

An Auto-Ethnographic Case-Story on the Development and Integration of Interprofessional Education: Part I - A Quest for Impact

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ABSTRACT

The following is an autoethnographic case-story, told through text and comic book art, spotlighting the barriers and facilitators associated with building an IPE/IPP program within a specific institution. Part 1 of this story, shared here, focuses on: a.) providing personal background and cultural context for the emergence of the role of Associate Dean of Interprofessional Education, d.) the steps taken to centralize efforts and, c.) the reasoning behind the primary focus of integrating IPE within the undergraduate (i.e., college) level. This story spotlights various resources that were utilized in this initial process, discusses the achievements and macro-, meso-, and micro-level challenges thus far, and in turn, hopefully serves as a preliminary guide for other IPE innovators and leaders.

INTRODUCTION

I recently accepted the position of Associated Dean of Interprofessional Education (AD-IPE) within the University of XX's College of Health Sciences (CHS) in order to integrate IPE within the undergraduate and graduate curricula and enhance interprofessional development and practice among academic and clinical faculty and affiliated healthcare providers. I had been playing in the IPE/IPP sandbox (through my research and teaching) for some time and felt well qualified for the position, but initially struggled significantly with finding a "starting line." Although there are certain scholastic blueprints for developing IPE programs (notably Brasher, Owen, & Haizlip, 2015), as a Sociologist, I felt somewhat like an outsider looking in. Therefore, in order to trace and keep track of my steps in this process and in turn, provide a bread-crumbs trail to others interested in cultivating an IPE/IPP program within their own institution we present this auto-ethnography as a case-story through text and comic book art. This part of the story (i.e. Part I) focuses specifically on providing context (personal and institutional) for the AD-IPE position, perceptions of being a social scientist within a primarily clinically-oriented field, the facilitators and barriers thus far in the process, and the preliminary efforts of integrating IPE within the undergraduate (i.e., college) level.

METHODS

Autoethnography, a qualitative research method, allows the author to write in a highly personalized style, drawing on their experience(s) to provide insights and understanding into socio-cultural and socio-historical occurrences through analysis and interpretation (Ellis & Bochner, 2000; Ellis, Adams, & Bochner, 2011; Denzin, 2014). From within this methodological framework, autoethnography is not just

about the self and the individual journey, but rather uses the self and the journey to explore various aspects of socio-cultural processes and mechanisms (Chang, 2008; 2016). In this particular autoethnography, I utilize my own journey and experiences as an opportunity to explore various nuances, phenomena, socio-cultural aspects and elements related to IPE, academia, and health professions education.

The primary data source for this study is a reflective journal used to “jot” field notes that I began one week after accepting the Associate Dean position and continue to utilize. The average entry was roughly three pages in length, hand-written in bullet-format, and later typed. The journal provides quick insights as to happenings and conversations, my perspectives on and reactions to these happenings and conversations, along with supporting evidence in the existing literature. For the first year (9/16-9/17), I entered my field notes on average, twice a week, but entries were more frequent if the week was busier. The journal served both as a tool to record experiences, perspectives, and observations, as well as a mechanism to compare/contrast these notes with data gleaned from relevant literature. Other data includes particular conversations with key personnel¹ involved in the journey, as well as specific information gleaned from prominent IPE handbooks, guides, websites and webinars.

All data gathering and analyses were conducted by the lead author. Conversation and content-related data were analyzed in tandem with the journal entries utilizing both deductive and inductive processes. During the first year, data were explored deductively, identifying reoccurring concepts and perceptions. Furthermore, simultaneously, the lead-author continued to examine the existing relevant literature to compare and contrast the common “themes” found in the data to previous empirical studies and narratives. After the 12 month period, these data were then re-analyzed using a more inductive approach – utilizing key terms from the existing literature (“support”, “center”, “competencies”, etc.) to further explore what had been unearthed in the preliminary stages of analysis. These analytic processes led to identifying and expounding on prominent experiences and perceptions.

As Wall (2006; citing Ellis & Bochner, 2000 and Reed-Danahay, 1997) notes, autoethnographies differ widely in regards to the dimensions of tone, structure, and intent. Similarly, autoethnographies differ in regards to the rigor of their methodology, theoretical foundation and inclusion, as well as their emphasis the personal narrative. Although this autoethnography maintains a highly personal tone, hopefully this does not detract from its content – including the theoretical and conceptual underpinnings as well as spotlighting of key issues related to IPE leadership and development within an academic context.

This case-story is told, in part, through comics, a medium shown to not only be effective in telling narratives and stories and teaching particular skills, but also more recently in spotlighting and discussing various sociological theory and concepts (Cioffi, 2009; Birge, 2010; Williams, 2011; 2012; Green, 2013; Al-Jawad, 2015; Mueller, Abrutyn, & Osborne, 2017). Comics can address serious multidimensional topics, constructs, and phenomena from various vantage points, and can present that complex material in a format that is digestible and relatable. Therefore, given these positive qualities, the apparent lack of utilization of the medium in the IPE realm, and the personal narrative nature of autoethnography as a method, comic art was selected as a vehicle to assist in telling the story of developing this IPE program.

