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The Ohio State University

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ASSESSING THE IMPACT OF INTERPROFESSIONAL EDUCATION ON THE ATTITUDES AND BEHAVIORS OF PRACTICING PROFESSIONALS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

Mark Harold Spencer, B.A., M.ED.

* * * * *

The Ohio State University
1983

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I wish to thank my parents for their support of my academic endeavors. Son Stephen and daughter Barbara have contributed joy. Final thanks, and love, is expressed to my most constant supporter, and my best friend, my wife Beverly.
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CHAPTER I
INTRODUCTION

An Overview

Interprofessional education is new; it has evolved in part in response to the increased complexity of contemporary societies. Interprofessional education and interprofessional practice as developed thus far address the fact that more and more traditional professionals are finding their competencies outstripped by the problems that people bring to them. Many of these problems are intricately interwoven—not singularly emotional, physical, or psychological. Webs of complexity surround issues that in prior times were simpler and more likely to yield to the ministration of a single professional such as the family doctor, the pastor, or the teacher. Baffling problems such as depression, child abuse, unemployment and alcoholism, might well make us yearn for days when an occasional ulcer, the common cold, or now and then a low grade on a report card were our most serious concerns (Cunningham, 1982).

Interprofessional education, and its intended product, interprofessional practice, are in part responses to criticisms of the professions and the traditional education of
the professions. In its 1972 *Profile on Professional Education* by Edgar H. Schein, the Carnegie Commission on Higher Education enumerated a number of criticisms being directed at the professions. Among them are:

The Professionals are so specialized that they have become unresponsive to certain classes or social problems that require an interdisciplinary or interprofessional point of view.

Professionals have become unresponsive to the needs of many classes of ultimate clients or users of the services, working instead for the organizations that employ them.

Professional education is almost totally geared to producing autonomous specialists and provides neither training nor experience in how to work as a member of a team, how to collaborate with clients in identifying needs and possible solutions, and how to collaborate with other professionals on complex projects.

Professional education provides no training for those graduates who wish to work as members of and become members of intra- or inter-professional projects teams working on complex problems.

Professional education generally under-utilizes the applied behavioral sciences, especially in helping professions to increase their self-insight, their ability to diagnose and manage client relationships and complex social problems, their ability to sort out the ethical and value issues inherent in their professional role, and their ability to continue to learn throughout their career (p. 59-60).

The traditional professional-client dyad, with attendant autonomy and omniscience of the professional, is under attack. In fact, the most pronounced shift in the traditional Western therapeutic dyad is probably a departure from the dyad itself (Wilson, 1970).

Today's professional and today's client both find themselves in a different environment, and bring new dimensions
to the practitioner/client relationship. Today's professional faces an incredible knowledge explosion. New technologies are being introduced at a breathtaking pace. To keep pace, the professional is forced to be very selective as to areas of concern, creating specialization and compartmentalization. The technologies and instruments which have made treatment breakthroughs possible have in turn diminished the need for training in interpersonal skills. In order to realize the economic benefits traditional to the professionals, today's professional is "a professional corporation," often accompanied by a corporate response to clients.

Many of today's clients are part of the "Future Shock" generation. The popular press and self-help authors have encouraged a more sophisticated client than ever before. Clients want to "pull their own strings," be informed about their state of health, and participate in decision-making. Today's consumer has a "factory-outlet" approach to costs of services but a litigious malpractice approach to quality of services. Client emphasis is on treatment of the whole person. The swirling environments around today's professional and today's client create a complex professional/client situation.

**Background of the Problem**

While the concept of interprofessional collaboration is not new in health care (Whitehouse, 1951; Patterson, 1959), the concept of a team approach involving a larger set of
human service professionals is relatively new (Ducanis and Golin, 1979; Kindig, 1975). Ducanis and Golin, who are involved in the education of health professionals at the University of Pittsburg, make these statements in their 1979 volume, *The Interdisciplinary Health Care Team*:

More and more in recent years, responsibility for the provision of human services to patients, clients, and others is shared by an interdisciplinary team of professionals. Underlying this development is the major assumption that an interdisciplinary team will bring together diverse skills and expertise to provide more effective, better coordinated, better quality services for clients.

Although the team approach has been widely heralded as a promising innovation in the delivery of human services, to date the concept has generated more rhetoric than research and an adequate theory of teams has yet to be formulated (p. 1).

What are the antecedents of team involvement? Heilman (1977) reviewed the literature and conducted a number of interviews in order to identify the competencies needed by health care personnel to function as a health care team. He was able to produce a list of 51 competencies, and also emphasized the need to develop training programs to assure the acquisition and use of the teaming competencies. One set of authors recognized three modes of educating teams: **pre-professional training** - exposing students to teams as a part of their professional training program; **continuing education** - workshops or seminars offered to practicing professionals; and **team development** - in-service training for members of an existing team or for persons within an organization (Ducanis and Golin, 1979).
The first of the three modes, pre-professional education, is the focus of interprofessional education for purposes of this study. A recent survey of a sample of 175 professional schools (including allied health, dentistry, nursing, medicine, and social work) yielded information about interprofessional education (Ducanis and Golin, 1979). With 124 schools (71%) responding, 90% of the respondents replied affirmatively regarding the importance of having specific curricular provision for teaching the functions of the health care team, 79% had considered such a course or unit, but only 34% actually had such a course in the curriculum. In interviews with some of the 34% offering a course, it was found that the course was an elective and considered by the students to be peripheral to their professional training.

While interprofessional education is by no means widespread, examples do exist. Experimental or continuing programs are reported at the Medical College of Virginia; The Division of Interdisciplinary Programs of the School of the Health Related Professions, University of Pittsburgh; Institute for Health Team Development at Montifiore Hospital and Medical Center in New York City; Office of Interprofessional Education in the Health Services, University of British Columbia; Yale Medical School; Colorado; Miami; University of Indiana; University of California San Francisco; John Hopkins; University of Wisconsin; University of Nevada Reno; and Medical College of Georgia (Harris, 1978; Ducanis and Golin,

One of the most ambitious programs of interprofessional education is in its tenth year at The Ohio State University. In the early 1970's, The Ohio State University and three Columbus area theological schools--Methodist Theological School in Ohio, Trinity Lutheran Seminary, and Pontifical College Josephinum--were involved in a reciprocal arrangement concerning the teaching of some interdisciplinary courses. Other educational institutions and professional organizations in the area were following their example. Dr. Van Bogard Dunn, Dean of the Methodist Theological School, was the catalyst to bring the various components together and evolve a structure. He enlisted the support of Ralph Widner, Director of the Academy for Contemporary Problems; Rudolph Janata, President of the Ohio Bar Association; and Dr. Donald Vincent, Director of Medical Education at Riverside Hospital in Columbus. Together they explored the feasibility of interprofessionally preparing those persons entering the helping professions of medicine, law, education, social work, and ordained ministry for more effective service.

The group expanded to include broader representation, and the structure formed. Known as "The Commission on the Role of the Professions in Society," its first director was Dr. Robert Browning of the Methodist Theological School. It then piloted its first intercollegiate seminar on ethical issues.
In its beginning, the Commission had no continuing operating budget or staff, so funding was constantly being sought to maintain and expand its work. Housing and most expenses were provided by the Academy for Contemporary Problems, and grants from the Board of Regents and the OSU Provost's office supported program development. In 1976 the Commission moved into the Mershon Center.

As the financial burdens eased, the Commission concentrated on the expansion of course offerings. The experimental intercollegiate seminar was again offered and open to students from law, medicine, nursing, education, social work, public administration, and theology. In 1975 new courses were designed and taught on ethical issues, total health care, and changing societal values. A three-day symposium on "Technology, Bureaucracy, and the Professions" was held that year, as was a two-day continuing education symposium which was a general overview of interprofessional education.

In 1976, Mrs. Mary Janata became the Commission's director. In 1977, the courses were regularized and offered in the official OSU Course Offering Bulletin. The Deans of the various member colleges began providing support from their budgets in the form of funds and faculty time.

1977 was also a year which saw structural changes which allowed the Commission to broaden its representation. A subcommittee on membership had been formed in response to inquiries from other colleges to join the Commission. A three-level structure, including an executive committee,
board of directors, and assembly, was established. The name was changed to "The Commission on Interprofessional Education and Practice," the name it retains today (Cunningham, et al, 1982).

A 1975 Harvard University national survey of interdisciplinary educational activities stated that the O.S.U. Commission was unique in the nation because of the number and breadth of professions involved (Alexander, 1975). After offering just one course involving students from four professions in its initial year, the Commission now coordinates four courses and a Summer Institute, involving students from seven professions and more than forty faculty members from the constituent academic areas.

**Statement of the Problem**

The interprofessional education program at The Ohio State University as well as other program examples have produced a limited amount of empirical evidence regarding impact on professional practice. The effectiveness of interprofessional teams themselves have been studied, the various educational programs have utilized end-of-course type evaluation, and students have been in field-based clinical experiences, but there is little evidence linking a preprofessional interprofessional educational program to later attitudes toward or involvement in interprofessional practice.
The Ohio State University Commission on Interprofessional Education and Practice listed three objectives in a 1981 grant proposal: 1) to introduce interprofessional education into the curricular structures of its respective units, 2) to train faculty teams from those academic units in planning and teaching interprofessional credit courses for students from the seven professions, and 3) to make practitioners aware of the possibilities of interprofessional practice through continuing educational programs which raise ethical, social, and clinical issues in interprofessional settings.

That grant proposal, accepted for funding by the W. K. Kellogg Foundation, specifically suggested evaluation regarding "the effect of pre-service courses in ethics, values, and teamwork on subsequent professional practice." Two graduate students working with the Commission proposed a survey research project consisting of a questionnaire sent to past course participants now in professional practice. The researchers posed two questions to guide in the development of the questionnaire: 1) What is the relationship between participation in a Commission course and subsequent attitudes toward, and involvement in, interprofessional cooperation? and 2) What are the differences among seven professions regarding interprofessional education and practice?

The present study was part of the larger assessment just described. The purpose of this study was to investigate the
influence of participation in interprofessional courses upon interprofessional attitudes and interprofessional practice. Three research questions were developed using a method for classifying types of information collected in survey research. In his 1978 book, *Mail and Telephone Surveys*, Dillman suggested that questions can be classified as requesting one or more of these types of information:

1. What people think is true: their beliefs;
2. What people say they want: their attitudes;
3. What people do: their behavior; and
4. What people are: their attributes.

Beliefs are an assessment of what a person thinks is true or false or what the person thinks exists or does not exist. Beliefs are comparable to awareness.

Attitudes are evaluative in nature and reflect respondents' views about the desirability of something. Attitude questions use words such as favor versus oppose, prefer versus not prefer, good versus bad, and desirable versus undesirable.

Behavior questions concern a respondent's actions or practice. They are a self-report of what a person did, is doing, or plans to do in the future.

Attribute questions deal with personal or demographic characteristics. Attribute information is usually collected to explore how belief, attitude, and behavior information differs for persons with various attributes. (p. 80)

The items contained in the various sections of the questionnaire were developed to explore the following research questions:

1. What is the influence of participation in interprofessional courses upon the beliefs of professionals regarding interprofessional education and practice?
2. What is the influence of participation in interprofessional courses upon the attitudes of professionals toward interprofessional education and practice?

3. What is the influence of participation in interprofessional courses upon the behavior of professionals with regard to interprofessional education and practice?

Overview of Research Procedures

A questionnaire was developed to assess the influence of participation in Commission-facilitated interprofessional courses on subsequent "Beliefs," "Attitudes," and "Behaviors" of professionals. The questionnaire was sent to approximately 400 practicing professionals who had taken an interprofessional course, and a matched group of 400 professionals who had not taken such a course. An initial mailing plus one follow-up mailing yielded 370 usable returns, representing a 47% return rate.

Influence on "Beliefs" was measured in three sections of the questionnaire. One section utilized a five-point response scale to a list of interprofessional issues. Two additional sections utilized a three-point scale for responses to lists of obstacles to and enablers of interprofessional cooperation. "Attitudes" were assessed using a five point Agreement/Disagreement scale to generate reactions to a list of attitude statements. "Behaviors" of respondents were assessed using Yes/No responses and open-ended responses.

Correlation coefficients were generated to explore the relationship between the independent variable, course
participation, and the dependent variables of Beliefs, Attitudes, and Behaviors. Correlation coefficients were evaluated on three criteria:

1. **Strength of relationship.** Correlation coefficients range from -1.0 to +1.0. The larger the coefficient, the stronger the suggested relationship.

2. **Pattern of relationship.** Correlation coefficients can be either positive or negative, depending on the contextual meaning of the questionnaire item. A stronger relationship is implied where the coefficients carry the sign anticipated. A pattern is implied when items whose coefficients are similarly signed also are compatible contextually.

3. **Consistency of relationship.** The more consistent the size and pattern of coefficients, the stronger the implied relationship.

**Summary**

The "Overview" section of this chapter introduced some of the changes which have occurred in the traditional roles of both the professional and the client in society. In the "Background of the Problem" section, interprofessional/interdisciplinary cooperation was presented as one method of enhancing effective professional services. Interprofessional education was suggested as a possible antecedent of increased interprofessional cooperation. The "Problem" for the study was assessing the impact of interprofessional education on subsequent professional practice. A questionnaire was organized around four types of information--Beliefs, Attitudes, Behaviors, and Attributes. The final
section of the chapter provided an overview of research procedures.

Chapter II will present a summary of related literature in four parts. First, additional references will be cited to supplement ideas presented in Chapter I regarding the need for interprofessional education. Second, the professions and professional education will be discussed to lead to the more specific topics which follow. Third, information regarding interprofessional teams and interprofessional education will be presented. The fourth part of Chapter II will consist of a brief summary in the shape of a conceptual framework for interprofessional education, with The Ohio State University's Commission program discussed in terms of the framework.
CHAPTER II
RELATED LITERATURE

The task of this study was to explore the impact of an interprofessional educational experience. In Chapter I the concept of interprofessional education was introduced. In this chapter related literature will be reviewed and a conceptual framework for interprofessional education will be developed.

The Need for Interprofessional Education

Cyril Houle commented on the changing environment in which professionals find themselves.

The intervention of the general public and of specific clientele groups is becoming bolder than ever before - often with the overt and covert support of at least some members of the professions concerned. Lay citizens are being selected for boards, commissions, and policy committees that were formerly wholly professional in their composition. Periodic reassessment of competence is becoming commonplace. Bureaus representing clients in their dealings with professionals are being institutionalized in governments and corporations. Private associations of consumers and citizen action groups are springing up everywhere. The number and variety of cases taken to courts or other adjudicative bodies is increasing. Payment for professional services is coming to a much greater extent than before from government, insurance companies, or other organizations that demand both competence and cost effectiveness. (Houle, 1980, p. 14)
Mention was made in Chapter I of the problem of professional insularity. Professional schools have been designed to produce autonomous specialists. According to Schein (1972), society is generating problems that require interdisciplinary team efforts for their solution and professionals who are less and less able to take part in interdisciplinary problem-solving efforts. The professions have been criticized for failing to develop connections with other professions and failing to train practitioners in the skills of working collaboratively with other professions. Schein continued:

The price of progress has been growing complexity and the interdependence of the different segments of society, resulting in social problems of corresponding complexity and interdependence. Yet the professions in general have not been able to look at problems holistically, have not used total-systems concepts, have not identified the interconnections between the areas they are traditionally responsible for, and have not striven to reduce the conceptual boundaries that exist between their underlying disciplines (p. 36).

Schein illustrated his point with an example of a professor of architecture hired to help various American Indian tribes in the design of their schools, homes, and other buildings. The architect had to work with the bureaucrats in government positions and with the Indian leaders, but reported the most difficulty working with the other professionals involved in the project—educators, economists, and lawyers—each of whom wanted to control the project (p. 28).

Rosalie Kane has also written extensively on the subject of interprofessional teams. Her 1978 monograph,
Interprofessional Teamwork, has been widely read in social work since its publication. Kane summarized four reasons for interprofessional teams.

1. People do not arrange their problems or divide them neatly along lines laid down by academic disciplines. Humans have multiple problems with multiple causation, and both problems and causes cross traditional discipline lines.

2. Member professions can benefit from interprofessional interaction.

3. Interprofessional cooperation is an ideal vehicle to enhance preventative services.

4. Interprofessional cooperation infers shared responsibility (or shared guilt) and can reduce errors. (p. 6)

Professions/Professionals

An understanding of the topics "profession" and "professional" is a fundamental part of a conceptual framework for interprofessional education. These topics have been the subject of a considerable body of literature. Numerous writers have attempted a definition of a profession (DeYoung, 1980; Riley and Baldridge, 1977; Starr, 1978; Stinnett, 1963; Yarmolinsky, 1978; Hughes, 1965; Flexner, 1915; Susman, 1960; Volmer and Mills, 1966; Kane, 1975).

Hughes stated that professions "profess," that is, they profess or claim to know better than others the nature of certain matters. Houle recorded that, while a widely quoted judicial opinion holds that the professional's "main purpose and desire is to be of service to those who seek his aid and to the community of which he is a necessary part" (State ex
rel. Steiner v. Yello, 1933, 174 Wash. 402, 25 Pac. 2d91), the more common view in recent years is that professionals are most interested in being well paid for services rendered, rather than being "of service."

The usage of the term profession was traced to the middle ages in Education and the Professions (History of Education Society, 1973). The term originally meant simply a public declaration or vow. During the medieval period the usage was extended to include any business or occupation publicly offered. By the sixteenth century, the term implied a more specialized relationship between a principal and a client, with accompanying particular knowledge, formal training, exclusive membership, and relatively high social status and monetary reward.

Houle's 1980 volume Continuing Learning in the Professions is useful in the discussion of the professions. Rather than debate which occupations are "professions" and which are not, Houle suggested professionalization as a process, dynamic as opposed to static. The former question, "Does the occupation in its idealized form or in practice possess the criteria of a profession?" has given way to a number of questions, each of which is based on a characteristic and inquires, "To what extent does the occupation possess this characteristic and how is it working toward its further refinement?"

Ducanis and Golin (1979) identified four stages of professionalization: 1) social demand or need to be filled,
2) recognition by society that some persons fill this need better than others; 3) outside recognition of special group; and 4) outside recognition of the right to control group membership. They also divided professions in terms of a hierarchy of three levels: Level I, Professionals, e.g. physicians; Level II, Professionals, e.g. nurses, physical therapists, teachers; and Level III, Supporting Personnel, e.g. nurses' aides, teachers' aides. Etzioni (1969) labelled social work, nursing, and teaching as "semi-professions," characterized by less-than-complete autonomy since members work in bureaucracies where they are subject to authority of those outside the profession. (Etzioni did not explain whether physicians or lawyers working in a bureaucracy become semi-professionals.) Wilensky and Labeaux (1958) classified professions into four groupings: 1) established professions, such as law and medicine; 2) marginal professions, or professions in process, such as nursing and social work; 3) new professions, such as hospital administrators or engineers; and 4) doubtful professions, such as morticians.

There has been little agreement regarding which occupations to include in comprehensive lists of professions. Blauch, in a 1955 report for the U. S. Office of Education, described the principal features of 34 professions. The 1950 census referred to 23 professions, and the 1980 census listed over one hundred titles under the category Professional and Technical. Houle studied seventeen professions, while Schein studied the six "major" professions.
The standard method of defining a profession has been by means of a list of characteristics. Blauch condensed his list to just three "earmarks":

1. An extended period of specialized study of a body of knowledge enabling members to perform a particular service.

2. Success measured by quality of service rendered, not financial gain.

3. Organized in associations to maintain and improve service.

In 1915 Flexner proposed six criteria: high level intellectual activities, based on science and learning, used for practical purposes, which can be taught, is organized internally, and is altruistic.

A half century later, Sussman (1966) indicated that three core characteristics of a profession were: service orientation, body of theoretical knowledge, and autonomy of the work group.

For purposes of this study, participants in the survey were provided a list of six characteristics distilled from various sources. The intent was to guide participants toward a concept of occupations arrayed along a continuum, with professions characterized as those occupations with a high degree of conformance with the following:

1. Mastery of specialized knowledge and skills resulting from a lengthy training period;

2. Significant degree of autonomy - internal control of admission to and regulation of the profession;

3. Emphasis on a service ideal and relevance of activities to societal values;
4. Required licensure or certification to practice in the profession;

5. Formal code of ethics;

6. High degree of prestige and influence in society.

The discussion in Chapter I alluded to criticisms or charges against the professions. Houle identified three clusters of accusations:

One cluster is the alleged failure of the professions to develop comprehensive service systems to care for all of the people who need help, particularly the poor and the socially least franchised. Included in this cluster are the failure to adapt traditional methods of service, elitism in admission to professions, uneven spatial distribution, and tendency to impede legislation or regulations that would remedy service deficiencies.

A second cluster of accusations involve putting self-interest ahead of public welfare. This includes conspiring to inhibit competition, protecting erring colleagues, and charging excessive fees.

A third cluster is a catch-all for demonstrated incompetence, dogmatism, sexism, coldness and impersonality, ordering unnecessary procedures, and inattention to new ideas. Related to this third cluster is a concern raised by sociologist Julius Roth (1974), who argued that sociologists and others should not worry so much about defining criteria for professions (the role of apologist for the professions), but should rather be concerned about the social and
theoretical problems inherent in the control and power consistent with the professional ideology.

Observers of the professions have acknowledged that the employment settings of most professionals have shifted away from the single practitioner model toward corporate employment. Today's settings include full-time self-employed; part-time self-employed; part-time employee of service organization; partner in a group practice; full-time employee of a service organization devoted to the delivery of the professional service; employee of an organization not primarily devoted to the delivery of the professional service; and employee of a professional association.

Regardless of the setting, the professions are experiencing a changing environment. The professions have never been more highly regarded (indeed, unrealistically exalted) nor better rewarded, while at the same time more distrusted or suspected of self-serving (Boley, 1977).

Graduate and Professional Education

Interprofessional education is one aspect of a larger discussion regarding graduate and professional education. Interprofessional/interdisciplinary education is one of several reforms called for in graduate and professional education. As early as 1960 Berelson recognized a need to reanalyze what graduate education should entail. Cremin (1978) identified four necessary components, one of which was "relationships among the several fields of knowledge."
The Second Newman Report (1973) included in its recommendations regarding graduate and professional education a recommendation for further exposure of students to practical, clinical, and interdisciplinary kinds of experiences. Hughes (1973) called for more "flexibility" in professional education.

Ann Heiss, in *Challenges to Graduate Schools* (1970), provided several recommendations which suggest an interdisciplinary emphasis. One recommendation was "to broaden the scope of scholarship and to promote concern for the interconnectedness of knowledge, faculty members and graduate students should have access to communication with, or study in, other disciplines." Another recommendation mentioned the development of interdisciplinary relationships by providing joint seminars, research projects, colloquia, and independent field study. Heiss reported the broad impression from her interviews of a general movement toward increasing interdisciplinary and multidisciplinary affiliations. She reported that 60% of the faculty interviewed foresaw an increase in interdisciplinary offerings in the next decade.

The National Society for the Study of Education, in its 61st yearbook *Education for the Professions* (Anderson, 1962), reported several relevant persistent problems in professional education. It identified problems of purpose, identity, standards, evaluation, and reform; problems of relations — with universities, society, the liberal arts, with other professions and the subprofessions; and problems
of uniqueness and autonomy on the one hand and cooperativeness and shared responsibility on the other. One of the authors listed four components of professional education, one of which was "opportunities for interdisciplinary exposure."

Gardner (1971) raised a question concerning the adequacy of professional education in various fields in preparing students to understand the multiple dimensions of human need that are present in each person and in equipping students to work together in teams to meet their needs. Indeed, the thesis was set forth that professional education as it now exists, instead of contributing to these ends, in actuality reduces student sensitivity to these objectives through its emphasis upon specialization apart from a larger, more inclusive concern for the whole person.

Mayhew and Ford (1974) reported seven problems facing professional education. The seventh problem stated: "Professional education must solve problems of relationship with other professions and with the subprofessions. As complex human problems requiring professional services become more and more interdisciplinary the problems of relationships will become more acute. Then, increasingly, professional practice will require the services of many workers trained somewhat differently from the professional himself."

Schiff (1970), referring to medical education, stated:

The rigidity of the post-Flexner medical school curriculum rooted in traditional teaching methods remains. By far the gravest single deficiency is
not only the lack of curricular bridges across the diverse medical specialties, but across the other key human service disciplines. The growing emphasis for specialization has increasingly parochialized the student physician's training and experience, even prior to his specialty training. The current medical school curriculum operates against the need for the student to concern himself with the comprehensive needs of his patient—let alone view such needs as his responsibility (p. 10).

Interprofessional education has also been described as an expected innovation in professional education. Jacobsen (1981), McDonnell (1979), Jencks and Riesman (1977), and Schein (1972) all predicted increased emphasis on interdisciplinary cooperation and team building components.

Mayhew (1970) noted the high level of interest in inter-disciplinary programs reported from a national survey of institutions offering graduate programs. The survey item stated, "Which of the following innovations do you believe will become a significant element in graduate and professional education for most students at your institution by 1980? (Check as many as are appropriate.)" (See Table 1.)

Teamwork among professionals is a natural outgrowth of the movement toward interdisciplinary approaches.

Interprofessional Teams

Kane (1975) suggested that a consensus definition of a team should include three elements: a common objective, differential professional contributions, and a system of communication. Ducanis and Golin (1979) defined the team as a functioning unit, composed of individuals with varied and
<table>
<thead>
<tr>
<th>Innovations</th>
<th>Institutional Responses</th>
<th>Innovations</th>
<th>Institutional Responses</th>
</tr>
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<tbody>
<tr>
<td>Closed-circuit TV</td>
<td>185</td>
<td>More work outside major</td>
<td>101</td>
</tr>
<tr>
<td>Computer-based instruction</td>
<td>197</td>
<td>Experience with a computer</td>
<td>246</td>
</tr>
<tr>
<td>Interdisciplinary program</td>
<td>286</td>
<td>Planned courses at more than one institution</td>
<td>166</td>
</tr>
<tr>
<td>Cooperative work study</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching internships</td>
<td>232</td>
<td>Separate research doctorates</td>
<td>30</td>
</tr>
<tr>
<td>New teaching degrees</td>
<td>111</td>
<td>Instruction about teaching</td>
<td></td>
</tr>
<tr>
<td>Programmed interaction</td>
<td>114</td>
<td>Joint Ph.D under two or more schools or departments</td>
<td>116</td>
</tr>
<tr>
<td>Modification of language</td>
<td>155</td>
<td>Shortening of time to complete doctorates</td>
<td>77</td>
</tr>
<tr>
<td>requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elimination of thesis</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early clinical or field experience</td>
<td>164</td>
<td>Other</td>
<td>7</td>
</tr>
</tbody>
</table>

specialized training, who coordinate their activities to provide services to a client or group of clients.

Using three sources as base references, Ducanis and Golin, Houle, and Kane, it is apparent that teams have been utilized in at least the following topic areas: child abuse, corrections, exceptional children, chronic illness, long-term care, anesthesia, learning disabilities, health planning, urban planning, euthanasia, family health care, geriatrics, mental retardation, early child development, and abortion. Settings described include community mental health agencies, rehabilitation services, juvenile court, legal aide agencies, and schools.

Rationale for the use of teams were listed in the first section of this chapter. Certainly, team functioning has been much-studied, under such headings as: task groups, group dynamics, communication in groups, team process, decision making process, team morale, leadership process, team size, group norms, and conflict resolution. Kane (1975) reviewed thirty journals for the period 1964-73 and found 229 teamwork accounts. She found that while team process has been studied, controlled studies of effectiveness were rare. She remarked, "It is somewhat puzzling that the inter-professional team is such an entrenched modality and yet remains relatively untested." Of the several process problems reported, communication among team members was most frequently mentioned, followed by status concerns and incongruous role expectations.
Ducanis and Golin (1979) reported extensive study of interprofessional teams. They confirmed the need for empirical observation of teamwork. They suggested a four-stage process for team evaluation:

1. How is team effectiveness or success to be measured?

2. Which elements of the team approach lead to more effective outcomes?

3. With which clients is the team approach most effective?

4. Under what conditions does the team operate most effectively? (p. 146-147)

Halstead (1976) also sought reassurance that team care was desirable. While he found evidence was slim, he did report "coordinated team care appears to be more effective than the customary fragmented care currently received by most persons with long-term illnesses." While undertaking some empirical observations, one interdisciplinary agency continued its support for the concept, "Interdisciplinary collaboration in the area of the handicapped is not a luxury nor simply an alternative mode of service delivery. Rather, it is an essential and vital process for effective service to clients." (Nisonger Center, 1982) Hooyman (1979) reported similar sentiments.

One issue of the Journal of Learning Disabilities was devoted to interdisciplinary efforts. (In fact, the journal purports to represent twenty-two disciplines.) Articles such as "Interdisciplinary Efforts in Learning Disabilities: Issues and Recommendations," "More on Interdisciplinary
Cooperation," and "Who Shall Teach the LD Child?" made up the issue (Wallace, 1976; Abrams, 1976; Lane, 1976). Larsen (1976), in the article "The Learning Disabilities Specialist: Role and Responsibilities," made the statement,

An unquestioned assumption underlying the provision of services to the learning disabled is that a "team" approach must be utilized when formulating and monitoring educational plans. A typical team may include the learning disability specialist, speech pathologist, school psychologist, physician, remedial reading teacher, social worker, and school nurse (p. 506).

Interprofessional Education

Szasz (1974) provided a useful short definition of interprofessional education as preparation of students for collaborative service relationships. The terms "health team education," "joint education," "human services team education," and "interprofessional education" often have been used relatively interchangeably. The term "interprofessional" has been used more broadly than the term "interdisciplinary" and has the breadth to include members of different professions, especially one outside the common health care disciplines.

Schein (1972) suggested three needed directions for professional education. The third direction was relevant to this study: "New curricular and new career paths which are inter- or transdisciplinary and which may lead eventually to new professions that have new blends of knowledge and skill underlying them." He suggested three possible meanings
for the term "interdisciplinary."

1. A curriculum that involves courses from two or more departments or disciplines leading to a degree named after one of them, or a degree "without specification."

2. A curriculum that involves several disciplines, all of which are located within a given school.

3. Schools that are from the outset interdisciplinary or transdisciplinary in their orientation in that they set as their goal the development of a new discipline that represents an integration of the disciplines represented. (p. 64-65)

Schein pointed out, however, that such curricula would not emerge until professors or practitioners from different disciplines recognize areas of interdependence and thus become motivated to learn each others' concepts, perspectives, and working styles.

