NEW STRATEGY IN EDUCATION OF HEALTH PROFESSIONALS IN SERBIA:
ANALYSIS OF STUDENTS’ READINESS FOR INTER-PROFESSIONAL EDUCATION

NOVA STRATEGIJA U OBRAZOVANJU ZDRAVSTVENIH PROFESIONALACA U SRBIJI:
ANALIZA SPREMNOSTI STUDENATA ZA INTERPROFESSIONALNU EDUKACIJU

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Summary

Introduction. Inter-professional education is the first step towards the effective collaborative practice of future health care workers and one of the prerequisites for the highest quality health care. Therefore, the aim of this study was to assess the readiness for inter-professional education among medical science students. Material and Methods. The research was conducted as a descriptive cross-sectional study by surveying 406 students of five study profiles at the Faculty of Medicine at the University of Novi Sad. The Serbian version of The Readiness for Inter-professional Learning Scale and questionnaire on sociodemographic data were used as research instruments. The Readiness for Inter-professional Learning Scale comprises a total of 19 items grouped into two sub-scales: “teamwork, collaboration and shared learning” and “role and responsibilities”. The methods of descriptive and inferential statistics were used, and statistically significant values were considered significant at the p <0.05 level. Results. The mean the Readiness for Inter-professional Learning Scale total score was 73.9, which indicates that students are generally ready for shared learning. The highest scores, that is, greater readiness for inter-professional learning was among physiotherapist students, female students and those who had previously completed secondary medical school. Medical students had significantly more negative attitudes towards this educational strategy. Conclusion. Despite the observed differences, attitudes of the majority of students in relation to all study profiles indicate their readiness to accept inter-professional education.

Key words: Education, Public Health Professional; Serbia; Students, Nursing; Attitude of Health Personnel; Inter-professional Relations; Cooperative Behavior

Sažetak

Uvod. Interprofesionalna edukacija je prvi korak ka efektivnoj kolaborativnoj praksi budućih zdravstvenih radnika i preduslova je najvišeg kvaliteta zdravstvene zaštite. Stoga je cilj ovog istraživanja bio da se proceni spremnost studenta medicinskih nauka prema interprofesionalnoj edukaciji. Materijal i metode. Istraživanje je sprovedeno kao deskriptivna studija preseka anketiranjem 406 studenata pet studijskih profilac Medicinskog fakulteta Univerziteta u Novom Sadu. Kao instrumenti istraživanja koristili su se srpska verzija Skala spremnosti za interprofesionalnu učenje (The Readiness for Interprofessional Learning Scale) i upitnik o sociodemografskim podacima. Skala spremnosti za interprofesionalno učenje sadrži ukupno 19 ajmupitanih u dve supskale: „Timski rad, saradnja i zajedničko učenje“ i „Uloge i odgovornosti“. Primjenjene su metode deskriptivne i inferencijalne statistike, a statistički značajnim smatrate su vrednosti nivoa značajnosti p <0.05. Rezultati. Prosečni ukupni skor prema The Readiness for Interprofessional Learning Scale bio je 73,9 što ukazuje da su studenti generalno spremni za zajedničko učenje. Najviši skor, odnosno veću spremnost za interprofesionalno učenje su imali studenti fizioterapije, studenti ženskog pola i oni koji su prethodno završili medicinsku školu. Studenti medicinske su značajno negativnije stave prema ovoj obrazovnoj strategiji. Zaključak. I pored uočenih razlika, stavovi većine studenata svih studijskih profilac ukazuju na njihovu spremnost za prihvatanje interprofesionalne edukacije.

Ključne reči: obrazovanje zdravstvenih profesionalaca; Srbija; studenti zdravstvene nege; stavovi zdravstvenih radnika; interprofesionalni odnosi; kooperativnost

Introduction

In response to all the challenges arising from rapid demographic and epidemiological transitions, modern health care systems are becoming increasingly complex and expensive, and consequently imposing additional requirements onto healthcare professionals [1]. The World Health Organization (WHO) in the Framework for Action on Inter-professional Education & Collaborative Practice identifies inter-professional collaboration in education and practice as an innovative strategy that will play a significant role in addressing the current problems of health workers around the world. As indicated in one of the conclusions of this report, inter-professional education (IPE) is an important step in preparing health professionals to work in a collaborative practice [2]. Inter-professional education as an educational strategy includes interventions where members of more than one health or social care profession, or both, learn interactively together with the aim to improve inter-professional collaboration and patient outcomes [3]. The term collaborative practice involves
collaboration of health workers from different professional backgrounds with patients, their families, and/or their communities to deliver the highest quality of care across settings [2].

