

BMJ Open Longitudinal impact of preregistration interprofessional education on the attitudes and skills of health professionals during their early careers: a non-randomised trial with 4-year outcomes

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ABSTRACT

Objective To assess whether a preregistration interprofessional education (IPE) programme changed attitudes towards teamwork and team skills during health professionals' final year of training and first 3 years of professional practice.

Design Prospective, longitudinal, non-randomised trial.

Setting Final year health professional training at three academic institutions in New Zealand.

Participants Students from eight disciplines eligible to attend the IPE programme were recruited (617/730) prior to their final year of training. 130 participants attended the IPE programme; 115 intervention and 372 control participants were included in outcome analysis.

Intervention The 5-week Tairāwhiti IPE (TIPE) immersion programme during which students experience clinical placements in interdisciplinary teams, complete collaborative tasks and live together in shared accommodation.

Main outcome measures Data were collected via five surveys at 12-month intervals, containing Attitudes Towards Healthcare Teams Scale (ATHCTS), Team Skills Scale (TSS) and free-text items. Mixed-model analysis of covariance, adjusting for baseline characteristics, compared scores between groups at each time point. Template analysis identified themes in free-text data.

Results Mean ATHCTS scores for TIPE participants were 1.4 (95% CI 0.6 to 2.3) points higher than non-TIPE participants ($p=0.002$); scores were 1.9 (95% CI 0.8 to 3.0) points higher at graduation and 1.1 (95% CI -0.1 to 2.4) points higher 3 years postgraduation. Mean TSS scores for TIPE participants were 1.7 (95% CI 0.0 to 3.3) points higher than non-TIPE participants ($p=0.045$); scores were 3.5 points (95% CI 1.5 to 5.5) higher at graduation and 1.3 (95% CI -0.8 to 3.5) points higher 3 years postgraduation. TIPE participants made substantially more free-text comments about benefits of interprofessional collaboration and perceived the TIPE programme had a meaningful influence on their readiness to work in teams and the way in which they performed their healthcare roles.

Conclusions TIPE programme participation significantly improved attitudes towards healthcare teams and these changes were maintained over 4 years.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This is a prospective, longitudinal, non-randomised trial of an immersive interprofessional education intervention, delivered to final year health students from eight disciplines.
- ⇒ Data were collected through validated scales and free-text comments over participants' final year of training and first 3 years of professional practice.
- ⇒ Group allocation was non-randomised and students who were more interested in interprofessional education may have chosen to attend the interprofessional programme.
- ⇒ The degree of Attitudes to Health Care Teams Scale or Teams Skills Scale change needed to indicate a meaningful change in clinical practice is unknown.
- ⇒ This study assessed learner attitudes and self-perceived teamwork skills but did not objectively measure teamwork skills, impacts on patient care or patient outcomes.

INTRODUCTION

Interprofessional practice enables different and complementary skill sets to contribute to collaborative, safe and high-quality healthcare.¹⁻³ Most health regulators require that graduates are competent to work within collaborative healthcare teams. This has prompted universities and training providers to offer interprofessional education (IPE) to preregistration healthcare students.⁴

IPE is integral to creating a collaborative practice-ready health workforce.⁵ IPE occurs when health professionals or students from two or more disciplines intentionally learn with, from and about each other.⁶ Evaluations of preregistration IPE have found improvements in students' collaborative knowledge, skills and attitudes.⁷ Short-term evaluations have found increases in knowledge and skills required for collaborative practice, improved

student attitudes towards collaboration and improved clinical behaviour and patient care,^{1 3 7 8} however, very few studies have assessed the longer term impact of preregistration IPE on subsequent professional practice, including whether immediate postgraduation changes are maintained over time and how interprofessional competencies and professional behaviour change during the early years of a health professional's career.^{9–12} There is also a paucity of data to indicate how interprofessional attitudes and teamwork abilities change over time irrespective of exposure to IPE.⁷ Worldwide, health professional training programmes have been urged to provide IPE despite a lack of evidence to demonstrate long-term changes in learners' attitudes, skills or clinical practice. Experimental longitudinal studies are needed that compare the interprofessional attitudes and skills of practising health professionals who did and did not participate in IPE programmes when they were students during their preregistration training.¹³

The Longitudinal Interprofessional Study was designed to examine the long-term impacts of attending a 5-week immersion programme delivered during health professional students' final year of preregistration training.¹⁴ The principal aim of the study was to assess whether participation in the IPE programme influenced attitudes to interprofessional teams and teamwork abilities observed at graduation and over the first 3 years of professional practice in the disciplines of dentistry, dietetics, nursing, medicine, occupational therapy, oral health, pharmacy and physiotherapy.