BACKGROUND & CONTEXT

¹ All individuals involved in this case-story were provided the manuscript before submission to ensure and confirm that the authors had not taken liberties in regards to the interpretation of or perspectives on specific conversations and happenings.

By the summer of 2016, I was about one year post-tenure and promotion and experiencing a “crisis of faith” in academia. As an applied, interdisciplinary scholar I felt a sense of figurative distance from the traditional sociological discipline and had experienced push-back at certain stages of my tenure review process for not being “sociological enough”. This pushed me to apply for positions with allopathic and osteopathic medical institutions, where I felt my work would have more “impact”.

This was a key term in my scholastic life, *impact* - it was all I heard in preparing for tenure review. It was of dire importance (according to University, College, and Department leadership) that my work had impact and that I be able to show that impact. As I prepared my dossiers for review, the inescapable “force” of impact loomed over my shoulders, but it also stayed with me even after I received tenure and promotion in the frame of; “What am I doing and why does it matter?” Impact translated from numbers (i.e., how often and where I published) to an on-the-ground and real-world assessment of what did my work actually “do”? Why was I choosing to continue to exist in what I felt was an academic echo chamber? Who was I helping with my work? I could see the value in my teaching, in bringing theory and concepts to light for students, to exposing them to issues and debates they may have been able to avoid in most other courses, to pushing them to make the familiar strange (Mills, 1959). I could see the value in my service-oriented work to my Department, College, University, and even discipline. But when I thought of my own research agenda, I knew it could be more applied, more interdisciplinary, more aligned with my teaching and service. I could *do* more. And I felt it could do more in a different setting.

Unbeknownst to me, at this same time the Administration of the neighboring College of Health Sciences (CHS) was interested in exploring and expanding its interdisciplinary and interprofessional offerings (i.e., courses, programs, development opportunities). Moreover, these initiatives were timed with the construction of a new 10-story tower designed to break down silos and bring together various health-oriented disciplines and professions to work and learn together. With the ink still wet on the new tower’s blueprints, the Dean of the CHS went looking for someone to lead the interdisciplinary and interprofessional charge within the College and University, someone to not only oversee current efforts, but also develop, administer, and evaluate future efforts.

It was not uncommon for the CHS Dean and I to have coffee meetings where we would discuss various happenings within the colleges and University at large and brainstorm on potential programs and directives.



She is known for her forward - and creative - thinking and her dedication to advancing how we teach, research, and practice healthcare.



Early Summer 2016

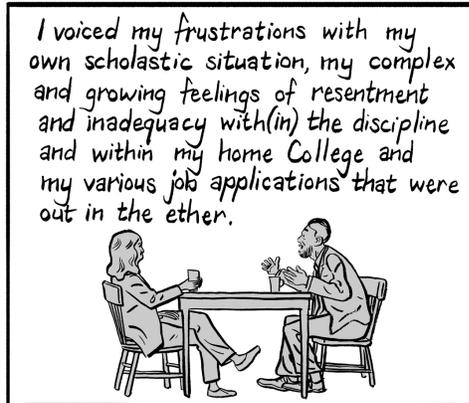
I feel like I have gone as far as I can here with my work



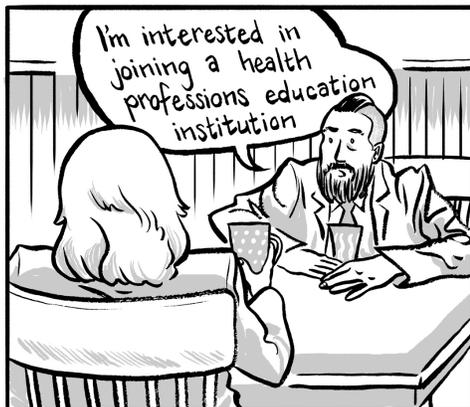
I needed to focus on the impact of my work to get tenure but I feel like it's only adding to a remedial conversation already present in the literature.



I voiced my frustrations with my own scholastic situation, my complex and growing feelings of resentment and inadequacy with(in) the discipline and within my home College and my various job applications that were out in the ether.



I'm interested in joining a health professions education institution



I want to have the potential to cultivate agents of change in the health professions!



There's a YouTube clip of a person hitting a spider with a shoe, and upon impact (what appears to be) hundreds of little spiders emerge and scatter. This, perhaps nightmarish, scenario was exactly what I wanted to do, but within the context of curriculum and programing. It was at this meeting when I first learned of the possibility of a position with the primary charge of constructing curriculum and programs that bridge disciplines, Colleges, and colleagues, and foster a culture of collaboration.