Ducanis and Golin (1979) identified three elements within interprofessional team education:

1. Cognitive (primarily didactic) information, including organizational theory, small group dynamics, and the sociology of the professions;

2. Effective (and experiential) learning — by participating in a team the students learn through experience how a team operates, how roles are established, and how leadership emerges;

3. Clinical training — by participating as part of a team in assessment, treatment, and similar activities with the client, the student learns the application of clinical skills with other professionals. (p. 157)

McCalley (1977) suggested four methods for achieving interprofessional education:
1. Mixing students of various professional disciplines in the same course and classroom;

2. Establishing a course dealing with interprofessional issues;

3. Mixing students in the clinical settings, particularly as members of primary health care teams;

4. Bringing together students, faculty members, and administrators of differing schools and disciplines in the planning of joint activities. (p. 178)

Schein also provided suggestions for implementing the new curricula. He suggested adapting the calendar and grading system to fit new learning modules. He called for more extensive use of part-time and adjunct faculty to broaden the base of faculty expertise. Learning modules were suggested dealing with the professional's ability to:

1) function as a generalist as well as a specialist;

2) function as a member of an intra or interprofessional team; and

3) function as a project manager of intra or interprofessional teams.

Examples of interprofessional education have been reported by numerous authors. Alexander (1975) reported that law/business joint programs have a long history, but he also found thirty major law schools which had joint degree interdisciplinary studies in areas other than law and business. He found five religion/social work programs and numerous religion/law programs. Another development Alexander reported was the emergence of coalitions or clusters of theological schools (fourteen clusters described). Within one
university (Harvard), he reported twenty joint studies programs and at least twelve "centers" or "institutes" which were in some way interdisciplinary.

The following examples are some of the various types of interdisciplinary programs reported in the literature:

1. Society for Health and Human Values, Philadelphia, Pennsylvania. Founded in 1969 by a group of professionals concerned with the educational relationship of medicine with the humanities, it sponsors annual meetings, publications, and institutes, to "coordinate the scholars and practitioners in the humanities, social and biological sciences, law, theology, and other disciplines who are working on human value questions in collaboration with scholars and practitioners in health education programs so that both may more clearly define their identity and task." Brochure, Society for Health and Human Values, 1975.

2. Center for Law and Religious Traditions, Catholic University of America, Washington, D. C. and Center for Ethics and Social Policy, University of California Berkeley, Berkeley, California. Both are examples of joint programs (law/religion) which sponsor seminars, workshops, and special projects.

3. Section on Law and Religion, Association of American Law Schools. This is an example of a professional association which encourages scholarly inquiry into the interrelationships between professional areas.

4. Apprenticeships in the Community, Harvard University. This program provides interprofessional field experiences for students in law, theology, education, and public policy.

5. Center for Interdisciplinary Education in Allied Health, College of Allied Health, University of Kentucky. The "Health Systems Clerkship" offers students in allied Health two to three week field experiences supplemented by classroom instruction.

This center has produced teaching modules, held a luncheon seminar series, sponsored national conferences, and initiated a resource collection.

7. Entry into the Educating Professions: An Interdisciplinary Doctoral and Postdoctoral Program, Teachers College Columbia University. This is an example of a new curricular offering to prepare educators to serve in an increasing variety of settings.

8. The Division of Interdisciplinary Programs for the School of Health Related Professions, University of Pittsburgh. Students from fifteen professions are involved in a course involving the interprofessional team.

Even though the survey referred to in Chapter I reported widespread interest in interprofessional education, implementation has been sparse. Ducanis and Golin (1979) described some of the problems inherent in team education. Institutional barriers may be administrative, academic, logistic (time, cost), and attitudinal. Individual barriers include acculturation of the individual to the profession, one profession's perception of another, and personal background.

The problem of what to teach and how to teach are important. Perhaps the most significant problem is the already crowded curriculum, and the costs of clinical instruction for teams. Hudson and Giacalone (1975) also commented on the importance of team education but acknowledged the problems associated with it.

Evaluation has the smallest literature base of any component of interprofessional education. Most of the programs mentioned, including the one at The Ohio State University, have been amply described, but few have been evaluated
beyond end-of-course type of assessment.

Perhaps the most thorough evaluation in interdisciplinary team education has occurred at the University of Kentucky's College of Allied Health Professions. As reported by Marion and others in the *Strategies for Evaluation Monograph Series*, a number of instruments have been developed to evaluate their program, including: a health professions attitude survey, checklists for goal achievement, structured log book, group effectiveness scale, climate gauge, test of health professions skills, health systems applications test, team interaction analysis, and the team lifeline. These instruments were primarily pre-post measures of changed attitudes or behaviors. Marion also reported on three year and five year follow-up studies, which assessed two dimensions—1) factors that affect student selection of location for professional employment and 2) extent to which the objectives of the program were carried over into the professional careers of the participants. Results indicated objectives of the program did carry over (no experimental control or comparison group used).

Interprofessional education at The Ohio State University has been the subject of several end-of-course evaluations. At the conclusion of each course students are asked to complete a course evaluation form. Faculty teams for each course also evaluate each course, and meet as a group to discuss results of student evaluations. Several graduate students at O.S.U. have analyzed certain aspects of the
courses in term papers for courses in their major areas. Alexander (1977) wrote a paper detailing historical antecedents of the formation of the Commission. Spencer (1981) discussed the interprofessional courses from a theory of organizations standpoint, using the metaphor of "loose couplings." A social worker masters thesis (Siehl, 1978) studied the group dynamics of students in an interprofessional course. Siehl identified several conceptual variables—attitudes toward other professions, trust, and cooperation—and then measured movement in those variables by means of a pre and post questionnaire. Results indicated: 1) students in the groups were shown to become more trusting; 2) students' attitudes toward other professions became more favorable; and 3) student groups became more cohesive.

Summarizing the Literature: Toward a Conceptual Framework for Interprofessional Education

A conceptual framework for interprofessional education can be constructed on several components presented in the preceding literature review. While the term "profession" has defied concise definition, the framework implies a certain category of occupations which tend to occupy one end of a continuum encompassing criteria such as autonomy and internal control of the profession, specialized skills, extensive training, and high prestige and influence. Interprofessional education is identified as one of several recent or proposed reforms/innovations within graduate and
professional education. Interprofessional education is predicated on the utility of interprofessional cooperation among practitioners for improved client service.

Interprofessional education can be described as two dimensional. Various teaching methods—classroom lecture, classroom simulated experiences, and field experiences constitute one dimension of interprofessional education. A second dimension encompasses various levels of interprofessional involvement, that is, the make-up of students and faculty in interprofessional education. Using these two dimensions—teaching methods and level of interprofessional involvement—it is possible to delineate a matrix for interprofessional education. In Figure 1, the four courses coordinated by The Ohio State University's Commission on Interprofessional Education and Practice are classified using the matrix.

The methodology and research procedures for the study are presented in Chapter Three. It will begin with a rationale for the survey design, and will describe the procedures followed in developing the questionnaire. The study's population will also be described. Following information regarding methods of distributing and collecting the questionnaire, details will be given regarding the data analysis measures utilized.
**Figure 1**

**MATRIX FOR INTERPROFESSIONAL EDUCATION**

<table>
<thead>
<tr>
<th>Clinic/Field Team Practice with Client Contact (Skill Orientation)</th>
<th>(4) Interprofessional Practicum in Clinical Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom: Team Practice with cases (Skill Orientation)</td>
<td>(3) Interprofessional Care</td>
</tr>
<tr>
<td>Classroom: Didactic Presentation: Team Involvement (Issue Emphasis)</td>
<td>(1) Changing Societal Values</td>
</tr>
<tr>
<td>Faculty: Single Profession</td>
<td>Faculty: One Profession</td>
</tr>
<tr>
<td>Students: Single Profession</td>
<td>Students: Multiple Profession</td>
</tr>
<tr>
<td>Faculty: Multiple Profession</td>
<td>Students: Multiple Profession</td>
</tr>
</tbody>
</table>

OR

| Faculty: Multiple Profession |
| Students: One Profession |

*Interprofessional courses at The Ohio State University*

(1) Changing Societal Values and the Professions
(2) Seminar on Ethical Issues Common to the Helping Professions
(3) Seminar on Interprofessional Care
(4) Interprofessional Practicum on Clinical Settings
CHAPTER III
METHODS OF INQUIRY:
COLLECTING AND ANALYZING THE DATA

This chapter describes the research procedures used in the study, including the development of the survey instrument, the identification of the study population, and the selection of procedures for analysis.

As indicated earlier, the problem under investigation in this study was the link between preprofessional interprofessional education and professional practice. The researchers sought to add empirical weight to the intrinsic appeal of interprofessional education.

Survey Design

The nature of the study dictated ex post facto design. This design was required because the researcher had no input into the experimental intervention, the course experience, but did have some input into the nature of the after-the-fact assessment. Measurements took place on two closely-matched groups, one of which received some treatment. A prototype for such a design was introduced by Chapin (1947) and was classified by Campbell and Stanley (1963) as "Static Group Comparison."
This design has been commonly used for investigating relationships among variables.

The design contained a selection threat to internal validity, because those who took Commission-facilitated courses self-selected themselves as participants. In most cases the course was taken as an elective. There was therefore the possibility that participation in the course was related to previously held values or attitudes, rather than participation influencing post-course values or attitudes. This threat was minimized by matching the two groups on demographic variables prior to the survey, and by including demographic variables on the survey for additional comparison. An additional possible intervening variable, the academic performance of students in the Commission courses, was not controlled.

The study focused on assessment of attitudes held by professionals toward interprofessional activities. An attitude has been defined as an expression, by word or deed, of an individual's reaction toward or feeling about a person, a thing, or a situation. Horrocks (1964) indicated that attitudes result from the impact of the environment, past or present, acting upon the personality (as developed to that point) of an individual. Attitudes are typically measured by having an examinee express or react to opinions, choose between contrasting statements or stimulus objects, or react overtly when presented with various other standard test situations.
The questionnaire has served as the main instrument for the collection of research data on attitudes. Horrocks identified six types of questionnaires: preference, stereotype, situational, social distance, opinion, and self-rating. The most widely used type is "opinion," which asks the examinee to agree or disagree with each item in a list of statements believed by the examiner to represent an attitude or various attitudes (Jackson and Messick, 1967). While a number of standardized scales have been developed, one is not available regarding attitudes toward interprofessional education and practice.

Two related assumptions were important. First, if attitudes result from the impact of the environment, it was reasonable to suggest that participation in an interprofessional course constituted an environmental impact. Second, it was reasonable to assume that attitudes can be measured by means of a questionnaire.

Development of the Survey Instrument

It was intended that questionnaire items be linked to the stated objectives of the various courses facilitated by the Commission. An analysis of the syllabi of the courses revealed five objectives common to the four courses. The course objectives remained relatively constant during the study period, 1975-81, for the eighteen sessions of the four courses. It was expected that each course would develop in students:
1. An awareness of current social values and ethical issues questions.

2. An understanding of the response of one's own profession to current social values and ethical issues questions.

3. An appreciation of the response of other professions to current social values and ethical issues questions.

4. An understanding that client problems often consist of a configuration of multiple attributes and problems.

5. An exposure to professional team process for client problem resolution.

Individual questionnaire items were generated to assess the actualization of the objectives by practicing professionals. Input, in the form of reaction to items as well as suggestions for additional items, was solicited from several groups knowledgeable regarding Commission purposes:

1. Faculty members representing teaching experiences in all four of the Commission courses.

2. Board of Directors and Executive Committee of the Commission, representing the seven academic areas and respective professional associations.

3. Commission Program Director and two Program Specialists.

Technical assistance in designing the questionnaire was provided by a psychologist experienced in survey research and several faculty members from the O.S.U. Faculty of Educational Foundations and Research. The questionnaire was pilot tested among a small group of graduate students and practitioners who were asked to assess the instrument for clarity, item congruence, and time required.
The questionnaire was divided into nine sections, Part A through I, each measuring one of the four categories of information in the research scheme by Dillman suggested earlier - either Beliefs, Attitudes, Behaviors, or Attributes. The complete questionnaire appears in Appendix A.

**Beliefs.** Responses to items in Parts A, C, and D of the questionnaire were used to assess the "Beliefs" of respondents. Part A involved reaction to eight social issues which were selected for use because of frequent mention in course syllabi. In Part A participants were asked for the extent to which they agreed or disagreed that each of the eight issues "suggest an interprofessional approach." The choices were structured so as to ascertain the intensity of the respondent's feeling by means of a close-ended structure with ordered answer choices, a five point Likert scale ranging from Strongly Agree through Strongly Disagree.

Responses to items in Parts C and D were also intended to assess "Beliefs." Part C listed ten situations which were thought to hinder or be obstacles to interprofessional activity. Participants were asked the extent to which they agreed, using a three point scale: 1) Very much an obstacle, 2) Somewhat an obstacle, 3) Not an obstacle. Part D dealt with events or situations which enable or tend to promote interprofessional activity. Respondents were asked to react to nine situations, giving their opinion whether each: 1) Helps very much, 2) Helps somewhat, or 3) Does not help.
Attitudes. Responses to items in Part B of the Questionnaire were used to assess the "Attitudes" of respondents. Twelve statements were included in Part B, each assuming a certain stance toward interprofessional education and practice. Four of the statements were negatively phrased in order to minimize the possibility of participants falling into a response set and to enhance internal reliability. Response choices were ordered along a five point scale, Strongly Agree through Strongly Disagree. Attitudes toward interprofessional education and practice were measured by the extent of agreement with positively phrased attitude statements and disagreement with negatively phrased statements.

Behavior. Responses to items in Parts E, F, G, and I of the questionnaire were used to assess the "Behavior" of respondents. In Part E, respondents were asked open-ended questions regarding the kinds of situations which promote the occurrence of interprofessional activities and also the kind of interprofessional activities in which they had participated. The unit of measurement for the two questions in Part E was the respondent's ability to provide an example, and secondarily, the type of example provided.

Two questions were included in Part F. Question #1 elicited a response regarding number of hours spent in interprofessional involvement during a typical week. Four response choices were possible: 1) not at all, 2) 1 - 3 hours a week, 3) 4 - 6 hours a week, and 4) 7 or more hours a week. Question two of Part F asked respondents to indicate
participation in any kind of interdisciplinary or inter-professional course during their professional education. Respondents were to indicate either Yes or No, and if Yes, to describe briefly.

For the one question in Part G, respondents were polled regarding the other professions with which they interact. Answer spaces numbered one through five were provided. The unit of measurement for this question was whether an answer was provided, and the number of professions listed.

Responses to the five items in Part I were recorded with a Yes/No structure. Information was acquired regarding:
1) awareness of at least one interprofessional team; 2) previous participation in interprofessional practice; 3) reading at least one journal from one's profession; 4) reading at least one journal from outside own profession; and 5) involvement on a board or committee in the community with persons from outside own profession.

Attributes. The eight questions included in Part H were used to collect demographic data. Responses from these questions were used to compare the similarity of the two sample groups, Course Participants and Non-participants. In addition, question #5 was used to assess the effect of professional experience prior to enrollment in a Commission course. This question called for a Yes/No response, with Yes also requiring a brief description.
The Study Population

The first interprofessional course was taught Spring Quarter, 1975. Because the course roster did not identify students by discipline, the thirty-four students who participated in that course were not included in the study. During the 1975-76 academic year, two of the primary courses were offered with sizable participation from six of the seven professions. That formed the base year for the study population with data utilized from the course rosters of the eighteen course sessions offered during the six subsequent academic years, 1975-76 through 1980-81.

An a priori criterion for the population was that it include course participants who had been graduated at least one year from the professional program in which they were enrolled. This criterion was instituted to allow course participants an opportunity to become practicing professionals by the time they responded to the survey. A check of each profession list against available OSU and theological school graduation records identified persons in each profession who had taken a Commission course and had graduated by the cutoff point of Autumn Quarter, 1981. The variations in the percentage of nongraduates among the seven professions may be in part attributed to differences in program length and part-time versus full-time student enrollments.

The selection of a comparison group was accomplished by selecting from each quarter's commencement list, by profession, a number of graduates equivalent to the number of course
participants graduating that quarter. For example, if four course participants received Master of Social Work degrees (M.S.W.) in Spring 1980, then four non-participant M.S.W. graduates were chosen by means of a stratified random sample for inclusion in the comparison group. The population consisted of course participants from 1975-76 through 1980-81 who had graduated by Autumn Quarter, 1981, and a matched comparison group of non-participant graduates. The sample consisted of persons from the population for whom current addresses were available. Sources for addresses were the OSU Alumni Association and the registrar's offices of the theological schools. As indicated by the data in Table 2, the population of graduates represents approximately 56% of total course participants. The final Course Participant group and Non-participant group represent almost 90% (422 out of 451) of the graduates.

Mailing and Return of the Questionnaires

To facilitate the identification of surveys upon return, they were printed on two colors of paper, one for Course Participants and one for Non-participants. A postage prepaid return envelope was also printed for respondents to use in returning the surveys. The completed survey occupied three sheets, front and back, and was designed to require about twenty minutes to complete.

To enhance participation two cover letters were included. The first was signed by the Commission Program Director and
<table>
<thead>
<tr>
<th>Program</th>
<th>Number Who Took Courses 1976 - 1981</th>
<th>Number With Confirmed Graduation Date -- 1977-81</th>
<th>Final Course Participant Group</th>
<th>Final Non-Participant Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Medical Professions</td>
<td>57</td>
<td>19</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Education</td>
<td>76</td>
<td>21</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Law</td>
<td>120</td>
<td>83</td>
<td>80</td>
<td>75</td>
</tr>
<tr>
<td>Medicine</td>
<td>83</td>
<td>34</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Nursing</td>
<td>139</td>
<td>96</td>
<td>90</td>
<td>84</td>
</tr>
<tr>
<td>Social Work</td>
<td>129</td>
<td>51</td>
<td>49</td>
<td>44</td>
</tr>
<tr>
<td>Theology*</td>
<td>197</td>
<td>147</td>
<td>137</td>
<td>135</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>801</strong></td>
<td><strong>451</strong></td>
<td><strong>422</strong></td>
<td><strong>409</strong></td>
</tr>
</tbody>
</table>

*Theology distribution:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Number</th>
<th>Participating</th>
<th>Non-participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinity Lutheran Seminary</td>
<td>77</td>
<td>50</td>
<td>46</td>
</tr>
<tr>
<td>Pontifical College Josephinium</td>
<td>39</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Methodist Theological School</td>
<td>81</td>
<td>61</td>
<td>58</td>
</tr>
</tbody>
</table>

the two graduate student researchers and explained the purpose of the survey and appealed for participation (Appendix B). The second letter was from the Dean or Director of the academic unit from which the person was graduated, also appealing for participation and announcing the support of the academic unit for the survey project (Appendix C). While the letters themselves were printed, the inside addresses of the
first cover letter were individually typed with name and address to personalize the letter.

While the cover letter contained the initial appeal for participation, an additional cover page was necessary. That page had two purposes: to give participants more information regarding why they were selected, and to define certain terms that were important to the content of the survey. Also included was an explanation of the investigators' need to identify each questionnaire with a number to facilitate record keeping and follow-up. (In only one instance was the explanation apparently inadequate. One respondent covered the identification number with black marker ink, rendering the number illegible.)

Because multiple definitions appear in the literature for certain terms used in the questionnaire, definitions were suggested for four terms to enhance comparability of response. The first of two terms, "Continuing Education" and "Life-long Learning" came directly from Continuing Learning in the Professions (Houle, 1980). The term "Team" was taken from Interprofessional Teamwork (Kane, 1975). The most problematic term was "Profession." The intent of the definition was to make participants aware of the potential breadth of the word. Six characteristics of a profession were distilled by the investigators from several sources, including Kane (1975), Houle (1980), Pavalko (1971), Schein (1972, and Wilensky (1958).
The surveys, cover letters, and return envelopes were packaged in a regular Commission business envelope and mailed by first class mail. The first mailing consisted of 831 pieces. Approximately 5% of the envelopes were returned unopened marked "undeliverable" because of a problem with the addresses. Of the remaining 792, 36% responded, with the response rate of Course Participants slightly higher than Non-participants.

After four weeks, complete packets, with a revised cover letter (Appendix D), were sent to all of the sample who had not responded. This second mailing increased the overall response rate to 47%. The final return rates by group were Course Participants, 50%, and Non-participants, 45% (see Table 3). Variations in the returns among the professions can be noted on Table 3. The mailing and return process was accomplished during the Autumn Quarter, 1982.

Data Analysis

The quantitative analysis occurred in two parts. The first procedure was descriptive. Utilizing formats available in the Statistical Package for the Social Sciences (SPSS), frequency counts, cross tabulations, and distribution analyses were produced. Observations were possible regarding professionals as one aggregate group and as two study groups - Course Participants and Non-participants.

The second procedure was explanatory, relying on interpretation of the correlation coefficients (Pearson's r) for
<table>
<thead>
<tr>
<th>Profession</th>
<th>Total Number Mailed</th>
<th>Undelivered</th>
<th>Total Number Surveyed</th>
<th>Number Unreturned</th>
<th>Number Returned</th>
<th>% of Return</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Medical Profs.</td>
<td>* 18</td>
<td>1</td>
<td>17</td>
<td>6</td>
<td>11</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>** 16</td>
<td>1</td>
<td>15</td>
<td>3</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Education</td>
<td>* 18</td>
<td>1</td>
<td>17</td>
<td>7</td>
<td>10</td>
<td>59%</td>
</tr>
<tr>
<td></td>
<td>** 20</td>
<td>1</td>
<td>19</td>
<td>10</td>
<td>9</td>
<td>47%</td>
</tr>
<tr>
<td>Law</td>
<td>* 82</td>
<td>3</td>
<td>79</td>
<td>43</td>
<td>36</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>** 73</td>
<td>5</td>
<td>68</td>
<td>48</td>
<td>20</td>
<td>31%</td>
</tr>
<tr>
<td>Medicine</td>
<td>* 30</td>
<td>2</td>
<td>28</td>
<td>15</td>
<td>13</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>** 35</td>
<td>2</td>
<td>33</td>
<td>24</td>
<td>9</td>
<td>27%</td>
</tr>
<tr>
<td>Nursing</td>
<td>* 90</td>
<td>6</td>
<td>84</td>
<td>44</td>
<td>40</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>** 84</td>
<td>8</td>
<td>76</td>
<td>38</td>
<td>38</td>
<td>50%</td>
</tr>
<tr>
<td>Social Work</td>
<td>* 49</td>
<td>3</td>
<td>46</td>
<td>22</td>
<td>24</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>** 44</td>
<td>5</td>
<td>39</td>
<td>26</td>
<td>13</td>
<td>33%</td>
</tr>
<tr>
<td>Theology</td>
<td>* 138</td>
<td>4</td>
<td>134</td>
<td>67</td>
<td>67</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>** 134</td>
<td>5</td>
<td>129</td>
<td>61</td>
<td>68</td>
<td>53%</td>
</tr>
<tr>
<td>Trinity Lutheran Seminary</td>
<td>* (46)</td>
<td>(1)</td>
<td>(45)</td>
<td>(17)</td>
<td>(28)</td>
<td>(62%)</td>
</tr>
<tr>
<td></td>
<td>** (46)</td>
<td>(2)</td>
<td>(44)</td>
<td>(20)</td>
<td>(24)</td>
<td>(55%)</td>
</tr>
<tr>
<td>Pontifical College Josephinium</td>
<td>(33)</td>
<td>(1)</td>
<td>(32)</td>
<td>(22)</td>
<td>(10)</td>
<td>(31%)</td>
</tr>
<tr>
<td></td>
<td>** (29)</td>
<td>(1)</td>
<td>(28)</td>
<td>(15)</td>
<td>(13)</td>
<td>(46%)</td>
</tr>
<tr>
<td>Methodist Theological School</td>
<td>* (59)</td>
<td>(2)</td>
<td>(57)</td>
<td>(28)</td>
<td>(29)</td>
<td>(51%)</td>
</tr>
<tr>
<td></td>
<td>** (59)</td>
<td>(2)</td>
<td>(57)</td>
<td>(26)</td>
<td>(31)</td>
<td>(54%)</td>
</tr>
</tbody>
</table>

Total: Course Participants: * 425  20  405  204  201  51%

Total: Non-participants: ** 406  27  379  210  169  45%

Combined Total: 831  47  784  414  370  47%

* Course Participants
** Non-participants
@ Numbers in parentheses represent subtotals for the three theological schools.
each of the independent variables. Correlation is generally considered to be a measurement of the "degree or strength of the relationship" between two variables (Blalock, 1979). Correlation permits the prediction of the dependent variable based on a knowledge of the independent variable. In examining correlation coefficients there are typically two factors to consider, the direction of the relationship determined by the sign (+ or -) and the strength of the relationship measured by the size of the coefficient. In examining a large number of similar correlations, additional factors to consider are the pattern and consistency of the correlations.

It was expected that the majority of the correlation coefficients for this study would be positive, showing some relationship between course participation and responses favorable to interprofessional activities. However, it was also expected that the coefficients would be of low magnitude, or in other words, showing only small differences between Course Participants and Non-participants. Small differences were expected because interprofessional interaction is basically an intrinsically appealing concept, and even Non-participants should favor the concept to some extent. The intention for using correlations as a data analysis technique was to explore whether a consistent pattern of positive coefficients was exhibited. If Course Participants consistently respond differently than Non-participants, even if in small magnitudes, then there would be clear indicators of
the nature of the underlying relationships between variables as suggested by the study's research questions.

The primary independent variable was participation in a Commission-facilitated interprofessional course. Related independent variables were: participation in any interdisciplinary or interprofessional course; participation in a non-Commission interdisciplinary course; and hours of involvement per week in interprofessional interaction. The dependent variables were: beliefs of professionals regarding interprofessional education and practice; attitudes of professionals toward interprofessional education and practice; and behavior of professionals with regard to interprofessional education and practice.

The research plan for the study has been summarized in Chapter Three. The type of research design was described as ex post facto. The study revolved around whether attitudes, beliefs, and behaviors were influenced by a course experience. Procedures for the development of the survey instrument were detailed, and the various sections of the questionnaire were linked to one of four categories of information - beliefs, attitudes, behaviors, and attributes. The study population was described, as were procedures for mailing and retrieving the questionnaires. Finally, the anticipated data analysis techniques were delineated.

Study findings, within the rubric of four categories of information, will be presented in Chapter Four. Findings will be reported for professionals as a group and for Course
Participants as opposed to Non-participants. An analysis of correlation coefficients will conclude the chapter.
CHAPTER IV
GENERAL FINDINGS:
COURSE PARTICIPANTS AND NON-PARTICIPANTS

The distribution of questionnaires to the sample and return of completed questionnaires from respondents was accomplished during Autumn Quarter 1982. As indicated earlier in Table 3, the rate of response was 47% of the sample. Tabulation and analysis of the responses occurred during Winter Quarter and Spring Quarter 1983.

The findings presented in this chapter are organized around four categories of information—Beliefs, Attitudes, Behaviors, and Attributes—which comprise the rubric utilized in designing the survey instrument. For each category, findings are reported in two ways. The larger segment of each report discusses frequency data for professionals as a group and as two subgroups. The smaller segment of each report addresses the relevance of correlational findings.

Belief

Data regarding Beliefs were acquired in Parts A, C, and D of the questionnaire, dealing respectively with Issues, Obstacles, and Enablers. These three parts, each containing eight to ten items, were seen as different ways of approaching
the same topic - respondents' familiarity with interprofessional ideas and perceptions of interprofessional issues.

Issues. The majority of the respondents (in both groups) agreed that the issues which were included in the instrument did indeed suggest the efficacy of an interprofessional approach. On seven of the eight issues, at least 80% of the responses were either Strongly Agree or Agree. The eighth issue, "Licensure, certification, recertification," was the only issue on which there was substantial disagreement. On this particular issue responses were mixed, divided among Agree, Undecided, and Disagree.

Modal responses to the eight issues are summarized as follows:


3. Undecided/Disagree Licensure, certification, recertification

Course Participants and Non-participants responded similarly to issues. On five of the eight issue, Course Participants were slightly more inclined to respond Strongly Agree. On "Life and death issues," the difference between responses of Course Participants and Non-participants was
somewhat larger, again Course Participants more frequently listing Strongly Agree. Percent responses for issues are summarized in Table 4.

Respondents were given an opportunity to list "Other" issues appropriate for interprofessional attention. Twenty-one Course Participants and five Non-participants responded. Examples included Domestic relations/child custody, Nuclear war, Mental health care, and Women's issues. A complete list appears in Appendix D.

Obstacles. Respondents' reactions were sought regarding situations which hinder or are obstacles to interprofessional activity. Respondents were asked "Rate the extent to which you feel each of the following is an obstacle to interprofessional awareness and cooperation." Respondents identified three of ten situations as Very much an obstacle. The remaining seven situations were rated as Somewhat of an obstacle; none of the situations were seen as Not an obstacle.

Modal responses regarding obstacles are summarized as follows:

1. Very much an obstacle
   - Lack of exposure to the viewpoints of others.
   - Lack of opportunities for exchange of information.
   - Time demands.

2. Somewhat of an obstacle
   - High degree of specialization.
   - Professional jealousies or misunderstandings.
   - Difficulty in knowing how to proceed.
   - Differences in problem-solving.
<table>
<thead>
<tr>
<th>Issues</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Life and death issues: abortion, euthanasia, wrongful birth</td>
<td>* 71.2</td>
<td>21.1</td>
<td>2.0</td>
<td>3.5</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>** 57.1</td>
<td>30.4</td>
<td>4.2</td>
<td>4.8</td>
<td>1.8</td>
</tr>
<tr>
<td>2. Professional ethics</td>
<td>* 39.4</td>
<td>41.9</td>
<td>7.1</td>
<td>9.6</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>** 36.3</td>
<td>45.8</td>
<td>6.0</td>
<td>10.7</td>
<td>-</td>
</tr>
<tr>
<td>3. Costs of human services</td>
<td>* 34.8</td>
<td>44.9</td>
<td>12.6</td>
<td>6.1</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>** 34.5</td>
<td>42.9</td>
<td>14.9</td>
<td>5.4</td>
<td>0.6</td>
</tr>
<tr>
<td>4. Licensure, certification, recertification</td>
<td>* 11.1</td>
<td>28.3</td>
<td>24.7</td>
<td>26.3</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>** 16.7</td>
<td>22.6</td>
<td>25.6</td>
<td>24.4</td>
<td>10.1</td>
</tr>
<tr>
<td>5. Privacy and informed consent</td>
<td>* 40.4</td>
<td>43.4</td>
<td>11.1</td>
<td>4.0</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>** 33.9</td>
<td>48.2</td>
<td>9.5</td>
<td>6.5</td>
<td>0.6</td>
</tr>
<tr>
<td>6. Understanding role of various professions</td>
<td>* 63.1</td>
<td>31.8</td>
<td>4.0</td>
<td>1.0</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>** 57.7</td>
<td>33.9</td>
<td>4.8</td>
<td>2.4</td>
<td>0.6</td>
</tr>
<tr>
<td>7. Quality of client care</td>
<td>* 59.1</td>
<td>29.8</td>
<td>7.6</td>
<td>2.5</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>** 52.4</td>
<td>38.7</td>
<td>3.6</td>
<td>4.2</td>
<td>0.6</td>
</tr>
<tr>
<td>8. Substance abuse</td>
<td>* 43.4</td>
<td>39.4</td>
<td>13.1</td>
<td>3.5</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>** 41.7</td>
<td>34.5</td>
<td>15.5</td>
<td>4.2</td>
<td>3.0</td>
</tr>
</tbody>
</table>

* Course Participants (N = 198)
** Non-participants (N = 168)
Lack of knowledge of effective use of groups. Suspicion that other professions might dominate. Apprehension that other professions might not value my profession's contribution.