METHODS

Study design

This was a 5-year quasiexperimental study with non-randomised, non-equivalent groups (those who attended the Tairāwhiti IPE (TIPE) programme and those who did not) and annual data collection points. This survey study was underpinned by a pragmatic postpositive paradigm¹⁵ containing free-text items to give further meaning and context to quantitative items. The study was conducted in accordance with the published protocol¹⁶ and findings are reported in accordance with the Transparent Reporting of Evaluations with Nonrandomized Designs (TREND) statement (online supplemental material 1).¹⁷

Participants

Senior students from health professional degree programmes eligible to take part in the TIPE programme were invited to participate in the study prior to commencing their final year of preregistration training. This included all students from a single-year cohort from the disciplines of: dentistry, dietetics, oral health, pharmacy, physiotherapy (University of Otago); medicine (University of Otago Wellington, a secondary campus of Otago University); nursing (Eastern Institute of Technology) and occupational therapy (Otago Polytechnic). These disciplinary cohorts represented all students who

were eligible to attend the TIPE programme. There were no exclusion criteria, but participants were withdrawn if they did not successfully complete their final year of training and, therefore were ineligible for professional registration.

Participants were recruited in two cohorts. Cohort 1, recruited in October 2014 (all disciplines except oral health and pharmacy) or February 2015 (pharmacy), represented all students who were eligible to attend the TIPE programme in 2015, a subset of whom participated in the programme. Cohort 2, recruited in February 2016 (all disciplines), represented students who were expected to attend the 2016 TIPE programme.¹⁶ Cohort 1 participants were recruited in class lectures, whereas cohort 2 participants were recruited via email invitation. Institutional administrative data were used to assess response rates to baseline surveys for each discipline involved.

Intervention

The TIPE programme caters for 70–75 final year preregistration students each year, drawn from a mix of health disciplines. Interprofessional collaborative practice,^{18 19} indigenous Māori health (hauora Māori),^{20 21} rural health and long-term condition management²² are the pillars of the 5-week immersion programme. The programme is underpinned by adult learning theories, with a focus on building social relationships and creating non-threatening learning environments.¹⁹ The programme is run in a region that has a high Māori (indigenous) and remote rural population and low levels of income and employment. Interprofessional learning outcomes are based on six core competency domains: communication; role clarification and appreciation; reflective practice; leadership and followership; shared decision-making and teamwork. Students experience supervised clinical placements in their own discipline (c.50%) and interdisciplinary teams (c.30%) and also complete collaborative tasks (c.20%). Students live and socialise together in shared accommodation for the duration of the programme. Teaching and learning are provided across diverse town and rural settings by an interprofessional teaching team employed by the University of Otago.^{14 23} Participants are required to successfully complete all aspects of the programme in order to graduate.

Control group students did not attend the TIPE programme (but were eligible to) and attended supervised clinical placements in their own discipline. Some of these students may have been opportunistically exposed to informal and/or less intensive (fewer hours and not involving living together) IPE opportunities.

Assignment

Enrolment of individual students into the TIPE programme was not random and varied depending on each discipline's requirements, as detailed in the protocol.¹⁶ Many students (but not all) deliberately choose to attend the programme; this may be due to interest in interprofessional practice, rural health and/or

hauora Māori. Only a portion of those who wish to attend are able to do so. No blinding was possible.

Outcomes

Participants' attitudes towards healthcare teams were assessed with the Attitudes Towards Health Care Teams Scale (ATHCTS),²⁴ as modified by Curran *et al.*²⁵ The ATHCTS contains 14 items on a five-point Likert scale; scores range from 14 to 70, with higher scores representing more positive attitudes towards teamwork. Participants' self-assessed ability to function within inter-professional teams was assessed with the Team Skills Scale (TSS).²⁶ The TSS contains 17 items on a five-point Likert scale; scores range from 17 to 85, with higher scores representing higher self-reported skills to function within an inter-professional team. The modified ATHCTS^{27 28} and the TSS^{29 30} were selected due to their high internal consistency when completed by student and graduate health professionals.

Free-text items elicited further information about scale responses and other comments about interprofessional care or the survey itself. For those who took part in the TIPE programme, surveys 3–5 (postgraduate) contained four additional items: two items on experiences of working in interprofessional teams; one item exploring the preregistration preparation to work in interprofessional teams and one item exploring the influence of TIPE on career choices. These items were placed at the end of the survey (and in this order) to minimise influence on other responses.

Data collection and survey instruments

Data were collected via surveys at baseline and 12-month follow-up intervals, capturing the end of the final year of training (survey 2) and first 3 years of professional practice (surveys 3–5). Baseline data for cohort 1 were collected by paper-based survey and inputted into an Access database (Microsoft, Redmond, Washington). Baseline data for cohort 2 and follow-up data for both cohorts were collected by a web-based survey (IBM Data Collection; IBM, Armonk, New York) administered by an independent research company. Follow-up surveys were administered each September to November (in 2015–2018 for cohort 1 and 2016–2019 for Cohort 2). Surveys contained sociodemographic items, the two standardised inter-professional outcome scales and free-text items online supplemental material 2. Surveys 2 and 3 data collection instruments and methods were piloted with a group of nurses to enable refinements of item wording and data collection processes; pilot nurses were recruited at the same time as cohort 1, but graduated 6 months ahead of cohort 1 participants.

Participant retention was maximised by collecting and regularly updating a range of contact details, regular communication with study participants, offering a certificate for completing each survey (that could count towards professional development requirements) and offering prizes for completion of each survey as well as

a larger prize for completing all surveys. Non-responders were followed-up with reminder phone calls and emails or texts (according to participant preference).

