The Readiness for Interprofessional Learning Scale (RIPLS): A problematic evaluative scale for the interprofessional field

Cornelia Mahler, Sarah Berger & Scott Reeves

To cite this article: Cornelia Mahler, Sarah Berger & Scott Reeves (2015) The Readiness for Interprofessional Learning Scale (RIPLS): A problematic evaluative scale for the interprofessional field, Journal of Interprofessional Care, 29:4, 289-291, DOI: 10.3109/13561820.2015.1059652

To link to this article: http://dx.doi.org/10.3109/13561820.2015.1059652

Published online: 15 Jul 2015.
EDITORIAL

The Readiness for Interprofessional Learning Scale (RIPLS): A problematic evaluative scale for the interprofessional field

Cornelia Mahler¹, Sarah Berger¹, and Scott Reeves²

¹Department of General Practice & Health Services Research, University of Heidelberg, Germany and ²Centre for Health & Social Care Research, Kingston University & St George’s, University of London, UK

Introduction

Reliable instruments are vital to measure interprofessional education (IPE) and to assure quality. Globally, the interprofessional field has, for the past 20 years or so, been designing and developing instruments to measure the impact of IPE across various educational and healthcare settings. These results can be used to benchmark and compare results on a national and international level in order to promote best practice interventions and improve IPE approaches. One of the first instruments developed to measure attitudes of students towards interprofessional learning was the Readiness for Interprofessional Learning Scale (RIPLS) (Parsell & Bligh, 1999). In this editorial, we argue that despite the continuing use of RIPLS, there remain a number of fundamental problems with this particular evaluative scale.

Development and dissemination of RIPLS

Researchers welcomed the RIPLS, which at the time was a first in a newly emergent field. It was produced using a sound methodological process including a literature search, an expert panel and a review process (Parsell & Bligh, 1999). At this early stage, these authors recognized the need for instrument development and when presenting their pilot study results mentioned the low internal consistency values of two of their subscales and the need “to confirm the scale as an instrument which might record shifts in attitudes” (Parsell & Bligh, 1999, p. 99).

Being the first instrument to measure attitude towards IPE, “early uptakers” in this emerging field started applying the instrument without retesting psychometrics of the instrument (Baxter, 2004; Hind et al., 2003; Horsburgh, Lamdin, & Williamson, 2001). These early publications lead to further uptake and dissemination, despite the acknowledged issues with internal consistency values of the subscales. Being one of the few researchers who performed testing of the instrument, McFadyen et al. (2005, p. 602) pointed out, “with such information readily available, it is surprising that some researchers have opted to employ RIPLS without it being more rigorously tested”. The popularity of the instrument is easily illustrated with the number of hits in electronic databases such as PubMed and CINAHL and the steady increase in publications. In addition, ongoing use and publication of the RIPLS has given rise to researchers translating the instrument into other languages and applying it in other settings and cultural contexts. There is now gathering evidence that both of the originally existing issues still remain and new problems seem to be emerging.

Problems with the scale

Based on current evidence, three key problems with the RIPLS need to be highlighted. The first aspect is the psychometrics. An initial glance at RIPLS shows that internal consistency (Cronbach’s alpha) seems to be satisfactory in the overall scale of the English version (Coster et al., 2008; Rose et al., 2009) and in most of the translations (Cloutier, Lafrance, Michallet, Marcoux, & Cloutier, 2015; Mahler, Rochon, Karstens, Szecsenyi, & Hermann, 2014; Simin, Milutinovic, Brestovacki, Andrijcic, & Cigic, 2010; Tamura et al., 2012). However, it becomes problematic when looking at the item-level and the subscale results. In particular, the Roles and Responsibilities subscale is problematic and unstable, with Cronbach’s alpha values mostly below 0.43 (King et al., 2012; McFadyen et al., 2005; McFadyen, Webster, & Maclaren, 2006; Morison, Marley, Stevenson, & Milner, 2008; Parsell & Bligh, 1999), which has even led researchers in some cases to omit this scale in the analysis of their data (Braithwaite et al., 2013; Ritchie, Dann, & Ford, 2013).

In addition, the underlying factor structure of the RIPLS shows further problems. Only the study by King et al. (2012) could confirm the underlying factor structure as suggested by McFadyen et al. (2005). At the same time, however, it also revealed weak internal consistency in the Roles and Responsibilities subscale. To date, most studies publishing data on exploratory or confirmatory analysis of the RIPLS show too much variation in factor structure. This variation has caused researchers to add and/or rearrange items and re-label subscales with individual labels for subscales such as Team Player (Wilhelmsson, Ponzer, Dahlgren, Timpka, & Faresjo, 2011) Interprofessional Education Opportunities, Uniqueness of Profession (Tamura et al., 2012) or Patient-centredness (El-Zubeir, Rizk, & Al-Khalil, 2006; Reid, Bruce, Allstaff, & McLernon, 2006). Others have ‘slightly modified’ the wording of the original version (Margalit et al., 2009; Snyder, Meyer, McGivney, & Smith, 2010) without testing possible effects on psychometrics. For this reason, it must be questioned, what the RIPLS instruments are actually measuring (Mahler et al., 2014).

