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LETTER

Interprofessional Education: Saudi Health Students' Attitudes Toward Shared Learning [Letter]

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Dear editor

We read with great interest the study by Dr. AlAhmari which explored the attitudes of final year respiratory care (RC), nursing and clinical laboratory science (CLS) students, from Saudi Arabia, regarding interprofessional education (IPE).[1] We were excited to see the positive attitudes demonstrated by healthcare students regarding IPE. However, we believe certain aspects of this study need to be addressed.

Firstly, the instrument used within the study to assess student attitudes towards IPE needs to be examined. The tool in question is the Readiness for Interprofessional Learning Scale (RIPLS) questionnaire developed by Parsell and Bligh in 1999.[2] This is a 19 item questionnaire with 3 subscales: Teamwork and Collaboration, Professional Identity, and Roles and Responsibilities.[2] Only two articles are cited for the justification of using this tool: the first is the original pilot study from Parsell and Bligh and the second is a study by McFadyen et al which studied a modified version of RIPLS with 4 subscales.[2,3] Both of these studies found the overall internal consistency of the instrument to be reasonable, however, this did not extend to the subscales. For example, the Roles and Responsibility subscale had an internal consistency of only 0.32 and 0.43 respectively.[2,3] These values are too low to be validated for use thus explaining why they have often been left out in some IPE studies.[4] Due to this issue, as well as others, there has been discussions regarding the optimum structure of this instrument with McFadyen et al suggesting 4 subscales as the ideal.[3] The lack of consistency between researchers, regarding the questionnaires structure, indicates its fragility. Whilst we understand using "off the shelf" tools can aid in progressing research with minimal resources, it is important to understand their nuances so as not to bias studies.[3] A discussion regarding its psychometric limitations should be included in a limitations section of the paper explaining how it may have impacted upon findings.

Secondly, 67 participants were recruited for this study and consented, however, no information is provided as to whether this process was randomized.[1] If randomization was not performed it could introduce an element of selection bias as healthcare students who agreed to partake might have had shared characteristics such already being more eager to undertake IPE. A simple randomization process would help to reduce such bias. Thirdly, we found the study could have expanded its scope by reporting the results in context to gender as well. As similarly

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structured IPE studies, have found females to have more favorable attitudes and readiness towards IPE than their counterparts.[5] It would have been a valuable insight to see whether these gender differences were echoed in this study.

In conclusion, whilst we believe the findings by Dr. AlAhmari are most likely correct, addressing these points will help bolster the results and improve the internal validity of the study. Consequently, this will aid in bringing about further research and policy change enabling defragmentation in delivering effective health care.

Disclosure

The authors report no conflicts of interest in this communication.

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