Cohort 1 participants who did not graduate as expected (eg, those studying part time, deferring studies or failing to meet course requirements) but who met registration requirements before July 2016 were included with their original cohort. Cohort 1 TIPE participants who met registration requirements between July 2016 and June 2017 were moved to cohort 2 for survey 3–5 data collection. Non-TIPE participants who met registration requirements after July 2016 and TIPE participants who met registration requirements after July 2017 were withdrawn from the study. TIPE participants who did not complete the programme were withdrawn from study.

Study size

Study size was determined by the number of students eligible to attend the TIPE programme from a single-year cohort. Cohort 2 was recruited from students who attended the TIPE programme in 2016 to increase power to detect differences between TIPE and non-TIPE groups (it was not feasible to recruit an additional complete year group). There were no major changes in curriculum influencing the comparability of cohort 1 TIPE participants to those from Cohort 2.

Statistical methods

Data analyses at individual student level were conducted using SAS V.9.4 software (SAS Institute, Cary, North Carolina). Baseline demographic, ATHCTS and TSS characteristics were compared for the TIPE and non-TIPE groups and for TIPE cohorts 1 and 2. Demographic items were compared with Wilcoxon rank-sum tests/Kruskal-Wallis tests or χ^2 tests. Baseline ATHCTS and TSS were compared with t tests. Mixed-model analysis of covariance compared scores, adjusted for discipline, baseline demographics, ATHCTS and TSS, with terms for whether graduates participated in the TIPE programme, time of survey, the interaction of TIPE programme and time and random terms for individual students. The impact of loss-to-follow-up and missing data was investigated with multiple imputation that included all the variables in the analysis model.

Qualitative analysis methods

Free-text data in surveys 3–5 were extracted from Excel documents into Word documents and managed in NVivo V.12 (QSR International). The qualitative analysis method has been described in depth elsewhere.³¹ In brief, template analysis was used to provide a systematic way of analysing the large data set while allowing in-depth thematic analysis.^{32 33} Unlike other forms of qualitative analysis that typically have only one or two levels of coding, it is common to use four or more levels to capture the most detailed aspects of the data.³⁴

Free-text analyses were undertaken by a team of qualitative researchers experienced in reflexive thematic analysis

(MB, BD, SP and EM). The initial template was based on the survey questions, with new versions of the template repeatedly updated as a priori themes changed and new codes were identified (online supplemental material 3). Initial coding was undertaken independently by one researcher (MB) on a line-by-line basis; items were analysed per survey, per cohort and per item, with each item coded separately; for example, responses to the item 'For what reason/s have you chosen to work or train in (clinical setting)' were coded under a separate grandparent node to responses to the item 'For what reason/s have you chosen to work or train in (location)'. The analysis explored variations and similarities across surveys and within context of the related quantitative findings (ie, survey year, cohort, study ID, demographics and related quantitative responses). Codes and categories were developed iteratively across surveys and crosschecked by a second researcher (BD), with all differences resolved through regular discussions. Themes and subthemes

were further examined to find and interpret patterns and outliers, as is typical in reflexive forms of thematic analysis. Thus far, codes had been applied survey-by-survey (ie, all data from one survey were analysed before moving to the next survey); MB and BD then crosschecked the coding by applying the template item-by-item (ie, each item was checked across all surveys before proceeding to the next item). Theme documentation was checked and discussed with other authors regularly throughout the analyses, from initial template development and template modifications until final themes and subthemes were agreed on by all researchers to ensure themes represented the data. In addition, the research team compared themes and data extracts with the quantitative survey results to find and interpret commonalities and differences—that is to say, instances where the free-text responses supported or expanded on the closed-question answers, and instances where contradictions existed. The relative frequency of themes within and across the longitudinal surveys is