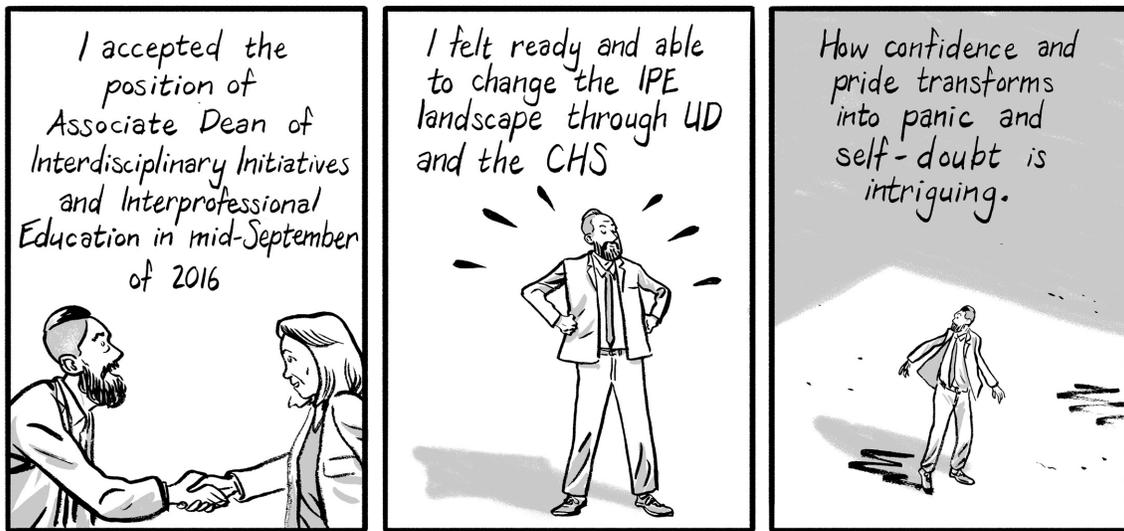
To be clear, "champions" of IPE (Brahers, Owens, & Haizlip, 2015; Aston et al., 2012; Ho, et al. 2008) already existed at the University before I embarked on this journey. The Dean and the Deputy Dean of the CHS had explicit notions of what they wanted, broad responsibilities of the leader(s) of the related initiatives, and a willingness and eagerness to push the agenda forward. They both were willing to put forth the financial, spatial, and personal resources to promote XX as a player in the IPE and IPP realms. Their interests coincided with the push from the new President of the University, who was calling for more interdisciplinarity and collaboration between Colleges.

It is important to note however, that although the University does have a number of graduate-level health-related programs (e.g., exercise science, nursing, health services administration, health promotion, applied physiology, medical sciences, physical therapy, communications sciences and disorders, biomechanics and movement science, among others, with still more in development), it does not have a medical school (although we do have a large number of "premeds" at the undergraduate level). I believe this is a key facilitator to the development of IPE at this specific University given the status and related power differentials nested within and between the health professions, and, in turn, health professions education. Stated differently, the nested and often perpetuated (through formal and informal means) occupational status hierarchy that can trickle down into health professions education, can impact the development, implementation, and effectiveness of interprofessional education (Michalec et al., 2013; Bell, Michalec, & Arenson, 2014; Macmilan & Reeves, 2014) – but lacking such a program meant little "contaminating drippage."

Another contextual issue that I consider a benefit to the development of IPE at the University is that I am not a healthcare provider. I am a sociologist that studies healthcare providers and health profession students. My research thus far had explored the socialization and professionalization processes nested within healthcare education, provider-patient interaction, and various structural and social-psychological aspects of healthcare delivery. My work crosses disciplinary boundaries, working on projects with various health care providers, and scholars from varying domains (psychology, education, policy, among others). Moreover, I have a background in IPE specifically, having worked with Thomas Jefferson University's Jefferson Center for Interprofessional Education (JCIPE) evaluation sub-group since 2009. In other words, I had relevant background without the internal ties or alliances. But to be clear, regardless of my work in this specific field, my lack of clinical credentials made me somewhat distinct from most IPE scholars (i.e., researchers and program developers) who were/are of a clinical ilk being nurses, doctors, physical therapists, nutritionists, dentists, medical social workers, etc., or from an education background. Many other social scientists playing in this sandbox, even those who were working/appointed within clinical disciplines were using specific theories and concepts as flashlights to expose key barriers and facilitators to IPE and IPP or "gaps" in the IPE/IPP literature (e.g., Hean & Dickson, 2005; Baker et al., 2011; Kitto et al., 2011; Paradis & Whitehead, 2015; among others), but were not necessarily attempting to build IPE/IPP curriculum or programs themselves. This is not to say such scholars were not influencing or involved in IPE programs, but rather that it was unlikely that these

types of scholars were/are *spearheading* comprehensive IPE development or the directors of IPE/IPP centers.

Moreover, this “other” perspective speaks to a larger contextual issue, how medical sociologists, and social scientists in general, are possibly perceived within the clinical realm. Link (2003), in his work, *The Production of Understanding*, highlights the “rule” of biomedical research and the related quieting of the sociological perspective in the clinical realm. He states, “And since much of the institutional power lies with the medical/biological perspective on mental and physical illnesses, the ideas of sociologists and other social scientists are at risk of being underappreciated” (458). This “institutional power” stems from the rise of authority and professional autonomy of medicine (Starr, 1982), and the perpetuated notion that clinical knowledge (acquired through health professions training, namely medical training) is the pinnacle of knowledge (Wear & Castellani, 2006), as well as the continued medicalization of behaviors (Conrad & Schnieder, 1981; Conrad, 2007). In turn, this biomedical focus not only impacts if and how we examine issues related to health and illness (i.e., micro, meso, macro-approaches), but also what aspects of health and illness are important to teach future healthcare professionals. If I was to take on this position, I would be an “infiltrator” of sorts, working within the clinical realm as an “other.” This opportunity was the primary driving force as to why I accepted the position – to have an impact on the healthcare workforce and healthcare delivery.....as a sociologist.



