An interprofessional socialization framework for developing an interprofessional identity among health professions students

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Abstract

Although health professional educational programs have been successful in equipping graduates with skills, knowledge and professionalism, the emphasis on specialization and profession-specific education has enhanced the development of a uniprofessional identity, which has been found to be a major barrier to interprofessional collaborative person-centred practice (IPCP). Changes within healthcare professional education programs are necessary to enable a shift in direction toward interprofessional socialization (IPS) to promote IPCP. Currently, there is a paucity of conceptual frameworks to guide IPS. In this article, we present a framework designed to help illuminate an IPS process, which may inform efforts by educators and curriculum developers to facilitate the development of health professions students' dual identity, that is, an interprofessional identity in addition to their existing professional identity, as a first step toward IPCP. This framework integrates concepts derived from social identity theory and intergroup contact theory into a dual identity model of IPS.

Keywords

Dual identity, dual professional and interprofessional identity, intergroup contact theory, interprofessional collaborative person-centred practice, interprofessional education, interprofessional socialization framework, social identity theory

Introduction

There is growing evidence supporting interprofessional education (IPE) as a key strategy for improving: interprofessional collaborative practice; health provider satisfaction, recruitment and retention; and client satisfaction and improved health outcomes leading to enhanced efficiencies and cost-effectiveness within the healthcare system (e.g. Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Reeves, Perder, Goldman, Freeth, & Zwarenstein, 2013; World Health Organization, 2010). IPE advocates for equity of roles across professions to enhance and reform healthcare practice (Baker et al., 2011). Hence, governments in Canada and around the world have funded IPE research to evolve healthcare delivery toward collaborative person-centred practice.

Currently, there is a paucity of evidence linking outcomes of IPE to quality of care (Reeves, MacMillan, & van Soeren, 2010; Zwarenstein & Reeves, 2006). Advocating for the equity of roles and contributions of all professions in the delivery of care is not seen as sufficient to transform current multiprofessional-centred model of care to an interprofessional collaborative person-centred practice (IPCP) model (Baker et al., 2011). Many professionals consider this view a threat to their own professional identity and therefore resist collaboration (Baker et al., 2011; Wakefield, Boggis, & Holland, 2006). These “turf protection” behaviors appear to be deeply rooted in the socialization processes of healthcare professionals (Arndt et al., 2009; Baker et al., 2011; Cameron, 2011). According to Baker et al. (2011), the development of healthcare professionals as distinct occupational workers has been based on a professionalization process aimed at securing and protecting exclusive areas of knowledge, work practices and tightly regulated professional entry. Similarly, in professional education, the emphasis placed on profession-specific socialization through a uniprofessional model of education shapes the values and identities of professional learners, isolating them from learners in other professions and results in the development of a “uniprofessional identity” (Carpenter & Dickinson, 2008; Gilbert, 2005).

Development of a strong uniprofessional identity leads individuals to view their own profession as different from and/or better than other related professions (Baker et al., 2011; Cameron, 2011; Lloyd, Schneider, Scales, Bailey, & Jones, 2011). This phenomenon is supported by the social identity theory (SIT) proposed by Tajfel & Turner (1986). According to SIT, individual’s identification with a social group (that is a specific profession) results in a profession-specific cognitive map and a system of orientation toward one’s chosen profession. This results in in-group favoritism that creates high levels of trust and cohesiveness among professional members and out-group discriminatory bias that leads to distrust toward those outside of their group. When students from different health professions who lack interprofessional educational experience are brought together, these in-profession and out-profession
behaviors interfere with effective collaboration (Baker et al., 2011; Cameron, 2011). Lloyd et al. (2011) found that an isolationist identity limits interprofessional communication across professions. Miscommunication among health professionals is one of the leading causes of patient safety incidents in the US and Canada (Canadian Patient Safety Institute, 2011; Institute of Medicine, 2003).

In addition, strong uniprofessional identities may cause many students (and professionals) to view interprofessional efforts to improve interprofessional collaboration as a threat to their own professional boundaries (Baker et al., 2011; Cameron, 2011; Lloyd et al., 2011). Recognition of the interconnectivity and complementarity of roles and perspectives of different healthcare professionals is lost in the uniprofessional model of education, which encourages students to focus exclusively on their own professional's practices.

To date, the focus of IPE literature has primarily been on descriptions of IPE program development and changes in learners' attitudes, knowledge and skills following these experiences (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; Hammick, Freeth, Koppel, Reeves, & Barr, 2007). However, Currie, Finn, & Martin (2007) suggest that the IPE focus should be expanded beyond structural and attitudinal changes to include interprofessional socialization (IPS) to help broaden existing uniprofessional identities into a combination of both a professional and an interprofessional identity (Baker et al., 2011; Carpenter & Dickinson, 2008).