Table 1 Baseline characteristics of TIPE and non-TIPE participants

Characteristic	TIPE cohort 1 (n=59)	TIPE cohort 2 (n=71*)	P	TIPE (n=130*)	Non-TIPE (n=443*)	P	Total
Female	66.1% (39/59)	75.4% (49/65)	0.26	71.0% (88/124)	69.9% (309/442)	0.82	70.1% (397/566)
Age	22 (22–23) n=59	23 (21–24) n=65	0.58	23 (21–24) n=124	22 (21–23) n=442	0.003	22 (21–24) n=566
Ethnicity†							
NZ European	59.3% (35/59)	60.9% (39/64)	0.85	60.2% (74/123)	55.0% (243/442)	0.31	56.1% (317/565)
Maori	10.2% (6/59)	14.1% (9/64)	0.51	12.2% (15/123)	5.9% (26/442)	0.017	7.3% (41/565)
Pacific	0.0% (0/59)	1.6% (1/64)	1.00	0.8% (1/123)	1.4% (6/442)	1.00	1.2% (7/565)
Chinese	16.9% (10/59)	10.9% (7/64)	0.33	13.8% (17/123)	17.4% (77/442)	0.34	16.6% (94/565)
Indian	8.5% (5/59)	6.3% (4/64)	0.64	7.3% (9/123)	4.3% (19/442)	0.17	5.0% (28/565)
Other	13.6% (8/59)	17.2% (11/64)	0.58	15.4% (19/123)	22.6% (100/442)	0.084	21.1% (119/565)
Discipline			0.40			<0.0001	
Dentistry	15.3% (9)	12.7% (9)		13.8% (18)	15.3% (68)		15.0% (86)
Dietetics	13.6% (8)	14.1% (10)		13.8% (18)	4.7% (21)		6.8% (39)
Medicine	20.3% (12)	12.7% (9)		16.2% (21)	15.1% (67)		15.4% (88)
Nursing	16.9% (10)	14.1% (10)		15.4% (20)	9.0% (40)		10.5% (60)
Occupational therapy	3.4% (2)	5.6% (4)		4.6% (6)	12.2% (54)		10.5% (60)
Oral health	0.0% (0)	8.5% (6)		4.6% (6)	0.0% (0)		1.0% (6)
Pharmacy	20.3% (12)	18.3% (13)		19.2% (25)	27.1% (120)		25.3% (145)
Physiotherapy	10.2% (6)	14.1% (10)		12.3% (16)	16.5% (73)		15.5% (89)
Previous location			0.020			0.95	
Major urban city	59.3% (35/59)	32.3% (21/65)		45.2% (56/124)	45.0% (197/438)		45.0% (253/562)
Regional city	23.7% (14/59)	32.3% (21/65)		28.2% (35/124)	28.5% (125/438)		28.5% (160/562)
Small town	8.5% (5/59)	20.0% (13/65)		14.5% (18/124)	16.0% (70/438)		15.7% (88/562)
Very small town/remote	8.5% (5/59)	15.4% (10/65)		12.1% (15/124)	10.5% (46/438)		10.9% (61/562)
ATHCTS	55.1 (5.3) n=57	55.5 (4.8) n=65	0.63	55.3 (5.1) n=122	53.3 (5.4) n=436	0.0003	53.8 (5.3) n=558
TSS	55.1 (13.9) n=57	52.6 (11.6) n=63	0.27	53.8 (12.8) n=120	54.8 (11.3) n=426	0.39	54.6 (11.7) n=546

*Six TIPE participants and one non-TIPE participant did not provide any Survey 1 (baseline) data.

†Participants could identify with more than one ethnicity.

ATHCTS, Attitudes Towards Health Care Teams Scale; TIPE, Tairāwhiti Interprofessional Education Programme; TSS, Team Skills Scale.

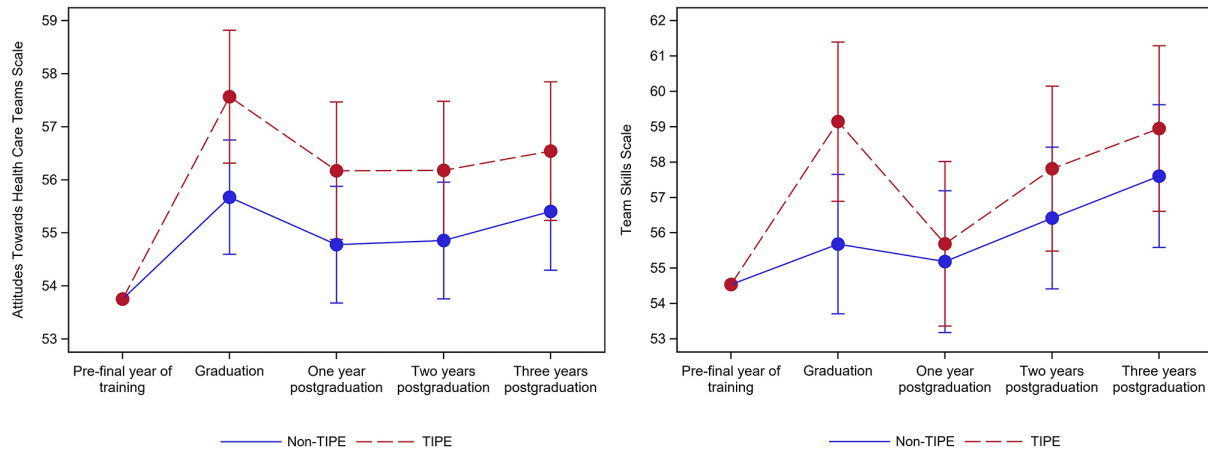


Figure 1 Changes in Attitudes Towards Health Care Teams Scale (left) and Teams Skills Scale (right) for those who did and did not participate in the Tairāwhiti Interprofessional Education Programme (TIPE). TIPE, Tairāwhiti Interprofessional Education Programme.

reported; using frequency and numerical data within a contextually based interpretation such as template analysis provides a broad sense for how different factors vary in importance to the participants and how these change over time (without mechanically linking isolated variables out of context).³⁵

Role of the funding source

The funder had no role in the study design, collection, analysis and interpretation of the data; writing of the protocol, or in the decision to submit the paper for publication.

Patient and public involvement

Students and early career health professionals were not involved in the design or conduct of this study. Regular study updates were sent to participants during the study. Results will be shared directly with study participants using existing distribution lists and shared with broader health professional and education communities through publication, presentation at scientific meetings, and through social media platforms.