Although I felt well versed in all things IPE, I immediately floundered. There were so many starting lines. I didn’t know where to begin, and I was fraught with concern that my panic would not only be exposed, but be perceived as a lack of ability. I wanted to get a lay of the land regarding what interdisciplinary and IPE-based programs and courses were already on the books within CHS. I also wanted to read-up on how to create (and sustain) institutional change. I also needed to more thoroughly explore examples of IPE and IPP-based programs, curriculum, and initiatives from other institutions. There was so much already happening within the College in terms of curriculum and programming that could be perceived as “IPE-friendly” – meaning they had the fundamental ingredients to “qualify” as IPE learning opportunities but required enhancement and/or further integration. Plus, the College had a knack of moving quickly and, in turn, I was playing an incredibly difficult game of catch-up. To add to the fervor, there was already an excitement and knowledge-base regarding IPE among the CHS faculty and now

they had someone to help them search out potential funding sources and opportunities, assist in designing evaluation and assessment protocols, and to help champion their programs in general.



But, as they say, "Necessity is the mother of invention."

INITIATIVE 1: THE BIRTH OF CIDER

Key texts and videos that explore elements of building an IPE program suggest gathering your champions and team-players, acquiring/collecting various resources, and developing a Center as primary strategies. A majority of the examples of IPE programs at other institutions had a Center of some sort. I had worked with and within a few Centers during my graduate and early professional career and the infrastructure alone, not to mention the work to sustain the Center's visibility, energy, and momentum, seemed liked a Herculean task.

Culture eats strategy for lunch



A Center could be the force to enhance, sustain, and promote this collaborative culture.

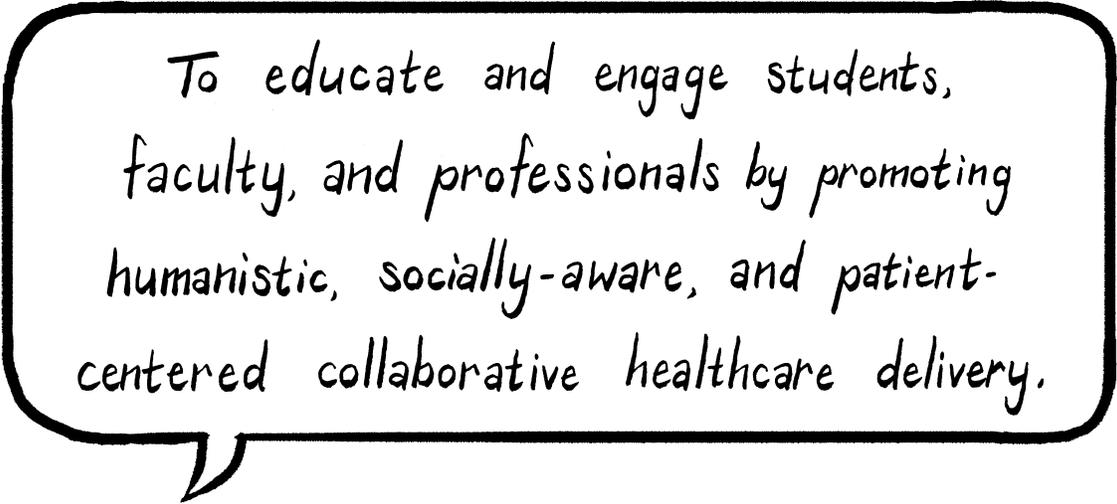
As noted earlier, there were many IPE-friendly courses and programs on the books at CHS when I took the position – and initially I intended to touch-based with each of them, but I realized that I could identify connective tissues/themes between their efforts from a centralized (and somewhat) situated location. Furthermore, I could develop the theme(s) regarding what IPE could “look like” at the University and unite others’ current and future efforts within that collective identity. There was value in building a hub for IPE on campus with its own maxims, directives, and goals. An IPE Center was the best approach to not only capture all (or at least most) of what was happening on campus, bringing it under a

comprehensive umbrella, but also a central home-base to develop and administer any future IPE-based initiatives, courses, programs.

To my chagrin, there is no “How to Run a Center for Dummies” but there are many IPE-based Centers already in existence – and, even more important, there are a number of IPE-based scholars out there who are willing to lend an ear and provide guidance (e.g., AIHC Mentoring Program). However, this brings up an important consideration – steal shamelessly.

With exemplars in mind, with Kotter’s (2012) *Leading Change* under my arm, and with colleagues’ notes in hand, I outlined a proposal for the Center for Interprofessional Development, Education, & Research (CIDER). This would be the Hall of Justice for our team. I assembled a Steering Committee, reaching out to faculty from various Colleges and local healthcare providers, all of whom I knew were interested in interdisciplinary and interprofessional education and development, and most of whom I had worked with in some capacity on previous projects and knew were team players.

I penned our motto:



To educate and engage students, faculty, and professionals by promoting humanistic, socially-aware, and patient-centered collaborative healthcare delivery.