From a SIT point of view, adoption of a dual identity creates an expanded "in-group" perspective beyond learners own professional roles to that of a shared understanding of how all health profession roles combine for effective collaborative and complementary teamwork. This shift mitigates out-group discrimination and distrust and improves IPCPCP. To accomplish this, IPE strategies are needed that breakdown misperceptions, prejudices and stereotypes among healthcare professionals emphasizing the complementarities of other healthcare professional roles and perspectives (e.g. Carpenter & Dickinson, 2008; Salvatori, Berry, & Eva, 2007; Xyrichis & Lowton, 2008).

Although the current IPE and collaborative practice literature acknowledges the importance of IPS, there is a lack of research investigating the actual process that learners must move through in order to develop a dual identity. The aim of this article is to describe an IPS framework created to re-conceptualize socialization processes that will assist healthcare professions learners to develop a dual identity.

Background

Professional socialization is associated with an adult role development process through which an individual becomes a mature member of a profession (Sewell, Haller, & Portes, 1969). Socialization into a profession provides the means for individuals to know "who they are" and the process they adopt in establishing their work-based norms, values, beliefs, knowledge, skills, expected roles and the profession's culture (Becker, Geer, Hughes, & Strauss, 1961; Hershey, 2007; Melia, 1987; Merton, Reader, & Kendall, 1957; Newman, 2005; Olesen & Whittaker, 1970; Simpson, 1967).

Professional socialization typically starts when people begin thinking about their future career or "who they want to be", termed anticipatory socialization, which results in career selection (Flanagan, 1979). An individual's career selection might begin as early as childhood and is shaped by their cultural and societal contexts. Beliefs acquired through societal and media input shape one's career selection, but these sources often contain myths about particular professions and prejudicial attitudes toward those in others (Adams, Hearn, Sturgis, & Macleod Clark, 2006; Hind et al., 2003; Flanagan, 1979). Hence, all students enter with various conceptions that range between myths and reality about their own profession and other professions (Hershey, 2007). Much of society's valuing of a profession is conveyed through print and visual media, distorting the reality yet shaping perceptions of other professionals outside a practitioner profession (Adams et al., 2006; Tunstall-Pedoe, Rink, & Hilton, 2003). Attitudes toward one's own profession, is adjusted in their primary professional socialization process through professional role learning. Professional role learning is influenced by societal valuing of the profession (professionalism) and integrated into the profession's norms, values and behaviors associated with professional practice (Adams et al., 2006; Hershey, 2007). However, their views about other professions remain divergent from reality.

Professional identity, which is the result of professional socialization results from learners interacting with individuals both within their professional education program (faculty and students) and in professional practice (Arndt et al., 2009; Hershey, 2007). Uni-professional education programs limit the understanding of others' roles resulting in development of uniprofessional identities (see Figure 1). Hence, professionals begin their careers lacking an understanding of and limited experience working as part of an interprofessional team (Hall, 2005).

Interprofessional socialization

IPS is a process of bringing learners from across different professional programs together to learn with, from, and about each other. This process creates the context for dual identity formation. To have an effective and meaningful interprofessional experience, team members must be familiar with the expertise and functions of others' roles (D'Amour & Ondasen, 2005; Hall, 2005). Interprofessional learners need to learn and practice how to collaborate across professions using an interprofessional team perspective to provide quality of care while still assuming their profession-specific roles. Development of a dual identity is the outcome of this socialization process and the first step for IPCPCP teamwork. The following section describes a model for IPS, which was derived from SIT (Tajfel & Turner, 1986) and intergroup contact theory (ICT) (Pettigrew, 1998) in which interprofessional values, beliefs, behaviors, knowledge and skills are integrated into individual's professional identity trajectory. Theoretically, this process will prepare the next generation of health professionals to successfully integrate interprofessional collaboration into their ongoing professional practice.

IPS framework

The combination of SIT (Tajfel & Turner, 1986) and ICT (Pettigrew, 1998) provide a useful framework for understanding IPS. SIT suggests that individuals develop a group identity in the process of socialization into a group; each person may simultaneously socialize and belong to other groups. According to Tajfel & Turner (1986), the group identity is part of an individual's self-concept, which derives from individual knowledge of membership in a particular group. This group identity, when established, leads individuals to see in-group members as different and better than out-groups and thereby display "in-group favoritism" and "out-group discrimination" in order to enhance their self-concept. According to Pettigrew (1998), if these in-groups and out-groups are brought together in an open and trusting environment, learning about and from
According to the literature, many students, even before entering their professional program, have already developed a perspective of their chosen career (Adams et al., 2006; Hind et al., 2003; Tunstall-Pedoe et al., 2003) allowing them to distinguish between their choice from other related professions. Maintaining the current focus on uniprofessional learning is likely to perpetuate existing misconceptions across professions.