RESULTS

Participants

Participant flow for both cohorts (including participant numbers at each follow-up and reasons for non-participation) is seen in online supplemental material 4. In total, 730 students were invited to participate (cohort 1 n=651, cohort 2 n=79), of which 611 completed the baseline survey (non-TIPE n=481, TIPE cohort 1 n=61, TIPE cohort 2 n=69). Following baseline data collection, 6 participants joined TIPE cohort 2, 40 participants were withdrawn as they did not complete their final year of training and 4 participants were withdrawn because they did not complete their TIPE placement. Baseline age, gender and ethnicity were broadly comparable between groups (despite a statistical difference for age) (table 1). Mean ATHCTS scores at baseline were higher in the TIPE

group than the non-TIPE group (mean (95% CI) 55.3 (54.4 to 56.2) vs 53.3 (52.8 to 53.8)).

Response rates ranged from 88% of invited participants completing survey 2 (see online supplemental material 4) to 73% of invited participants completing survey 5 (TIPE=87%; non-TIPE=69%). TIPE participants were significantly more likely to complete their fifth survey than non-TIPE participants ($p<0.0001$). There was no significant difference in survey 5 response rates between TIPE cohort 1 and cohort 2 ($p=0.71$). Dietetic, female and NZ European participants were less likely to be lost to follow-up. Those of other ethnicities and those with lower baseline ATHCTS scores were more likely to be lost to follow-up.

Outcome scales

The differences in adjusted ATHCTS scores between TIPE and non-TIPE students were not significantly different between the surveys (interaction of exposure and time $p=0.70$). Mean scores for TIPE participants were significantly higher than non-TIPE participants ($p=0.002$). Mean TIPE participant scores were 1.9 (95% CI 0.8 to 3.0) points higher at graduation and 1.1 (95% CI -0.1 to 2.4) points higher 3 years postgraduation (figure 1).

The differences in adjusted TSS scores between TIPE and non-TIPE students were significantly different between surveys (interaction of exposure and time; $p=0.040$). Mean TSS scores for TIPE participants were significantly higher than non-TIPE participants ($p=0.045$). Mean-adjusted scores for TIPE participants were 3.5 (95% CI 1.5 to 5.5) points higher at graduation than and 1.3 (95% CI -0.8 to 3.5) points higher 3 years postgraduation (figure 1).

The estimates from multiple imputation, that included all the variables in the analysis model, were similar to those from the complete data analysis (see online supplemental material 4).

Table 2 Frequency of themes from free-text comments made after completing Attitude Towards Health Care Teams and Teams Skills Scales

Interprofessional teamwork—attitudes and experiences	Number of comments*					
	One year post-graduation		Two years post-graduation		Three years post-graduation	
	TIPE (n=117)	Non-TIPE (n=320)	TIPE (n=115)	Non-TIPE (n=305)	TIPE (n=113)	Non-TIPE (n=298)
Benefits of interprofessional teams or collaboration	103	16	98	8	78	17
▶ Enjoyable or positive	39	5	34	3	29	7
▶ Others' expert perspectives, support, learning	37	5	32	0	28	2
▶ Patient care, experiences and outcomes	27	6	32	5	21	8
Challenges of interprofessional teams or collaboration	41	34	56	27	35	29
▶ Not on the same page, role/input not understood or valued	18	20	27	16	26	14
▶ Inefficient, inconvenient for example, time pressures, paperwork	16	9	20	8	3	11
▶ Hard to communicate for example, availability, staffing issues, incompatible software	7	5	9	3	6	4
Interprofessional interaction outside of formal team	32	19	29	28	29	17

*Participants could make more than one free-text comment within an item response. TIPE, Tairāwhiti Interprofessional Education Programme.

Qualitative findings

Participants made 696 free-text comments in surveys 3–5 relating to interprofessional attitudes and skills (tables 2 and 3). Most participants in the TIPE group, and a few

participants in the non-TIPE group, used this opportunity to expand on their quantitative scale responses. Three themes were identified: 'benefits of interprofessional teams or collaboration'; 'challenges of interprofessional

Table 3 Examples of free-text comments made after completing Attitude Towards Health Care Teams and Teams Skills Scales

Interprofessional teamwork—attitudes and experiences	Examples of comments (TIPE and non-TIPE)
Benefits of interprofessional teams or collaboration ▶ Enjoyable or positive ▶ Others' expert perspectives, support, learning ▶ Patient care, experiences and outcomes	<ul style="list-style-type: none"> – At times can be daunting when you are new to the team or it is a complex case. However I always find I learn more from others working this way.—Survey 5, TIPE, Dietetics, #1768 – I really enjoy having others to explore reasons behind patients' challenges and come up with creative solutions to manage these that I may not have come up with in my own. The IDT is a great source of support when working with difficult cases.—Survey 5, TIPE, Physiotherapy, #0317
Challenges of interprofessional teams or collaboration ▶ Not on the same page, role/input not understood or valued ▶ Inefficient, inconvenient, for example, time pressures, paperwork ▶ Hard to communicate for example, availability, staffing issues, incompatible software	<ul style="list-style-type: none"> – At times it can be very difficult when other members of the team don't value your opinion.—Survey 3, TIPE, Nursing, #0258 – Sometimes meetings take too long... you do not need a Registered house officer and a consultant at the meeting. We have real work to do and while MDTs are important you don't need all the doctors there if one knows all the patients.—Survey 3, non-TIPE, Medicine, #8376
Interprofessional interaction outside of formal team	<ul style="list-style-type: none"> – Some collaboration with local GPs/pharmacists on the telephone to discuss patients' needs.—Survey 3, TIPE, Dentistry, #9045 – My current role [in community pharmacy] does not involve many interactions as much as I'd like, but when I do I ensure to approach each situation from an interdisciplinary approach.—Survey 5, TIPE, Pharmacy, #4640

GP, general practitioner; IDT, interdisciplinary team; IPE, interprofessional education; MDT, multidisciplinary team.