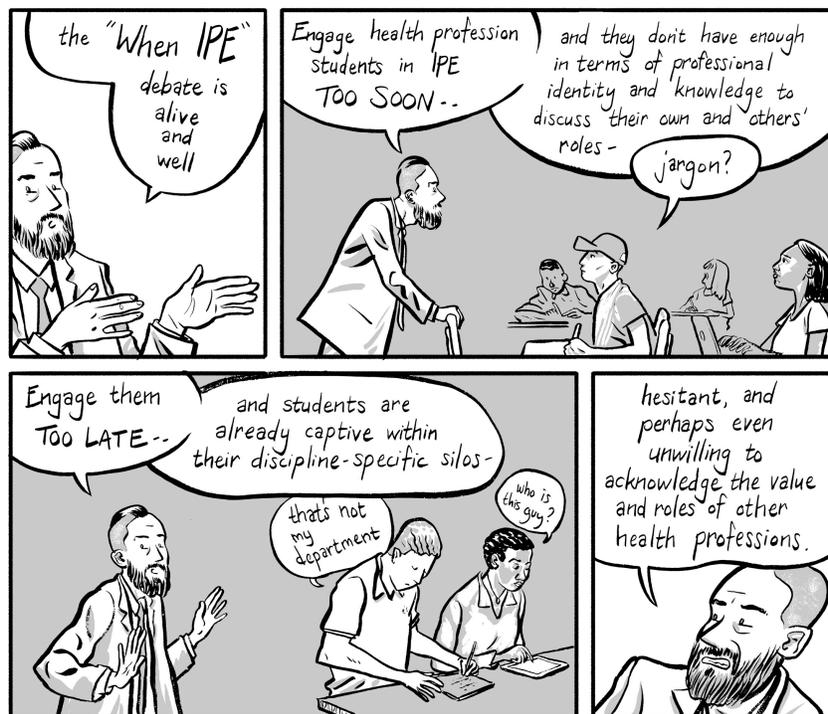
We mapped and outlined the key values (interprofessionalism, patient- and family-centeredness, patient safety and quality care, social justice, and integrated care), and characteristics (cultural humility, understanding, leadership (through team dynamics), trust, other-orientation, respect, and resilience). These were the attributes, behaviors, and traits we wanted to instill in all program and course participants regardless of whether they were students, faculty, and/or professionals. These also were the attributes, behaviors, and traits each CIDER member would reflect in their everyday interactions, research, and practice. These

are the foundations of CIDER and the vision of CIDER was to spread these positive attributes and behaviors like a cold at a daycare.

But then came the hard part. What were our objectives? What were we going to actually “do” and how would we have *impact* within the College, University, and healthcare community?

INITIATIVE 2: WHERE/HOW CAN WE HAVE *IMPACT* (AKA “BACK TO BASICS”)

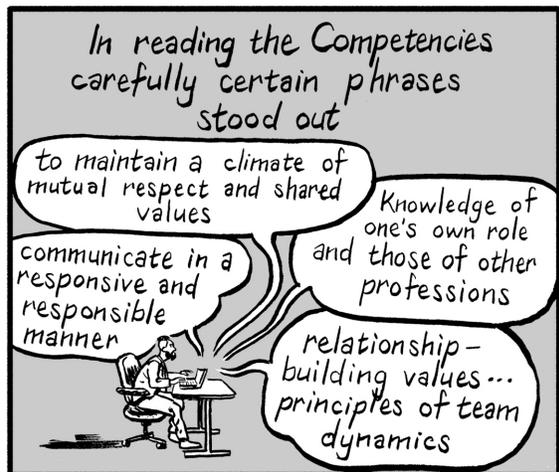
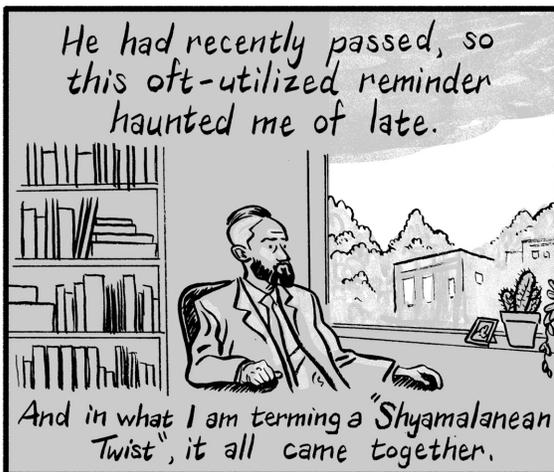
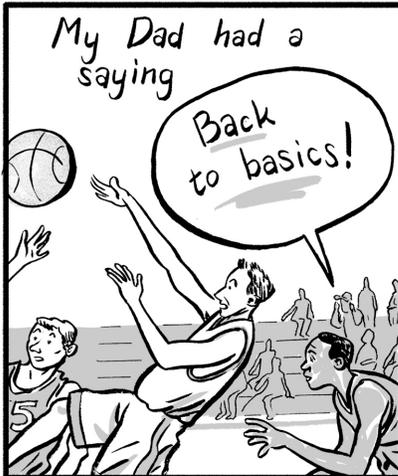
I had to focus, and the question was, “What do we want IPE to look like at the University?” Our IPE and IPP programs could be unique and creative, but we needed to use what we already knew about IPE in general, and root *everything* in the basics – the IPEC Competencies. The IPEC Core Competencies, and sub-competencies (2016) were/are the roadmap departments/schools were using to help fulfill IPE-related accreditation standards, and to help design and evaluate/assess their IPE programs. Therefore, the IPEC Core Competencies *had* to be nested in whatever we did. The next question was, where do we focus our initial efforts? *When* would IPE and related learning strategies have the most “impact?”