When students of medical faculties study traditionally, uni-professionally, only with students from their study group/discipline, with little (or no) opportunities to learn with students from other groups/disciplines they are deprived of a chance to get to know what students from other professions know and their ways of thinking. In addition, in this kind of educational system, stereotypes about other professions can be developed which form barriers in the effective delivery of comprehensive care for patients [4]. Due to fragmented, outdated and static curricula vocational education produces “ill-equipped graduates” with systemic problems such as mismatch of competencies to solve patient problems, poor teamwork and a narrow technical focus without broader contextual understanding. However, the development of most of these problems comes from the so-called tribalism of the professions or the tendencies of various professions to act in isolation from or even in competition with each other [1]. On the contrary, the results of the research collected over more than five decades indicate that the IPE provides effective collaborative practice that optimizes health services, strengthens the health system and improves health outcomes [2].

Despite being internationally recognized as an important educational strategy, the integration of IPE into the standard curriculum remains a significant challenge [5]. Numerous barriers in implementation and achievement of positive IPE outcomes are described in the literature, and students’ baseline attitudes such as stereotyping and prejudice are often cited as the biggest barrier of all [6–8]. Negative students’ attitudes can be a major barrier in the learning process, and it is important to know the concept of “the readiness for IPE”, that is, to assess students’ attitudes towards IPE because it underlies the essence of accepting this educational strategy [8]. The implementation of IPE requires a rigorous assessment that must start at the very beginning of curriculum development process [9, 10]. The Readiness for Inter-professional Learning Scale (RIPLS) is often used to assess students’ readiness for IPE [9, 11].

The initiative to introduce the strategy of inter-professional learning and innovate traditionally, uni-professionally and biomedically oriented higher education of health professionals in Serbia started in 2015. This initiative is a part of activities under Erasmus + KA2 project titled “Reinforcement of the Framework for Experiential Education in Healthcare in Serbia” (ReFEEHS) [11].

Considering the above mentioned, the aim of this study was to assess the readiness of students of different study profiles towards IPE, based on the analysis of their attitudes.

**Material and Methods**

**Study Design and Participants**

The survey was conducted as a cross-sectional study by interviewing the students at the Faculty of Medicine of the University of Novi Sad during October and November 2016. The study included students of five study profiles: integrated study of medicine, pharmacy and dentistry, basic academic studies of nursing and physiotherapy. The criterion for choosing the year of study was that students started their clinical practice in actual settings.

**Instrument**

The Serbian version of The Readiness for Inter-professional Learning Scale (RIPLS) was used as a research instrument [12]. The authors of the original 19-item scale, Parsell and Bligh, used a 5-point Likert scale for evaluation, from 1 = strongly disagree to 5 = strongly agree [12]. The total score on the scale ranges from 19 to 95, with a higher score indicating more positive attitudes and greater students’ willingness towards inter-professional learning [13, 14].

The validity of RIPLS, i.e. its factor structure was not the same in various contexts and cultures [4, 9, 11]. The Serbian version of RIPLS, based on the results of exploratory factor analysis, confirms a two-factor structure. The subscales of “teamwork, collaboration, shared learning” and “role and responsibilities” were singled out [11].

**Procedure**

The research was conducted at the start of the theory class in the lecture rooms of the Faculty of Medicine. The authors contacted the subject teachers of all study profiles and jointly determined the best period for conducting the research. The authors first briefly presented the concept of inter-professional learning to the students, then they explained the purpose of the research and how to fill in the questionnaires. All present students were invited to participate in the research. The questionnaire was distributed in paper form, and the planned amount of time for filling it out was 20 minutes.

**Data Analysis**

The Statistical Package for Social Sciences, version SPSS 23, was used for statistical data processing. Only questionnaires completely filled-in were processed statistically. The reliability of RIPLS was analyzed using the Cronbach’s alpha (α) coefficient. Descriptive and inferential statistics were applied.

Demographic data and results for each statement in the RIPLS scale were analyzed by means of descriptive analysis including frequency, percentage, mean and standard deviation (SD). In order to calculate the RIPLS total score, the responses were first reversed for the statements with negative connotation [6, 11, 14]. Mean total scores and subscale scores were compared by t-test for two different groups. Mean values
obtained from several different groups were compared using the one-way analysis of variance (ANOVA) with Tukey’s post hoc test. A partial eta squared ($\eta^2$) and Cohen’s d coefficient were used to determine the magnitude of the impact. Multivariate linear regression was used to identify factors that affect the total RIPLS score. Standardized beta coefficient was used to discriminate the effects of each factor. By calculating the semi partial correlation coefficients, a unique contribution of each factor was established. Statistically significant values were considered significant at the $p < 0.05$ level.

### Results

Out of 406 students included in the study, 377 (92.9%) answered all questions. All questions were answered by 96.4% of student pharmacists (that being the highest percentage), 93.0% of physiotherapy students and 92.6% of nursing students. A slightly lower percentage of dentistry students (89.6%) responded to all questions in the questionnaire and the lowest response was among medical students (88.3%). Distribution of demographic data for the whole sample as well as in relation to the study program is given in Table 1.