Responses were quite similar for Course Participants and Non-participants. Course Participants were slightly more optimistic regarding "Time demands" but were slightly less optimistic regarding "Differences in problem-solving approaches." Rates of response to the obstacles are summarized in Table 5.

Respondents were asked to list under "Other" additional obstacle situations of their own choosing. A total of twenty-eight "Other" obstacles were listed. The complete list is recorded in Appendix , but examples include: lack of appreciation or knowledge of interprofessional activities, Differences in status among professions, Stereotyping, and Insecurity with one's own professional role.

Enablers. Respondents were asked (Part D) "Rate the extent to which you feel each of the following enables or helps promote interprofessional awareness and cooperation."

Four of the nine situations were most frequently rated Helps very much. The remaining five situations were most frequently rated under the category Helps somewhat.

Responses to situations are summarized as follows:

1. Helps very much Interprofessionally-oriented continuing education. Interprofessional learning experiences during professional training.
<table>
<thead>
<tr>
<th>Obstacles</th>
<th>Very much an obstacle</th>
<th>Somewhat of an obstacle</th>
<th>Not an obstacle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High degree of specialization</td>
<td>* 25.3</td>
<td>55.6</td>
<td>18.7</td>
</tr>
<tr>
<td></td>
<td>** 22.0</td>
<td>56.5</td>
<td>20.8</td>
</tr>
<tr>
<td>2. Lack of exposure to the viewpoints of others</td>
<td>* 65.2</td>
<td>30.8</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>** 66.7</td>
<td>29.8</td>
<td>2.4</td>
</tr>
<tr>
<td>3. Lack of opportunities for interprofessional exchange of information</td>
<td>* 59.6</td>
<td>33.8</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>** 60.7</td>
<td>35.1</td>
<td>3.6</td>
</tr>
<tr>
<td>4. Time demands</td>
<td>* 47.0</td>
<td>43.4</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>** 56.0</td>
<td>40.5</td>
<td>3.0</td>
</tr>
<tr>
<td>5. Professional jealousies or misunderstandings</td>
<td>* 43.9</td>
<td>48.0</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>** 44.9</td>
<td>40.1</td>
<td>13.7</td>
</tr>
<tr>
<td>6. Difficulty in knowing how to proceed</td>
<td>* 17.2</td>
<td>68.7</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>** 19.6</td>
<td>64.3</td>
<td>15.5</td>
</tr>
<tr>
<td>7. Differences in problem-solving approaches</td>
<td>* 14.1</td>
<td>61.6</td>
<td>23.7</td>
</tr>
<tr>
<td></td>
<td>** 13.7</td>
<td>55.4</td>
<td>30.4</td>
</tr>
<tr>
<td>8. Lack of effective knowledge of groups</td>
<td>* 14.6</td>
<td>59.6</td>
<td>24.2</td>
</tr>
<tr>
<td></td>
<td>** 15.5</td>
<td>54.2</td>
<td>29.8</td>
</tr>
<tr>
<td>9. Suspicion that other professions might dominate</td>
<td>* 29.3</td>
<td>44.4</td>
<td>25.8</td>
</tr>
<tr>
<td></td>
<td>** 31.0</td>
<td>42.3</td>
<td>26.2</td>
</tr>
<tr>
<td>10. Apprehension that other professions not value my profession's</td>
<td>* 21.7</td>
<td>41.9</td>
<td>35.9</td>
</tr>
<tr>
<td>contribution</td>
<td>** 24.4</td>
<td>45.2</td>
<td>29.8</td>
</tr>
</tbody>
</table>

* Course Participants (N = 198)
** Non-participants (N = 168)
Peer acceptance among professionals regarding the idea of interprofessional cooperation.
Confidence among professionals in group interaction skills.

2. Helps somewhat

Topic-related interprofessional newsletter.
Economic subsidies or incentives for interprofessional activities.
Periodic recertification that utilizes an interprofessional component.
Increased public awareness of existing interprofessional cooperation.
Encouragement and support from administrative personnel.

The differences between the responses of Course Participants and Non-participants were small but did demonstrate a pattern. On seven of the nine situations Course Participants chose helps very much more than did Non-participants. The differences in percentage responses were more pronounced for the "Enabler" items than for either "Issues" or "Obstacles."
The rates of response are reported in Table 6.

In Part D respondents were invited to suggest situations of their choosing under "Other." Sixteen were listed. Several of the respondents said one successful interprofessional experience promotes future successful experiences. Several examples spoke to some specific event or situation, which because of its uniqueness or importance led to interprofessional activity. The complete list of "Others" appears in Appendix F.
<table>
<thead>
<tr>
<th>Situations which enable</th>
<th>Helps very much</th>
<th>Helps somewhat</th>
<th>Does not help</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interprofessionally-oriented continuing education</td>
<td>* 64.1</td>
<td>33.8</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>** 54.8</td>
<td>43.5</td>
<td>0.6</td>
</tr>
<tr>
<td>2. Topic-related interprofessional newsletter</td>
<td>* 24.7</td>
<td>60.6</td>
<td>12.6</td>
</tr>
<tr>
<td></td>
<td>** 22.6</td>
<td>64.9</td>
<td>10.7</td>
</tr>
<tr>
<td>3. Interprofessional learning experiences during professional training</td>
<td>* 81.3</td>
<td>17.7</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>** 72.0</td>
<td>25.6</td>
<td>1.2</td>
</tr>
<tr>
<td>4. Economic subsidies or incentives for interprofessional activities</td>
<td>* 33.8</td>
<td>55.6</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>** 29.8</td>
<td>47.6</td>
<td>20.8</td>
</tr>
<tr>
<td>5. Periodic recertification that utilizes an interprofessional component</td>
<td>* 23.7</td>
<td>52.5</td>
<td>21.2</td>
</tr>
<tr>
<td></td>
<td>** 15.5</td>
<td>53.0</td>
<td>29.2</td>
</tr>
<tr>
<td>6. Increased public awareness of existing interprofessional cooperation</td>
<td>* 37.4</td>
<td>48.5</td>
<td>13.1</td>
</tr>
<tr>
<td></td>
<td>** 32.1</td>
<td>51.8</td>
<td>14.3</td>
</tr>
<tr>
<td>7. Peer acceptance among professionals regarding the idea of interprofessional cooperation</td>
<td>* 73.2</td>
<td>24.2</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>** 68.5</td>
<td>29.2</td>
<td>1.2</td>
</tr>
<tr>
<td>8. Confidence among professionals in group interaction skills</td>
<td>* 54.5</td>
<td>40.4</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>** 44.0</td>
<td>46.4</td>
<td>7.7</td>
</tr>
<tr>
<td>9. Encouragement and support from administrative personnel</td>
<td>* 54.0</td>
<td>39.9</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>** 56.5</td>
<td>36.3</td>
<td>6.0</td>
</tr>
</tbody>
</table>

* Course Participants (N = 198)
** Non-participants (N = 168)
Attitudes

Twelve statements comprised the "Attitudes" section (Part B) of the questionnaire. They were statements regarding the value of various aspects of interprofessional education and practice, and were intended to force respondents to make value judgements. The responses revealed that professionals assign relatively high value to interprofessional ideals. On nine of the twelve statements, almost 90% of the responses were either Strongly Agree or Agree (adjusting for statements which were negatively worded). The remaining three statements received mixed responses, divided among Agree, Undecided, and Disagree. Those three statements referred to previous coursework, improved client care, and group dynamics training.

"Attitudes" responses are summarized as follows:

1. Strongly agree
   Professional schools should attempt to deal with ethics or values issues of the profession.

2. Agree
   An interprofessional approach is required today because issues are more complex. Courses in interprofessional awareness should have high priority in professional preparation programs. Changing societal values do significantly influence the roles of the professions in society. Professional associations should take a leading role in promoting interprofessional activities. The clinical/practical component of professional school curricula should provide opportunities for interprofessional interaction. Interprofessional cooperation in actual practice is a realistic goal.
Interprofessional cooperation can significantly promote communication and understanding among the professions. Professional continuing education programs should include aspects of interprofessional interaction.

3. Agree, Undecided, and Disagree

My professional coursework provided sufficient insight regarding the values perspectives of other professions. An interprofessional approach does necessarily lead to improved client care. Most professionals need further training in group dynamics before getting involved with interprofessional teamwork.

Differences between responses of Course Participants and Non-participants were most pronounced for the "Attitudes" portion of the survey. On seven of the twelve statements Course Participants had a larger percentage of responses under Strongly Agree or Agree than did Non-participants. Course Participants showed strong support for the concepts of: 1) an interprofessional approach, 2) interprofessional courses, 3) involvement of professional associations, 4) the appropriateness of dealing with ethics, 5) interprofessional clinical education, and 6) interprofessional continuing education. In addition, Course Participants reported that their professional coursework provided sufficient insight regarding the values perspectives of other professions. Course Participants, however, would have liked additional interprofessional course emphasis. All responses are recorded in Table 7.
<table>
<thead>
<tr>
<th>Attitude Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An interprofessional approach is required today because issues are more complex.</td>
<td>* 37.4</td>
<td>54.0</td>
<td>5.1</td>
<td>3.5</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>** 29.4</td>
<td>56.5</td>
<td>4.8</td>
<td>6.0</td>
<td>1.8</td>
</tr>
<tr>
<td>2. Courses in interprofessional awareness should have high priority in professional programs.</td>
<td>* 39.9</td>
<td>44.9</td>
<td>10.1</td>
<td>5.1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>** 23.8</td>
<td>53.6</td>
<td>13.1</td>
<td>8.9</td>
<td>-</td>
</tr>
<tr>
<td>3. My professional coursework provided sufficient insight regarding values perspectives of other professions.</td>
<td>* 4.0</td>
<td>32.8</td>
<td>13.6</td>
<td>41.4</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>** 4.2</td>
<td>16.1</td>
<td>13.7</td>
<td>50.0</td>
<td>15.5</td>
</tr>
<tr>
<td>4. Changing societal values do not significantly influence the role of the professions in society.</td>
<td>* 1.5</td>
<td>3.0</td>
<td>7.1</td>
<td>48.0</td>
<td>40.4</td>
</tr>
<tr>
<td></td>
<td>** 1.2</td>
<td>3.0</td>
<td>7.7</td>
<td>47.0</td>
<td>40.5</td>
</tr>
<tr>
<td>5. An interprofessional approach does not necessarily improve client care.</td>
<td>* 4.5</td>
<td>32.8</td>
<td>12.6</td>
<td>34.3</td>
<td>15.7</td>
</tr>
<tr>
<td></td>
<td>** 3.6</td>
<td>39.9</td>
<td>13.7</td>
<td>32.1</td>
<td>10.0</td>
</tr>
<tr>
<td>6. Professional associations should take a leading role in promoting interprofessional activities.</td>
<td>* 37.9</td>
<td>55.1</td>
<td>4.0</td>
<td>2.5</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>** 22.0</td>
<td>62.5</td>
<td>10.7</td>
<td>3.0</td>
<td>0.6</td>
</tr>
<tr>
<td>7. Professional schools should not attempt to deal with ethics or values issues of the profession.</td>
<td>* 0.5</td>
<td>-</td>
<td>1.5</td>
<td>22.7</td>
<td>75.3</td>
</tr>
<tr>
<td></td>
<td>** -</td>
<td>1.8</td>
<td>1.8</td>
<td>34.5</td>
<td>61.3</td>
</tr>
<tr>
<td>8. The clinical component of professional school curricula should include interprofessional interaction.</td>
<td>* 50.0</td>
<td>48.0</td>
<td>4.0</td>
<td>2.5</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>** 39.3</td>
<td>55.4</td>
<td>1.2</td>
<td>3.0</td>
<td>0.6</td>
</tr>
<tr>
<td>9. Interprofessional cooperation in actual practice is an unrealistic goal.</td>
<td>* 1.0</td>
<td>2.0</td>
<td>6.6</td>
<td>54.5</td>
<td>35.9</td>
</tr>
<tr>
<td></td>
<td>** 0.6</td>
<td>1.2</td>
<td>13.1</td>
<td>56.5</td>
<td>27.4</td>
</tr>
<tr>
<td>10. Interprofessional cooperation can significantly promote communication and understanding among professions.</td>
<td>* 46.5</td>
<td>48.5</td>
<td>2.5</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>** 43.5</td>
<td>52.4</td>
<td>2.4</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>11. Most professionals need further training in group dynamics before interprofessional involvement.</td>
<td>* 15.7</td>
<td>37.9</td>
<td>21.7</td>
<td>22.7</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>** 11.3</td>
<td>39.3</td>
<td>28.6</td>
<td>19.6</td>
<td>0.6</td>
</tr>
<tr>
<td>12. Professional continuing education programs should include aspects of interprofessional interaction.</td>
<td>* 36.4</td>
<td>58.6</td>
<td>3.5</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>** 22.0</td>
<td>66.1</td>
<td>7.7</td>
<td>3.6</td>
<td>-</td>
</tr>
</tbody>
</table>

* Course Participants  \( N = 198 \)
** Non-participants  \( N = 168 \)
Behavior

Four sections of the questionnaire (Parts E, F, G, and I) were intended to generate information regarding the exposure to and level of involvement in interprofessional activities. Items within three of the sections were open-ended and allowed respondents to give examples in their own words.

Situations which promote interprofessional activities. The first "Behavior" question addressed situations which tend to promote interprofessional activities. The question was open-ended, allowing respondents to list events or situations which might promote interprofessional activities. As indicated by the data in Table 8, almost 80% of the sample responded with at least one example of an event or situation. In addition, almost 40% listed two examples. While Course Participants as a group had a higher percentage listing at least one example, Non-participants had a slightly higher percentage of persons with two, three, or four examples.

The large volume of open-ended responses were placed into sixteen "type of situation" categories. The distribution of responses into the categories is depicted in Table 9. Most of the responses fell into the first three categories: 1) Issue-specific situations, 2) Ongoing client/patient team situations, and 3) Workshops, meetings, and conferences.
### TABLE 8
**SITUATIONS SUGGESTED BY RESPONDENTS WHICH PROMOTE INTERPROFESSIONAL ACTIVITIES**

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>No examples listed</th>
<th>One example listed</th>
<th>Two examples listed</th>
<th>Three examples listed</th>
<th>Four examples listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Participants</td>
<td>40 20.2 76 38.3 57 23.8 17 8.6 8 4.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-participants</td>
<td>38 22.6 58 34.5 43 25.6 19 11.3 10 5.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 9
**CATEGORIES OF SITUATIONS WHICH PROMOTE INTERPROFESSIONAL ACTIVITIES**

<table>
<thead>
<tr>
<th>Situations</th>
<th>Course Participants</th>
<th>Non-Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Issue-specific situations</td>
<td>73 26.7</td>
<td>58 24.1</td>
</tr>
<tr>
<td>2. Ongoing client/patient team situations</td>
<td>70 25.6</td>
<td>57 23.6</td>
</tr>
<tr>
<td>3. Workshops, meetings, and conferences</td>
<td>36 13.2</td>
<td>34 14.1</td>
</tr>
<tr>
<td>4. Experiences during professional education</td>
<td>20 7.3</td>
<td>13 5.4</td>
</tr>
<tr>
<td>5. Situations initiated by one profession</td>
<td>19 6.9</td>
<td>11 4.6</td>
</tr>
<tr>
<td>6. Crises; unusual events</td>
<td>18 6.6</td>
<td>8 3.3</td>
</tr>
<tr>
<td>7. Community involvement</td>
<td>7 2.6</td>
<td>18 7.5</td>
</tr>
<tr>
<td>8. Social relationships; acquaintances</td>
<td>8 2.9</td>
<td>13 5.4</td>
</tr>
<tr>
<td>9. Continuing education situations</td>
<td>7 2.6</td>
<td>10 4.1</td>
</tr>
<tr>
<td>10. Situations promoted by mutual respect</td>
<td>6 2.2</td>
<td>8 3.3</td>
</tr>
<tr>
<td>11. Teaching situations</td>
<td>5 1.8</td>
<td>3 1.2</td>
</tr>
<tr>
<td>12. Journals; newsletters</td>
<td>- -</td>
<td>4 1.7</td>
</tr>
<tr>
<td>13. Situations initiated by client</td>
<td>- -</td>
<td>3 1.2</td>
</tr>
<tr>
<td>14. Situations financially subsidized</td>
<td>2 .7</td>
<td>- -</td>
</tr>
<tr>
<td>15. Situations administratively mandated</td>
<td>2 .7</td>
<td>- -</td>
</tr>
<tr>
<td>16. Research situations</td>
<td>- -</td>
<td>1 .4</td>
</tr>
</tbody>
</table>
"Issue-specific situations" occurred on a one-time basis, were of limited duration, and were initiated because of some specific issue or problem. The following examples were among the 131 responses in this category.

Child custody in domestic relations case. (Law)

Pulling the plug on a respirator. (Nursing)

To provide effective patient care within the hospital setting, interprofessional activities are a must. We met formally and informally to discuss issues, prompted by our own dedication to provide quality care. (Was not mandatory by the institution.) (Social Work)

Nursing home placement of family members. (Theology)

"On-going client/patient team situations" were interprofessional activities which were continuous and structured. They often occurred because of the employment setting, for example, a hospital or mental health agency. Examples from among the 127 responses in this category included:

Regularly scheduled staffings in school system regarding placement of a particular student. (Allied Medical Professions)

Situations where persons of different professions serve clients in the same organization regularly. (Education)

Clinical case conferences requiring interprofessional input to properly assist the patient or client. (Medicine)

The third large category of responses was "Workshops, meetings, and conferences." Responses in this category were often connected with inservice programs or programs of professional associations. Examples were:
Inservice training for other staff members and/or support staff. (Allied Medical Professions)

Conferences like the ones the Commission sponsors. (Nursing)

Inviting other professionals to professional meetings. (Theology)

Examples for the other categories of responses are available in the complete list of the 288 responses included as Appendix G.

Also illustrated in Table 9 is the similarity of responses for Course Participants and Non-participants.

Examples of interprofessional activities. The "Behavior" items of the questionnaire continued by asking respondents to describe an interprofessional activity in which they had participated. Approximately 70% of the sample responded with one example; almost 8% listed two examples, as shown in Table 10.

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>Did not list any activities</th>
<th>One activity described</th>
<th>Two activities described</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Course Participants</td>
<td>53</td>
<td>26.8</td>
<td>128</td>
</tr>
<tr>
<td>Non-participants</td>
<td>54</td>
<td>32.2</td>
<td>103</td>
</tr>
</tbody>
</table>
Responses were assigned to ten categories of activities, with a large proportion falling into the two categories containing the most examples, "Ongoing client/patient team situations" and "Issue-specific situations." (See Table 11.)

Some examples from the first category were:

I am currently involved with developing an interdisciplinary team directly connected to a patient teaching program on home maintenance care. I am the core member of the team. Patients receive excellent teaching. I feel good about this. (Nursing)

The Teen Pregnancy Task Force, a committee established to deal with the problem of teenage pregnancy, has provided a good exchange of information and feelings and a good means of coordinating services in the community. (Social Work)

My chaplain ministry in a hospital was aided by talks and presentations by doctors, nurses, and hospital administrators.... (Theology)

...We have a Juvenile Council. A juvenile who has committed an offense must appear before the council with his/her parents. The council consists of a chaplain, social worker, school officials, attorney, law enforcement officials, and community representatives. The purpose is to recommend to the Commander the most effective way to handle the case. It has been fairly effective. Second offense rate is very low. (Law)

Examples of the second most frequent category of responses, "Issue-specific situations," included:

I helped a young child who was injured...to achieve a good recovery over a long time and fit into school, home, church, and social activities. It is satisfying to see a child's confidence in his own recovery grow as he is involved in daily activities and events he didn't dream possible. (Allied Medical Professions)

I participated in a Stroke Rehabilitation Patient Education Program, a total job rehabilitation program in which clients received quality care. (Education)
**TABLE 11**

**CATEGORIES OF ACTIVITIES IN WHICH RESPONDENTS PARTICIPATED**

<table>
<thead>
<tr>
<th>Types of activities</th>
<th>Course Participants</th>
<th>Non-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>1. Ongoing client/patient team situations</td>
<td>58</td>
<td>40.0</td>
</tr>
<tr>
<td>2. Issue-specific situations</td>
<td>44</td>
<td>30.3</td>
</tr>
<tr>
<td>3. Experience during professional education</td>
<td>20</td>
<td>13.8</td>
</tr>
<tr>
<td>4. Workshops, meetings, conferences</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>5. Community involvement</td>
<td>7</td>
<td>4.8</td>
</tr>
<tr>
<td>6. Continuing education situations</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>7. Professional association activities</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>8. Teaching and research situations</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>9. Social relationships; acquaintances</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>10. Situations prompted by mutual respect</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

A community problem occurred when drugs, purchased at school, showed up at a church youth outing. Law enforcement was alerted. A local abuse center worked with both schools and church in a preventive program with grass roots parental support and participation. (Theology)

A typical example is helping a family as they try to decide whether to discontinue mechanical ventilation on a terminal patient. Working with clergy to help that family arrive at a decision which will not make them feel guilty is a rewarding experience. Also involved are nurses, social workers, etc. I feel that this type of decision requires input from the several professions because too often the family views the doctor's advice as lacking a human element. (Medicine)

A complete list of the 259 responses to this item appears
in Appendix H.

There were small differences between the responses given by Course Participants and Non-participants. A slightly larger percentage of Course Participants listed an example of an activity in which they had participated. There were also slight differences in the types of activities suggested. Course Participants were more likely to list "Ongoing client/patient team situations," while Non-participants more frequently mentioned "Issue-specific situations." Non-participants had a large number of responses under "Workshops, meetings, conferences," but Course Participants had a large number of responses under "Experiences during professional education."

Hours of interprofessional activity per week. Respondents estimated the time they were involved in interprofessional activities during a typical work week. Four response choices were available, ranging from "Not at all" to "7 or more hours a week." A few respondents wrote in a fifth option, "Occasionally," and that response was inserted between "Not at all" and "1-3 hours a week." Just under three-fourths of all respondents listed some involvement during a typical week. The most frequently designated amount of time was "1-3 hours a week," with the second most frequent amount being "7 or more hours a week."

Course Participants indicated a slightly higher level of activity, 77.2% reporting some activity compared to 70.3% for Non-participants. In addition, the number of hours of
involvement per week was slightly higher for Course Participants. A summary of the data regarding reported hours spent in interprofessional activities appears in Table 12.

TABLE 12
HOURS SPENT IN INTERPROFESSIONAL ACTIVITIES IN A TYPICAL WORK WEEK

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>Not at all</th>
<th>Occasional</th>
<th>1 - 3 hours</th>
<th>4 - 6 hours</th>
<th>7 or more hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Participants</td>
<td>44 (22.8%)</td>
<td>3 (1.6%)</td>
<td>75 (38.9%)</td>
<td>25 (13.0%)</td>
<td>46 (23.8%)</td>
</tr>
<tr>
<td>Non-participants</td>
<td>49 (29.7%)</td>
<td>6 (3.6%)</td>
<td>67 (40.6%)</td>
<td>15 (9.1%)</td>
<td>28 (17.0%)</td>
</tr>
</tbody>
</table>

Enrollment in any kind of interdisciplinary course. The researchers were interested in whether respondents had any kind of interdisciplinary or interprofessional course, not just a Commission-sponsored course. The questionnaire item asked, "During your professional education, did you take any interdisciplinary or interprofessional course?" In addition, the question asked, "If yes, please describe briefly." All of the Course Participants responded affirmatively to this question. Approximately 5% of the Course Participant group reported that they also had taken some other interdisciplinary course in addition to the Commission course(s). For the Non-participant group, 26% took an interdisciplinary course of
some kind. Reported in Table 13 are responses in terms of taking an interdisciplinary course. Reported in Table 14 are the types of the courses taken.

**TABLE 13**

"DID YOU TAKE ANY INTERDISCIPLINARY OR INTERPROFESSIONAL COURSE?"

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>Course Participants</td>
<td>198</td>
<td>100.0</td>
</tr>
<tr>
<td>Non-participants</td>
<td>47</td>
<td>28.8</td>
</tr>
</tbody>
</table>

**TABLE 14**

DESCRIPTION OF INTERDISCIPLINARY COURSE TAKEN

<table>
<thead>
<tr>
<th>Type of Course</th>
<th>Course Participants</th>
<th>Non-Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>OSU Commission course(s)</td>
<td>190</td>
<td>94.9</td>
</tr>
<tr>
<td>Interdisciplinary course within own college (non Commission)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interdisciplinary course within own college plus Commission course</td>
<td>9</td>
<td>4.5</td>
</tr>
<tr>
<td>OSU Commission course plus one at another university</td>
<td>1</td>
<td>.5</td>
</tr>
</tbody>
</table>

Involvement with other professions. Respondents provided information regarding which professionals were most often included in interprofessional activities: "In order of frequency, most frequent being #1, list the other professions with which you have been involved or are most likely to be
involved on an interprofessional basis." The questionnaire provided spaces numbered one through five for responses. The majority of the respondents were able to reply to this item, with 90% listing at least one profession and 84% listing at least three professions. Response frequencies are summarized in Table 15. Course Participants were slightly more likely to name more than one profession than were Non-participants.

**TABLE 15**

IN VolVEMENT WITH OTHER PROFESSIONS

<table>
<thead>
<tr>
<th>Number of listings</th>
<th>Course Participants</th>
<th>Non-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listed one profession</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Listed two professions</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Listed three professions</td>
<td>89%</td>
<td>79%</td>
</tr>
<tr>
<td>Listed four professions</td>
<td>68%</td>
<td>52%</td>
</tr>
<tr>
<td>Listed five professions</td>
<td>33%</td>
<td>32%</td>
</tr>
</tbody>
</table>

A wide variety of profession titles were listed by respondents. The list was made more manageable by grouping similar titles. Frequency totals were calculated for each professional title. The total number for each profession represents the number of times the profession was listed, regardless of where in the ranking it appeared. Depicted in Table 16 are the ten most frequently listed professions. Totals should be viewed in the context of the discrepancy in sample size for the various professions involved in the study.
Physicians, Social Workers, and Nurses were the three most frequently mentioned professions. Following these were Lawyers, Educators, Allied Medical Professions, and General Medical/Health Care Professionals. The complete list of all professions mentioned by respondents appears in Appendix I.

The rank ordering by Course Participants and Non-participants was similar. References to Medicine and Nursing were somewhat higher for Course Participants.

### TABLE 16
MOST FREQUENTLY LISTED PROFESSIONS

<table>
<thead>
<tr>
<th>Professions</th>
<th>Course Participants</th>
<th>Non-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of times</td>
<td>Number of times</td>
</tr>
<tr>
<td></td>
<td>Rank Order listed</td>
<td>Rank Order listed</td>
</tr>
<tr>
<td>1. Physicians</td>
<td>1 105</td>
<td>1 65</td>
</tr>
<tr>
<td>2. Social Workers</td>
<td>3 88</td>
<td>2 56</td>
</tr>
<tr>
<td>3. Nurses</td>
<td>2 90</td>
<td>7 42</td>
</tr>
<tr>
<td>4. Lawyers</td>
<td>4 57</td>
<td>3 53</td>
</tr>
<tr>
<td>5. Educators</td>
<td>5 46</td>
<td>4 53</td>
</tr>
<tr>
<td>6. Allied Medical Professionals</td>
<td>6 45</td>
<td>6 47</td>
</tr>
<tr>
<td>7. Medical/Health Care</td>
<td>9 39</td>
<td>5 49</td>
</tr>
<tr>
<td>8. Clergy</td>
<td>7 45</td>
<td>9 27</td>
</tr>
<tr>
<td>9. Psychologists</td>
<td>8 41</td>
<td>8 31</td>
</tr>
<tr>
<td>10. Other Medical Personnel</td>
<td>10 27</td>
<td>10 20</td>
</tr>
</tbody>
</table>

**Intra and interprofessional involvement.** Additional information regarding Behavior was collected by means of the following five questionnaire items:
1. Awareness of at least one interprofessional team.
2. Previous participation in interprofessional practice.
3. Reading at least one journal from one's own profession.
4. Reading at least one journal from outside one's own profession.
5. Involvement on a board or committee in the community with persons from outside one's own profession.

The first item (Part I of the questionnaire) asked for a response to the statement, "I am aware of at least one interprofessional team that works together regularly to help its client." Almost two-thirds of the respondents (both groups) answered in the affirmative, although the Course Participant group had a slightly higher percentage of awareness than Non-participants (see Table 17).

TABLE 17
INTRA AND INTERPROFESSIONAL INVOLVEMENT

<table>
<thead>
<tr>
<th></th>
<th>Course Participants</th>
<th>Non-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1. I am aware of at least one interprofessional team.</td>
<td>67.9%</td>
<td>32.1%</td>
</tr>
<tr>
<td>2. I have participated in interprofessional practice.</td>
<td>73.7%</td>
<td>26.3%</td>
</tr>
<tr>
<td>3. I read at least one journal from my own profession.</td>
<td>95.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>4. I read at least one journal from outside my own profession.</td>
<td>38.5%</td>
<td>61.5%</td>
</tr>
<tr>
<td>5. I am involved on a board or committee in my community with persons from outside my profession.</td>
<td>47.4%</td>
<td>52.6%</td>
</tr>
</tbody>
</table>
The second item asked respondents regarding their own participation in interprofessional practice. Again, approximately two-thirds of the respondents said they had participated in interprofessional practice. Course Participants as a group reported 73.7% participation, while Non-participants reported 57.7% participation.

Question three of this section asked for a Yes/No response to: "I read at least one journal from my own profession." The responses to this statement were almost unanimous, over 95% "Yes." The answers of Course Participants and Non-participants were very similar.

The fourth question asked respondents to report whether they read at least one journal from outside their own profession. Over a third of all respondents, 38.7%, answered affirmatively. There was no difference between response percentages of Course Participants and Non-participants.

The final item in this section assessed involvement on a board or committee in the community with persons from outside one's own profession. Almost half of the respondents reported involvement. Course Participants reported a slightly higher level of participation in the community than did Non-participants.

Attributes

Responses to the eight questions included in Part H of the questionnaire were used to assess the personal characteristics of respondents. Attribute information was collected
in order to determine the comparability of two groups of professionals, Course Participants and Non-participants.

**Age.** The first "Attribute" item placed respondents into one of five age groups. Respondents circled the appropriate group for present age. As illustrated in Table 18, over 75% of the respondents were in the 25-34 age group. Another 13% were in the 35-44 group. Relatively few respondents were less than 25 years of age or over 45 years of age.

The age groups were similar for Course Participants and Non-participants. The responses of the two groups were within a few percentage points of each other in each age category.