This debate, however, has been specific to graduate-level education and training (i.e., medical school, pharmacy school, physical therapy school, etc.). In recent papers, our research team argued that students were coming to their respective health professions education institutions, and therefore, IPE programs, steeped in anticipatory socialization regarding their own and others’ future health professions. The resulting firmly held stereotypes of health professions were a significant hurdle for IPE faculty to overcome in their attempts to not only dispel negative perceptions but also foster team-based thinking and communication, and mutual respect (Michalec et al. 2017a; 2017b). We noted that a novel

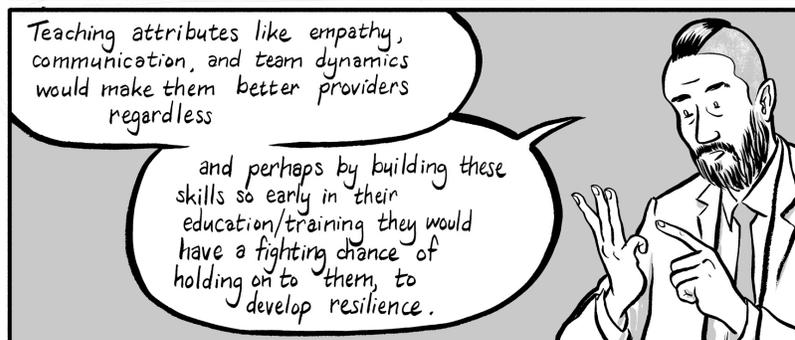
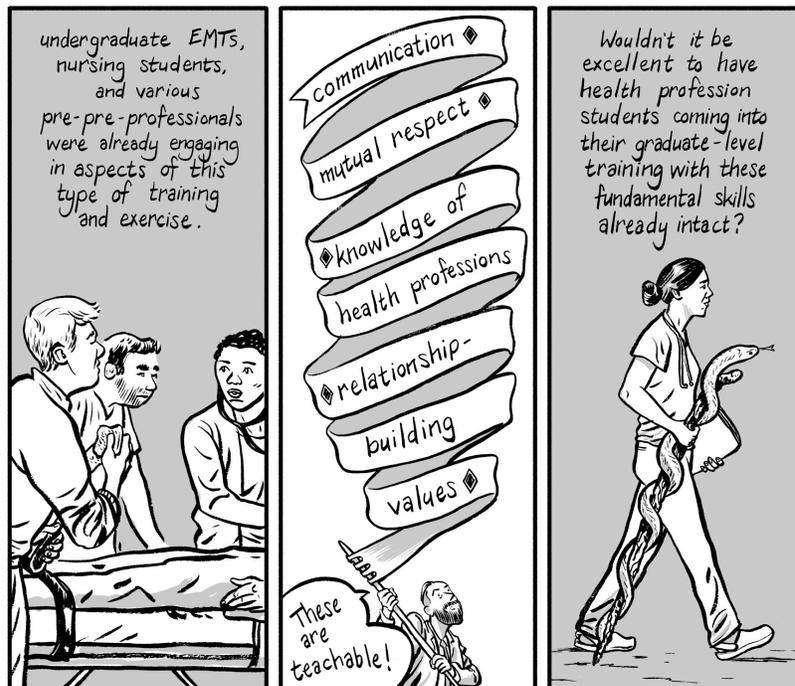
approach would be to not only utilize the formal aspects of IPE to engage student with the competencies, but also the informal aspects – the times and space students came together before the IPE program began, in the hallways, in study groups, at lunch, etc. Students stated that these were instances of where they were *actually* learning about their colleagues from the other health professions (Michalec et al., 2017b). To these students, the sense of team and collaboration being taught in the formal aspects of their IPE program felt forced, and in turn they were hesitant to internalize IPE values. Furthermore, whereas a majority of the IPE-based literature on the contact hypothesis had focused on the Mutual Intergroup Differentiation model of cognitive group representation, we argued that IPE leaders and scholars should also be utilizing the Personalization and Common In-Group Identity models to explore how students may embrace a professional identity *and* an interprofessional identity (Michalec et al., 2017b). Put simply, there were venues and processes that were ripe for IPE-based teaching/learning strategies but were not being heavily utilized or explored.

Furthermore, nursing students were clearly engaging in professional-level education and training at the undergraduate/college-level. Moreover, as an advisor of the pre-med students, I knew that these pre-professionals had to engage significantly with their future profession by junior/senior year of their undergraduate/college years. Adams et al. (2006) show that professional identity formation is evident before students begin their graduate-level (i.e., post-baccalaureate) education and training. Utilizing Goldie's (2012) framework on professional identity formation processes (among medical students), it could be argued that, in fact, professional identity formation was happening among various health pre-professionals (e.g. pre-PT, pre-OT, pre-speech pathology, pre-PA, etc.) because of their intense focus on their future profession through specific course work as well as admission-based requirements such as shadowing, preceptorships, research, and practicums (Michalec et al., 2018). However, despite this professional relevance in the undergraduate/college years, a majority of IPE programming was nested within the graduate-level.