Table 4 Frequency of themes from free-text comments made by Tairāwhiti Interprofessional Education programme graduates about influence of pre-registration training on their professional practice

Influence of pre-registration training on preparation for workforce and TIPE on career	Number of comments*		
	One year post-graduation (n=117)	Two years post-graduation (n=115)	Three years post-graduation (n=113)
Participated in an IPE course	102	90	93
▶ TIPE helpful	34	21	32
The way I do my job	102	87	83
▶ Understand others' roles/perspectives	17	16	6
▶ Connecting with other health professionals	48	30	43
▶ Collaborating to prioritise patient well-being	15	10	7
▶ Thriving in interprofessional teams	15	15	16
▶ Hit the ground running	4	5	5
▶ Interprofessional champions	0	2	1
No perceived influence	22	14	24

*Participants could make more than one free-text comment within an item response.
IPE, interprofessional education; TIPE, Tairāwhiti Interprofessional Education Programme.

teams or collaboration'; 'interprofessional interaction outside of formal teams'. Additional examples of verbatim extracts for each theme are given in online supplemental material 5.

Comments about interprofessional benefits were split across three main areas: (1) a positive and enjoyable experience (2) support and learning received from other health practitioners and (3) enabling better patient care, experiences and outcomes. Almost all of the comments regarding benefits (across all surveys) were from TIPE participants.

Comments about interprofessional challenges particularly related to not feeling valued or understood. Other subthemes were related to inefficient processes or communication difficulties. Fewer comments were made about interprofessional challenges than benefits by TIPE participants, while more comments were made about challenges than benefits by non-TIPE participants. Comments about interprofessional interactions outside of formal teams (or lack thereof) were often made by clinicians working in primary care.

Three themes were identified from TIPE participants' comments related to how preregistration training (of any type) prepared them for working in teams or the influence of TIPE on their careers (table 4). The two most common areas of comment were that the TIPE prepared them to work in interprofessional teams and influenced the way in which they performed their job. A smaller number of comments indicated that TIPE participation had not influenced their career. Examples of verbatim extracts for each theme are given in online supplemental material 6.

DISCUSSION

Students who attended the TIPE programme became more positive about teamwork and their teamwork skills over the course of their final year of preregistration

training than students who did not attend. TIPE participants' attitudes to healthcare teams remained higher during their first 3 years of clinical practice than those of their peers who did not attend TIPE. Despite representing just 5 weeks out of 3–6 years of each student's training, the TIPE programme had a measurable impact on learner attitudes that was statistically significant and sustained longterm.

The quantitative changes in attitudes measured were supported by longitudinal free-text analysis,³⁶ with the qualitative findings indicating a greater impact of the IPE programme than the degree of score change on the quantitative scales. These early career health professionals described key benefits that they perceived arose from interprofessional teamwork, along with the challenges that they faced when working in teams. Graduates who attended the TIPE programme made substantially more (unprompted) comments about the benefits of interprofessional collaboration across the full 3 years of graduate follow-up than those who did not attend. Many TIPE graduates perceived that the programme had a meaningful influence on their readiness to work in teams and the way in which they performed their healthcare roles.

Strengths and limitations

This study recruited a high proportion of the eligible population and had excellent retention rates over prolonged follow-up, reducing the risk that findings were influenced by non-response bias. Results from multiple imputation and complete case analyses were similar. Although students were aware of the nature of the research, most had little investment in the quantitative outcomes, reducing potential for scores to be affected by social desirability bias.

To our knowledge, this is the first study to explore the impact of preregistration IPE on early career



health professional attitudes and skills using a quasi-experimental design. This study also has the longest post-IPE programme follow-up, covering not only the final year of preregistration training but also the first 3 years of professional practice. Pollard and Miers found that after 9–12 months of qualified practice, graduates exposed to an interprofessional curriculum had higher Interprofessional Relationships Scale scores than those who experienced a uniprofessional curriculum. However, these two cohorts were from different year groups, had different disciplinary composition and represented only one-third of eligible participants rather than an entire year cohort.³⁷

Despite the ATHCTS and TSS having high internal consistency, the degree of change necessary to indicate a meaningful change in clinical practice has not been established; it is possible that the outcome scale changes shown in this study are not observable in clinical practice; however, the related qualitative findings indicate that there was a meaningful impact on practice. A key limitation of this study is that although it captures learner attitudes to healthcare teams and self-perceived teamwork abilities, it was not able to independently measure teamwork skills nor impact on patient care or outcomes. Objective assessment tools of interprofessional competencies are available,³⁸ but conducting these assessments with such a large number of participants working in very diverse practice settings over time was not feasible.