The value of Cronbach’s alpha for the RIPLS scale on the whole was 0.87 with the optimal mean inter-item correlation (0.34). Internal consistency was confirmed for the teamwork, collaboration and shared learning subscales ($\alpha = 0.93$), whereas a mean inter-item correlation of 0.44 indicated that the correlation between items was strong. Although the value of the Cronbach’s alpha for role and responsibilities was small (0.44), the mean inter-item correlation was 0.21, which is acceptable for a scale with fewer items.

### Table 2. Mean scores for each RIPLS item

| Item/Tvrdnja | All Students | Medicine | Nursing | Dentistry | Pharmacy | Physiotherapy |
|--------------|--------------|----------|---------|-----------|-----------|---------------|
| M ± SD       | M ± SD       | M ± SD   | M ± SD  | M ± SD    | M ± SD    | M ± SD        |

Learning with other students will help me become a more effective member of a health care team/ Učenje sa studentima drugih studijskih profila pomoći će mi da postanem efikasniji član zdravstvenog tima

Patients would ultimately benefit if health-care students worked together to solve patient problems/Pacijenti bi imali korist ako bi studenti različitih studijskih profila radili zajedno

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Shared learning with other health-care students will increase my ability to understand clinical problems
Zajedničko učenje sa studentima drugih studijskih profila povećalo bi moju sposobnost da shvatim klinički slučaj
Learning with health-care students before graduation would improve relationships after graduation/Učenje sa studentima drugih studijskih profila pre diplomiranja poboljšalo bi odnose posle diplomiranja
Communication skills should be learned with other health-care students/Komunikacijske veštine bi trebalo da se uče zajedno sa studentima drugih studijskih profila
Shared learning will help me to think positively about other professionals/Zajedničko učenje sa studentima drugih studijskih profila će mi pomoći da razmišljam na pravi način o svim zdravstvenim profesionalcima
For small group learning to work, students need to trust and respect each other/U malim grupama koje uče da radite, studenti treba da razvijaju poverenje i međusobno poštovanje
Team-working skills are essential for all health care students to learn/Veštine timskog rada studenti svih studijskih profila treba da nauče pre diplomiranja
Shared learning will help me to understand my own limitations/Zajedničko učenje sa studentima drugog studijskog profila će mi pomoći da razumem sopstvene mogućnosti i ograničenja
I don’t want to waste my time learning with other health-care students/Ne želim da gubim svoje vreme učeći sa studentima drugih studijskih profila
It is not necessary for undergraduate health-care students to learn together/Nije neophodno da studenti različitih studijskih programa zdravstvenih nauka uče zajedno
Clinical problem-solving skills can only be learned with students from my own department/Veštine rešavanja kliničkih problema mogu se jedino učiti sa studentima sopstvnog studijskog profila
Shared learning with other health-care students will help me to communicate better with patients and other professionals/Zajedničko učenje sa studentima drugih studijskih profila pomoći će mi da bolje komuniciram sa pacijentima i ostalim stručnjacima
Clinical problem-solving skills can only be learned with students from my own department/Pozdravio/la bih mogućnost da učestvujem u nekim opštim predavanjima ili radionicama sa studentima drugog studijskog profila
Shared learning with other health-care students will help me to communicate better with patients and other professionals/Zajedničko učenje sa studentima drugih studijskih profila će mi pomoći da razjasnim suštini zdravstvenih problema pacijenata
Shared learning before graduation will help me become a better team worker/Zajedničko učenje sa studentima drugih studijskih profila će mi pomoći da postanem bolji timski radnik
The function of nurses and therapists is mainly to provide support for doctors/Uloga medicinskih sestara je uglavnom da obezbede podršku za doktore
I’m not sure what my professional role will be/Nisam siguran/a šta je i šta će biti moj profesionalni zadatak
I have to acquire much more knowledge and skills than other health-care students/Moram usvojiti mnogo više znanja i veština nego studenti drugog studijskog profila
skills should be taught to students of all study programs before graduation. As for their future professional roles and responsibilities, students of medicine and dentistry were the most confident of all.

The mean score for the teamwork, collaboration and shared learning subscale was 64.2 (SD = 9.6), and 9.5 (SD = 2.3) for the role and responsibilities subscale, while the mean RIPLS total score was 73.9 (SD = 10.5) (Table 2). Significant differences were found among the students of different study programs regarding the value of the mean RIPLS total score ($F(4,372) = 21.11, p = 0.000$). Subsequent comparisons using the Tukey’s HSD test showed that only mean score of medical students (M = 68.0, SD = 11.5) differed from the students of other study programs, and the difference was big according to Cohen’s indicator.