It all started to take shape: a.) At root, the IPEC Competencies were basic, fundamental traits, behaviors, and knowledge that could be taught (at least the seeds could be sown) b.) professional development

was starting in the undergraduate years for at least some (if not most) of the health professions, c.) previous research showed that graduate-level IPE could feel forced into already saturated curricula, and, d.) there was evidence of anticipatory socialization of students entering their graduate-level training that negatively impacted the internalization of IPE values.



This was a gap in the IPE competency continuum, a lack of IPE at the undergraduate/college level – a lack of an “IPE pipeline” - and therefore this would be CIDER’s primary initiative, integrating IPE at the undergraduate/college level.

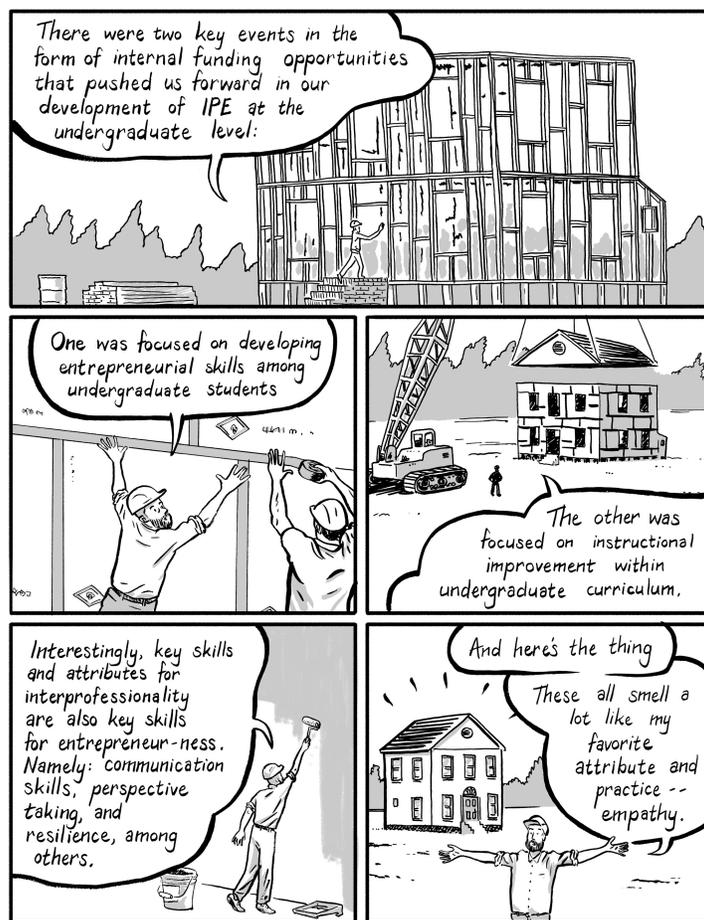
Of the current (albeit remarkably few) college-level IPE programs² in existence, they include not only specific IPE-designated courses, but IPE-designated minors and majors, service and community-based learning opportunities, and clinical exposure experiences. Interestingly, a majority of the offerings of IPE at the undergraduate-level appear to operate as their own entity, with their own designation and own course call numbers as though IPE was in fact its own department. Although I understood the design of these types of programs, I felt that such a structure further segregated the health disciplines, and thus another example where health pre-professionals were distanced (physically, scholastically, and socio-emotionally) from non-health pre-professionals (Michalec, 2012). Perhaps it could be effective to utilize what was already in play at my current institution rather than build an entirely separate department, major, or curricular path? I knew that if I wanted students and faculty to really take IPE seriously and be able to show a specific “pipeline” into graduate-level IPE, I would certainly have to have some sort of evidence that students were indeed exposed to (i.e., taught) the competencies in a formal manner. And if so, why reinvent the wheel?



² It is important to note that many of these institutions also have graduate- and professional-level IPE Programming as well.

For decades IPE scholars have been evaluating and assessing courses, programs, and sessions that call themselves “IPE”. These affairs can range from multiple courses over multiple years to seminars that last mere hours, and vary immensely in regards to structure, approach, framework (e.g., simulation exercises, reflection-based, PBLs, service-learning, etc.), and degree of dedication to IPE competencies. Yet, they all appear to cut the IPE mustard. Given this extensive variety, I struggled to find what specific ingredients had to be present in a course or a program to make it officially count as IPE. Clearly, IPE was not a one-size-fits-all due to the nature of various health professions education institutions and their respective schools/departments (and financial situations). I knew that more and more health profession education institutions had to showcase their IPE learning to pass their own specific accreditation standards – so I looked there. I also needed to explicitly formulize ways in which CIDER would integrate IPE into the undergraduate curriculum, and for that we would need funding.

As Brashers, Owen, & Haizlip (2015: 96) state, “Garnering significant external funding can be a key step in increasing institutional visibility, promoting faculty scholarship, expanding programs, and recruiting new IPE champions.” External funding is super, but when you’re just starting out it may be easier to go for “quick wins” (Kotter, 2012), and for me, those opportunities came in the form of potential *internal* funding.