Exposure to the TIPE programme was the key difference between graduates in both arms of our study, with all other elements of their education being broadly comparable. Allocation to the TIPE programme was not random and many students (but not all) deliberately chose to attend; this choice may have been related to their interest in interprofessional practice. TIPE students had more positive attitudes to healthcare teams at baseline, but these were controlled for in analytic models. Consistent with other TIPE evaluations, those who attended the TIPE programme reported valuing the experience highly; this may have made them more positive about the impact of the experience on their subsequent careers.^{23 39}

Longitudinal analysis of free-text comments allowed exploration of changes through time³⁶ and integration of free text and quantitative findings.⁴⁰ Variations in theme frequencies across the longitudinal surveys were crucial to understanding the context (rather than generalisability) of how participants perceived the importance of different factors over time. However, we used inferential statistics from the quantitative data to compare those who participated in TIPE and those who did not because it was not appropriate to use frequency counts of qualitative data to make such comparisons.

There is a paucity of studies exploring the effects of pregraduation IPE learning activities during health professionals' early careers. Postgraduate recollections of preregistration IPE experiences and perceived impacts

of IPE on teamwork abilities have been reported previously.^{39 41 42} Hylin *et al* found that graduates, who had spent 2 weeks in an interprofessional training ward, had lasting positive and negative impressions of this course and they considered that they promoted teamwork in the workplace 18 months postgraduation.⁴² Graybill *et al* found that the former students recalled IPE experiences after they had completed their training and they were in the workplace.⁴¹ Our study extends these findings through longer duration follow-up, the inclusion of a non-IPE exposed control group, the ability to quantify the relative proportions of graduates who did and did not perceive a lasting impact from IPE participation, and the contextually based integration of free-text findings to aid interpretation of the quantitative results.

Meaning and implications

This study indicates that immersive IPE programmes for senior preregistration students improve teamwork skills and attitudes to collaborative practice, which are sustained over time. The 5-week TIPE programme is resource intensive and involves a relatively small number of students at one time. The magnitude of the quantitative changes observed may cause some to question whether this is a useful investment. This study should increase the confidence that short-term changes in interprofessional competence previously observed are maintained over time. The TIPE programme is specific to the setting in which it is delivered; however, it is likely that these findings could be generalised to similarly intense preregistration IPE programmes elsewhere, provided these provide a similar mix of learning experiences and learning outcomes.

CONCLUSIONS

An explicit interprofessional training experience improved attitudes towards healthcare teams and these changes were maintained over 4 years. Perceptions of teamwork skills improved at graduation. Participation in the TIPE programme appeared to influence how early career clinicians from a range of disciplines viewed their skills and performed their roles.