**TABLE 18**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Course Participants Freq.</th>
<th>Course Participants %</th>
<th>Non-participants Freq.</th>
<th>Non-participants %</th>
<th>Course Participants &amp; Non-participants Combined Freq.</th>
<th>Course Participants &amp; Non-participants Combined %</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNDER 25</td>
<td>6</td>
<td>3.0</td>
<td>5</td>
<td>3.0</td>
<td>11</td>
<td>3.0</td>
</tr>
<tr>
<td>25 - 34</td>
<td>148</td>
<td>75.1</td>
<td>128</td>
<td>77.6</td>
<td>276</td>
<td>76.2</td>
</tr>
<tr>
<td>35 - 44</td>
<td>30</td>
<td>15.2</td>
<td>19</td>
<td>11.5</td>
<td>49</td>
<td>13.5</td>
</tr>
<tr>
<td>45 - 54</td>
<td>9</td>
<td>4.6</td>
<td>13</td>
<td>7.6</td>
<td>22</td>
<td>6.1</td>
</tr>
<tr>
<td>OVER 55</td>
<td>4</td>
<td>2.0</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Present profession. The next item asked for an open-ended response to the question, "What is your present profession?" While the majority of respondents indicated the title of one of the seven professions, Allied Medical
Professions, Education, Law, Medicine, Nursing, Social Work, Theology, a number of individuals responded with such profession titles as "administrator," "educator," or "consultant." Those responses are summarized in Table 19. Again, Course Participants and Non-participants gave similar responses. Most of the respondents reported continued involvement in some way in one of the seven professions included in the study.

**Years of professional practice.** The third question in Part H asked respondents how long they had been practicing members of their present professions. Three response choices were available, 1-2 years, 3-4 years, and 5 or more years. Responses were divided among the three almost equally. The third choice, 5 or more years, was indicated slightly more than the other two choices. Comparison between Course Participants and Non-participants indicated similarity between the two groups. Responses for Course Participants were slightly higher for the 3-4 years category, while responses for Non-participants were slightly higher for 5 or more years. (Table 20)

**Highest degree level.** Question four asked respondents the highest degree they had received. This question called for an open-ended response. The most frequent response was Master's, followed by Bachelor's and J.D. The responses are summarized in Table 21. Responses between Course Participants and Non-participants follow the pattern of similarity for Attributes.
<table>
<thead>
<tr>
<th>Profession</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clergy</td>
<td>66</td>
<td>57</td>
<td>123</td>
</tr>
<tr>
<td>2. Nursing</td>
<td>34</td>
<td>30</td>
<td>64</td>
</tr>
<tr>
<td>3. Law</td>
<td>32</td>
<td>20</td>
<td>52</td>
</tr>
<tr>
<td>4. Medicine</td>
<td>14</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>5. Social Work</td>
<td>18</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>6. Administrator within profession</td>
<td>8</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>7. Allied Medical Professions</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>8. Instructor within profession</td>
<td>5</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>9. Education</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>10. Theology/ Educator</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>11. Administrator/ Instructor within profession</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>12. Consultant/ Instructor within profession</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>13. Business</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>14. Consultant within profession</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>15. Counselor</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>16. Employed parttime within profession and graduate student</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. Unemployed</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18. Judge</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>19. Waitress</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>
TABLE 20
YEARS OF PRACTICE IN PRESENT PROFESSION

<table>
<thead>
<tr>
<th>Years of Practice</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>52</td>
<td>26.8</td>
<td>48</td>
</tr>
<tr>
<td>3 - 4 years</td>
<td>74</td>
<td>38.1</td>
<td>50</td>
</tr>
<tr>
<td>5 or more years</td>
<td>68</td>
<td>35.1</td>
<td>66</td>
</tr>
</tbody>
</table>

TABLE 21
HIGHEST EARNED DEGREE

<table>
<thead>
<tr>
<th>Degree</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>1. Master's</td>
<td>117</td>
<td>59.4</td>
<td>106</td>
</tr>
<tr>
<td>2. J.D.</td>
<td>34</td>
<td>17.3</td>
<td>22</td>
</tr>
<tr>
<td>3. Bachelor's</td>
<td>26</td>
<td>13.2</td>
<td>23</td>
</tr>
<tr>
<td>4. M.D.</td>
<td>13</td>
<td>6.6</td>
<td>10</td>
</tr>
<tr>
<td>5. Ph.D.</td>
<td>6</td>
<td>3.0</td>
<td>4</td>
</tr>
<tr>
<td>6. D. Min.</td>
<td>1</td>
<td>0.5</td>
<td>1</td>
</tr>
</tbody>
</table>

Prior work experience. Respondents were questioned regarding whether they had professional work experience prior to receiving their most recent degree. Over half of each group indicated some prior experience. Most frequently, the prior experience was 1-2 years or 3-4 years. Very few professionals reported work experience of longer than ten years. These data are presented in Table 22. There was no
consistent pattern of differences in work experience between Course Participants and Non-participants.

### TABLE 22

YEARS OF PRIOR PROFESSIONAL WORK EXPERIENCE

<table>
<thead>
<tr>
<th>Years of Work Experience</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>0</td>
<td>96</td>
<td>48.7</td>
<td>75</td>
</tr>
<tr>
<td>1 - 2</td>
<td>33</td>
<td>16.7</td>
<td>22</td>
</tr>
<tr>
<td>3 - 4</td>
<td>27</td>
<td>13.7</td>
<td>28</td>
</tr>
<tr>
<td>5 - 7</td>
<td>21</td>
<td>10.7</td>
<td>13</td>
</tr>
<tr>
<td>8 - 10</td>
<td>5</td>
<td>2.5</td>
<td>16</td>
</tr>
<tr>
<td>11 - 15</td>
<td>8</td>
<td>4.1</td>
<td>3</td>
</tr>
<tr>
<td>16 - 20</td>
<td>3</td>
<td>1.5</td>
<td>5</td>
</tr>
<tr>
<td>21 and above</td>
<td>2</td>
<td>1.0</td>
<td>-</td>
</tr>
</tbody>
</table>

The work experiences listed were placed into one of five categories. Among those who reported prior professional work experience, the highest percentage described that work as "Practice in the same profession as now." Those persons who responded this way apparently practiced at a lower level the same profession for which they were seeking advanced training. For example, a large group of nursing students had practiced nursing with a bachelor of science degree, and were pursuing a master of science degree. The second highest percentage regarding type of work was "Practice in some other profession." This was especially true for students in Medicine and
Theology. These data are summarized in Table 23.

Course Participants reported less prior work experience than Non-participants. Course Participants were just as likely to have had work experience in a profession other than their present profession, while Non-participants' work experience was predominately in the same profession as now.

TABLE 23

<table>
<thead>
<tr>
<th>Type of Prior Work Experience</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>No prior work experience</td>
<td>96 51.3</td>
<td>75 47.2</td>
<td>171 49.9</td>
</tr>
<tr>
<td>Practice in same profession as now</td>
<td>38 20.3</td>
<td>47 29.6</td>
<td>85 24.6</td>
</tr>
<tr>
<td>Practice in some other profession</td>
<td>35 18.7</td>
<td>14 8.8</td>
<td>49 14.2</td>
</tr>
<tr>
<td>Practice in same profession - student standing</td>
<td>11 5.9</td>
<td>7 4.4</td>
<td>18 5.2</td>
</tr>
<tr>
<td>Non-professional work experience</td>
<td>3 1.6</td>
<td>14 8.8</td>
<td>17 4.9</td>
</tr>
<tr>
<td>Practice in job related to current profession - clerical/technical aspects of the profession</td>
<td>4 2.0</td>
<td>2 1.3</td>
<td>6 1.7</td>
</tr>
</tbody>
</table>

Current profession. The sixth "Attribute" question was a follow-up on previous information regarding current
profession and degree area. The item asked for a Yes or No response to whether the professional was still practicing in the same profession in which the most recent degree was received. Ninety-five percent of the respondents replied affirmatively. (See Table 24.) There was only a very slight difference between groups.

**TABLE 24**  
**CURRENT PROFESSION COMPARED TO AREA OF MOST RECENT DEGREE**

<table>
<thead>
<tr>
<th>Practicing in same profession</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>189 95.9</td>
<td>159 96.4</td>
<td>348 96.1</td>
</tr>
<tr>
<td>No</td>
<td>8 4.1</td>
<td>6 3.6</td>
<td>14 3.9</td>
</tr>
</tbody>
</table>

Membership in professional associations. The final question in the section involved membership in professional associations. From the frequency data presented in Table 25, it is possible to state several observations. Almost 60% of all respondents held memberships in professional associations at three levels, local, state, and national. The percentage holding memberships was highest at the national level (60.9%), with local membership slightly lower (57.7%), and state memberships still lower (54.1%). The majority of those respondents holding memberships held only one at each level. For multiple memberships, the same ranking applied, that is, most frequently at the national level, then local, and then state.
### TABLE 25

**MEMBERSHIPS IN PROFESSIONAL ASSOCIATIONS**

<table>
<thead>
<tr>
<th>Memberships in professional associations</th>
<th>Course Participants</th>
<th>Non-participants</th>
<th>Course Participants &amp; Non-participants Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Local level -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>69</td>
<td>34.8</td>
<td>86</td>
</tr>
<tr>
<td>1</td>
<td>93</td>
<td>47.0</td>
<td>50</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
<td>13.1</td>
<td>25</td>
</tr>
<tr>
<td>3+</td>
<td>10</td>
<td>5.0</td>
<td>7</td>
</tr>
<tr>
<td>State level -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>77</td>
<td>38.9</td>
<td>91</td>
</tr>
<tr>
<td>1</td>
<td>94</td>
<td>47.5</td>
<td>59</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>10.6</td>
<td>13</td>
</tr>
<tr>
<td>3+</td>
<td>6</td>
<td>3.0</td>
<td>5</td>
</tr>
<tr>
<td>National level -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>69</td>
<td>34.8</td>
<td>74</td>
</tr>
<tr>
<td>1</td>
<td>86</td>
<td>43.4</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>24</td>
<td>12.1</td>
<td>27</td>
</tr>
<tr>
<td>3+</td>
<td>19</td>
<td>9.6</td>
<td>12</td>
</tr>
</tbody>
</table>

At each level, Course Participants demonstrated a higher rate of involvement than did Non-participants. For Course Participants, the percent of respondents holding memberships at the local and state levels was 65%, compared to 49% for Non-participants. At the national level, 65% of Course Participants reported memberships, while 56% of Non-participants did so.
Correlational Findings

Each item on the study questionnaire was assigned a study code number to facilitate keypunching the results. Each response became a unit of information which could be manipulated and compared to other units of information. The primary independent variable was participation in a Commission-facilitated interprofessional course. The one questionnaire item which best isolated that variable was contained within question eight of Part H of the questionnaire:

In which Commission courses did you participate?

1. Changing Societal Values
2. Interprofessional Care
3. Ethical Issues
4. Clinical Settings
5. None of the above

All of those respondents who took a Commission course circled at least one of the answers one through four of this question. All who did not take a Commission course circled "None of the above." Therefore, number four, which happened to be key punch item #73, effectively distinguished between the two groups.

Comparing responses (Yes or No) on item # 73 to responses on all of the dependent variables (Beliefs, Attitudes, and Behaviors) produced a correlation coefficient for each dependent variable. Because answering "No" to "None of the above" meant the respondent did take a Commission course, a negative correlation coefficient on #73 demonstrated correlation between course participation and the dependent variables.
Correlation coefficients were also generated for three supporting independent variables: participation in any interdisciplinary/interprofessional course, participation in an interdisciplinary course other than the Commission's, and involvement per week in interprofessional activity. These coefficients were produced by identifying the one item on the questionnaire which distinguished that variable, then comparing each of those items against all of the items representing the dependent variables.

Correlation coefficients are listed in Table 26. The levels of significance varied according to the size of the coefficient. Significance levels are referenced at the bottom of the table.

Beliefs: Issues. The correlation coefficients corresponding to "Beliefs" items were of the smallest magnitude of any of the three sections - Beliefs, Attitudes, and Behaviors.

Coefficients for "Issues" were low, but were all negative and demonstrated a pattern of relationship. Three of the coefficients were closer to zero than the others, indicating little relationship for the issues of "Professional ethics," "Cost of human services," and "Licensure, certification, recertification." Four coefficients were slightly higher, .04 to .08, while only one coefficient was larger than .10 (for the issue of "Life and death issues.").

Correlation coefficients were generated for the three supporting independent variables. Coefficients linking these independent variables to "Issues" were small but also
### TABLE 26

**SUMMARY OF CORRELATION COEFFICIENTS**

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Independent Variables</th>
<th>Commission interprof. course</th>
<th>Any interdisc./ course</th>
<th>Interdisc. course other than Comm.</th>
<th># of hours of interprof. activity per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELIEFS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issues:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Life and death issues: abortion, euthanasia, wrongful birth.</td>
<td>-0.13385</td>
<td>0.15600</td>
<td>0.13461</td>
<td>0.14402</td>
<td></td>
</tr>
<tr>
<td>2. Professional ethics.</td>
<td>-0.00818</td>
<td>0.02600</td>
<td>0.07328</td>
<td>-0.17964</td>
<td></td>
</tr>
<tr>
<td>3. Costs of human services.</td>
<td>-0.01369</td>
<td>0.00864</td>
<td>0.01053</td>
<td>-0.09926</td>
<td></td>
</tr>
<tr>
<td>4. Licensure, certification, recertification.</td>
<td>-0.01956</td>
<td>0.01010</td>
<td>0.05361</td>
<td>-0.23347</td>
<td></td>
</tr>
<tr>
<td>5. Privacy and informed consent.</td>
<td>-0.04356</td>
<td>0.07083</td>
<td>0.07732</td>
<td>-0.09942</td>
<td></td>
</tr>
<tr>
<td>6. Understanding role of various professions.</td>
<td>-0.08547</td>
<td>0.11868</td>
<td>0.12291</td>
<td>-0.13071</td>
<td></td>
</tr>
<tr>
<td>7. Quality of client care.</td>
<td>-0.04134</td>
<td>0.05761</td>
<td>0.07344</td>
<td>-0.23975</td>
<td></td>
</tr>
<tr>
<td>8. Substance abuse.</td>
<td>-0.05431</td>
<td>0.08956</td>
<td>0.09611</td>
<td>-0.07322</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 26 (continued)

**Obstacles:**

1. High degree of specialization.  -0.04003  0.06108  0.07225  -0.06028
2. Lack of exposure to the viewpoints of others.  0.00910  0.02477  0.08397  0.03962
3. Lack of opportunities for interprofessional exchange of information.  0.02484  0.00268  0.05598  0.15182
4. Time demands.  0.12089  -0.12226  0.07538  0.03480
5. Professional jealousies or misunderstandings.  -0.05607  0.06295  0.04522  -0.04133
6. Difficulty in knowing how to proceed.  -0.00316  0.02921  0.05463  0.06787
7. Differences in problem-solving approaches.  -0.07733  0.01483  -0.09945  -0.04511
8. Lack of knowledge of effective use of groups.  -0.04374  0.09098  0.14901  0.00734
9. Suspicion that other professions might dominate.  0.00571  0.05135  0.12848  -0.07461
10. Apprehension that other professions might not value my profession's contribution.  0.03922  0.02472  0.13226  -0.01726
<table>
<thead>
<tr>
<th>Enablers</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Value 3</th>
<th>Value 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interprofessionally-oriented continuing education.</td>
<td>-0.08268</td>
<td>0.09559</td>
<td>0.10959</td>
<td>0.00950</td>
</tr>
<tr>
<td>2. Topic-related interprofessional newsletter.</td>
<td>-0.01303</td>
<td>-0.00477</td>
<td>-0.01347</td>
<td>0.05195</td>
</tr>
<tr>
<td>3. Interprofessional learning experiences during professional training.</td>
<td>-0.14141</td>
<td>-0.14454</td>
<td>0.08492</td>
<td>-0.01198</td>
</tr>
<tr>
<td>4. Economic subsidies or incentives for interprofessional activities.</td>
<td>-0.12019</td>
<td>0.08290</td>
<td>0.00582</td>
<td>0.03549</td>
</tr>
<tr>
<td>5. Periodic recertification with an interprofessional component.</td>
<td>-0.12099</td>
<td>0.09972</td>
<td>0.04681</td>
<td>-0.06976</td>
</tr>
<tr>
<td>6. Increased public awareness of existing interprofessional cooperation</td>
<td>-0.05963</td>
<td>0.06294</td>
<td>0.06227</td>
<td>-0.03051</td>
</tr>
<tr>
<td>7. Peer acceptance among professionals regarding interprofessional cooperation.</td>
<td>-0.05981</td>
<td>0.00919</td>
<td>-0.07645</td>
<td>-0.00495</td>
</tr>
<tr>
<td>8. Confidence among professional in group interaction skills.</td>
<td>-0.13479</td>
<td>0.10698</td>
<td>0.02158</td>
<td>-0.06145</td>
</tr>
<tr>
<td>9. Encouragement and support from administrative personnel.</td>
<td>0.01242</td>
<td>0.01140</td>
<td>0.05902</td>
<td>-0.11704</td>
</tr>
<tr>
<td>Attitudes</td>
<td>Score 1</td>
<td>Score 2</td>
<td>Score 3</td>
<td>Score 4</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>1. An interprofessional approach is required today because issues are complex.</td>
<td>-0.11432</td>
<td>0.15708</td>
<td>0.14372</td>
<td>-0.09518</td>
</tr>
<tr>
<td>2. Courses in interprofessional awareness should have high priority.</td>
<td>-0.16860</td>
<td>0.20992</td>
<td>0.19197</td>
<td>-0.12655</td>
</tr>
<tr>
<td>3. My professional coursework provided sufficient insight regarding other professions.</td>
<td>-0.17453</td>
<td>0.12741</td>
<td>-0.01094</td>
<td>-0.14751</td>
</tr>
<tr>
<td>4. Changing societal values do not influence the role of professions in society.</td>
<td>-0.00104</td>
<td>0.02239</td>
<td>0.04492</td>
<td>0.01574</td>
</tr>
<tr>
<td>5. An interprofessional approach does not necessarily lead to improved client care.</td>
<td>0.06792</td>
<td>-0.21670</td>
<td>-0.18048</td>
<td>0.09969</td>
</tr>
<tr>
<td>6. Professional associations should take a leading role in promoting interprofessional activities.</td>
<td>-0.16607</td>
<td>0.15996</td>
<td>0.09736</td>
<td>-0.14442</td>
</tr>
<tr>
<td>7. Professional school should not attempt to deal with ethics or values.</td>
<td>0.15761</td>
<td>-0.18992</td>
<td>-0.16017</td>
<td>-0.06813</td>
</tr>
<tr>
<td>8. The clinical component of professional school should provide for interprofessional interaction.</td>
<td>-0.13400</td>
<td>0.16051</td>
<td>0.12372</td>
<td>-0.11447</td>
</tr>
<tr>
<td>9. Interprofessional cooperation in actual practice is an unrealistic goal.</td>
<td>0.06378</td>
<td>-0.12187</td>
<td>-0.16776</td>
<td>0.16900</td>
</tr>
</tbody>
</table>


<p>| | | | |</p>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>10. Interprofessional cooperation can significantly promote communication and understanding among the professions.</td>
<td>-0.00143</td>
<td>0.02512</td>
<td>0.08051</td>
</tr>
<tr>
<td>11. Most professionals need further training in group dynamics before getting involved with interprofessional teamwork.</td>
<td>-0.01419</td>
<td>0.07919</td>
<td>0.17651</td>
</tr>
<tr>
<td>12. Professional continuing education should include aspects of interprofessional interaction.</td>
<td>-0.16947</td>
<td>0.20198</td>
<td>0.17759</td>
</tr>
</tbody>
</table>
TABLE 26 (continued)

BEHAVIOR

1. Aware of at least one inter-professional team that works together regularly.  
   -0.04826 0.03238 -0.03041 -0.40243

2. I have participated in interprofessional practice.  
   -0.15698 0.17749 0.11402 -0.50927

3. I read at least one journal from my own profession.  
   0.00465 -0.00229 -0.00042 -0.15245

4. I read at least one journal from outside my own profession.  
   0.00869 0.06680 0.17180 -0.16268

5. I am involved on a board or committee in my community with persons from outside my profession.  
   -0.03752 0.05131 0.04625 -0.05918

*Levels of significance varied with the size of the correlation coefficient.

The following guidelines describe that variation:

<table>
<thead>
<tr>
<th>Correlation coefficient</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.05 - .07</td>
<td>.1</td>
</tr>
<tr>
<td>.08 - .10</td>
<td>.05</td>
</tr>
<tr>
<td>.11 and higher</td>
<td>.01</td>
</tr>
</tbody>
</table>
demonstrated a pattern suggesting a relationship. Coefficients were at least .10 for "Life and death issues," and "Understanding the role of various professions." In addition, activity per week was related to three additional issues, "Professional ethics," "Licensure, certification, recertification," and "Quality of client care."

Beliefs: Obstacles. A pattern of relationships was not necessarily demonstrated for "Obstacles to interprofessional activities." The coefficients were evenly divided between positive and negative, indicating that a relationship could be suggested for some items but that a relationship in the opposite direction, non-participation, was implied for other items. For the independent variables "Any interdisciplinary course" and "Interdisciplinary course other than the Commission," coefficients were more consistent in terms of sign but were low, demonstrating a pattern of slight correlation. For the variable, "Number of hours of interprofessional activity per week," a pattern of relationship was not indicated, again due to the mix of positive and negative coefficients.

Beliefs: Enablers. Contrary to the results for "Obstacles," responses regarding situations which enable or promote did exhibit a pattern of relationship. Course Participants consistently responded differently than did Non-participants. Eight of the nine coefficients were negative, and four of those eight were .12 or higher. The coefficients for two of the situations, "Topic-related interprofessional newsletter"
and "Encouragement and support from administrative personnel," were small enough to suggest virtually no correlation.

The data for two of the supporting independent variables suggested slight correlation between course participation and responses on the dependent variables. For both "Any interdisciplinary course" and "Interdisciplinary course other than the Commission," coefficients were fairly consistent in terms of sign but were generally of low magnitude. For the variable "Number of hours of interprofessional activity per week," there were mixed negative and positive coefficients of low magnitude, not demonstrating a pattern of relationship.

**Attitudes.** Responses to the twelve "Attitudes" statements produced a stronger picture of correlation than the ones produced for any of the three "Issues" sections. Eleven of the twelve coefficients combine to suggest a correlation between course participation and attitudes. Remembering that items numbered 4, 5, 7, and 9 were purposely negatively phrased, and therefore should have produced a positive coefficient, it can be said that nine of the twelve coefficients suggested a relatively strong correlation. Coefficients for the remaining three statements were very low, not suggesting a relationship in either direction. Seven of the nine coefficients demonstrating the relationship were at least .10, and five of the nine were at .15. The attitude statements corresponding to those five highest coefficients were ones which support the objectives of this study:
interprofessional awareness, interprofessional involvement of professional associations, dealing with ethics, interprofessional continuing education, and insight regarding other professions.

The pattern of relationship continued for the three supporting independent variables. For "Any interdisciplinary course," all twelve of the coefficients carried the expected sign to create a pattern of relationship. Nine of the twelve were at least .12, and three were at least .20. Eleven of the twelve coefficients for "Interdisciplinary course other than the Commission" implied a small degree of correlation. For "hours per week," ten of the twelve coefficients suggested a relationship, with seven of those at least .09.

Behavior. Five of the "Behavior" items of the questionnaire were selected for computation of correlation coefficients.

1. Aware of at least one interprofessional team that works together regularly.
2. Have participated in interprofessional practice.
3. Read at least one journal from my own profession.
4. Read at least one journal from outside my own profession.
5. Am involved on a board or committee in my community with persons from outside my profession.

Only the second item demonstrated correlation across the four interdependent variables. The coefficients demonstrated a relationship between participation and each of the independent measures. The highest coefficient was generated for "hours per week," indicating that those who reported at least
one previous interprofessional involvement also reported more hours spent on an ongoing basis in interprofessional involvement.

Summary

The "Belief" items dealt with Issues, Obstacles, and Enablers. The majority of respondents indicated a high level of awareness regarding interprofessional concepts. Most agreed that the suggested issues were indeed appropriately interprofessional. Only one issue, "Licensure, certification, recertification," was not rated as interprofessional. The responses of Course Participants showed a consistent tendency to be slightly more alert to the interprofessional possibilities for certain issues.

Almost 90% of the professionals expressed agreement toward nine of twelve attitude statements. The variable of Course Participation produced systematic variation on seven of the twelve statements, indicating a relationship between Course Participation and favorable attitudes toward interprofessional activities.

Most professionals reported interprofessional activity, usually either in an ongoing team situation or a one-time, issue specific collaboration. Most also identified other professions with which they interact. The majority were aware of an interprofessional team now functioning, and had participated at least once themselves on a team. Less than
40% read journals from outside their profession. Level of interprofessional activity varied positively with course participants.

Professionals were mostly in the 25-34 age category. Most had 3-4 years of professional experience. The most frequently reported degree held was Master's, followed by J.D. and Bachelor's. Most did not have prior professional work experience. Approximately 45% held memberships in professional associations. For none of the "Attribute" variables was there systematic variance between Course Participants and Non-participants.

An analysis of correlation coefficients indicated a clear pattern of relationship between course participation and the Beliefs, Attitudes, and Behaviors of respondents. Relationship was most strongly suggested with regard to Attitudes. Supplemental independent variables also produced a pattern of correlation.

Conclusions which can be drawn from the findings are presented in Chapter Five. The final chapter will also contain limitations connected with this study, as well as topics for further study.
CHAPTER V
CONCLUSIONS AND RECOMMENDATIONS

This final chapter will be devoted to summarizing the study, discussing the findings in light of related literature, and offering some concluding thoughts. It will also mention the limitations of the research methodology, and will suggest topics for further study.

Summary

Educators, practicing professionals, and consumers have recently suggested an increased emphasis on an interprofessional approach to the delivery of professional services. While the professional of today is often more highly specialized and compartmentalized than ever before, client problems of today are more multidimensional, complex, and difficult to accommodate within single specialty areas. Client maladies cross boundaries among specialty areas within professions, between and among professions, and among the physical, emotional, and intellectual dimensions of persons seeking assistance.

Literature in related topic areas suggests a conceptual framework for interprofessional education. Interprofessional education rests on a broad understanding of the nature of the
term "profession." The professions have traditionally been described in terms of a number of exclusive criteria, but recent trends call for a description of professions arrayed along a continuum based on certain descriptors. An interprofessional approach is one response to criticisms of the professions in today's society. Interprofessional education is among several reforms in graduate and professional education. It responds to calls for increased flexibility, integration of different fields of knowledge, and attempts to temper specialization with concern for the "whole person." Interprofessional teams are not in themselves innovations, but today there is increased emphasis and increased breadth suggested for teams. A matrix derived from the conceptual framework for interprofessional education, within which examples of interprofessional education can be classified, assigns courses to different levels based on teaching approach and student mix.

A prominent example of pre-service interprofessional education is the program at The Ohio State University. Under the auspices of the Commission on Interprofessional Education and Practice, students from seven professions take courses team taught by faculty from the seven areas: Allied Medical Professions, Education, Law, Medicine, Nursing, Social Work, and Theology. The course objectives include exposure to the interprofessional team concept, familiarization with the values perspectives of the various professions, and interprofessional dialogue centered on case presentation and field
observation.

The study described here is a survey research project designed to evaluate the Commission courses. The researchers attempted to assess the impact of an interprofessional course on subsequent attitudes and behaviors of practicing professionals. Eight hundred recent graduates of professional programs, half of whom had taken an interprofessional course, were polled. Slightly less than half of those polled responded.

Between 1975 and 1981, the academic units associated with the Commission sponsored a total of eighteen sessions of the following courses: Changing Societal Values and the Professions; Seminar on Interprofessional Care; Seminar on Ethical Issues Common to the Helping Professions; and Interprofessional Seminar in Clinical Settings.

There were five course objectives common to the four courses. Each course hoped to develop in students:

1. An awareness of questions involving current social values and ethical issues;

2. An understanding of the response of one's own profession to current values questions and ethical issues;

3. An appreciation of the response of other professions to current values questions and ethical issues;

4. An understanding that client problems often consist of a configuration of attitudes and problems; and

5. An exposure to interprofessional team process for client problem resolution.

A 60 item questionnaire was developed using the foundation of the course objectives. The questionnaire consisted
of four sections, each representing a particular category of information. The four categories were: Beliefs - awareness, extent of exposure to some concept; Attitudes - value judgments, preferences; Behavior - extent of certain activities; and Attributes - personal information.

The survey was completed and returned by 370 respondents (47%). The analysis of data occurred in two parts. First, SPSS formats were utilized to produce frequency counts, cross tabulations, and distribution analyses. Those frequency data were presented for the entire group of respondents and for the two comparison groups, interprofessional course participants and non-participants. The second analysis procedure involved interpretation of correlation coefficients (Pearson's r) for each independent variable. The primary independent variable was participation in a Commission-facilitated interprofessional course. Supplemental independent variables were participation in any interdisciplinary course, participation in a non-Commission interdisciplinary course, and hours of involvement per week in interprofessional interaction. The dependent variables were beliefs of professionals regarding interprofessional education and practice, attitudes of professionals toward interprofessional education and practice, and behavior of professionals with regard to interprofessional education and practice.

Most professionals agreed that a number of contemporary issues were appropriate for interprofessional attention. Most professionals were aware of current obstacles and
enablers to interprofessional activity. Responses to an attitude inventory revealed that most professionals support the concepts of interprofessional education and interprofessional practice. A majority of professionals reported participation in interprofessional practice, regardless of previous course participation. Course Participants and Non-participants provided similar responses regarding beliefs and attributes. For attitude and behavior variables, there was variance between the responses of Course Participants and Non-participants. Course Participants demonstrated stronger support of interprofessional attitudes and reported more interprofessional activity.

Discussion

Perhaps the best way to begin to expand on the results which have been reported is to discuss possible stages which pertain to an interprofessional approach. In the review of the literature presented earlier, an argument was made for the desirability of an interprofessional approach among professionals in practice.

This study presents an interprofessional approach as a concept. Three stages suggest the process by which a professional adopts an interprofessional approach. These stages are awareness, acceptance, and implementation. The three stages correspond to three types of information collected by the study: beliefs, attitudes, and behaviors. The three types of information are the operational components of the
three stages of the interprofessional approach.

The first stage is awareness. At stage one the professional is exposed to the concept of an interprofessional approach, and has some idea how interprofessional interaction would affect certain situations. The awareness stage corresponds with beliefs.

At the second stage of the interprofessional approach, corresponding to the attitudes section of the questionnaire, the professional accepts the benefits inherent in interprofessional cooperation. A stage two professional has formed the attitude that there are distinguishable advantages to an interprofessional approach for certain categories of client/patient situations.

Stage three of this framework of an interprofessional approach involves implementation or utilization of interprofessional principles. The corresponding operational component of implementation is behaviors. A stage three person combines awareness, acceptance, and implementation.

