprofessional teamwork is complex. Understanding the faculty experience is important, especially for medical and nursing faculty. They prepare the students who form the central nurse–physician dyad. Although evidence linking IPE to improved patient outcomes and reduced healthcare costs remain unclear (Reeves et al., 2013), participants were committed to IPE. Our analysis found that nursing and medical faculty shared remarkably similar
perspectives, and illuminated the factors that faculty perceived as critical for successful IPE. The findings were consistent with other studies, but also revealed fresh perspectives.

Authentic experiences provide depth (Gonzalo, Haidet, & Wolpaw, 2014), strengthen didactic learning and its relevance to clinical practice (Dornan et al., 2006), and foster relationships (Manninen, Henriksson, Scheja, & Silen, 2013). Participants in this study concurred: authentic experiences deepened student appreciation for teamwork, provided opportunities for building relationships intra- and inter-professionally, and inspired students to test collaborative approaches alongside faculty mentors. The usefulness of tools, such as debriefing and narrative reflection has been discussed (Clark, 2009; Rudolph, Simon, Raemer, & Eppich, 2008; Sambunjak, Straus, & Marusic, 2006). This study underscores how these tools help students internalize collaborative knowledge, skills and attitudes.

The most robust exemplars of authentic clinical experiences identified by faculty were those where students worked alongside high-functioning collaborative teams. Creating these experiences was limited by the availability of placements, and faculty commitment and time required for making arrangements. The unique attributes provided by international experiences in countries with less rigorous, or absent, health profession regulations were also revealed. These findings emphasize the importance of revisiting regulatory standards to allow for greater IPE innovation (Josiah Macy Jr. Foundation, 2013). Additionally, faculty valued the usefulness of role modeling and mentorship, particularly at pre-licensure levels where close supervision is possible, even though definitions of role modeling and mentorship vary within the literature and advantages appear unclear (Benbassat, 2014; Hoffman, Harris, & Rosenfield, 2008; Sambunjak et al., 2006).

Students perceive IPE more positively when academic experience and professional practice connect (Oandasan & Reeves, 2005a). Faculty participants said clinical environments where nursing and medical staff exemplified collaborative, quality-driven patient care created optimal IPE opportunities. Faculty felt that incivility, disruptive behavior and derogatory/cynical humor negatively affected student education (Berk, 2009; Luparel, 2011). A Joint Commission Alert (2008) has also linked intimidating and disruptive behavior to medical error, poor patient satisfaction and preventable adverse outcomes. Nonetheless, faculty reported poor behaviors in some clinical settings, incidences that undermined student perceptions of interprofessional collaboration, and frustrated faculty efforts to link IPE theory to practice.

Structural curricular challenges included logistics typical of academic medical centers, such as curricular differences, student scheduling and faculty workload (Oandasan & Reeves, 2005b). However, faculty noted others. The first was the inconsistency in faculty awareness about IPE being formally present within a single program. Factors accounting for variability included personal involvement in IPE, relevant committee membership or departmental position.

Matching undergraduate nursing and graduate medical students also presented challenges. Age differences have been explored (Anderson & Thorpe, 2008), and IPE positioning in the curriculum has favored early integration (Oandasan & Reeves, 2005a). Faculty participants differentiated curricular timing from a mastery differential, explained as student capacity for engaging in IPE experiences, based on content preparation. Typical curriculum plans in nursing and medical education may account for the mastery gap. Nursing integrates content and clinical application early in the curriculum, whereas medicine introduces clinical applications later. While each student population demonstrates strengths, medical students may need more preparatory coaching in clinical applications, and nursing students may need more in interprofessional communication. Some faculty circumvented this gap by introducing material new to both groups, e.g. quality improvement methods.

Faculty described complex and varied barriers to engagement, ranging from engaging resistant peers, to building relationships and sharing resources interdepartmentally. These factors have consistently hindered IPE integration (Bennett et al., 2010; Oandasan & Reeves, 2005b). Although participants agreed that committed executive leadership was imperative (Bennett et al., 2010), grassroots faculty efforts were also effective. Participants at two sites built cadres of faculty supporters, which expanded IPE engagement and neutralized resisters.

Particularly noteworthy were interconnected issues of inad- equate faculty development, and large numbers of adjuncts. Development focused on faculty IPE preparation is critical (Steinert, 2005). Faculty development activities mentioned by participants were attended by ‘regular’ faculty, but clinical adjuncts lacked time, and attendance was unfunded. Adjunct clinical expertise is valuable, but the difficulty of engaging them in curricular discussions accounts, in part, for disconnects between IPE theory and clinical implementation.

In relation to study limitations, faculty who participated were committed to IPE. All nursing faculty participants were female. The proportion of women medical faculty was representative, but distributed unevenly among the three institutions. All the institutions were research intensive universities, located in the Midwest, and affiliated with large academic medical centers. Faculty from institutions otherwise Carnegie classified, smaller, from stand-alone programs (e.g. nursing only), or from different regions might produce different results. The single-interview method was used; a longitudinal study might further illuminate faculty experience.

Concluding comments

In this study we investigated perceptions of IPE through a faculty lens. The focus of this article was limited to selected findings little discussed from faculty perspectives in the literature: the complexities of intentional curriculum design and pedagogy, the influence of clinical environments, the importance of inter-faculty partnerships, and the preparation and engagement of faculty.

Participants felt the most powerful interprofessional experiences were authentic, and occurred in environments that valued patient quality and safety over hierarchy. Meaningful IPE experiences were planned and executed collaboratively and interdepartmentally. The best clinical circumstances were those where students could depend on excellent faculty role modeling, and help to process their experiences in context. The importance of preparing students in advance to assure parity in content mastery and equivalency in experiential outcomes was emphasized.

Implications for educators and administrators include engaging and preparing faculty by setting IPE as a priority, structuring departments to encourage inter-faculty collaboration, increasing opportunities for authentic student experience, using effective pedagogy, and preparing students who differ in maturity and mastery for interprofessional experiences. Methods for greater student contact with high-functioning collaborative teams, pedagogies to assure student capacity to achieve IPE outcomes despite mastery differentials, and inclusive faculty engagement should be explored. Also, it is critically important to integrate IPE consistently throughout the curriculum, engage adjunct clinical faculty as well as regular faculty, and join forces with clinical partners to create genuinely collaboration-friendly clinical environments. Finally, policy makers should revisit regulations that inhibit IPE innovation.
Further research is needed to compare the value and costs of authentic clinical experience with simulation. Faculty experience with IPE at different types of institutions should be explored. Finally, further research is needed to examine attitudinal and institutional factors underpinning fundamental change toward IPE. The faculty participants in this study considered IPE objectives both worthwhile, and a formidable commitment.

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

References