Spoiler alert: (most) health profession students lose empathy during their education and training (Hojat et al., 2009; Michalec, 2010; Nunes et al. 2011; Ward et al., 2012). What if we tried to teach undergraduate health pre-professions students empathy and the ability to recognize affective (i.e., emotional) states so they could possibly be even better at empathic communication (because they would be more keen to recognize certain displays of emotional states)? What if, by training undergraduate health pre-professionals in affect recognition and empathy they built empathic resilience so that when they encountered challenging barriers and hurdles they had some sort of emotio-cognitive fortitude and were able to persevere? What if this training was purposeful in its intent to register students from varying health pre-professions and included opportunities to learn with, about, and from each other, and engaged students in aspects of the core competencies? Formal training in empathy (in healthcare settings) is available thanks to Helen Reiss's *Empathetics* (<http://empathetics.com/>), and Paul Ekman's, the guru of affect recognition, development of training modules to enhance our ability (and perhaps willingness) to better understand what emotions others are experiencing (<https://www.paulekman.com/micro-expressions-training-tools/>). But these training modules should be taken individually. Therefore, the key was creating opportunities for students to learn with, from, and about each other - and certain teaching/learning strategies often employed in IPE programs fit perfectly with this type of program, notably experiential learning, reflection, simulation, and shared assignments and didactics. Also, we would utilize *informal* spaces to enhance the opportunities for these health pre-professionals to learn about and with (and perhaps even from) each other, specifically art museums, coffee shops, and newly designed study spaces. This course would be CIDER's first official curricular offering.

So you might be asking yourself, "But didn't he say he wasn't reinventing the wheel?" Yes, the empathy and affect recognition course is indeed a newly designed course that will be purposely *interpre*-professional – but this course is just one small piece of a plan to integrate IPE-based learning strategies into the majority of health pre-professions education at the University (*insert maniacal laugh here). The instructional improvement grant provided the opportunity to corral a sub-group of CIDER members (i.e., a "Faculty Learning Community" (Cox, 2004) whose main objective would be to explore if and how to integrate IPE at the undergraduate level, and pilot certain IPE-based strategies within specific courses. This grant not only bought time, it bought space to think this through with fewer cooks in the kitchen. The "Faculty Learning Community" (FLC) would be charged with integrating (and, in turn, sustaining) IPE-based teaching and learning strategies (Oandasan & Reeves, 2005) at the undergraduate level of the CHS curriculum in order to cultivate and promote specific behaviors and attributes among health pre-professionals. The plan is three-fold: 1.) Examine and explore methods and techniques to effectively implement and integrate IPE at the undergraduate level, 2.) Identify 3-5 "IPE-friendly" CHS undergraduate courses (diverse student body of health pre-professionals) to be offered in Spring 2018 to implement specific IPE-based teaching/learning opportunities, and construct a pilot-study (i.e., evaluation and assessment protocol), and 3.) Develop outline of a future training seminar (and related online toolkit) for faculty, instructors, and teaching assistants to encourage integration of IPE strategies into their courses. The strategies we are exploring are commonly found in many IPE programs showcased in previous research (e.g., experiential, simulation, observation-based, appreciative inquiry, group-based/shared, exchange-based, among others), and the primary goal is to nest certain strategies in already offered courses that tend to have various health pre-professionals registered. We will work with the instructors and TAs of those courses, oversee/guide the implementation of the strategies, and construct and administer respective evaluation and assessment protocols. By working with the current

curricular structure we are not adding to the already burdened requirements, we are not forcing students to “do” something in addition to everything else they have to do, and we’re making it a part of the entirety of the students’ academic experience, not something they can choose to take as an elective – and we believe this type of approach to integration will work effectively at the undergraduate level. Our current debate is the feasibility and benefit (to students) of an IPE certificate program.

We believe that with this approach we will have health pre-professionals graduating from our University with the fundamentals, the basics, in IPE. These students will be able to hit the ground running with any IPE program offered at their graduate education/training institution. We believe that because of their previous exposure to and engagement with IPE these students will be more willing and able to embrace collaborative and team-based care. With the planned integration of IPE learning strategies into the majority of CHS undergraduate curriculum as the scaffolding, and the empathy and affect recognition class, as well as an Introduction to Interprofessional Education and Care course, and an Ethics in Health and Healthcare course (both in development) as the cornerstones, our initiative of IPE at the undergraduate level is novel, creative, fundamentally sound and grounded, and most importantly the potential for significant impact on the future healthcare workforce.

I wanted to offer this case-story and present it in an auto-ethnographic framework, to be honest and transparent in the process(es) of building an IPE program at a particular University.



In writing it, I realized I was fueled by a lot of inner strife and conflict - which I wasn't necessarily fully aware of at the time I accepted the position.



A key turning point was when the School of Nursing asked for a presentation of my vision

and key pushes in the development process were related to funding opportunities



Of course I understand that the situation at this University regarding interest in IPE administration among, specific departments and schools, and resource/effort allocations is/may be quite different than at other institutions -



- but perhaps this story has offered some form of roadmap for those in similar situations--

You're not alone!



PART 1
of this case-story has focused on how our team explored IPE at the undergraduate level.



PART 2
will explore our current efforts in Simulation-based learning and IPE at the graduate level.

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