Viewed in the context of these three stages of an interprofessional approach, the findings enumerated in Chapter Four begin to take on additional meaning. First of all, the respondents as a combined group exhibited certain characteristics relative to an interprofessional approach. Second, as the report of the findings proceeded through the three categories of information, larger differences between Course Participants and Non-participants became apparent the higher the stage of the interprofessional approach.
Stage One. The first section of the questionnaire, which dealt with "Beliefs," corresponded to stage one of the framework just introduced. The "Beliefs" portions utilized lists of Issues, Obstacles, and Enablers. An analysis of the findings for this section revealed that at stage one there were only very slight differences between Course Participants and Non-participants. The questionnaire items in this section did very little to discriminate between the two groups of professionals.

However, general observations at stage one of the interprofessional approach are possible from the findings of the "Belief" section. It can be stated that most of the professionals surveyed have an awareness of or some exposure to interprofessional activities. Over 90% of all of the respondents could agree on interprofessional issues. At least 80% of the respondents could agree on potential obstacles and enablers for interprofessional activities. While the responses generally support the concept of interprofessional education (for example: strong agreement on two obstacles, "Lack of exposure to the viewpoints of others" and "Lack of opportunities for interprofessional exchange of information;" and strong agreement for the enabler, "Interprofessional learning experiences during professional training"), the similarity of responses from the two groups of respondents seems to minimize the influence of the Commission courses on stage one-type awareness. While the interprofessional courses may have contributed to the awareness of Course Participants
a similar level of awareness was achieved by Non-participants exclusive of Commission courses. There were very slight differences between the groups on the "Enabler" items, suggesting that Course Participants, having been exposed formally to the concept, may have been slightly better able to recognize situations which promote interprofessional activities.

One final comment, regarding beliefs/awareness involves responses to "Licensure, certification, recertification." This was the only issue for which there was not strong agreement regarding an interprofessional approach. This result was not suggested in the literature and may be an appropriate item of discussion for course faculty.

Stage Two. If stage one of the interprofessional approach consists of awareness of the notion, then stage two of the framework implies acceptance. A professional exhibiting stage two characteristics would choose an interprofessional approach when a choice was presented. This level of involvement is indicative of the "Attitudes" items on the questionnaire. Those items forced respondents to demonstrate their preferences.

Both Course Participants and Non-participants reported favorable attitudes toward the interprofessional statements. For the majority of the twelve statements, 80 - 90% of the responses were in support of interprofessionalism. This overwhelming general support again demonstrates the intrinsic appeal of the concept.
At stage two, however, the degree of support from the two groups of respondents was different. Both groups supported the concept, but Course Participants more strongly supported the concept. A small difference, statistically significant, was demonstrated on eleven of the twelve attitude statements.

It appears that participation in a Commission course enables a professional to adopt a stronger degree of commitment to interprofessionalism. Participation in any interdisciplinary course, excluding the Commission courses, also seems to generate stronger acceptance.

A lesser degree of agreement occurred on two of the attitude statements, dealing with interprofessional group dynamics and actual impact on client care. Those responses can perhaps be explained by suggesting that the statements pertain to the next stage of the interprofessional approach--implementation.

Stage Three. A framework for discussing interprofessionalism has been suggested. The three stages of the framework are progressive, starting with awareness, moving to acceptance or commitment, and concluding with implementation. At the third stage, implementation, larger differences appeared between the responses of Course Participants and Non-participants. Although many non-participants had implemented interprofessional activities, more Course Participants had done so.
Responses to two items in Part I of the questionnaire are indicative of the difference between stages of involvement, and between the two groups of respondents. The first question asked if respondents were aware of an interprofessional team. Course Participants' rate of awareness was 68%, and Non-participants' rate was 60%. The second question asked respondents to indicate whether they had participated in inter-professional practice. The responses were 74% and 57% for the two groups. This difference between the groups was reflected in the correlation coefficients across each of the four independent variables (.15, .17, .11, .50).

The stage three involvement of Course Participants was evident across several dimensions. Course Participants listed more situations that promote interprofessional involvement. They also listed more examples of activities in which they had participated. Course Participants' activities were more frequently institutionalized into their professional practice, while Non-participants engaged more frequently in issue-specific, one-time situations.

It is possible to generalize regarding situations where interprofessional activity takes place. The professional setting is a determining factor. Professionals working as part of some organization, agency, or institution as opposed to those in private practice more frequently provided examples of interprofessional practice. Certain issues more frequently were mentioned. Those issues generally involved life-threatening illness, radical professional
treatments, threats to traditional family structures and professional treatments around which there are no universally-accepted ethical positions. Medical issues and the physician were involved in a majority of the examples. Medical professionals led the list of other professions with which respondents were involved. Involvement in a professional association increased the frequency of interprofessional involvement.

Nearly 25% of Non-participants reported taking an interdisciplinary course other than a Commission course; however, they provided no descriptive information about those courses. This group of Non-participants reported more interprofessional activity than the rest of the Non-participants, but not as much as Course Participants.

The sample also responded regarding: membership in professional associations; reading professional journals; and involvement on a board or committee in the community. While Course Participants did show a higher level of involvement in professional associations, they were not distinguished from Non-participants on the other two items.

Attributes. Responses to the "Attributes" items supported the comparability of the two groups of respondents. Information about age, years of professional practice, highest degree attained, prior work experience, and present profession is useful as a part of a general data base on professionals. Sample selection methods dictated that respondents would be relatively young and would have only a few
years of professional experience. While results cannot be generalized to all professionals, they do strengthen the survey design regarding new professionals in practice.

Conclusions

The statistical procedure used in the data analysis was designed to measure the degree or strength of relationship between two variables. The intent was to assess whether a dependent variable, such as interprofessional behavior, could be predicted based on knowledge of an independent variable, such as previous participation in an interprofessional course.

Three research questions were developed for this study. The first research question was, "What is the influence of participation in interprofessional courses upon the beliefs of professionals regarding interprofessional education and practice?" The results of this study provide no basis for suggesting that course participation has any influence, beyond an almost imperceptibly slight one, on subsequent beliefs. At the level of beliefs, or awareness, regarding interprofessional activities, both Course Participants and Non-participants demonstrated a high level of agreement on potential interprofessional issues, obstacles to interprofessional activities, and situations which promote interprofessional activities.

The second research question was, "What is the influence of participation in interprofessional courses upon the
A relationship was suggested between course participation and subsequent attitudes. Course Participants demonstrated stronger agreement with a series of attitude statements regarding interprofessional education and practice. Statistically, the suggested influence was small, with coefficients in the .12 to .20 range (reflecting 1% to 4% of the variance). But the coefficients were consistent in sign and pattern. If Strongly Agree and Agree responses were combined, both Course Participants and Non-participants had 90% of their responses in these categories. But Course Participants consistently had a 10% higher level of Strongly Agree responses.

A higher stage of an interprofessional approach was suggested to coincide with attitudes. At this second stage, identified with an acceptance or commitment regarding the worth of interprofessional activities, differences between the responses of Course Participants and Non-participants were more clearly distinguishable than at the stage one.

The third research question was, "What is the influence of participation in interprofessional courses upon the behavior of professionals with regard to interprofessional education and practice?" Course participation seemed related to greater interprofessional behavior. Across the primary independent variable and three secondary independent variables, a pattern of small differences was shown to be statistically significant between Course Participants and Non-participants.
Course Participants were more frequently able to describe an interprofessional activity in which they had participated and more frequently responded that they had participated in interprofessional practice.

The third stage of the interprofessional approach was implementation, which coincides with the behavior section of the questionnaire. The pattern suggested by the data was cumulative in terms of stage of interprofessional approach and strength of relationship with course participation. When a higher stage of the interprofessional approach was examined, a stronger relationship was demonstrated.

There are two features which restrict these conclusions. The first restriction is dictated by the size of the correlation coefficients. While demonstrating a pattern, the coefficients were very small. Any influence attributed to course participation represents a very small percentage of all factors operating to influence professional behavior.

The second restriction has been alluded to several times, and involves potential weaknesses in the study itself. There was unavoidable self-selection in the sample. There was also differences in numbers among the professions based on the courses' enrollment history. Several weaker questionnaire items survived the pilot study.

Despite the few weaknesses cited above, the findings and conclusions presented within this study represent an important addition to the data base of interprofessional education and practice. Interprofessional education does appear to make a
difference, even if only a small one. It is not within the purview of this study to "prove" the value of interprofessional cooperation. That value is assumed. This study now offers tentative validation of pre-professional educational courses as mechanisms for promoting interprofessional practice.

Recommendations

This study can be viewed as an initial step in assessing the impact of an innovative educational endeavor. Further research is indicated in a number of areas.

First, it would be useful to investigate the influences of the courses on a course by course basis. If the courses are impactful, further research could identify what specifically about the courses accounts for that? Further research is necessary about the various components of the courses, and the components' respective impact. Differences in impact occur among the four courses. Certain of the courses may be more influential. Certain courses may emphasize more stage three-type experiences, and should perhaps be emphasized. Additional research on a course-specific basis is possible using the data base from this study. Similarly, comparisons are possible between Course Participants who took one course and those who took more than one.

A profession by profession analysis is possible and necessary. This type of analysis is currently underway by the Commission, but may be limited by the differences in
sample sizes among the professions. Research will be necessary into possible status differences among the professions, and ways those differences impact on both course experience and cooperation in practice.

Another recommendation for further research is to avoid the self-selection threat and the ex post facto nature of the present study. "Pre-test," (before course experience), measurements of students taking courses and similar professional students not taking interprofessional courses can help isolate the effects of the course experiences. Attitude measures before the course, immediately after the course, and then some time later may assist in making more definitive observations of course effects.

The many examples of interprofessional activities available in Appendices G and H, while not specifically germane to the research questions of this study, represent a ready data source. In depth examination of these examples may yield important insights into the dynamics of interprofessional activities.

A three-stage framework describing the interprofessional approach was presented in this chapter. Those three stages were awareness, acceptance, and implementation. A fourth stage may also exist--research and development. A professional who is pursuing research on the notion of an interprofessional approach, or is teaching the notion to prospective professionals, is a person who has gone beyond stage three. The stage four professional seeks to add to new
knowledge or new understanding to the notion of an interprofessional approach.

Beyond specific course assessment, other components of the Commission on Interprofessional Education and Practice are open to further study. No one has yet studied the faculty at The Ohio State University who teach interprofessional courses. Some of the faculty teach interprofessionally as a part of regular load, while for others it constitutes overload. It would be interesting to know why faculty choose to be involved, and whether involvement influences their standing within their respective colleges.

An examination of course materials, texts, and handouts might be undertaken. A substantial cache of case studies have been collected. Those cases could be analyzed for commonalities. Someone could examine the course outlines of the four courses for common core elements, perhaps with an eye toward development of a core text.

Ultimately, this study rested on the beliefs, attitudes, and behaviors of professionals in practice. Further study of professionals in practice is appropriate. Practice setting, length of service, community mores—all probably influence the amount of interprofessional activity. If interprofessional cooperation is indeed a worthwhile goal, then these additional research areas must be pursued.
APPENDIX A

ATTITUDE SURVEY OF PRACTICING PROFESSIONALS

This survey is an attempt to assess the attitudes and experiences of professionals regarding interprofessional education, interprofessional practice, and life-long learning for professionals. The respondents are a sample of recent graduates of The Ohio State University professional schools or the Columbus Cluster of Theological Seminaries. Each questionnaire is identified with a code number to simplify recordkeeping and follow-up procedures. Individual identities will not be divulged and only group responses will be reported.

The following definitions will be helpful in understanding many of the questions:

CONTINUING EDUCATION: an organized effort to maintain or achieve an individual level of accomplishment by extending and amplifying knowledge, sensitivity, or skill.

LIFE-LONG LEARNING: an ongoing self-directed effort, either formal or informal, to establish, maintain, or elevate understanding and competence.

INTERPROFESSIONAL PRACTICE: two or more professions working together collaboratively, with open dialogue, in an effort to maintain or achieve a level of accomplishment or level of client service by extending and amplifying knowledge, sensitivity, or skill.

TEAM: a group with a specific task or tasks, the accomplishment of which requires interdependent and collaborative efforts of its members.

PROFESSION: an occupation characterized by the following:
1. Mastery of specialized knowledge and skills resulting from a lengthy training period.
2. Significant degree of autonomy - internal control of admission to and regulation of the profession.
3. Emphasis on a service ideal and relevance of activities to societal values.
4. Required licensure or certification to practice in the profession.
5. Formal code of ethics.
6. High degree of prestige and influence in society.

Note: The distinction between a profession and other occupations is often an unclear one. For this survey, the characteristics listed above will serve to describe a continuum, with "professions" being those occupations with a high degree of agreement with the characteristics.
PART A: First, we are interested in your reaction to a number of issues. Circle the number which identifies the extent to which you agree or disagree that the issues listed suggest an interprofessional approach. Responses should reflect your personal opinion, using the scale:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. Life and death issues: abortion, euthanasia, wrongful birth.
2. Professional ethics.
3. Costs of human services.
4. Licensure, certification, recertification.
5. Privacy and informed consent.
6. Understanding role of various professions.
7. Quality of client care.
8. Substance abuse.
9. Other? (please specify)

PART B: Next, indicate your agreement or disagreement with the following statements regarding interprofessional education and practice.

1. An interprofessional approach is required today because issues are more complex.
2. Courses in interprofessional awareness should have high priority in professional preparation programs.
3. My professional coursework provided sufficient insight regarding the values perspectives of other professions.
4. Changing societal values do not significantly influence the role of the professions in society.
5. An interprofessional approach does not necessarily lead to improved client care.
6. Professional associations should take a leading role in promoting interprofessional activities.
7. Professional schools should not attempt to deal with ethics or values issues of the profession.
8. The clinical/practical component of professional school curricula should provide opportunities for interprofessional interaction.
9. Interprofessional cooperation in actual practice is an unrealistic goal.
10. Interprofessional cooperation can significantly promote communication and understanding among the professions.
11. Most professionals need further training in group dynamics before getting involved with interprofessional teamwork.
12. Professional continuing education programs should include aspects of interprofessional interaction.
PART C: We are interested in things which promote or hinder interprofessional activity. Rate the extent to which you feel each of the following is an obstacle to interprofessional awareness and cooperation. Again, respond from your personal opinion.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Very much an obstacle</th>
<th>Somewhat of an obstacle</th>
<th>Not an obstacle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:29</td>
<td>1. High degree of specialization.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:30</td>
<td>2. Lack of exposure to the viewpoints of others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:31</td>
<td>3. Lack of opportunities for interprofessional exchange of information.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:32</td>
<td>4. Time demands.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:33</td>
<td>5. Professional jealousies or misunderstandings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:34</td>
<td>6. Difficulty in knowing how to proceed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:35</td>
<td>7. Differences in problem-solving approaches.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:36</td>
<td>8. Lack of knowledge of effective use of groups.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:37</td>
<td>9. Suspicion that other professions might dominate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:38</td>
<td>10. Apprehension that other professions might not value my profession's contribution.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:39</td>
<td>11. Other (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

PART D: Rate the extent to which you feel each of the following enables or helps promote interprofessional awareness and cooperation.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Helps very much</th>
<th>Helps somewhat</th>
<th>Does not help</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:40</td>
<td>1. Interprofessionally-oriented continuing education.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:41</td>
<td>2. Topic-related interprofessional newsletter.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:42</td>
<td>3. Interprofessional learning experiences during professional training.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:43</td>
<td>4. Economic subsidies or incentives for interprofessional activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:44</td>
<td>5. Periodic recertification that utilizes an interprofessional component.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:45</td>
<td>6. Increased public awareness of existing interprofessional cooperation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:46</td>
<td>7. Peer acceptance among professionals regarding the idea of interprofessional cooperation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:47</td>
<td>8. Confidence among professionals in group interaction skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:48</td>
<td>9. Encouragement and support from administrative personnel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1:49</td>
<td>10. Other (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
PART E: The next two questions relate to the extent of your personal involvement in interprofessional activities.

1:50-51 1. What kinds of events or situations do you find promote the occurrence of interprofessional activities.

2. Describe an interprofessional activity in which you have been a participant. Include such things as how you felt about the experience, how effective you thought it was, how client care was or was not improved, etc.

PART F: Please circle the appropriate response to the following questions.

1:54 1. During a typical work week, how many hours of the week are you involved in interprofessional activities?

1. NOT AT ALL
2. 1-3 HOURS A WEEK
3. 4-6 HOURS A WEEK
4. 7 OR MORE HOURS A WEEK

1:55 2. During your professional education, did you take any interdisciplinary or interprofessional courses?

1. YES
2. NO

IF YES, PLEASE DESCRIBE BRIEFLY. ___________________________

PART G: In order of frequency, most frequent being #1, list the other professions with which you have been involved or are most likely to be involved on an interprofessional basis.

2:8-9
2:10-11
2:12-13
2:14-15
2:16-17 1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________
PART H: We would like to ask a few questions about personal characteristics for statistical comparison.

2:18
1. What is your age?
   1. UNDER 25
   2. 25-34
   3. 35-44
   4. 45-54
   5. OVER 55

2:19-20
2. What is your present profession?

2:21
3. How long have you been a practicing member of your present profession?
   1. 1-2 YEARS
   2. 3-4 YEARS
   3. 5 OR MORE YEARS

2:22
4. What is the highest level degree you have received?
   HIGHEST LEVEL DEGREE ______________________
   FIELD OF STUDY ______________________

2:25,26
5. Did you have professional work experience prior to receiving your most recent professional degree?
   1. YES (NUMBER OF YEARS) __
   2. NO
   IF YES, PLEASE DESCRIBE BRIEFLY. ______________________

2:29
6. Are you still practicing in the same profession in which you earned your most recent degree?
   1. YES
   2. NO

2:30
7. At which levels do you hold memberships in professional associations?
   (Circle all that apply.)
   1. LOCAL LEVEL (NUMBER OF MEMBERSHIPS) __
   2. STATE LEVEL (NUMBER OF MEMBERSHIPS) __
   3. NATIONAL LEVEL (NUMBER OF MEMBERSHIPS) __

2:33
8. In which Commission courses did you participate?
   1. CHANGING SOCIETAL VALUES
   2. INTERPROFESSIONAL CARE
   3. ETHICAL ISSUES
   4. CLINICAL SETTINGS
   5. NONE OF THE ABOVE
PART 1: Finally, please answer YES or NO to the following:

1. I am aware of at least one interprofessional team that works together regularly to help their clients.
   1. YES  2. NO

2. I have participated in interprofessional practice.
   1. YES  2. NO

3. I read at least one journal from my own profession.
   1. YES  2. NO

4. I read at least one journal from outside my own profession.
   1. YES  2. NO

5. I am involved on a board or committee in my community with persons from outside my profession.
   1. YES  2. NO

THANK YOU MOST SINCERELY FOR YOUR COOPERATION AND PATIENCE IN COMPLETING THIS SURVEY. PLEASE RETURN IN THE ENVELOPE PROVIDED AS SOON AS POSSIBLE. ADDITIONAL COMMENTS OR CONCERNS YOU WISH TO SHARE WILL ALSO CERTAINLY BE APPRECIATED.

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

THE COMMISSION ON INTERPROFESSIONAL EDUCATION AND PRACTICE
THE OHIO STATE UNIVERSITY
APPENDIX B

COMMISSION COVER LETTERS
The Commission on Interprofessional Education and Practice at The Ohio State University needs your help on an evaluation study we are undertaking. As with any educational program, continual evaluation and feedback are important if that program is to improve. As a former participant in one or more of the courses offered by the Commission, we are sure you are concerned about issues affecting interprofessional education and practice. Your unique understanding of the goals of interprofessional education and their relationship to actual practice in your field can provide us with invaluable insights about the feasibility of those goals.

The study itself will examine participation in interprofessional courses as it relates to attitudes, awareness, and actions of practicing professionals. The research will also compare those factors for any corresponding differences and/or similarities which may exist among the seven member professions. Attitudes toward lifelong learning and continuing education as they pertain to interprofessional education will also be surveyed.

Your voluntary assistance is essential to the success of this study. You have a perspective which comes from both your interprofessional education courses and actual in-the-field practice. It is a perspective the Commission needs to understand better in order to evaluate its own breadth and limitations.

We hope, therefore, that you will take a few minutes to fill out the enclosed questionnaire. All responses will be confidential. We are interested in how each member profession relates to interprofessional education, so only group responses will be reported. Each individual response is important, however, for the validity and reliability of the instrument. We hope, then, that you will complete the questionnaire and return it in the enclosed envelope by Oct. 18, 1982. If for any reason, you feel that you cannot participate in this study, please return your unanswered questionnaire in the envelope.

Thank you in advance for your assistance.

Sincerely,

Mary M. Janata
Program Director

Sara Battison
Kellogg Fellow

Mark H. Spencer
Kellogg Fellow

Encl.
As a graduate of one of the Ohio State University professional schools, we are sure that you are concerned with the growing complexity of issues facing practicing professionals today. Many of these issues seem to cross professional boundaries. At times, it might seem helpful to be able to consult with a member of one of the other professions.

The Commission on Interprofessional Education and Practice at The Ohio State University was formed as a response to this need. The Commission is attempting to facilitate interprofessional communications, education, and cooperation among the members of seven professions. Those professions include education, law, medicine, nursing, allied medicine, social work, and theology. We have reached a point in our brief history where we feel a need to evaluate our goals. Are the goals realistic? Are we beginning to accomplish them? What future goals should be formulated? The goals are related to attitudes, awareness, and actions of practicing professionals regarding interprofessional cooperation. The study will examine these factors and make comparisons for any corresponding differences and/or similarities which may exist among the seven professions. Attitudes toward life-long learning and continuing education as they pertain to interprofessional education will also be surveyed.

Your voluntary assistance is essential to the success of this study. As an active, concerned professional, you have the day-to-day experience and contact with issues to be able to provide us with insightful feedback.

Would you, then, take a few minutes to fill out the enclosed questionnaire? All responses will be confidential. We are interested in how each member profession relates to interprofessional education, so only group responses will be reported. Each individual response is important, however, for the validity and reliability of the instrument. We hope, therefore, that you will complete the questionnaire and return it in the enclosed envelope by Oct. 18, 1982. If for any reason, you feel you cannot participate in this study, please return your unanswered questionnaire in the envelope.

Thank you in advance for your assistance.

Sincerely,

Mary M. Janata
Program Director

Sara Battison
Kellogg Fellow

Mark H. Spencer
Kellogg Fellow
As a graduate of one of the Columbus Cluster of Theological Seminaries, we are sure that you are concerned with the growing complexity of issues facing practicing professionals today. Many of these issues seem to cross professional boundaries. At times, it might seem helpful to be able to consult with a member of one of the other professions.

The Commission on Interprofessional Education and Practice at The Ohio State University was formed as a response to this need. The Commission is attempting to facilitate interprofessional communications, education, and co-operation among the members of seven professions. Those professions include education, law, medicine, nursing, allied medicine, social work, and theology. We have reached a point in our brief history where we feel a need to evaluate our goals. Are the goals realistic? Are we beginning to accomplish them? What future goals should be formulated? The goals are related to attitudes, awareness, and actions of practicing professionals regarding interprofessional co-operation. The study will examine these factors and make comparisons for any corresponding differences and/or similarities which may exist among the seven professions. Attitudes toward life-long learning and continuing education as they pertain to interprofessional education will also be surveyed.

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Thank you in advance for your assistance.

Sincerely,

Mary M. Janata
Program Director

Sara Battison
Kellogg Fellow

Mark H. Spencer
Kellogg Fellow

Encl.
September 1, 1982

Dear Colleague:

As Director of the School of Allied Medical Professions, College of Medicine, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. As a member of the Commission, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission influences the member colleges.

It is important that graduates of the School of Allied Medical Professions participate in gathering information for this study. As practicing professionals, your experience in the field and your attitudes about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and the School of Allied Medical Professions.

Sincerely,

[Signature]
Robert L. Atwell, M.D.
Director

RJA: rmc
Dear Colleague,

As Dean of the College of Education, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our college has been a member of the Commission for two years. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission feeds back to the member colleges.

It is important that graduates of the College of Education participate in gathering information for this study. As practicing professionals, your experience in the field and your attitudes about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and the College of Education.

Sincerely,

Robert A. Burnham
Dean

RAB/mm
Dear Colleague:

I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our College has been a member of the Commission for several years. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission feeds back to the member colleges.

It is important that graduates of the College of Law participate in gathering information for this study. As practicing professionals, your experience in the field and your attitudes about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and the College of Law.

Sincerely,

[Signature]

James E. Meeks
Dean

JEM/mb
September 2, 1982

Dear Colleague:

As Dean of the College of Medicine, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our College has been a member of the Commission for several years. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission benefits all of us.

In order that our graduates participate in gathering information for this study, we are asking your help. Your experience and your attitudes about professional education can provide helpful information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and the College of Medicine.

Sincerely,

Manuel Tzagournis, M.D.
Dean

Acting Vice President for Health Services

MT: mjf
Dear Alumnus:

As Director of the School of Nursing, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our school has been a member of the Commission since its inception 7 years ago. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission feeds back to the member colleges.

It is important that graduates of the School participate in gathering information for this study. As practicing professionals, your experience in the field and your attitudes about professional education can provide discerning information to the Commission and to the faculty in nursing.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for your assistance to the Commission and to your School.

Sincerely,

Edna L. Fritz, Director
School of Nursing
Dear Colleague:

As Dean of the College of Social Work, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our College has been a member of the Commission for several years. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission can have a functional effect in the preparation of our students.

It is important that graduates of the College of Social Work participate in gathering information for this study. As practicing professionals, your experience in the field and your attitudes about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and the College of Social Work.

Sincerely,

Thomas M. Meenaghan, Ph.D.
Acting Dean

TMM/br
Dear Alumnus,

As Academic Dean of the Josephinum School of Theology, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our School of Theology has been a member of the Commission since its inception. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission feeds back to the member colleges.

It is important that graduates of the Josephinum School of Theology participate in gathering information for this study. As practicing professionals and ministers of the Church, your experience in the field and your attitude about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and our School of Theology.

Sincerely,

Rev. Frederick M. Jelly, O.P.
Academic Dean
School of Theology
Dear Colleague,

As Dean of the Methodist Theological School in Ohio, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our school has been a member of the Commission since its beginning. In fact, as you may realize, Methesco founded this important movement. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission feeds back to the member colleges.

It is important that graduates of Methesco participate in gathering information for this study. As practicing ministers, your experience in the field and your attitudes about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and Methesco.

Sincerely,

C. M. Kempton Hewitt, Ph.D. (Dunelm)
Dean

CMKH:mb
enc.
Dear Colleague,

As Academic Dean of Trinity Lutheran Seminary, I am writing to ask for your help in the evaluation study of the Commission on Interprofessional Education and Practice. Our school has been a member of the Commission for 8 years. As a member, we are affected by the work of the Commission in many ways. Any improvements or changes made in the work of the Commission feeds back to the member colleges.

It is important that graduates of Trinity participate in gathering information for this study. As practicing professionals, your experience in the field and your attitudes about professional education can provide discerning information to the Commission.

I hope, then, that you will be able to find a few minutes to fill out the Commission's questionnaire and return it in the enclosed envelope.

Thank you for the service you are doing for the Commission and Trinity.

Sincerely,

James M. Childs, Jr.

Enclosures
APPENDIX D
"OTHER" INTERPROFESSIONAL ISSUES

1. Domestic relations - child custody
2. Human sexuality
3. Educational placement within public school system (i.e. Learning Disabled self-contained class vs. resource educably Mentally Retarded class, emotionally handicapped class, private school)
4. Professional education curriculum
5. Education of various professionals
6. Threat of nuclear war
7. Nuclear armament/disarmament
8. Mental health care
9. Working together to provide services for the mentally ill
10. Dealing with families (informing)
11. General social priorities
12. Effects of poverty on family life
13. Psychiatric hospital - probate
14. Methods of continuing interprofessional cooperation in practice of the professions
15. Expanding areas of care and services
16. At the "interface" of issues or professions
17. Marriage, Divorce, Remarriage
18. Preparing client for death - terminal patients
19. Intervention/management of terminally ill patients
20. Variations of or substitutes for the "medical model"
21. Independent management of one's profession
22. Control of practice
23. Patients' rights
24. Decision making in determining an appropriate intervention strategy for clients with questionable outcomes
25. Women's issues
26. Almost all topics
APPENDIX E

"OTHER" OBSTACLES TO INTERPROFESSIONAL ACTIVITY

1. Failure to appreciate usefulness of interprofessional cooperation
2. Disinterest by profession
3. Apathy
4. Lack of awareness of need for an interprofessional approach
5. No desire to reach consensus
6. Egocentricity
7. Personal self-sufficiency
8. Lack or respect
9. Difference in social status
10. Other professions frequent failure to recognize ministry as a profession of equal status with whom they might cooperate
11. Better than thou syndrome
12. Money
13. Problems with proper organization of interprofessional groups
14. Value base
15. Lack of a common language
16. Tradition
17. Another obstacle to interprofessional cooperation is the ambiguity with which health professionals deal with controversial issues, such as patient's right to die or
right to refuse treatment. Because individual professionals are extremely uncomfortable with such issues and because there are not even very many clear intra-professional guidelines for dealing with these difficult issues, interprofessional cooperation becomes almost impossible. The common tactic which results is inter-professional avoidance of such issues.

18. Dominance/submissive pattern of interaction

19. Male/female stereotyping which impinges on several of the professional groups - basically an imbalance of power

20. Professional ethics

21. Cost of program

22. Individual maturity

23. Jealousy among same profession

24. Different schools of thought in professional education re: goals of treating someone, i.e. cure vs. viewing people where they are in wholistic disease trajectory

25. Different faith approaches

26. Lack of knowledge about expertise/skills of other professions

27. Misunderstanding of professional roles

28. Fear that others may tell you how to better do your job
APPENDIX F

"OTHER" ENABLERS TO INTERPROFESSIONAL ACTIVITY

1. Interprofessional organizations (i.e. The Association For Care of Children's Health)
2. Experience in dealing with other professionals to solve your client's problem
3. Regular interprofessional patient-care conferences
4. Experience in working with other competent professionals
5. Activities which promote joint professional work — such as the child protection team I now serve on. Discuss child abuse cases with Family Services — School, Hospital, Clergy, Social Work, Law professionals
6. Rather than abstract discussion, groups should work towards tangible goals
7. Good interprofessional role models
8. Specific time set aside
9. Clear and evident community needs or problems (ex. substance abuse)
10. Understanding the role of vocation (not just a job) and the cooperation of each for total health (wholeness) care
11. Personal/professional commitment/vision of possibilities of "community" (with fellow professionals and with community at large)
12. Respect for each other
13. Security in own professional role
14. Confidence in one's own approach to eliminate professional jealousy
15. Events with special speakers, banquet style, perhaps.
16. The recognition that there is no absolute in any one profession to the problems of life
APPENDIX G
EXAMPLES OF SITUATIONS WHICH PROMOTE INTERPROFESSIONAL ACTIVITIES

<table>
<thead>
<tr>
<th>SITUATION #</th>
<th>CATEGORY TITLE</th>
<th>KEY PUNCH #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Issue-specific situations</td>
<td>04</td>
</tr>
<tr>
<td>2</td>
<td>Ongoing client/patient team situations</td>
<td>01</td>
</tr>
<tr>
<td>3</td>
<td>Workshops, meetings, and conferences</td>
<td>05</td>
</tr>
<tr>
<td>4</td>
<td>Experiences during professional education</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>Situations initiated by one profession</td>
<td>02</td>
</tr>
<tr>
<td>6</td>
<td>Crises; unusual events</td>
<td>07</td>
</tr>
<tr>
<td>7</td>
<td>Community involvement</td>
<td>08</td>
</tr>
<tr>
<td>8</td>
<td>Social relationships; acquaintances</td>
<td>09</td>
</tr>
<tr>
<td>9</td>
<td>Continuing education situations</td>
<td>06</td>
</tr>
<tr>
<td>10</td>
<td>Situations prompted by mutual respect</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Teaching situations</td>
<td>13</td>
</tr>
<tr>
<td>12</td>
<td>Journals; newsletters</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Situations initiated by client</td>
<td>03</td>
</tr>
<tr>
<td>14</td>
<td>Situations financially subsidized</td>
<td>15</td>
</tr>
<tr>
<td>15</td>
<td>Situations administratively mandated</td>
<td>16</td>
</tr>
<tr>
<td>16</td>
<td>Research situations</td>
<td>14</td>
</tr>
</tbody>
</table>

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OPEN-ENDED RESPONSES TO PART E, ITEM 1, "EVENTS OR SITUATIONS WHICH PROMOTE INTERPROFESSIONAL ACTIVITIES."