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REFERENCES

- Lapkin S, Levett-Jones T, Gilligan C. A systematic review of the effectiveness of interprofessional education in health professional programs. *Nurse Educ Today* 2013;33:90–102.
- Oandasan I, Baker GR, Barker K. Teamwork in Healthcare: promoting effective teamwork in health care in Canada. In: *Canadian health services research Foundation*, 2006.
- Reeves S, Lewin S, Espin S. *Interprofessional teamwork for health and social care*. Wiley-Blackwell, 2010.
- Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010;376:1923–58.
- World Health Organisation. *Framework for Action on Interprofessional Education & Collaborative Practice (WHO/HRH/HPN/10.3)*. World Health Organisation: Health Professions Network Nursing & Midwifery Office: Department of Human Resources for Health, 2010.
- Centre For The Advancement Of Interprofessional Education. Interprofessional Education – A Definition. In: *CAIPE Bulletin*. 13, 1997.
- Nelson S, White CF, Hodges BD, et al. Interprofessional team training at the Prelicensure level: a review of the literature. *Acad Med* 2017;92:709–16.
- Darlow B, Coleman K, McKinlay E, et al. The positive impact of interprofessional education: a controlled trial to evaluate a programme for health professional students. *BMC Med Educ* 2015;15:98.
- Browne FR, Zuccherio Renee' A, Hooker EA, et al. Longitudinal outcomes of a brief interprofessional educational experience with or without an interprofessional education course. *J Interprof Care* 2021;35:74–82.
- Cox M, Cuff P, Brandt B, et al. Measuring the impact of interprofessional education on collaborative practice and patient outcomes. *J Interprof Care* 2016;30:1–3.
- Reeves S, Pelone F, Harrison R, et al. Interprofessional collaboration to improve professional practice and healthcare outcomes. *Cochrane Database Syst Rev* 2017;6:CD000072.
- Reeves S, Perrier L, Goldman J. Interprofessional education: effects on professional practice and healthcare outcomes (update). *Cochrane Database Syst Rev* 2013;2013:Cd002213.
- McNaughton S. The long-term impact of undergraduate interprofessional education on graduate interprofessional practice: a scoping review. *J Interprof Care* 2018;32:426–35.
- Pullon S, Gallagher P, McKinlay E. Interprofessional education in a rural clinical setting: a quick start innovation for final year health professional students – case study. In: Bin K, Abdulrahman K, Mennin S, et al, eds. *Handbook of medical education*. New York: Routledge International, 2015: 197–9.
- Giddings LS, Grant BM. A Trojan horse for positivism?: a critique of mixed methods research. *ANS Adv Nurs Sci* 2007;30:52–60.
- Darlow B, Brown M, Gallagher P, et al. Longitudinal impact of interprofessional education on attitudes, skills and career trajectories: a protocol for a quasi-experimental study in New Zealand. *BMJ Open* 2018;8:e018510.
- Des Jarlais DC, Lyles C, Crepaz N, et al. Improving the reporting quality of nonrandomized evaluations of behavioral and public health interventions: the trend statement. *Am J Public Health* 2004;94:361–6.
- Hean S, Craddock D, Hammick M, et al. Theoretical insights into interprofessional education: AMEE guide No. 62. *Med Teach* 2012;34:e78–101.
- Oandasan I, Reeves S. Key elements for interprofessional education. Part 1: the learner, the educator and the learning context. *J Interprof Care* 2005;19 Suppl 1:21–38.
- Durie M. Te whare tapa whā. In: Tipene-Leach D, ed. *Whaiora: Maori health development*. Auckland, NZ: Oxford University Press, 1998.
- Pere RR, Nicholson N. *Te wheke a celebration of infinite wisdom*. 2nd ed. Wairoa, NZ: Ao Ako Global Learning New Zealand, 1997.
- Wagner EH, Sandhu N, Coleman K, et al. Improving care coordination in primary care. *Med Care* 2014;52:S33–8.
- McKinlay E, Gallagher P, Wilson C, et al. Social learning, shared accommodation and interprofessional education: I think those conversations that you have at the dinner table *J Interprof Educ Pract* 2016;5:1–6.
- Heinemann GD, Schmitt MH, Farrell MP, et al. Development of an attitudes toward health care teams scale. *Eval Health Prof* 1999;22:123–42.
- Curran VR, Sharpe D, Forristall J. Attitudes of health sciences faculty members towards interprofessional teamwork and education. *Med Educ* 2007;41:892–6.
- Hepburn K, Tsukuda RA, Fasser C. Team skills scale. In: *Team performance in health care: assessment and development*. New York: Kluwer Academic/Plenum Publishers, 2002.
- Curran VR, Sharpe D, Forristall J, et al. Attitudes of health sciences students towards interprofessional teamwork and education. *Learning in Health and Social Care* 2008;7:146–56.
- Hayashi T, Shinozaki H, Makino T, et al. Changes in attitudes toward interprofessional health care teams and education in the first- and third-year undergraduate students. *J Interprof Care* 2012;26:100–7.
- Curran V, Heath O, Adey T, et al. An approach to integrating interprofessional education in collaborative mental health care. *Acad Psychiatry* 2012;36:91–5.
- Fulmer T, Hyer K, Flaherty E, et al. Geriatric interdisciplinary team training program: evaluation results. *J Aging Health* 2005;17:443–70.
- Brown MJ, Pullon S, McKinlay E, et al. Template analysis of a longitudinal interprofessional survey: making sense of free-text comments collected over time. *J Res Interprof Pract Educ* 2022;12.
- Cassell C, King N. Using templates in the thematic analysis of text. In: Cassell C, Symon G, eds. *Essential guide to qualitative methods in organizational research*. London: SAGE Publications Ltd, 2004.
- King N. What will hatch? A Constructivist Autobiographical account of writing poetry. *J Constr Psychol* 2008;21:274–87.
- Brooks J, McCluskey S, Turley E, et al. The utility of template analysis in qualitative psychology research. *Qual Res Psychol* 2015;12:202–22.



- 35 Maxwell JA. Using numbers in qualitative research. *Qualitative Inquiry* 2010;16:475–82.
- 36 Balmer DF, Richards BF. Longitudinal qualitative research in medical education. *Perspect Med Educ* 2017;6:306–10.
- 37 Pollard KC, Miers ME. From students to professionals: results of a longitudinal study of attitudes to pre-qualifying collaborative learning and working in health and social care in the United Kingdom. *J Interprof Care* 2008;22:399–416.
- 38 Curran V, Hollett A, Casimiro LM, *et al.* Development and validation of the interprofessional collaborator assessment rubric (ICAR). *J Interprof Care* 2011;25:339–44.
- 39 Pullon S, Garrett S, Garnett A, *et al.* Five years on: influences on early career health professionals from a rural interprofessional pre-registration immersion program. *Aust J Rural Health* 2021;29:146–57.
- 40 Rohrer JM, Brümmer M, Schmukle SC, *et al.* "What else are you worried about?" - Integrating textual responses into quantitative social science research. *PLoS One* 2017;12:e0182156.
- 41 Graybill E, Heggs A, Truscott S, *et al.* Using the critical incident technique to measure long-term outcomes of interprofessional education. *J Interprof Care* 2017;31:533–6.
- 42 Hylén U, Nyholm H, Mattiasson A-C, *et al.* Interprofessional training in clinical practice on a training ward for healthcare students: a two-year follow-up. *J Interprof Care* 2007;21:277–88.