Strategies for breaking down myths and misconceptions proposed by Allport (1954) and Pettigrew (1998) are theorized to result in greater learner openness to shifting their uniprofessional perspective. Uniprofessional perspective transformation can occur through "cross-professional interactions" where pre-existing commonly held views are intentionally and critically challenged through open interactive discussions and debates among the learners. To reach the "openness" in perspective, learners should reflect critically upon their own views and existing assumptions about their own and other professions and reconsider previously held misconceptions (Sockman & Sharma, 2008). Toward the end of this stage, learners adopt enhanced clarity about their own roles, knowledge and skills and gain new understandings of other professions thereby increasing their readiness for interprofessional role learning.

Stage two: interprofessional role learning – interprofessional collaboration

Interprofessional role learning incorporates the norms, values, and behaviors necessary for moving toward IPCPCCP. To facilitate the interprofessional role learning, learners need to be engaged in interactions allowing for discussions around shared understanding of each other’s roles, knowledge and skills and subsequent exploration of how to work across professions more effectively. An ideal strategy for this stage of IPS is using a case-based teamwork approach focused on development of their interprofessional collaboration competencies (Canadian Interprofessional Health Collaborative (CIHC), 2010). As learners practice interprofessional collaboration, they continue to break down previous uniprofessional barriers and to learn more from, with, and about each other, leading to development of a sense of belonging to the interprofessional team (Clark, 1997). This interprofessional sense of belonging helps learners transform their single professional view of practice into a broader interprofessional view that values other professional contributions into client care (Carpenter & Dickinson, 2008; Dovidio, Gaertner, & Saguy, 2007). As learners move toward developing an interprofessional identity, they learn to view IPCPCCP through the lens of a member of an interprofessional community. The outcome of this phase results in learners who are poised to move forward in developing their interprofessional identity.
Individuals learning and working in interprofessional collaborative groups create the climate for equity of roles and valuing different professional perspectives. Creating an environment conducive to reflection on collaborative teamwork relationships helps learners to concurrently identify with their own profession and the interprofessional team/practice, resulting in further corrections of their previous professional myths and prejudices and creating a dual identity. This dual identity development is believed to increase the willingness of learners to seek collaborative teamwork following graduation.

These three stages of IPS are not simply linear, rather the stages are iterative. As the learners begin to develop a dual professional and interprofessional identity, they will continue learning and working with each other, which in turn results in learners being more open to other opinions and perspectives leading to IPCPCP teamwork. Furthermore, the IPS is not just a one-level process, but the IPS is also influenced by intra-individual factors and larger systemic factors. Personal factors include: individuals' interprofessional beliefs and behaviors, their affinity to exhibit either an individualistic or a collectivistic orientation and previous interprofessional experiences (Hojat et al., 2001; Reeves & Freeth, 2006; Tschannen, 2004). Learners with positive past interprofessional experience, high interprofessional beliefs and a collectivistic orientation are theorized to respond more favorably to IPS than those who lack or have negative past interprofessional experiences, low interprofessional beliefs and behaviors and an individualistic orientation.

The systemic factors that influence IPS include: professional education programs, professional regulations and healthcare delivery models (AIPHE, 2008; D'Amour & Oandasan, 2005; Gilbert, 2005; Hall, 2005; Ho, 2006; Oandasan & Reeves, 2005). IPS requires educational programs to eliminate professional silos and provide their students with cross-professional learning opportunities (Hall, 2005). This is a response to policy initiatives advocating a move toward IPCPCP model of care by creating a new paradigm of education, which shifts uniprofessional education to a combination of intraprofessional education and IPE (Cerra & Brandt, 2011; D'Amour & Oandasan, 2005). This new paradigm requires an IPS process, which enables students to develop a dual identity (Carpenter & Dickinson, 2008; Cerra & Brandt, 2011; Clark, 1997).

Current systems of professional regulation encourage traditional uniprofessional patterns of practice (Cameron 2011; Cornes, Manthorpe, Huxley, & Evans, 2007). This uniprofessional approach may be a significant barrier for professionals who seek collaboration across professions because of the uniprofessional standards of practice and the professional accountability outlined by their respective regulatory bodies (Cameron, 2011).