Situation #1: ISSUE-SPECIFIC SITUATIONS

Allied Medical Professions (Course Participants)
1. Special education meetings in school districts.
2. Client placement.
3. Client program planning.
4. Unfortunately, in the laboratory, the situation that most often sparks interprofessional activity is when there is a complaint or problem related to lab service or results.
5. Events around a topic which are problem-solving endeavors, taking back what you learn to your own role or position.
6. In the release of medical information pertinent to a staff member.
7. Patient care.
8. Providing for the handicapped or injured child to be active in school and community and social activities.

Allied Medical Professions (Non-participants)
1. Client problems that can best be solved by overlap of opinions - occupational therapist, physical therapist, physician.
2. Abnormal physiologies.

Education (Course Participants)
1. Working in neonatal critical care area of large hospital. Many professions involved. Team: M.D., nurses, social worker, physical therapist, nutritionist. (consultants to team - attorney, clergy)
2. Administrative support of such activities.

Education (Non-participants)
1. Family counseling - interaction with school and place of employment in some cases.
2. Decision-making in risks and benefits of technology to progress in social standards.

Law (Course Participants)
1. Child custody in domestic relations case.
2. Professional is recommending a course of action to the client such as a medical treatment.
### Situation #1 continued: "Issue-specific situations"

3. Especially family violence.

4. Those situations where the ramifications overlap many fields, such as: medical, legal, religious, social, psychological, etc.

5. Also when government agencies get involved.

6. Malpractice problems.

7. In the area of hospital law, there is a great opportunity for interprofessional cooperation. Especially in medical/moral issues, this type of cooperation is necessary and often utilized.


#### Law

**Non-participants**

1. Interaction between lawyers and doctors to solve medical malpractice problems. Interaction between lawyers and businessmen to solve business law problems; to structure a legal practice.

2. Subject-oriented seminars.

3. Criminal cases.

4. Family law.

5. Work-related questions regarding liability or interpretations of law.

6. Tax litigation; tax planning.

#### Medicine

**Course Participants**

1. Areas of conflict arising as a result of poor communication.

2. Problems in the client's "social situation" or with economics.

3. Terminal care.

4. Chronic illness and treatment of same.

5. Patients with chronic diseases who need medical, psychosocial, and financial support.

#### Medicine

**Non-participants**

1. Different legal/social/ethical cases seem to promote an interprofessional approach.

2. Group discussion on pertinent client or patient problems on an individual problem basis, i.e. what diet therapy for a particular patient - nurse, dietician, physician.
Situation #1 continued: "Issue-specific situations"

Nursing
(Course Participants)

3. In medicine there has been an increase in interprofessional interaction due to the complexity of situations that arise in patient care - i.e., euthanasia, abortion, substance abuse, etc. I would say that these kinds of situations lent themselves well to an interprofessional approach.

1. A supportive administration that provides interdisciplinary rounds periodically as well as adequate communication between disciplines.

2. Patient's death and dying.

3. Home going (discharge plans).

4. Hospital health programs.

5. Multiple system failure patients.

6. Being in the right place and the right time, being seen and being available.

7. When a person/family has difficulty with financial or housing matters we call in social services and work together to gather information to provide the best care available. When a person needs education about diets, dietary person is called in.

8. Participation in rehabilitation of spinal cord injured and brain damaged patients in rehabilitation centers.

9. Discharge planning.

10. Communication of any kind about patient care and/or progress - feedback to MD's, social workers, other nurses about patient's progress at home.

11. In the private hospital the distinction between professions was strong - almost like different class systems - very little interaction between professional groups. (Admittedly there were fewer of each group in the small hospital.)


13. Pulling the plug on a respirator.


Nurses
(Non-participants)

1. Specific workshops.

2. Interprofessional task force.
Situation #1 continued: "Issue-specific situations"

3. Crisis/disaster brings medicine, law, and general public together to attain common goals.

4. I was a public health nurse (just quit). The needs of my clients precipitated any referrals as needed to other professionals.

5. When a crisis occurs on my hospital unit the various professions meet and discuss solutions.

6. Work on a controversial issue or program.

7. Client related activities.

8. Very ill patients that require the expertise of several professionals.

9. When one profession wants to accomplish a certain goal but it realizes it can only do that with the cooperation of other professionals.

10. Informal discussions (regularly) between interprofessionals to discuss ethics of the interprofessions.

11. Stressful times - code.

12. Primary nursing.

Social Work
(Course Participants)

1. Mental health seems to coordinate well with psychiatrists, however, the OB/GYN's I've worked with were not familiar with social work and slowly began making referrals after 2 years.

2. Implementing these treatment plans: difficult client problems.

Social Work
(Non-participants)

1. To provide effective patient care within the hospital setting, interprofessional activities are a must - we met formally and informally to discuss issues, prompted by our own dedication to provide quality care. (Was not mandatory by the institution.)

2. Situations where a client clearly requires the help of several different professionals. This very clear need initiates the interaction.

3. Current "hot" topics appear to act as a stimulus for workshops.
<table>
<thead>
<tr>
<th>Situation #1 continued: &quot;Issue-specific situations&quot;</th>
</tr>
</thead>
</table>
| **Theology**  
  (Course Participants)  |
| 1. Marriage/family law issues.  |
| 2. Fears/phobias.  |
| 3. Especially in hospital (chaplaincy) situations.  |
| 5. Family/marriage abuses.  |
| 6. Hospitalization of parishioners.  |
| 7. Surgery.  |
| 9. Family decisions on euthanasia.  |
| 10. Psychiatric hospitalization due to probate.  |
| 11. Nursing home placement of family members.  |
| 12. A stand or movement "against" an issue, proposal, organization, etc., that can be simply stated. Presence of a catalyst person—even one who is committed to interprofession activities and gathers others to pursue his/her vision.  |
| 13. Parishioners who are hospitalized.  |
| 15. Care for elderly and terminal.  |
| 16. Care for poor who are sick.  |
| 17. Involvement in social services and programs.  |
| 18. Involvement outside church - i.e., I was very involved in Women's Crisis Center and worked closely with lawyers, medical personnel, social workers, etc.  |
| 19. Also in rural situation where we have been, I worked closely with doctor in several situations, he was good at working toward holistic approach to health including spirituality.  |
| 20. Primarily issue-oriented, problem-solving type experiences. Such as medical, mental health, and religious community representations working with bio-ethics, etc.  |
| 21. Transitions from hospital care to nursing home or hospice care.  |
Situation #1 continued: "Issue-specific situations"

22. Family crises.
23. Death.
25. Medical.
26. Intervention for the chemically dependent people.
27. In a hospital setting but almost always with a nurse rather than a doctor.
28. Personal crises - illness, family relationships.
30. Value-evaluation systems.
31. Human rights - quality of life situations.
32. All economic problems from ongoing to survival including ecological.
33. Illness.
34. Death.

Theology (Non-participants)

1. Programs designed to meet specific needs of persons (Hospice is one example).
2. Family crises.
3. Estate planning.
4. Family crises.
5. Alcohol and drug abuse.
7. Need in areas where responsibilities overlap: Medical care, divorce, nursing homes service, etc.
8. Death.
9. Issue-oriented setting: i.e., hunger, etc.
10. Hospital visits, counseling, deaths, alcoholism, child neglect and abuse.
11. When decision making with regard to significant areas (medical treatment, legal proceedings, etc.) are made in an arena of providing the best interaction between various parties.
Situation #1 continued: "Issue-specific situations"

12. Death; legal matters.
13. Counseling regarding pre-marriage preparation or post-wedding dilemmas.
14. Life and death.
15. Hospital visits; patient relationships; court cases.
16. Life and death issues; ethical/medical issues; legal matters which entail various professions; nuclear arms issues/events.
17. Situations when various disciplines work together on a common problem.
18. Making hospital visits; sometimes calls in nursing homes.
19. Mutual involvement in a person's case -- i.e., dying patient, doctor/clergy relation.
20. Alcoholism.
22. The church is sometimes a vehicle for bringing together various professions for discussing issues.
23. Counseling; illness.
24. People who are in need of assistance (welfare).

Situation #2: ONGOING CLIENT/PATIENT TEAM SITUATIONS

Allied Medical Professions (Course Participants)

1. Regularly scheduled staffings in school system re. placement of particular student.
2. Planning meetings.
3. Patient care conferences - interprofessional.
4. Planning for disposition and care of patients after discharge from hospital.

Allied Medical Professions (Non-participants)

1. Common goals or problems.
2. Team meetings.
4. Professional education for multidiscipline groups.
Situation #2 continued: "Ongoing client/patient team situations"

5. Time to interact with other professions.
6. Complex problems.
7. Working together to solve common problems - needs cause results.
8. Team approach in clinical settings.

Education (Course Participants)
1. Interaction with other professionals.
2. Hands on experience.
3. Issues which involve a wide cross-section of the community.
4. Informal meetings.
5. Areas of human care and concern involving medical, legal, counseling, educational and on-going support.

Education (Non-Participants)
1. Situations where persons of different professions serve clients in the same organization regularly.
2. Personal counseling.

Law (Course Participants)
1. Different professionals assisting one patient/client at the same time.
2. Legal practice.
3. Situations involving both an emotional or physical problem and a legal issue.
4. Work with low income clients with multiple problems.
5. Shared delivery of services.
7. Trials.
8. Often the nature of your particular practice requires the involvement with other professions.

Law (Non-participants)
1. Working with another professional regarding same client.
2. Situations involving the interaction between professions dependent on another profession.
3. Real life work experiences.
4. Ad hoc need.
5. Joint meetings on relevant subjects.
Situation #2 continued: "Ongoing client/team situations"

**Medicine (Course Participants)**

1. Clients with broad interprofessional needs.
2. Difficulties in client care or progress.
3. Clinical case conferences requiring interprofessional input to properly assist the patient or client.
4. Initial management of malpractice cases.
5. Patient care: MD/RN

**Medicine (Non-participants)**

1. On the job experience working with another team member to benefit the patient.

**Nursing (Course Participants)**

1. Patient care conferences.
2. Interprofessional group therapy sessions.
3. Primary nursing.
4. Structure within work situations to bring people together.
5. Weekly meetings about specific patients and their care being discussed. Input from each profession.
6. Consistent contact with given professional individuals rather than the day to day changes in your professional relationships.
7. Interdisciplinary patient care conferences.
8. Patient care conferences.
10. I have worked in both a large medical center and a smaller private hospital. I have found that the concept of interprofessionalism was much stronger and more utilized in the large medical center (a strong teaching atmosphere).
11. Patients or clients usually have multiple needs which usually require interprofessional services.
12. My work with the U.S. public health service as a Community Health Nurse with the Navajos and Hopis utilized interprofessional skills on a daily basis in effort to problem-solve and coordinate varied services for multitudes of complex problems.
**Situation #2 continued: "Ongoing client/team situations"**

13. Utilization review committee or quality assurance committees within the hospital.

14. Working environments that include a process for interdisciplinary approaches.

1. "On the job" opportunities to interrelate.

2. Patient care conferences.

3. Team approach to client care.


5. Works towards a common goal or a common task.

6. Membership on same committees.

7. Patient care conferences with multidiscipline caregivers, i.e., public health nurse, home health aid, P.T., O.T., S.T.

8. Interprofessional client conferences.

9. When one profession wants to accomplish a certain goal but it realizes it can only do that with the cooperation of other professionals.

10. Problem or goal which stimulates need for interprofessional cooperation.


12. Consulting with various other professionals re: optimal patient care.

13. Patients in need of a multidisciplinary care approach in order to achieve maximum health care.


15. Continual presence of several professions in same work environment.

16. Team conferences.

17. Multidisciplinary team philosophy.

18. When nurses and doctors go on round together to discuss patients.
Situation #2 continued: "Ongoing client/patient team situations."

Social Work (Course Participants)

1. Case conferences - one to one interactions.
2. I have always been employed in an interprofessional setting and nearly all the services I provide to clients (patients) involve interprofessional collaboration, just as a matter of course.
3. I have worked on an interprofessional treatment team. This did promote interprofessional activity.
4. When professions are working towards goals for a client.
5. "Team settings."
6. Task forces.
7. Work related situations calling on joint effort to problem resolution.
8. Team meetings regarding patients.
9. Case conferences once a week with all disciplines.
10. Weekly interprofessional conferences to discuss clients' problems, treatment plan, etc.
11. Designing individual treatment plans for clients.
12. Utilizing a treatment team approach to work.
13. If you are working with people around their problems I feel interdisciplinary approach is best.
14. I work on interdisciplinary teams in a medical setting.

Social Work (Non-participants)

1. Case teamwork.
2. Consulting, co-therapy.

Theology (Course Participants)

1. Hospitalization of parish members - with doctors and nurses.
2. Structured dialogued groups.
3. Clinical Pastoral Education in a local hospital/mental hospital.
4. People needing specific help with social needs.
Situation #2 continued: "Ongoing client/patient team situations"

5. Chaplaincy.

6. Hospital and counseling.

7. Hospital or rest home circumstances where a priest or minister is involved.

8. In my regard the greatest occurrence is in the health care areas.

9. Being a priest, I find that much of my interprofessional involvement occurs in the hospital setting. I have had many "growth" experiences due to my interaction with hospital staff on various levels. Being a financial administrator in a boys' high school, I am also in contact with various other professions.


11. Counseling with other professionals.

12. Centered around health care as a wholistic approach.

13. A work environment where interprofessional cooperation/coordination is required.


15. Actual daily opportunities

16. Those that are voluntary.

17. Taking the time to sit down and discuss issues with other professionals whose paths we cross in our work.

18. Counseling situations in which I have worked with a professional from the mental health centers.

19. Promotion of a team approach in the care of patients.

Theology (Non-participants)

1. Open small group dialogues.

2. When two or more professionals come in contact with the same client.

3. Pastoral counseling

4. Opportunities for open dialogue and sharing or reflection upon current techniques or procedures are very helpful.

5. Small group meetings
Situation #2 continued: "Ongoing client/patient team situations"

6. In the health service environment where I have been, events here are pain which goes with emotional response - a wholistic healing takes interprofessional activities between medical personnel and theologians or chaplains.

7. Common goals - needs.

8. Use of many professions to problem solve or help in community decisions.

9. Client-oriented setting, i.e. hospital.

10. Situations involving hospitals or the state hospital.

11. Patient care conferences.

12. Issue of common interest.

13. Personal counseling of a person with problems.

14. Primarily, when an interested or disinterested third party seeks help from two or more professionals or asks their cooperation and so provides an excuse for cooperation and interaction. Secondarily, when a professional experiences a professional need to seek out another professional for help, this seems to occur only "as a last resort" type of situation.

15. Designed programs.

16. Small group sessions/workshops where there is a high degree of free interchange of ideas, values, and learnings.

17. Medical clinic mental health clinic.

18. The well being of a person in both the spiritual and physical (sickness).

19. Health care instruction.

Situation #3: "WORKSHOPS, MEETINGS, AND CONFERENCES"

Allied Medical Professions (Course Participants)

1. Workshops or conferences in specialized areas - MR, CR. Education School Resource Committee meetings

2. Staff meetings.

3. Inservice training for other staff members and/or support staff

4. Lectures
<table>
<thead>
<tr>
<th>Situation #3 continued: &quot;Workshops, meetings, and conferences&quot;</th>
</tr>
</thead>
</table>
| **Allied Medical Professions**  
  (Non-participants) | 1. Clinics. |
| | 2. Job situation - inservice education. |
| | 3. Professional education committee. |
| | 4. Roundtable discussions at state or national meetings. |
| | 5. My current position in Department of Pediatrics. |
| **Education**  
  (Course Participants) | 1. Interprofessional committee memberships. |
| | 2. O.S.A.A.P. |
| **Education**  
  (Non-participants) | 1. Combined professional meetings. |
| | 2. Lecturing. |
| | 3. Interprofessional meetings. |
| | 4. Conferences. |
| | 5. Management seminars. |
| **Law**  
  (Course Participants) | 1. Interprofessional committees within the various professional associations (like a doctor/lawyer committee in a bar assoc). |
| | 2. Interprofessional committees. |
| | 3. Public forums/panel discussions. |
| | 1. Agreements between the American Bar Association and American Institute of CPA's re: issuance of opinion of legal liability necessary for financial statements; agreements between the ABA and AMA. |
| | 2. Guest speakers of interest to different professions. |
| **Law**  
  (Non-participants) | NO EXAMPLES. |
| **Medicine**  
  (Course Participants) | NO EXAMPLES. |
| **Medicine**  
  (Non-participants) | NO EXAMPLES. |
| **Nursing**  
  (Course Participants) | 1. Concern for quality of care at most economic level. |
| | 2. Conferences. |
| | 3. Mental Health Association meetings, workshops with the mental health professionals. |
| | 4. Administration of hospital pushing for interprofessional activities and open-minded physicians - organized events |
Situation # 3 continued: "Workshops, meetings, and conferences"

that are geared for the interprofessional approach.

5. Interprofessional conferences on topics of common interest.

6. Conferences like the ones the Commission sponsors.

7. Workshops that teach people the skills needed to work cooperatively.

Nursing
(Non-participants)

1. Staff meetings.

2. Conferences in which individuals from various professions are presenters; discussion groups - interprofessional at conference.

3. In-service lectures given to company employees.

4. Committee work.

5. Inservice topics to share information with all disciplines.

Social Work
(Course Participants)

1. Conferences/workshops.


3. Inservice training involving professionals outside of organization.

4. Conferences, workshops, seminars, etc.

5. Joint meetings of professional groups or organizations.

6. Conference attendance involving interdisciplinary approach to topics.

7. Task force.

Social Work
(Non-participants)

1. Seminars and workshops that are assigned to address a specific topic with applicability to a wide range of professions.

2. Workshops.

3. Case conferences.

Theology
(Course Participants)

1. Specific training events bringing many professions together where all can relate and share regarding a particular situation

2. Hospital sponsored events regarding specific diseases, cases, philosophies
Situation #3 continued: "Workshops, meetings, and conferences"

3. I would like to see some forums/seminars with dialogue by responsible spokespersons from the various disciplines addressing an ethical topic of concern to all involved.

4. Medical personnel are many times called upon to be present at large public functions.

5. Interprofessional seminars or workshops within a church setting, e.g. a workshop on marriage for engaged couples.

6. Inservice interprofessional training.

7. State conventions, workshops.

8. Interprofessional seminars, workshops, dealing with a specific issue.

9. Seminars and convocations.

10. Topical seminars.

11. Hospital seminars.

12. Seminars and one day symposiums such as those sponsored by the Commission.

Theology (Non-participants)

1. Interprofessional training programs centered on subjects of common interest.

2. Seminars.

3. Lectures.

4. Seminars or workshops designed to include a variety of professionals.

5. Local medicine and religion committee of American Medical Association - planned meetings.

6. Ministerial associations or ecumenical groups with similar interests that I have participated in have occasionally had interprofessional opportunities.

7. Special sessions or seminars (tax deductible).

8. Inviting other professionals to professional meetings.

9. Workshops related to a particular topic.

10. Seminars, etc., with an opportunity for questions, dialogue, etc.

11. Workshops with two or more professions.
**Situation #3 continued: "Workshops, meetings, and conferences"**

12. Speakers from one profession speaking with members of another profession's association (i.e. medical doctor speaking to a ministers' association meeting).

13. Seminars - topic approached from various professional groups involved.

14. Workshops.

**Situation #4: "EXPERIENCES DURING PROFESSIONAL EDUCATION"**

<table>
<thead>
<tr>
<th>Allied Medical Professions</th>
<th>Education</th>
<th>Law</th>
<th>Medicine</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Course Participants)</td>
<td>(Course Participants)</td>
<td>(Course Participants)</td>
<td>(Course Participants)</td>
<td>(Course Participants)</td>
</tr>
<tr>
<td>1. Commission courses.</td>
<td>1. Ethics classes.</td>
<td>2. Other than my involvement in an interprofessional education course at OSU. I have not been involved in interprofessional activities.</td>
<td>1. Most important were the many experiences during my professional training.</td>
<td>1. As a nursing student, took part in an interprofessional study group which looked at a variety of topics. This was a great experience and one which I wish all students would have an opportunity to experience.</td>
</tr>
<tr>
<td>2. Ethics classes.</td>
<td>2. Ethics classes.</td>
<td>2. Professional training.</td>
<td>2. Most important were the many experiences during my professional training.</td>
<td>2. As a nursing student, took part in an interprofessional study group which looked at a variety of topics. This was a great experience and one which I wish all students would have an opportunity to experience.</td>
</tr>
<tr>
<td>3. Interprofessional classes.</td>
<td>3. Interprofessional classes.</td>
<td>3. Incorporation of interprofessionally-oriented courses in professional study.</td>
<td>3. Most important were the many experiences during my professional training.</td>
<td>3. As a nursing student, took part in an interprofessional study group which looked at a variety of topics. This was a great experience and one which I wish all students would have an opportunity to experience.</td>
</tr>
<tr>
<td>4. Find the student most malleable, seem most open to learning and understanding other professions. I have worked on two interprofessional teams, one good that needed work, the other a true charade.</td>
<td>4. Find the student most malleable, seem most open to learning and understanding other professions. I have worked on two interprofessional teams, one good that needed work, the other a true charade.</td>
<td>4. Incorporation of interprofessionally-oriented courses in professional study.</td>
<td>4. Most important were the many experiences during my professional training.</td>
<td>4. As a nursing student, took part in an interprofessional study group which looked at a variety of topics. This was a great experience and one which I wish all students would have an opportunity to experience.</td>
</tr>
</tbody>
</table>

**Allied Medical Professions (Non-participants)**

1. Interprofessional seminars (graduate courses).

**Education (Course Participants)**

NO EXAMPLES

**Education (Non-participants)**

NO EXAMPLES

**Law (Course Participants)**

1. Other than my involvement in an interprofessional education course at OSU. I have not been involved in interprofessional activities.

2. Professional training.

3. Incorporation of interprofessionally-oriented courses in professional study.

**Law (Non-participants)**

NO EXAMPLES

**Medicine (Course Participants)**

NO EXAMPLES

**Medicine (Non-participants)**

NO EXAMPLES

**Nursing (Course Participants)**

1. As a nursing student, took part in an interprofessional study group which looked at a variety of topics. This was a great experience and one which I wish all students would have an opportunity to experience.
Situation #4 continued: "Experiences during professional education"

2. Courses like the ethical issues one at OSU.

3. I think interprofessional learning and clinical work during professional training is imperative as a formulative influence to help professionals learn to interact. Otherwise, once they are out in practice there is currently little support or help for professionals learning or trying to work together.

4. Planned course work which includes clinical application component.

Nursing  
(Non-participants)

1. Educational events.

2. Involve students early in their education with communicating and consulting other professions.

3. Collegial activities.

Social Work  
(Course Participants)

1. I took the Ethical Issues Course through the College of Social Work.

2. Seminars.

3. University related activities.

Social Work  
(Non-participants)

NO EXAMPLES

Theology  
(Course Participants)

1. OSU professional courses.

2. Interprofessional course taken at OSU while I was in seminary.

3. The kind offered by the OSU Commission on Interprofessional Education and Practice.

4. Unfortunately, the most prevalent areas of interprofessional activities seem to be near educational centers, i.e. colleges, universities or clinical settings. Apart from that, where it seems to work fine among students, in my area of the country this is not heard of.

5. Ones that are built-in requirements.

6. Required interprofessional courses should be required in all advanced degree programs.

Theology  
(Non-participants)

1. Course during graduate work also required interprofessional work.

2. Education programs.

3. Educational experiences - workshops, lectures.
Situation #4 continued: "Experiences during professional training"

4. Clinical Pastoral Education.

5. Clinical Pastoral Education involving medical personnel and counselors and religious counselors.

6. Course work such as Clinical Pastoral Education.

7. Classes.

8. Graduate schools.

Situation #5: "SITUATIONS INITIATED BY ONE PROFESSION"

Allied Medical Professions
(Course Participants) NO EXAMPLES

Allied Medical Professions
(Non-participants) 1. Assertive professional.

Education
(Course Participants) NO EXAMPLES

Education
(Non-participants) 1. My professional activities demand it by requiring one to look at family and child from several areas.

Law
(Course Participants) 1. From an attorney's point of view, daily contact with clients creates a need to know elements of medicine, sociology, and psychology. As an attorney, I am constantly consulting with other professionals in order to better represent my clients.

2. Situations where the professional needs consultations and advice on unfamiliar subjects such as a lawyer handling a medical-related case. Also, a situation where the professional is recommending a course of action to the client such as a medical treatment.

3. Problems or cases that call for the expertise or experiences of another professional in order to reach a well-reasoned solution.

4. Normally, by the time I am involved a crisis has occurred or an illegal act has been committed. Normally, I am drawing on others to use their expertise in prosecution of a criminal offender.

5. Working with other professionals to help solve your client's problems. (Specifically, physicians, economists, and social workers in personal injury and criminal cases.)
**Situation #5 continued: "Situations initiated by one profession"**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law</td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td></td>
</tr>
<tr>
<td>Medicien</td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>1. In the hospital, interprofessional care occurs most often when one profession realizes their inability to take care of all the patient's needs.</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td>2. Lack of knowledge, need to seek out other professionals.</td>
</tr>
<tr>
<td></td>
<td>3. Unclear legal point.</td>
</tr>
<tr>
<td></td>
<td>4. Many times there are &quot;problems&quot; (i.e. wrong diet ordered, person not receiving appropriate treatment from respiratory therapy or physical therapy).</td>
</tr>
<tr>
<td></td>
<td>5. Area of nursing that makes nurses responsible for most direct care.</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>1. Group care conferences on specific patients.</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td>2. Contacting other people for information on clients with rare diagnosis.</td>
</tr>
<tr>
<td></td>
<td>3. When I need to utilize special skills that I have not been trained in, i.e. social work, medicine.</td>
</tr>
<tr>
<td></td>
<td>4. When doctors specifically order for different professionals to be brought in on a case.</td>
</tr>
<tr>
<td>Social Work</td>
<td>1. When situations arise where different professionals find they are dependent on one another to resolve a problem.</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td>2. Where one profession needs the help of another.</td>
</tr>
<tr>
<td>Social Work</td>
<td>1. Interacting with referral sources.</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
</tbody>
</table>
**Situation #5 continued: "Situations initiated by one profession"**

**Theology (Course Participants)**

1. A multileveled need from some parishoner which requires some knowledge on my part of what treatment he is or isn't receiving from other professionals.

2. Somebody has to see a need, followed by someone setting up a special confrontation.

3. People needing specialized counseling or therapy.

4. Involvement in actual client care where a need on the part of one professional for information leads to contact with other professionals of different fields.

5. In counseling, I often make referrals and offer to accompany the person to the place referred.

6. Referrals by a professional to a professional in another discipline.

7. Client needs that require referral, i.e. professional counseling; legal action.

**Theology (Non-participants)**

1. Problems/difficulties with a person or situation that is beyond my skill and knowledge.

2. Crisis and/or counseling situations in which my experience/knowledge is not sufficient to come to a proper resolution.

3. Referral work.

**Situation #6: "CRISES; UNUSUAL EVENTS"**

**Allied Medical Professions (Course Participants)**

1. Acute issue such as impairment, malpractice, and discipline among professional co-workers.

2. Caring for terminally ill patient.

**Allied Medical Professions (Non-participants)**

1. Emergencies.

2. Emergencies or crises.

**Education (Course Participants)**

1. Crisis situations.

**Education (Non-participants)**

NO EXAMPLES

**Law (Course Participants)**

1. Often this is brought about by crisis intervention.

2. Mainly medical events in which a terminal illness is involved, in incapacitation.
<table>
<thead>
<tr>
<th>Situation #6 continued: &quot;Crises; unusual events&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Law</strong> (Non-participants)</td>
</tr>
<tr>
<td><strong>Medicine</strong> (Course Participants)</td>
</tr>
<tr>
<td><strong>Medicine</strong> (Non-participants)</td>
</tr>
<tr>
<td><strong>Nursing</strong> (Course Participants)</td>
</tr>
<tr>
<td><strong>Nursing</strong> (Non-participants)</td>
</tr>
<tr>
<td><strong>Social Work</strong> (Course Participants)</td>
</tr>
<tr>
<td><strong>Social Work</strong> (Non-participants)</td>
</tr>
<tr>
<td><strong>Theology</strong> (Course Participants)</td>
</tr>
<tr>
<td><strong>Theology</strong> (Non-participants)</td>
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</tr>
</tbody>
</table>
Situation #6 continued: "Crises; unusual events"

5. Community crisis center.
6. Crisis events.

Situation #7: "COMMUNITY INVOLVEMENT"

- **Allied Medical Professions**
  - **Course Participants**: Local and state boards for voluntary agencies.
  - **Non-participants**: Community activities

- **Education**
  - **Course Participants**: Other interprofessional committees in job situation and in community.
  - **Non-participants**: Community projects

- **Law**
  - **Course Participants**: Membership in voluntary organizations.
  - **Non-participants**: NO EXAMPLES

- **Medicine**
  - **Course Participants**: Community and civic work, e.g. United Appeal
  - **Non-participants**: Community involvement - politics, school, church, etc.

- **Nursing**
  - **Course Participants**: Serving as a representative of my profession in educational and health care activities.
  - **Non-participants**: Clinical internship negotiations within community.