This leads to the second key criticism of the RIPLS scale in its current version. The problems with the factor structure variation
highlight the fact that we do not know exactly what we are measuring with this instrument. In our opinion, the explanation for the problems identified with the construct validity is due to the lack of a sound theoretical framework at the time of its original development.

At the same time, interestingly, this early instrument contained first targets in terms of interprofessional competencies. The subscales of the RIPLS parallel individual aspects of the recently developed interprofessional competencies frameworks of the CIHC (Canadian Interprofessional Health Collaborative, 2010) and IPEC Expert Panel (Interprofessional Education Collaborative Expert Panel, 2011). The discussed deficits in the RIPLS instrument strengthen the rationale for more work and research in development of the theoretical foundation for IPE and collaboration to guide what we measure and evaluate (Thannhauser, Russell-Mayhew, & Scott, 2010).

A third problem lies in the attempt to measure an attitude which, as assumed from the title, still needs to be developed: Readiness for Interprofessional Learning. The use of the word “readiness” in the title raises the question of how students, who do not know what they need to learn and which attitudes they need to develop, can be expected to judge this. Parsell and Bligh (1999, p. 99) mention the intention for their developed instrument, “at this early stage, however, we believe in the relevance of the instrument, and that it can be used by teachers and students to explore attitudes and perceptions towards shared learning”. Furthermore, they maintain that “there is a need to measure the effectiveness of shared learning activities at different times which would provide evidence of changing attitudes” (Parsell & Bligh, 1999, p. 99). It is acknowledged that an instrument is necessary to measure change in attitudes, however it is also stated that it is not clear if the RIPLS can measure a change in attitude, and if so, which reference ranges are to be assumed.

This notwithstanding, RIPLS has been applied as a pre- and post-intervention measure (Bradley, Cooper, & Duncan, 2009; Sheu et al., 2012), although it was only developed (and tested so far) to assess ‘readiness’—whatever this construct means in this instrument—prior to an IPE experience. As a result, the RIPLS in its present version cannot be regarded as a sound instrument to be used to compare and benchmark findings. Moreover, it can also not be used to assess or improve IPE interventions based on results produced. This leaves two possibilities for the future: to keep using the RIPLS in awareness of all the underlying problems (not recommended) or to choose a different instrument to measure specific interprofessional outcomes, which we recommend. (There is of course also a third option—a refinement of the tool; however this cannot be done without grounding it on a new or existing theoretical framework).

Importantly, other instruments are now available. A wide range of instruments have been developed and adapted in the past few years for the measurement of individual aspects of interprofessional learning activities and interprofessional competencies. It seems to be more appropriate to apply individual scales to measure different interprofessional competencies. If in need of a quantitative measurement tool, existing tools should be screened and psychometrics for the appropriate setting should be verified. A wide range of tools are available on the website of the US National Centre for Interprofessional Practice and Education (https://nexusipe.org/measurement-instruments) as well as from the Canadian Interprofessional Health Collaborative (CIHC, 2012).

Concluding comments

Parsell and Bligh (1999) developed an early instrument to measure attitudes of students towards IPE. As discussed, the piloted instrument showed potential problems from the start, which were also identified by the authors. These problems were initially overlooked by researchers in quick need of an instrument. Meanwhile it seems that the RIPLS, due to its establishment, has continued to be applied without substantial further testing. The remaining problems in the psychometrics and factor structure of the instrument nevertheless mean we do not really know what it is that we are measuring when applying the RIPLS and nor can we accurately benchmark or compare results. Fortunately, in the meantime, a vast number of instruments have been developed and adapted to measure different aspects of interprofessional competencies. The fact that a specific instrument is applied often does not automatically mean it is the best. Newer instruments that are grounded on theoretical frameworks and represent defined concepts are recommended. Therefore, it is well advised to look closely and critically at existing psychometrics published as well as underlying theoretical frameworks to verify the suitability of the instrument for the purpose needed in the interprofessional field.

Declaration of interest

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

Note

1. Parsell & Bligh employ the term ‘shared learning’ instead of interprofessional education. At the time of publishing their 1999 paper, shared learning was a popular term in the literature. Over time, it has been replaced with a more consistent use of interprofessional education.

References