Finally, socializing healthcare providers unprofessionally has perpetuated the current form of multiprofessional care in the healthcare system, causing healthcare professionals to work somewhat independently from each other in meeting their own professional-identified client care goals. However, the IPCPCP model of care is a dynamic process that requires a partnership between healthcare professionals and their clients, in which healthcare professionals, as a team with their patients, should work together to meet clients' needs (Carpenter & Dickinson, 2008; D'Amour et al., 2005).

**Discussion**

The IPC framework may be embedded in professional educational programs, curricula. In the early stages of professional education, the focus should be on stages 1 and 2 of the IPS framework. As students move forward in their professional education, the focus should move to interprofessional collaboration and dual identity development (the stage 3 of IPS framework). During the first stage of the framework (breaking down barriers), IPE should facilitate the elimination of students' previous misconceptions related to the roles and contribution of other professions. Students should be provided with an open and trusting environment wherein they are encouraged to critically challenge and reflect on their own/each others' perspectives in order to improve collaborative practice. By doing so, students may gain an awareness of their narrow uniprofessional perspective and its impact on collaboration which may encourage them to broaden their perspective. This openness to developing new perspectives may be achieved through interprofessional role learning and
collaborative team practice assisting learners to adopt a dual professional and interprofessional identity. This approach allows learners to observe, interact and reflect on their learning to gain a full understanding of what constitutes interprofessional collaborative practice among practitioners in a variety of professional roles (Blumer, 1969; Clark, 2009). As a result, learners gain the ability to apply knowledge gained from recognizing and valuing the complementary roles and perspectives of each professional member to future practice (Clark, 1997; Wakefield et al., 2006). Theoretically, the adoption of a dual identity leads to the creation of ongoing interprofessional collaborative practice cultures following graduation. The IPS may also be relevant in post-licensure continuing professional education but will needs testing to confirm its applicability.

Furthermore, educational institutions must take steps to break down the uniprofessional educational barriers by fostering a cultural paradigmatic shift toward IPE for collaborative person-centred practice (Cameron 2011; Gilbert, 2005; Hall, 2005; Ho, 2006). This cultural shift will require governance and management structures that encourage collaborative environments for developing joint curricula and sharing of resources amongst all professions (Ho, 2006). Sustainability and effectiveness of this cultural shift requires formal leaders and champions who can establish structures and parameters for implementation and evaluation to guide the strategic change direction. Thus, allocation of both human and fiscal resources are essential to stimulate change, interest and commitment across a variety of stakeholders (e.g. faculty/educators, administrative, clinicians and managers) (AIPHE, 2008; D'Amour & Ondasdan, 2005; Ho, 2006; Ondasdan & Reeves, 2005).

It is also important that professional governing bodies and government shift from a uniprofessional approach to scope of professional practice to a more collaborative approach with other regulatory bodies. A more integrative approach to interprofessional practice may be achievable by developing and integrating common interprofessional competencies within their professional practice and quality assurance programs (Cameron, 2011; Gilbert, 2005; Ho, 2006).

At this point in time, the IPS framework has not been empirically tested. The framework was developed based on extensive review of the IPE, IPCPCCP and socialization literatures. The model is underpinned by two social psychological theories (SIT and ICT). Testing the model in health professional programs will inevitably result in refinements in the framework. Systematic testing of the model within a larger program of research is necessary for ensuring that theory driven IPE designed to foster a dual identity among health professions students is based on a solid body of evidence.

Concluding comments

In practice, "turf protection" behaviors are still amongst the most common barriers to interprofessional collaboration. These behaviors are deeply rooted in the way healthcare professionals are socialized and educated, that is programs that isolate them from other healthcare professionals, and result in development of solely uniprofessional identities. This isolationist identity creates a lack of understanding about, limits exposure to, and supports persistent negative stereotypical attitudes toward other professionals resulting in prevailing myths and misunderstanding about other professional colleagues’ roles and contributions (Clark, 1997; Salvatori et al., 2007; Xyrichis & Lowton, 2008).

Changes within educational preparation of health professional learners are theorized to enable a shift in learners’ socialization process toward development of strategies for cross-professional learning promoting interprofessional behaviors and subsequent collaborative person-centred practice. While there is recognition of the need for such a shift, little is known about the IPS process that leads to development of interprofessionalism in health and social care professionals. This article therefore outlined the development of a framework that described a three-stage socialization process whereby health professions students can be guided by faculty to adopt a dual identity. This approach, it was argued, may help overcome previous challenges experienced with successful implementation of interprofessional person-centred collaborative practice.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the writing and content of this article.

References