- **Social Work**
  - **Course Participants**: NO EXAMPLES
  - **Non-participants**: NO EXAMPLES

- **Theology**
  - **Course Participants**: Community problems or need - school, church, hospital, and law enforcement with substance abuse information, related areas such as value clarification and decision making by youth.
  - **Non-participants**: Task or political cause oriented work groups
Situation #7 continued: "Community Involvement"

3. Community celebrations (Health Care Days, etc.).

4. Parish ministry.

5. Sometimes a priest or minister is called upon to address a civic function.

Theology (Non-participants)

1. Community events.

2. Service clubs such as Rotary, Lions, can help, but are not the real answer.

3. Community ideas workshop.

4. Community projects.

5. Civic ad hoc committees, etc., with members from various professions.

6. Civic groups.

7. Involvement in community programs.

8. Social service.

9. A community need or crisis.

10. Support groups.

11. A community need that requires input from more than one discipline.

Situation #8: "SOCIAL RELATIONSHIPS; ACQUAINTANCES"

Allied Medical Professions (Course Participants) NO EXAMPLES

Allied Medical Professions (Non-participants) NO EXAMPLES

Education (Course Participants) NO EXAMPLES

Education (Non-participants) NO EXAMPLES

Law (Course Participants) 1. Dinners or social gatherings.

2. Common office space.

3. Friendships.

Law (Non-participants) NO EXAMPLES

Medicine (Course Participants) 1. Informal gatherings.
Situation #8 continued: "Social relationships; acquaintances"

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Medicine (Non-participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Sports competitions/tournaments: the</td>
</tr>
<tr>
<td></td>
<td>generation of trusts; fun in games without</td>
</tr>
<tr>
<td></td>
<td>burning competition serves to establish</td>
</tr>
<tr>
<td></td>
<td>open discussion later.</td>
</tr>
<tr>
<td></td>
<td>2. Daily personal contacts; friendships;</td>
</tr>
<tr>
<td></td>
<td>family.</td>
</tr>
<tr>
<td>Nursing (Course Participants)</td>
<td></td>
</tr>
<tr>
<td>Nursing (Non-participants)</td>
<td></td>
</tr>
<tr>
<td>Social Work (Course Participants)</td>
<td></td>
</tr>
<tr>
<td>Social Work (Non-participants)</td>
<td></td>
</tr>
<tr>
<td>Theology (Course Participants)</td>
<td></td>
</tr>
<tr>
<td>Theology (Non-participants)</td>
<td></td>
</tr>
</tbody>
</table>

1. Kiwanis-type organizations, except these exclude women so I have no input nor reap any benefits.
2. Social mixers for fellowship.

Situation #9: "CONTINUING EDUCATION SITUATIONS"

Allied Medical Professions (Course Participants) 1. Continuing education programs.

Allied Medical Professions (Non-participants) 1. Continuing education.
2. Continuing education courses.
### Situation #9 continued: "Continuing education situations"

<table>
<thead>
<tr>
<th>Field</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td>1. Continuing education.</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td><strong>Law</strong></td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td></td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td><strong>Medicine</strong></td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td></td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td></td>
</tr>
<tr>
<td>(Course Participants)</td>
<td>1. Continuing education classes.</td>
</tr>
<tr>
<td></td>
<td>2. Interprofessional Continuing Education activities.</td>
</tr>
<tr>
<td></td>
<td>3. Continuing education presentations.</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td><strong>Social Work</strong></td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>(Course Participants)</td>
<td></td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
<tr>
<td><strong>Theology</strong></td>
<td></td>
</tr>
<tr>
<td>(Course Participants)</td>
<td>1. Well-known speakers to keynote an education/dialogue event.</td>
</tr>
<tr>
<td></td>
<td>2. Educational or problem-solving conferences in institutions such as hospitals, prisons, mental health facilities.</td>
</tr>
<tr>
<td></td>
<td>3. Education opportunities around issues which effect all professional groups.</td>
</tr>
<tr>
<td>(Non-participants)</td>
<td></td>
</tr>
</tbody>
</table>

1. Continuing education events that consciously promotes interprofessional activities.
2. Continuing education credits.
3. Formal continuing education.
4. Continuing education opportunities.
## Situation #10: "SITUATIONS PROMPTED BY MUTUAL RESPECT"

<table>
<thead>
<tr>
<th>Profession</th>
<th>(Course Participants)</th>
<th>(Non-participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Medical Professions</td>
<td>NO EXAMPLES</td>
<td>1. Observing what other professions have to offer.</td>
</tr>
<tr>
<td>Education</td>
<td>NO EXAMPLES</td>
<td>1. Peer acceptance among professionals.</td>
</tr>
<tr>
<td>Law</td>
<td>NO EXAMPLES</td>
<td>1. A fuller awareness of the problems of societal members which can be addressed in a team approach.</td>
</tr>
<tr>
<td>Medicine</td>
<td>1. When an affluent figure of one group openly accepts interaction with another group and respects the other group's (profession's) judgements - others then seem to take this lead and also interact together.</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>1. Knowledge, attitudes (i.e., respect for other's contribution), behaviors which facilitate achievement of goals thru interprofessional cooperation (requires education and experience).</td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td>1. Respect of other professions and that they each have a role and value.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Familiarity with the profession seems to be the most notable factor in coordinating services and working together. I've worked in a medical setting and in mental health.</td>
<td>NO EXAMPLES.</td>
</tr>
</tbody>
</table>
Situation #10 continued: "Situations prompted by mutual respect"

Theology (Course Participants)
1. It seems to be more with the people who are involved. If they are secure within themselves, there is much more cooperation and interaction.

2. Acceptance of the concept of wholistic health care - attempting to put these concepts into practice.

Theology (Non-participants)
1. Willingness to help periodically, teach in public schools, when the specialty areas and opportunity arises.

Situation #11: "TEACHING SITUATIONS"

Allied Medical Professions (Course Participants)
1. Interprofessional patient teaching plan.

Allied Medical Professions (Non-participants)
NO EXAMPLES

Education (Course Participants)
1. Patient education.

Education (Non-participants)
1. Teaching and studying.

Law (Course Participants)
NO EXAMPLES.

Law (Non-participants)
NO EXAMPLES.

Medicine (Course Participants)
1. Teaching: MD/ASCW/TA

Medicine (Non-participants)
NO EXAMPLES.

Nursing (Course Participants)
NO EXAMPLES.

Nursing (Non-participants)
1. Teaching CPR.

Social Work (Course Participants)
1. Teaching/taking classes with other professionals.

Social Work (Non-participants)
NO EXAMPLES.

Theology (Course Participants)
1. Education of youth in church - with Teachers.

Theology (Non-participants)
1. Teaching grade school.
Situation #12: "JOURNALS; NEWSLETTERS"

Allied Medical Professions (Course Participants)  NO EXAMPLES.
Allied Medical Professions (Non-participants)  NO EXAMPLES.
Education (Course Participants)  NO EXAMPLES.
Education (Non-participants)  1. Newsletters.
Law (Course Participants)  NO EXAMPLES.
Law (Non-participants)  NO EXAMPLES.
Medicine (Course Participants)  NO EXAMPLES.
Medicine (Non-participants)  NO EXAMPLES.
Nursing (Course Participants)  NO EXAMPLES.
Nursing (Non-participants)  NO EXAMPLES.
Social Work (Course Participants)  NO EXAMPLES.
Social Work (Non-participants)  NO EXAMPLES.
Theology (Course Participants)  NO EXAMPLES.
Theology (Non-participants)  1. Newsletters.
2. Interprofessional journals and newsletters
3. Newsletters.

Situation #13: "SITUATIONS INITIATED BY CLIENT"

Allied Medical Professions (Course Participants)  NO EXAMPLES
Allied Medical Professions (Non-participants)  1. Assertive client.
Situation #13 continued: "Situations initiated by client"

Education (Course Participants) NO EXAMPLES.
Education (Non-participants) NO EXAMPLES.
Law (Course Participants) NO EXAMPLES.
Law (Non-participants) NO EXAMPLES.
Medicine (Course Participants) NO EXAMPLES.
Medicine (Non-participants) NO EXAMPLES.
Nursing (Course Participants) NO EXAMPLES.
Nursing (Non-participants) 1. Consumer demands for quality care.
Social Work (Course Participants) NO EXAMPLES.
Social Work (Non-participants) NO EXAMPLES.
Theology (Course Participants) 1. Client unhappy with services rendered or treatment, requesting intermediary involvement in situation, i.e. hospital care.
Theology (Non-participants) NO EXAMPLES.

Situation #14: "SITUATIONS FINANCIALLY SUBSIDIZED"

Allied Medical Professions (Course Participants) NO EXAMPLES.
Allied Medical Professions (Non-participants) NO EXAMPLES.
Education (Course Participants) NO EXAMPLES.
Education (Non-participants) NO EXAMPLES.
Law (Course Participants) NO EXAMPLES.
Law (Non-participants) NO EXAMPLES.
Medicine (Course Participants) NO EXAMPLES.
### Situation #14 continued: "Situations financially subsidized"

<table>
<thead>
<tr>
<th>Course</th>
<th>Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Nursing</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Nursing</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Social Work</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Social Work</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Theology</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Theology</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
</tbody>
</table>

1. Have financial incentives or are available w/o financial limitations.

### Situation #15: "SITUATIONS ADMINISTRATIVELY MANDATED"

<table>
<thead>
<tr>
<th>Course</th>
<th>Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Medical Professions</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Allied Medical Professions</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Education</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Education</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Law</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Law</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Medicine</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Medicine</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Nursing</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Nursing</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Social Work</td>
<td>Course Participants</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Social Work</td>
<td>Non-participants</td>
<td>NO EXAMPLES.</td>
</tr>
</tbody>
</table>

1. Administrative mandate.

1. Requirements of accrediting body.
Situation #15 continued: "Situations administratively mandated"

<table>
<thead>
<tr>
<th>Course</th>
<th>Participants</th>
<th>Non-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| (Course Participants)         | NO EXAMPLES.
| Theology                      |              |                  |
| (Non-participants)            | NO EXAMPLES.

Situation #16: "RESEARCH SITUATIONS"

<table>
<thead>
<tr>
<th>Course</th>
<th>Participants</th>
<th>Non-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Medical Professions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| (Course Participants)         | NO EXAMPLES.
| Allied Medical Professions    |              |                  |
| (Non-participants)            | NO EXAMPLES.
| Education                     |              |                  |
| (Course Participants)         | NO EXAMPLES.
| Education                     |              |                  |
| (Non-participants)            | 1. Researching.
| Law                           |              |                  |
| (Course Participants)         | NO EXAMPLES.
| Law                           |              |                  |
| (Non-participants)            | NO EXAMPLES.
| Medicine                      |              |                  |
| (Course Participants)         | NO EXAMPLES.
| Medicine                      |              |                  |
| (Non-participants)            | NO EXAMPLES.
| Nursing                       |              |                  |
| (Course Participants)         | NO EXAMPLES.
| Nursing                       |              |                  |
| (Non-participants)            | NO EXAMPLES.
| Social Work                   |              |                  |
| (Course Participants)         | NO EXAMPLES.
| Social Work                   |              |                  |
| (Non-participants)            | NO EXAMPLES.
| Theology                      |              |                  |
| (Course Participants)         | NO EXAMPLES.
| Theology                      |              |                  |
| (Non-participants)            | NO EXAMPLES.

1. Researching.
## APPENDIX H

**EXAMPLES OF INTERPROFESSIONAL ACTIVITIES PARTICIPATED IN**

<table>
<thead>
<tr>
<th>SITUATION #</th>
<th>CATEGORY TITLE</th>
<th>KEY PUNCH #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ongoing client/patient team situations</td>
<td>01</td>
</tr>
<tr>
<td>2</td>
<td>Issue-specific situations</td>
<td>02</td>
</tr>
<tr>
<td>3</td>
<td>Experience during professional education</td>
<td>06</td>
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<td>Situations prompted by mutual respect</td>
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## OPEN-ENDED RESPONSES TO PART E, ITEM 2

### EXAMPLES OF INTERPROFESSIONAL ACTIVITIES PARTICIPATED IN

### Situation #1: "ONGOING CLIENT/PATIENT TEAM SITUATIONS"

<table>
<thead>
<tr>
<th>Allied Medical Professions</th>
<th>1. Working on an interprofessional team. Client care was improved - in so much as each discipline focused on an area. Disappointment was that certain professions had more power on the team.</th>
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<tbody>
<tr>
<td>(Course Participants)</td>
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<tr>
<td></td>
<td>1. Patient care - good experience and improved client care.</td>
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<td>2. Team meetings.</td>
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<td>3. Patient care rounds - usually good; helps to educate staff; coordinates goals to aid patient.</td>
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<td></td>
<td>4. Have occasionally worked with members of other allied health professions to solicit them or their input for my teaching programs (usually clinical). This was quite effective in that expert opinion on a topic was invariably viewed as more credible by the students.</td>
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<tr>
<td>Allied Medical Professions</td>
<td></td>
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<tr>
<td>(Non-participants)</td>
<td>NO EXAMPLES</td>
</tr>
<tr>
<td>Education</td>
<td>1. I have worked in a program which functioned on a teamwork basis, i.e. counselors, instructors, and job placement people all served our clients. I felt that client care in the program was adequate and met program objectives.</td>
</tr>
<tr>
<td>(Course Participants)</td>
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</tr>
<tr>
<td>(Non-participants)</td>
<td>1. Our office is composed of both attorneys and social service staff. This promotes a more holistic approach to solving a client's problems; problems which always cross &quot;profession&quot; borders.</td>
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<tr>
<td>Law</td>
<td>2. At Ft. Eustis, Va., we have a juvenile council. A juvenile who has committed an offense must appear before the council with his/her parents. The council consists of a chaplain, social worker, school officials, attorney, law enforcement officials, and community representatives. The purpose is to recommend to the Commander the most effective way to handle the case. It has been fairly effective. Second offense rate is very low</td>
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<tr>
<td>(Course Participants)</td>
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|                                    | 3. I feel that my legal experience plays a
Situation #1: "Ongoing client/patient team situations"

Law (Non-participants)

1. Day to day contact in work environment.

Medicine (Course Participants)

1. Group rehabilitation conferences.
2. Discussions with nurses.
3. Difficulties in client care or progress. The experiences were very effective and I thought worthwhile. Client care was improved dramatically.

4. Riverside interprofessional group.
5. Ward rounds. Mayo Clinic. It could be more effective if more time given to it.

Medicine (Non-participants)

1. Psycho-social rounds on hospital wards beneficial to understanding the programs, not necessarily beneficial to patient.
2. Psycho-social rounds at the hospital - good for team approach to long term care of patients with chronic problems. Included nursing, clergy, and psychology/psychiatry.

Nursing (Course Participants)

1. Neonatal critical care. The team meets weekly for coordination of clients' activity and needs, work on discharge planning.
2. Patient care conference on not only problem solving for the child's negative reaction to her illness but on promoting her positive actions. Nursing was more or less group leader in the sense of stimulating problem solving. Majority of times it is positive but sometimes frustrating because non-compliance in following up the plan, due to circumstances out of nursing control.
3. We met 1-2 times per month to discuss a particular patient or problem with doctors and other health care persons involved in that patient and we meet in the presence of a group leader which is a psychologist. Sometimes it is very effective and other times not depending on the group interaction and how the dialogue goes. Patient care is usually improved by it.
4. In my particular nursing unit, Grand Rounds are done at bedside and include medicine, nursing, pharmacy, LPN, and others. The difficult opinions concerning the end -
Situation #1 continued: "Ongoing client/patient team situations"

point in patient care are brought forward and examined - making the best possible solutions available to put into practice.

5. I work in a hospital where the "team" includes doctor, nurse, social worker, and school teacher. It gives a holistic approach to the treatment team. Problem: doctor sometimes thinks he's the boss!

6. Weekly meetings about patient care were effective with the patients.

7. I am currently involved with developing an interdisciplinary team directly connected to a patient teaching program on home maintenance of a catheter. I am the core member of the team. Patients receive excellent teaching. I feel good about this problem.

8. Interdisciplinary team on inpatient psychiatric unit. Highly effective due to diversity of approach and acceptance of peers by team members.

9. I am on a nursing-pharmacy committee; we look at problems that have arisen due to current practice. Research is done, discussion and a plan of action is taken.

10. I have had physicians working closely with me in evaluating patient status and teaching inservice programs. We both benefited from the expertise of each other.

11. Very informal meetings called together on an as-needed basis to discuss particularly difficult patients. Generally lead to improved, more well-rounded care as a result of openness of all staff to input of others.

12. I have been a participant/observer in a rehabilitation center where interdisciplinary teams met once per week to discuss client progress. I felt it was very effective in communicating all aspect of client care and promoted interdisciplinary decisions.

13. Care conferences for a critically injured patient. Physical therapy, occupational therapy, nursing, dietary, social services, and psychiatry all joined to formulate a care plan. The experience was very positive and productive. The interprofessional conference did lead to an improvement of the care of the patient.
Situation #1 continued: "Ongoing client/patient team situations"

14. Doctors and nurses working together to improve patient care and patients have a shorter more pleasant hospital stay.

15. Consultation meetings with physicians - usually very useful in increasing understanding and improving patient care.

16. Daily EMS review with all services as related to the Emergency Dept./CCHMC.

17. I am a member of an interdisciplinary evaluation and diagnostic team at a children's psychiatric hospital. This sort of approach lends itself to conscientious, integrated care and is critical.

18. Communicate daily with multiple disciplines coordinating and planning patient care.

19. Care and discharge planning conducted by a physician with participation by nurses, social workers, psychiatrist, pastoral care, and dietician.

20. Public Health Service - Community Health Nurse. Utilized interprofessional skills daily to coordinate multiple services, professions. Better able to provide quality services. It is necessary to come together as professionals at times, otherwise no one group can effectively meet the needs of individuals or populations. The "whole" is greater than the sum of its parts.

21. Was involved in a "medication committee" whose various disciplines were used within the hospital to improve the system. Working with both pharmacy - medical records, etc., ironed out problems that were brought forth that otherwise would have been overlooked and thus the end result could have had many flaws.

22. Frequently involved with patient care situations involving Occupational Therapy, Physical Therapy, social work, nursing, medicine, and occasionally theology.

**Nursing**
(Non-participants)

1. Client care conference - all disciplines come together - duplication of services cut to minimum.

2. Rounds or meetings with social services, physical therapy, occupational therapy, etc., periodically to see how patients are progressing.
Situation #1 continued: "Ongoing client/patient team situations"

3. Staff development at my agency includes nurses, social workers, psychiatrists, psychologist and paraprofessionals - very effective to improvement of client care.

4. I'm involved in an interdisciplinary private practice providing individual, family, group therapy and mental health consultation and education. Very supportive atmosphere, increased potential for conflict however we all feel free to disagree.

5. Nurse member of a multidisciplinary team - the physician and I collaborated in presenting the medical/nursing issues. I felt good about the status accorded the nursing component. In my practice setting, nurses are more colleagues to physicians and team coordinators for client care. It is very positive in improved client care and self-satisfaction.

6. Patient care conferences in hospital and community and agency meetings. Felt very valuable to identify patient problems, develop alternative means of dealing with specific problems. Improved client care because group goals established with each discipline oriented to certain goals.

7. Interprofessional-consultative group for ODH. I felt the second group lacked effective group leadership - became ineffective and physician-dominated.

8. Nursing by multidisciplinary team approach-coordinated patient care with pharmacist, physician, social worker, dietician. Excellent, effective experience, client received best care - increased confidence, relationships.

9. Team conference in an acute care setting - very much enjoyed the experience and obtaining professional opinion of others. It was very effective approach to improve client care.

10. Nursing/Respiratory Therapist relationship forming a health care plan to meet the client's needs. I felt good about the approach and my ability to establish a rapport with another health professional.

1. Member of interdisciplinary child abuse team. M.D.'s feel that they can assume all roles, client care suffers. Lack of role clarity between nursing and social work.
Situation #1 continued: "Ongoing client/patient team situations"

2. Teen Pregnancy Task Force - ad hoc committee established to deal with the problem of teenage pregnancy. Good exchange of information and feelings. Good means of coordinating services in the community.

3. Worked on an interprofessional treatment team - due to diverse training it was often difficult to reach a consensus of what exactly was the problem.

4. "Team" meeting.


6. Hospital staff - legal, public child welfare situation. I felt an equal with all professionals and felt client care was improved.

7. Case conferences, open communication with staff and family - meetings are most effective.

8. Weekly interprofessional conferences were very effective in getting at all aspects of clients' situation thereby establishing the best treatment plan. Conferences took place in a retirement/long term care facility, which is certainly conducive to such discussions. Clients were better helped because of it.

9. I work in a setting which utilizes an interprofessional approach. I have very positive experience and feel that I am a contributing member of the team.

10. The activity was an interdisciplinary team in a group home. The experience was positive and the members' input improved planning with and for the client.

11. CMHC. Worked as a clinician. I dealt with nurses, aides, rehabilitation counselors, and persons with B.A. in miscellaneous fields. Client care was not improved for the most part because 1) clients did not care to improve (chronically mentally ill population of geriatrics), 2) clients' health too poor to improve, 3) staff involved were too many and too much variance of interest to provide the necessary consistency of approach.

12. My work setting provides that opportunity daily. It is a mutual learning experience
Situation #1 continued: "Ongoing client/patient team situations"

1. In my social work practice, I meet regularly with Physical Therapy, Occupational Therapy, Dieticians, Speech Therapy, and Physicians to discuss patient care - this is an enlightening process - promotes better understanding, cooperation, improves relationship, cohesiveness and provides better patient care.

2. Case staffing with a multidisciplinary team. Was not helpful as some professionals were locked into their own approaches.

3. Neonatal Team - included physician, nurse, and social worker - worked very well. All were open to input and felt emotional/social aspects as important as medical aspects.

1. We utilize a treatment team approach where I am employed. It is essential to quality services at this agency. It is difficult to make it operative but it works.

Social Work (Non-participants)

2. Involvement at Univ. Hospital on a regular basis for members of my congregation, particularly cancer. Hampered by Doctors' Residents. My impression is that they see other professions as not really being too useful in the care of their patients.

3. Hospital staff/clergy meeting. Good experience, a lot of ideas and discussion of problem areas.

Theology (Course Participants)

3. Clergy-doctor dialogue. The group was somewhat effective in establishing an awareness of each others values to patient care. The obstacles were MDs' condescending attitudes and some pastors' legalistic views on life.

4. Working with a family who had a member who was critically ill. When they became concerned with the medical care he was receiving, I went with them to talk to the doctor. I think this made them less anxious and less intimidated.

5. In dealing with a parishoner who was hospitalized, I found the honest and frank sharing of information about the person's illness most helpful in working with the person's emotional and spiritual needs. I felt accepted and helped by those who I talked with.
Situation #1 continued: "Ongoing client/patient team situation."

6. Chaplaincy - not a great degree of success. We needed a regularly scheduled time to gather for case work. Interaction was hit and miss, but where it occurred it was a great asset to client well-being.

7. Have referred people to psychologists and generally have been pleased with the results for the client and the insights the professionals gave me.

8. Medical/Religious - mainly different hospital ministries, conferring with medical personnel about patients.

9. Chaplain ministry in St. Louis hospital aided by talks and presentations by doctors, nurses, and hospital administrators and with much use of verbatim accounts of encounters with patients.

10. Dealing with members of congregation involved in major operations. Working with doctors and nurses helped to relieve anxiety of patients.

11. Involved in a Women's Crisis Center with lawyers, medical personnel, and social workers.

12. Hospital health care situations.

13. I just completed a year internship at Pine Crest Christian Hospital, where all patient care involves interdisciplinary teams. Some teams were more successful in using a true team approach than were others, but generally they worked very well and patients seemed to profit considerably. For me, it was the most rewarding work experience of my life. I would gladly spend the rest of my working life in such an environment.

14. I am a chaplain in a correctional institution. Most of our work with the resident involves interprofessional activity.

15. A program at the local hospital regarding pastoral care of patients. The heavily fundamental types who most need the exposure profit the least, are most hostile, and in the end profit the least. Pastoral care services are improved only to the extent the pastor seeks change or growth. Outside of that, little advantage to patient.

16. My work setting provides that opportunity daily. It is a mutual learning experience in daily problem solving from a multidisciplinary approach.
Situation #1 continued: "Ongoing client/patient team situations."

17. Myself and mental health psychologist worked with the person but not at the same time. I think it was good. I have never been a part of a team approach to health care.

18. As a pastoral counselor, I continue to work cooperatively with all others who are involved in the patient's care. I wouldn't choose any other way. It is very effective; improves care by unifying the patient's I.C.P.

1. The dialogue that took place was only between clergy and medical doctors. It began an ongoing-personal trust establishing relationship, i.e., it helps create more open communication between the two groups.

2. No formal activity, but contacts on informal level felt good. Client care improved because of share information.

3. It was a positive experience. I worked with a hospital that viewed the chaplain as part of the healing team. The patient(s) tended to appreciate this cooperation. I think they received better care.

4. Ministers, doctors, hospital staff, welfare agencies working together in patient care.

5. In the Health Service setting medical personnel on all levels have too much to "do for" patients at a given time to become impersonal in attitude. The Theologian as I am creates personal relationship with patients or clients to restore personal integrity and clearing aberrations leaving the client with experience of care, appreciation, and wholistic health.


7. Hospital-sponsored programs uniting the medical (doctors, nurses) and pastoral (ordained clergy).

8. Again, working with a patient in the state hospital was helped by others. Helped to get an in depth analysis from another professional.

9. Care conference in a hospital. A teenage boy was in a coma with a brain tumor and his distraught mother was causing problems with the medical staff. The care conference was positive. I felt good about the interaction. Decisions were reached toward...
Situation 01 continued: "Ongoing client/patient team situations."

- Providing the patient and mother more personalized care.

10. Hospital - awkward - considered out of the area of experience - family response dealt with separately.

11. As a priest/educator, I am involved in interprofessional activity every day. It's a satisfying experience. We have professional contact with other groups (law, medicine, social work) that is generally distant, usually cooperative.

12. Team counseling in a hospital psychiatric unit - extremely beneficial experience. The interplay between the professions: psychiatry, medicine, nursing, clergy was remarkable - a perfect team - client care was of importance and benefitted greatly.

13. Child protective teams - discuss and evaluate child abuse cases - many professions.

Issue #2: "ISSUE-SPECIFIC SITUATIONS."

<table>
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<tr>
<th>Allied Medical Professions (Course Participants)</th>
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<tr>
<td>1. School Resource Committee meetings in which &quot;problem&quot; students in elementary public schools are brought to attention of school staff core group (principal, psychologist, counselor, concerned teacher, and others invited). Since I am not, as an Occupational Therapist, typically involved except in specialized cases, I felt somewhat out of synch with procedures of meeting. Felt I offered new insight, however, into some of described problem areas. Felt otherwise it became too involved in regard to suggested forms of remediation.</td>
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<tr>
<td>2. I.E.P. (individual education plan) meeting for school age child. OT, PT, and speech therapist worked on goals, with input given to classroom teacher. Very effective and good information sharing. Client care greatly improved because of continuity of goals and treatment approaches.</td>
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<tr>
<td>3. The activity was planning the allocation of resources of our outpatient facility. It was rewarding in that differing priorities were freely expressed and consensus was reached with virtual unanimity.</td>
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| 4. Helping a young child who was injured and recovering achieve a good recovery over a long period of time and fit in to school, home, church, and social activities. It
Situation #2 continued: "Issue-specific situations."

is satisfying to see a child's confidence in their own recovery grow as they are involved in daily activities and events they didn't dream possible. A challenge to instill confidence in parents and teachers that the child can do many activities with some modifications.

5. Most recently I have been part of an inter-professional group to form a holistic health residential/retreat center. It involved educators, physicians, nurses, theologians, social workers, and counselors - if nothing else happens (in terms of actually getting money to start the center) it was extremely beneficial as a sharing/growing experience. If it is successful - then in my opinion, client care will be improved.

1. Current - I am the Occupational Therapist on high risk follow-up clinic team - consisting of neonatologists, pediatrician, and social worker. My diagnostic evaluations are held in respect by the physicians - makes me feel very professional! And because all evaluations are respected we work well together and parents seem very pleased in the results.

2. Adaptive scaling with PT, OT, and child's doctor and parent - Important aspects of child's problems/parent handling - can be considered (different problems by different professionals) - generally good experience.

3. Follow-up nutritional counseling revealed that client was at starvation level for one month. Lab studies and nursing service conveyed message to M.D. who urged client to return for more information regarding adequate diet. Felt that I had to initiate the activity. Know that M.D. intervention improved chances of client compliance.

4. Hospital Administration is bringing the specific profession into a common goal. That is my entire job.

5. Deinstitutionalization meeting

Allied Medical Professions
(Non-participants)

1. Stroke Rehabilitation Patient Education Program - good. Total job rehabilitation program also good. Client will receive quality care.

2. Cooperation between school and counseling agency. Caused less conflict for client

3. Deciding on foster care for children in a neglect case. I feel the legal aspect was
Situation #2 continued: "Issue-specific situations."

less caring and more concerned for the letter of the law. However, after discussion and alternatives suggested a compromise was reached and I felt to the advantage of the children.

NO EXAMPLES.

1. Child custody. I felt the experience was worthwhile and effective in retrospect. Although I would have liked a different result with respect to the resolution of the custody issue itself, my client was served because this approach saved him money, and the children were served by minimizing the trauma.

2. Child custody matters involve social workers and psychologists. It was necessary to have their input into devising a program to better help client regain custody of her child. Client was improved, although the final input of the other specialists was negative and she did not regain custody.

3. As a lawyer, worked with psychiatrist, physician, and psychologist in assessing and dealing with stress syndrome elicited from racial discrimination. Client committed suicide.

4. As an attorney, I often use other professionals as consulting experts, both formally as trial witnesses and informally for pre-trial education.

5. Extensive rate making hearing. Client an agency of the state. Its' interests are co-extensive with the above stated activities.

6. To date I have been involved in none. However, I have observed the disposition of an estate and the subsequent adoption process regarding the minor children that survived the simultaneous death of the parents in an auto accident.

7. Divorce mediation by psychologist, attorney, wife and husband, very effective in helping couple to compromise on a dissolution of marriage. Improve client care by saving money and avoiding hostility. I plan to do more.
8. I had a client whose wife had died. Through the cooperation of medical professionals, I have been able to help client determine whom was negligent, and will be able through continued contact to recover financially for my client's personal loss.

Law (Non-participants)

1. Tax litigation - experts are key and must work together. Also tax planning; corporate planning.

Medicine (Course Participants)

1. My psychiatric residency involves much interdisciplinary work, but much blurring of professional limits occurs in daily team meetings. This, I feel, causes greater tension among different professionals, and causes a lack of open discussion of all the client issues. Overall, though, the approach is best for the patient.

2. Case conferences regarding patients with chronic diseases or pediatric patients who are victims of abuse/neglect.

Medicine (Non-participants)

1. Examples as above (diet therapy) very effective in solving a particular problem.

2. A typical example would be a family trying to decide to discontinue mechanical ventilation on a terminal patient, working with clergy to help that family arrive at a decision which would not make them feel guilty is a rewarding experience. Also involved are usually nurses, social workers, etc. I felt that this type of decision requires input from the several professions because too often the family views the doctor's advice as lacking a human element. Sometimes clergy, nurses, etc., can help give the decision a more human note.

Nursing (Course Participants)

1. I have been involved in a cardiac rehabilitation workshop. It improved my sense of what professionals can provide for patients' needs. I now know more of who to contact and how to work with not against other professionals.

2. I worked in a child development organization (community social agency) and nurses, physicians, teachers, social workers and dieticians worked with children and their families to improve quality of life style. It was excellent! And the families did improve in various aspects of their life and it was very rewarding to see children's values slowly change, and families become more independent.
Situation #2 continued: "Issue-specific situations."

3. A question was raised as to whether or not to give a medication felt inappropriate. Doctors, other nurses, and lawyers were involved. Helped patient care.

4. Case (client with mental illness) worked with RN, MD, and psychiatrist. Worked very well.

5. Multiple trauma patient - involved respiratory therapist, radiologist, and administrators.

6. With cardiac patients - we could identify their needs more closely: 1) religion, 2) educate families, 3) educate patient - emphasize certain areas if needed for specific patients.

7. I am also becoming involved with an independent home care company. Again as a member of a pharmacy/nurse team, I believe I am a respected member. Find interdisciplinary activities personally rewarding.

8. One example - we now use a micro drip tubing on IV's that are set at a rate of 100 or less sec. that few IV's clot, less chance of "run away IV's," less chance of overloading (with fluids) patients. We feel so far that patient care has been improved, preventive measures have been taken for potential problems.

9. Hospital staff/Home care staff conference regarding specific patient - very useful as a rule.

10. Intra-agency patient care conferences - effective in increasing understanding.

11. I take care of sick families. As a nurse I am concerned when parents stop showing up to visit their baby. I will bring this to the doctor's attention and to the social worker's attention. Between us we might try to cover all the bases to get the family into the setting more. Social worker checks on possible transportation problems - arranges bus passes, discusses bill payment with worried parents. What government funds are available to help our. The doctor may try to call parents regularly to fill them in on the infant's progress - keep them informed. Sometimes all our efforts fail, but we often can open up better lines of communication and trust.
Situation #2 continued: "Issue-specific situations."

12. A mentally retarded pregnant teenager. The patient's father was the father of the baby. Experience complicated with uncertain rights and wrongs about placement of mother and infant.

13. I have participated in interprofessional activities with a physician regarding a psychological consultation which resulted in improved patient care and in family system intercommunication.

Nursing (Non-participants)

1. Patient care conference involving nursing, dietary, occupational therapy. Nursing presented the case and all contributed to planning care plan. Time involved was lengthy. Patient care improved as all disciplines felt actively involved in care.

2. Educator, nurse (myself), and parent and psychologist planning parent education workshops for parents of developmentally disabled children - fairly effective but difficult as we had no history with one another, each had specific "pet" area and pet peeves, and our task was to be done in a short period of time - 2 months - while each was involved full time in job activities. There were disagreements about need for needs assessment and the delayed start of actual program planning.

3. I have been working with a neurosurgeon, an oncologist, and another physician on clinical trials with a new pain management regimen. It's very rewarding as we work together.

4. Disaster - positive growth experience but needed assistance of non-trained "help" (volunteers) also hindered progress (delayed it - definite obstacle).

5. Cardiac rehabilitation program involves contributors from nursing, allied medicine, social work, medicine. I feel this approach is beneficial in providing the best care and education for the client.

6. I have in the past met with nurses and social workers to discuss discharge planning. Physicians were invited but seldom came. It assisted all (including and especially the family) in getting the necessary preparation, and education taken care of before discharge.

7. Interprofessional discussion re death and dying and code status decision-making.
Situation #2 continued: "Issue-specific situations."

Lack of time and lack of openness and ingrained opposite schools of thought re: death and dying and wholistic care resulted in non-effective, hostile feelings.

8. The activity was the development of an educational program to expand the nurses' skills in a particular area. Initially the level of nurse performance needed to be firmly established. This was accomplished through nurse/physician collaboration. This gives nurses the opportunity to educate physicians about nursing practice and legal issues.

9. RNs, Respiratory Therapists, and physicians involved in providing optimal care to patients on an inpatient pulmonary unit in acute care hospital - excellent opportunity for exchange of knowledge and ideas if staffing sufficient. Patients benefit by getting the best of all professions.

10. In hemodialysis the physicians are very responsive to listening, interacting, and offering further information, about medicine and health care.

Social Work (Course Participants)


Social Work (Non-participants)

1. Utilization Review - team approach worked fairly well. General medical social work - not as effective, physician sometimes did not acknowledge significance of psychological aspects in reaction to illness.

Theology (Course Participants)

1. Prepared a death notification process for local law enforcement agencies, using nurses, cops, mental health directors, and pastor. Very effective. We agreed on a need and met it. Not much happens until a need is identified.

2. Community problem - drugs showing up in church youth outing - purchased at school. Law enforcement alerted. Local abuse center working with both schools and church in preventive program with grass roots parental support and participation.

3. A "code-blue" just last Wednesday where each of us, medicine and chaplaincy personnel, had a role. I believe "client care" was enhanced greatly.

4. Involvement with home nursing service. I feel professionally affirmed. Our interaction helps client care and their attitude toward the service.
Situation #2 continued: "Issue-specific situations."

5. Family decision on euthanasia. Doctor explained the medical situation. I talked them through the spiritual dimension. I felt good about it. Patient was treated as a whole human being. Family felt good about it.

6. Informal connecting with lawyers to meet needs of person in crisis - divorce, financial.

7. Informal connecting with doctors to meet emotional needs that result in asocial, antisocial behavior.

8. A lawyer, social worker, and I (clergy) helped a rather senile lady in the area of administration of goods and concern for her life style. I feel together we were effective.

9. Pastoral counselor on a team caring for a forensic psychiatric patient in a hospital setting. I felt comfortable interacting on the team. Our interaction promoted effective care for the patient because a variety of factors were considered before a treatment plan was implemented.

10. Rural situation where I worked with doctor. All of us felt the teamwork and trust was important, clients benefitted definitely. We learned to recognize our own limitations as well as strengths and could rely on each other, mutual support.

11. Drug rehabilitation.

12. I was (am) part of a group providing support to the family of a missing woman who had some history of mental illness. The weakest link was her medical doctor, who delayed referral to psychiatric care. Strongest link was clergy and law enforcement personnel (in 2 states). Family was aware they were being cared for and what was being done at all times.

13. Just beginning work in a hospital organization. Feel it will be an exciting and effective venture. All involved professions seem eager to get underway.

14. Chaplain in a hospital and police chaplain, in both cases patient/client care was improved as soon as roles were clearly understood.

15. Negotiations with health professionals and social workers in behalf of a parishoner in
Situation #2 continued: "Issue-specific situations."

17. Usually crisis with law enforcement personnel.
19. Sat on a board which discussed life-support systems on dying patients. The group assembled to help families make serious decisions in hospital settings. This was effective, families had the input of several differing groups of people. Care was improved and shown to family and client.
21. A life/death experience in hospital. Sympathetic counseling with parents of dying child. Doctor/priest relationship good, but felt doctor thought the spiritual/psychological aspects were secondary.

1. Depression workshop involving MD's, clergy, psychologists. I felt good about it as there was an acceptance of the contribution each profession made in dealing with clients exhibiting depression symptoms. It was effective for me as it helped me identify "depressives" and because it gave me an awareness of what my limitations are and consequently when I need to make referrals.
2. Hospice of Muskegon - very positive experience (on the Board: helped organize and begin).
3. Held workshop on spouse abuse for clergy. As clergy may counsel an abused spouse, they needed some background and sociological/psychological information. Workshop was well rated by the clergy who participated. Only time will tell if it was really successful.
Situation #2 continued: "Issue-specific situations."

4. Wills Clinic - client care was improved very much because of specialized people involved shared their knowledge.

5. A psychologist from community center came to our church to lead an evening program about transactional analysis and how to help with communications in the family. I thought it was very helpful and presented so that people could understand and benefit from it.

6. Hospital (general) chaplaincy program. I felt good about the experience. It was effective for me. I felt that client (patient) care was improved due to the total person care that was achieved by medical doctors, social workers, and ministers.

7. Currently involved in Christian Conciliation Service - clergy and attorneys working together. It is effective. Client care is good, but rather than coming from a strictly professional approach the background is of religious conviction, i.e., "professionalism" is almost non-existent.

8. Hospice program - very helpful, everyone cooperated. Good experience.

9. There was an incident in which a man with a serious heart condition was in danger of dying and the family was asked to determine whether to use life support if the heart stopped. The physician, the family, and the clergyman discussed the matter and reached a consensus.

10. Tribunal work with a psychiatrist - it was very helpful - he knows what personality is present and I can then apply my minority opinion to the situation.

11. A child custody situation of trying to work with the guardians and juvenile court for the best interests of the child involved. I was extremely frustrated because of the way the law is written.

12. Counseling with a doctor about a cancer patient to "compare notes" so to speak about what each was saying and how we (the three of us) could work together better. The experience was rewarding and fairly valuable although the frustration of pre-cooperative behavior still remains.

13. Death preparation workshops with a funeral director, lawyer, insurance agent, and
Situation #2 continued: "Issue-specific situations."

myself (minister) - very good experience.

14. Youth drug abuse - worked with medical doctor on family counseling with the family and family doctor together.

15. Intensive Care Unit - experience with family, felt doctor in charge was honest with me and it helped in dealing with the family.

16. Involved in aiding decision making concerning life supports for 10 year-old child. Discovered reluctance on physician's part to share information and/or value my opinion - felt I was left to "pick up pieces."

17. I find that the work occurrence in the above question describes my major involvement. Most of my experience has somehow tied in with the church.

18. "Cancer Residency for Clergy" a 3-day program put on by Luthern Hospital, LaCrosse, Wisc. - excellent program - helps me to better understand cancer - the role of the health care professionals - and my ability to minister to the cancer patient and family.

19. Chaplain for hospital - very positive experience - gave opportunities to utilize medical/technical aspects as well as emotional/spiritual.

20. Working on nuclear freeze.

21. Grief - medical interaction with me as the minister. I felt good about it. The doctor and I were better able to prepare the family for the events that were going to take place.

Situation #3: "EXPERIENCE DURING PROFESSIONAL EDUCATION"

Allied Medical Professions (Course Participants)

1. Continuing Education Conference - good experience in terms of staff improving interpersonal and professional relationships - communication and understanding of problems.

2. Class - interprofessional - too much emphasis on "team building" and calling on those with special expertise, not hearing the sometimes good solutions of the quieter ones. Need more emphasis on group dynamics with concepts of small group interaction and relational skills within the problem solving framework.
Situation #3 continued: "Experience during professional education."

Allied Medical Professions (Non-participants) NO EXAMPLES.

Education (Course Participants) NO EXAMPLES.

Education (Non-participants) NO EXAMPLES.

Law (Course Participants) 1. Law school ethics seminar. Effective.

2. "An interdisciplinary Dialogue" 3-hour course, OSU, Fall 1981, a complete waste of time.

3. Only experience was with two courses I took in Law School. I found both courses enlightening and I would be considerably less hesitant to become involved in interprofessional client care.

4. Professional school course about ethics. Useful to compare different professional attitudes toward death, euthanasia, abortion. I have not been confronted with such issues professionally.

5. Interprofessional seminar at OSU. Understanding of the other professions increased.

Law (Non-participants) NO EXAMPLES.

Medicine (Course Participants) NO EXAMPLES.

Medicine (Non-participants) NO EXAMPLES.

Nursing (Course Participants) 1. I participated in a formal interprofessional ethics course of pre-nursing, pre-law, pre-med, pre-pharmacy, etc., students. I feel it was beneficial to me but it is not at all indicative of situations and the problem solving that goes on in the working world.

2. Grad. course in which we discussed ethical issues from the aspect of a theological, legal, medical, and allied medical viewpoint. It increased my awareness of other disciplines' approach to difficult situations. Yes, it has improved client care.

3. My most striking interprofessional experiences have been two courses offered by the Commission which I took as a student in 1977 and 1979. They were very positive, stimulating, broadening experiences and were unique in
Situation #3 continued: "Experience during professional education."

my training (i.e. there was no such rich opportunity within my professional school). I believe the courses have had a strong effect on my professional practice since graduation. I am more aware of inter-professional issues, other professionals' perspectives, and of ways of collaborating.

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<thead>
<tr>
<th>Profession</th>
<th>Experience</th>
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</thead>
<tbody>
<tr>
<td>Nursing (Non-participants)</td>
<td>I believe the courses have had a strong effect on my professional practice since graduation. I am more aware of inter-professional issues, other professionals' perspectives, and of ways of collaborating.</td>
</tr>
<tr>
<td>Social Work (Course Participants)</td>
<td>1. Interprofessional class on ethics. Excellent.</td>
</tr>
<tr>
<td>Social Work (Non-participants)</td>
<td>1. Course during Seminary. Ability to share and learn of the frustrations of other professions and how we can avoid those frustrations.</td>
</tr>
<tr>
<td>Theology (Course Participants)</td>
<td>2. I felt good about the theological contingent being present in the course. The inter-professional arena was one which allowed us to get started. There is a long road ahead. I was glad to air my perspective and listen to others. This kind of healthy dialogue can only lead to improved client care.</td>
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<tr>
<td></td>
<td>3. C.P.E. (clinical pastoral education). I felt client care was greatly improved in the hospital. However, there is a reluctance among the medical profession to use and respect others in the professional care of people.</td>
</tr>
<tr>
<td></td>
<td>4. I participated in one interprofessional course at OSU (Meth. Hosp.). From comments made &quot;under their breath,&quot; I heard derogatory remarks by medical professionals regarding the place and value of clergy on a multi-disciplinary team. Essentially the medical people took charge of each client involved and we really never were able to constructively include the offerings of other disciplines. The client was only a patient.</td>
</tr>
<tr>
<td></td>
<td>5. Program on Prof. Ethics at OSU - very effective.</td>
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<td>6. OSU Commission activities.</td>
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<td>7. I had very good feelings about the experience. I felt my input was accepted by others and taken into account for the final analysis. I feel the client was</td>
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</tbody>
</table>
Situation #3 continued: "Experiences during professional education."

cared for better all around because of the number of different professionals involved. I wish I could be part of a group like that again.

8. I participated in a law practicum. I do not feel that my presence was accepted. In fact, the areas in which I had insight were not deemed important and perhaps disruptive.

9. Interprofessional learning experience during professional training.

10. My doctoral project for the D.Min. was "Pastoral Care as an Integral Part of Total Health Care: The Pastor on the Interprofessional Team." In chaplaincy I worked as a member of the health care team.

1. I participated in a class where many professions were involved - client care improved, professions communicated and I felt very good about the experience, mainly because everyone seemed to benefit.

2. Clinical Pastoral Education - C.P.E. was a negative experience for me. Instead of gaining confidence I felt inadequate. The idea is good. My supervisor and I did not communicate well. The negative experience did not significantly help me with client care.

3. While in seminary I worked for the Human Resources Center. I felt that it was a good experience to learn about psychology at work, and also further preparation for parish work. Also it developed compassion for the less fortunate in our society.

4. Clinical Pastoral, The Methodist Hospital, Jax. This was an extremely helpful program as part of my preparation for priesthood. Besides the direct involvement with members of the medical community, it gave awareness of other professions - particularly important for Catholic clergy because of hospital visitation; also some contact with Social Work would be helpful for Catholic clergy.

5. Pastoral care and teaching. This experience was very effective in reaching young people who had emotional and learning problems. Once the emotional problems were dealt with many of the learning problems disappeared.

6. Clinical Pastoral Education Quarter in a general hospital. Most meaningful and
Situation #3: "Experiences during professional education."

productive course in my seminary experience. Client care was definitely improved.

7. Clinical Pastor Education unit - it helped me to see working of hospital - mixed feeling toward helpfulness of inter-professional relations.

8. Clinical Pastoral Education experience at Children's Hospital where chaplain worked with medical staff, both doctors and nurses, in the emergency room. I felt that this greatly improved the situation for this meant that the whole family was being cared for in situations but were often very stressful.

9. Opportunity to interact with students from other theological schools (Methesco and Trinity Lutheran) in worship, classes, and extra curricular. This provided a forum for dialogue with an understanding of our traditions - simply a beginning in "unity." It was most profitable on every level: i.e., scholastic, ethical, social, and spiritual.

10. The only interprofessional activity was C.P.E. and I felt the experience was beneficial and effective for all concerned especially the client.

Situation #4: "WORKSHOPS, MEETINGS, CONFERENCES"

Allied Medical Professions (Course Participants) NO EXAMPLES.

Allied Medical Professions (Non-participants)

1. I'm on the professional education committee of a major health agency. It has been a negative experience overall with little communication and/or rapport established between participants. I do not feel Drs. on committee are interested in the allied health professions and their role - or in them as persons. I wonder if this attitude continues in their work scene? If so, it would certainly impact client care.

2. Allied health alumni associations - primarily helped by getting to know other professionals in a social setting.

3. Seminar on de-institutionalization.


Education (Course Participants) NO EXAMPLES.
Situation #4 continued: "Workshops, meetings, conferences."

Education (Non-participants)

1. Combined meetings.

2. As a member of volunteer groups, I have met and exchanged ideas and information concerning my field and acquired new information regarding other disciplines. How this affects "client care" I'm unsure.

3. American Management Association seminar - positive feelings about interchange problems, ideas, and solutions.

Law (Course Participants)

1. Doctor/lawyer committee of CBA - not much accomplished - idea of promoting better relations between these professionals - didn't see much impact at all on clients.

Law (Non-participants)

NO EXAMPLES.

Medicine (Course Participants)

NO EXAMPLES.

Medicine (Non-participants)

NO EXAMPLES.

Nursing (Course Participants)

1. A 3-day infant stimulation seminar, involving physical and occupational therapists, psychologists, doctors, nurses, and social workers was really helpful for improving my patient care. The workshop not only improved my personal knowledge, but also made community resources more available.

Nursing (Non-participants)

1. CF conference in Washington, D.C. It was interesting to get the views of social workers, doctors, and clinicians on care of CF patient. Positive experience - gave us some ideas on care that we hadn't used.

2. Coordinated workshop - speakers from various professions - most doctors, nurses, dieticians. Felt somewhat tense dealing with the other professionals but the workshop was received well by the nurse audience and I feel client care thus benefitted.

3. Professional practice committee reviewing nursing policies and procedures - very effective.

4 ICU Committee meeting with administration, physicians, and nursing. Discussed the revision of crash care supplies and medications which is beneficial to efficiency of patient care. Discussed visitor information pamphlet which benefitted interpersonal relationships between client, family, and staff.
Situation #4 continued: "Workshops, meetings, conferences."

5. Seminars - I enjoy and am motivated to learn more by having more interaction with other health professionals.

Social Work  
(Course Participants)

NO EXAMPLES.

Social Work  
(Non-participants)

1. Harding Hospital Symposium - excellent - learned skills which could be used in my client contact.

Theology  
(Course Participants)

1. Upcoming workshop of an equal number of clergy/hospital staff participating.

2. Small church workshop was good and did speak to small churches in 100 memberships but more than 25. It was the first workshop of its kind so can not say about improvements.

3. Every year, a local hospital has a one day symposium where doctors and other health care officials speak and interact with clergy. Usually it includes white males, so I feel very excluded. The lecture is somewhat helpful and helps me with my clients in the hospital. It's just frustrating being left out.

4. Eight week series sponsored by Bob Russell at Northminster Presbyterian Church. Different speakers from a variety of academic/medical disciplines from OSU and surrounding colleges discuss the Arts/Medical Science Issues with a variety of denominations of clergy. Client care improved only by the raising of consciousness and sensitivity to different issues/interpretations.

Theology  
(Non-participants)

1. Seminar sponsored by AMA Medicine and Religion Committee - out of it grew a chaplaincy. Also had experience with program sponsored by medical groups and churches. Good. Some learning in counseling for me - but more would be welcome.

2. Seminar for clergy sponsored by Columbus hospital at which a doctor and patient spoke to the group of pastors on the dynamics of being a patient.

3. Conference on battering (of women and children) - positive, good opportunity to get viewpoints from a wide range of people. Builds confidence in other professionals.

4. At a National Catholic Education Association Convention, I went to a workshop "The School
Situation #4 continued: "Workshops, meetings, conferences."

and the Child of Divorced Parents. It was effective and much valuable information was taken back to the school and parish in which I worked.

Situation #5: "COMMUNITY INVOLVEMENT."

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<tr>
<th>Allied Medical Professions</th>
<th>NO EXAMPLES.</th>
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<tbody>
<tr>
<td>(Course Participants)</td>
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<tr>
<td>(Non-participants)</td>
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1. Promotion of Children's Dental Health Month - felt a team effort was worthwhile, more comprehensive, more effective, and promoted better working relationships.

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<th>Law (Course Participants)</th>
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1. I am frequently asked for a legal opinion concerning issues that arise in a hospital.
2. County Advisory Board on Mental Health - little impact, no power.

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1. Assessment for future needs in a chronically ill elderly patient facility. Interaction with nursing, social service, medicine, largely needed. Patient usually benefitted if facilities are available.
2. Family session including nurse and social worker. Abortion after IUD pregnancy. Enhanced outcome.

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<thead>
<tr>
<th>Nursing (Course Participants)</th>
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1. Discussion on nursing roles, physician roles. Not effective created resentment - had nothing to do with client care.
2. In community health as a public nurse this model also works - but in a more informal less structured way.

1. Arthritis Foundation - Allied Health Professions Committee There was only one nurse on this committee for a period of time with many OT's and PT's. I felt voiceless - in a minority. Everything was directed towards the OT's and PT's so I finally quit the committee.
Situation #5 continued: "Community involvement."

2. One evening I had a patient who unexpectedly went into metabolic acidosis. My initial assessment brought the doctor in to examine her and his frequent orders through the evening were based on my assessments and interpretation of lab results, etc. Respiratory Therapy also became involved in doing several treatments and lung assessments. I thought the care given to this patient was excellent and improved with the interprofessional element. This was a very satisfying situation for me because 1) I felt a vital part of the patient's care and my voice was appreciated, and 2) the client greatly benefitted from the quality care given.

Social Work
(Course Participants)

1. A mental health center working with M.D., nurses, psychologist, and business personnel. All are supposed to have same goal, provide best service for client.

2. Determining treatment for psychiatric patients minimally effective. Certain professions had more authority and power and over-ruled others. Got frustrating at times. Client care not hurt, but not improved either.

3. I work with latency age children who are labelled emotionally disturbed and their families in a residential treatment center. I believe an interprofessional approach is by far the most effective way of helping my clients. We provide for all of the children's needs round-the-clock and it is absolutely necessary that we take on an interprofessional approach.

Social Work
(Non-participants)

1. Discussion regarding a mentally retarded youth. Involved were teacher, social worker, physician, occupational therapist. Interaction generated new ideas and approaches to the situation. A more organized program was developed for the person. I thought it was very worthwhile.

Theology
(Course Participants)

NO EXAMPLES.

Theology
(Non-participants)

1. Community Mental Health Players. Also Peace Resource Center of Muskegon - working well.

2. Community emergency relief during hurricane. I felt good about working in a joint effort with other professionals providing assistance.
Situation #5 continued: "Community involvement."

3. Civic ad hoc committees, etc., with members from various professions. Also seminars with opportunities for questions, dialogue.

4. Red Cross Chapter Board and Executive Committee. A number of professionals working together asking for each other's expertise. It worked well because we had a common goal and all recognized the value of various approaches and input.

5. Working on Medina County Mental Health Association - clergy, lawyers, social workers, psychologists, we worked together well, exchanged ideas, reasonably effective results.

Situation #6: "CONTINUING EDUCATION SITUATIONS"

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<tr>
<th>Allied Medical Professions (Course Participants)</th>
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<tbody>
<tr>
<td>Allied Medical Professions (Non-participants)</td>
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<tr>
<td>Education (Course Participants)</td>
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<tr>
<td>Nursing (Course Participants)</td>
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<td>Nursing (Non-participants)</td>
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</table>

1. Seminar on the rights of a dying person. (awareness level)

2. Interdisciplinary cardiac rehabilitation conference for post infarction patients are among the most common and effective of these situations.

1. Continuing education programs - view the care of clients from various approaches - medical, nursing, social work, nutrition - need more with interaction between professionals rather than divided work sessions.
Situation #6 continued: "Continuing education situations."

Social Work
(Course Participants)

2. Development of a hospital program.

1. Inservice on spouse abuse involving nurses, medical technologists, and social workers. Valuable experience, shared thoughts, etc.

2. I find continuing education events to be the most relaxed places to initiate interprofessional discussions and begin building contacts which are later useful to me and my clients.

Social Work
(Non-participants)

NO EXAMPLES.

Theology
(Course Participants)

1. Seminar for recently unemployed. A great interprofessional community effort to deal with subject. Well-planned, well-shared, well-received! Lots of contacts made by clients and planners.

2. Death and dying seminar. Hosted by funeral directors. Could have been a little more personal, not so "professional" since this is where death most deeply affect us all!

3. Bio-ethics seminar held within hospital setting. Exchange was spirited but cordial leading to better local cooperation among the professional community. Professions were extremely parochial, and for some participants the input of other professions was inspirational.

Theology
(Non-participants)

NO EXAMPLES.

Situation #7: "PROFESSIONAL ASSOCIATION ACTIVITIES"

Allied Medical Professions
(Course Participants)

NO EXAMPLES.

Allied Medical Professions
(Non-participants)

NO EXAMPLES.

Education
(Course Participants)

NO EXAMPLES.

Education
(Non-participants)

1. AAMFT - very effective.

Law
(Course Participants)

1. Community education regarding "granny-battering" for senior citizens - learned about non-legal concerns from other panelists - also from seniors concerning individual problems - felt enriched from sharing process.
Situation #7 continued: "Professional association activities."

Law (Non-participants) 1. Dinner meeting sponsored by local bar association and medical society regarding introduction of medical evidence and expert testimony. Very informative.

Medical (Course Participants) NO EXAMPLES.

Medical (Non-participants) NO EXAMPLES.

Nursing (Course Participants) 1. I participated as a nurse from a community agency in a monthly group meeting of other community professionals interested in health planning and another group interested in the community's youth projects.

Nursing (Non-participants) 1. I'm on several boards. All care for much of these types of things.

Social Work (Course Participants) NO EXAMPLES.

Social Work (Non-participants) NO EXAMPLES.

Theology (Course Participants) NO EXAMPLES.

Theology (Non-participants) 1. The only activity I participated in is a community ministerial association that sometimes used M.D. to share with us. My feeling is it is not enough, too superficial and client care has not improved.

2. The Gahanna Ministerial Association participated in an open dialogue session with the local school board concerning teenage problems in today's society. Implementation of ideas was an area that I have not personally heard about or been asked to participate.

3. Clergy support group with local psychologist—we aid one another in counseling and administrative thinking—cross-denomination great!

4. In our area we have a clergy group which includes counselors and from time to time we invite others to come and visit this group.

Situation #8: "TEACHING AND RESEARCH SITUATIONS."

Allied Medical Professions (Course Participants) 1. Patient education committees: effective and patient care has improved, is more standardized and complete care due to its formation.
**Situation #8 continued: "Teaching and research situations."**

<table>
<thead>
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<th>Notes</th>
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<td>Non-participants</td>
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</tr>
<tr>
<td>Education</td>
<td>(Course Participants)</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Education</td>
<td>Non-participants</td>
<td>1. Writing a research paper using several views - was very effective in finding actual independent/dependent variables. NO EXAMPLES.</td>
</tr>
<tr>
<td>Law</td>
<td>(Course Participants)</td>
<td>NO EXAMPLES.</td>
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<tr>
<td>Law</td>
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<tr>
<td>Medicine</td>
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<tr>
<td>Theology</td>
<td>(Course Participants)</td>
<td>NO EXAMPLES.</td>
</tr>
<tr>
<td>Theology</td>
<td>Non-participants</td>
<td>1. Jail ministry - prayer service, visitation; teaching - Providence Hospital School of Nursing regarding medical ethics; teaching-instruction within context of religion.</td>
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</table>

**Situation #9: "SOCIAL RELATIONSHIPS: ACQUAINTANCES"**

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<td>Law</td>
<td>(Course Participants)</td>
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**Situation #9 continued: "Social relationships; acquaintances."**

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<th>(Course Participants)</th>
<th>(Non-participants)</th>
<th>Example</th>
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<tbody>
<tr>
<td>Law</td>
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<tr>
<td>Medicine</td>
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<tr>
<td>Medicine (Non-participants)</td>
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<td>Social Work (Non-participants)</td>
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<tr>
<td>Theology (Course Participants)</td>
<td>1. Open-house social mixer for several professionals. Good experience to meet others in a relaxed setting. Less reluctance to refer and openness to advice about a client from another professional.</td>
<td>NO EXAMPLES.</td>
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<tr>
<td>Theology (Non-participants)</td>
<td>NO EXAMPLES.</td>
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**Situation #10: "SITUATIONS PROMPTED BY MUTUAL RESPECT."**

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<th>Profession</th>
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<th>(Non-participants)</th>
<th>Example</th>
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<tbody>
<tr>
<td>Allied Medical Professions</td>
<td>1. Seminars- excellent, less pedantic, attendees treated like grown-ups and equally able to contribute.</td>
<td>NO EXAMPLES.</td>
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<tr>
<td>Allied Medical Professions (Non-participants)</td>
<td>NO EXAMPLES.</td>
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<td>Education</td>
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<td>Education (Course Participants)</td>
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Situation #10 continued: "Situations prompted by mutual respect."

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<th>Field</th>
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<td>Medicine (Course Participants)</td>
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<tr>
<td>Nursing (Course Participants)</td>
<td>1. Works great when each member is secure in their own role function.</td>
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<tr>
<td>Social Work (Course Participants)</td>
<td>1. I am strongly in favor of interprofessional practice. It is generally an effective process, although lack of understanding of each other's profession and role can greatly impede the process. Client care is generally improved by interprofessional practice, but only if the professionals know how to work with each other. I think other professionals value interprofessional activity and will attempt to improve their skills in this area.</td>
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<tr>
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<td>Theology (Non-participants)</td>
<td>1. Greater trust level and respect for mutual abilities.</td>
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<tr>
<td>Professions</td>
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<td>7. Medical/Health Care</td>
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<td>8. Clergy</td>
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<td>9. Psychologists</td>
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<td>10. Other Medical Personnel</td>
<td>10 27</td>
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<td>11. Nutritionists/Dieticians</td>
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<tr>
<td>12. Social Service Agency/Welfare Dept./Children's Services</td>
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<tr>
<td>13. Law/Police/Criminologists</td>
<td>14 15</td>
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<tr>
<td>14. Business/Marketing/Bankers/Auditors/Economists</td>
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209
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<th>Group</th>
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BIBLIOGRAPHY


Nisonger Center (1982). Factors Affecting an Interdisciplinary Clinical Team. Nisonger Newsletter Executive Summary, The Ohio State University, 6(4).