Significantly more positive attitudes towards inter-professional learning were among females ($t(375) = -5.67, p = 0.000$) and students who had previously completed secondary medical school ($t(375) = -2.67, p = 0.008$). Although the differences in the total score ($F(375) = 21.11, p = 0.000$). Subsequent comparisons using the Tukey’s HSD test showed that only mean score of medical students (M = 68.0, SD = 11.5) differed from the students of other study programs, and the difference was big according to Cohen’s indicator (Table 3).

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**Table 3. RIPLS scores: differences in relation to students’ demographic characteristics**

| Demographic characteristics | Total RIPLS/UKUPNI RIPLS | TC & SL/TRS & ZU | R & R/U & O |
|----------------------------|-------------------------|-----------------|----------|
| Demografske karakteristike | M ± SD | 95% CI | M ± SD | 95% CI | M ± SD | 95% CI |
| All students/Svi studenti (n=377) | 73.9 ± 10.5 | 72.9 | 74.9 | 64.2 ± 9.6 | 63.2 | 65.2 | 9.5 ± 2.3 | 9.4 | 9.8 |
| Study group/Studijska grupa | | | | | | |
| Medicine/Medicine | 68.0 ± 11.5 | 66.1 | 70.0 | 59.1 ± 11.1 | 57.2 | 61.1 | 8.8 ± 2.3 | 8.4 | 9.2 |
| Nursing/Sestrinstva | 77.2 ± 8.9 | 74.7 | 79.7 | 66.5 ± 8.6 | 64.1 | 69.0 | 10.5 ± 2.3 | 9.8 | 11.2 |
| Dentistry/Stomatologije | 76.1 ± 8.3 | 74.2 | 78.0 | 65.6 ± 7.2 | 64.0 | 67.6 | 10.3 ± 2.0 | 9.7 | 10.8 |
| Pharmacy/Farmacije | 77.8 ± 7.7 | 76.1 | 79.6 | 68.1 ± 7.3 | 66.4 | 69.8 | 9.6 ± 2.1 | 9.1 | 10.1 |
| Physiotherapy/Fizioterapije | 78.2 ± 7.5 | 75.6 | 80.6 | 68.5 ± 7.0 | 66.1 | 70.6 | 9.7 ± 2.4 | 8.8 | 10.5 |

| Gender/Pol | | | | | | |
| Male/Muški | 69.1 ± 12.3 | -9.3 | -3.8 | 60.1 ± 11.9 | -8.2 | -3.1 | 8.9 ± 2.4 | -1.5 | -0.5 |
| Female/Ženski | 75.7 ± 9.0 | 65.7 | 8.4 | 9.9 ± 2.3 | |

| Previously completed education/Prethodno završena škola | | | | | | |
| Grammar School/Gimnazija | 72.2 ± 9.7 | -5.1 | -0.7 | 62.3 ± 9.2 | -4.3 | -0.3 | 9.1 ± 2.1 | -4.3 | -0.3 |
| Secondary Medical school Medicinska škola | 75.1 ± 10.8 | 65.1 | 9.9 | 9.9 ± 2.3 | |

| F (df), p-value | 21.11 (4, 372), 0.000 | 18.08 (4, 372), 0.000 | 8.73 (4, 372), 0.000 |
| F (df), p-value | 21.11 (4, 372), 0.000 | 18.08 (4, 372), 0.000 | 8.73 (4, 372), 0.000 |
| F (df), p-value | -5.67 (375), 0.000 | -4.39 (375), 0.000 | -3.67 (375), 0.000 |
| F (df), p-value | -5.67 (375), 0.000 | -4.39 (375), 0.000 | -3.67 (375), 0.000 |
| F (df), p-value | -2.67 (375), 0.008 | -2.25 (375), 0.025 | -2.50 (375), 0.012 |
| F (df), p-value | -2.67 (375), 0.008 | -2.25 (375), 0.025 | -2.50 (375), 0.012 |
| F (df), p-value | 0.02* | 0.01* | 0.02* |
| F (df), p-value | 0.02* | 0.01* | 0.02* |
| F (df), p-value | 0.02* | 0.01* | 0.02* |

| TC&SL = teamwork, collaboration and shared learning; R&R = role and responsibility; M = mean; SD = standard deviation; CI = Confidence interval; F = ANOVA; t = t-test; df = degrees of freedom; $\eta^2$ = eta squared; $d$ = Cohen’s d indicator (*small effect; ** medium effect; † large effect); TRS & ZU = timski rad, saradnja i zajedničko učenje; U & O = uloge i odgovornosti, M = prosek; SD = standardna devijacija; CI = Interval poverenja; F = ANOVA; t = t-test; df = stepen slobode; $\eta^2$ = eta kvadrat; d = Cohen indikator (* mala; ** srednja; † velika) |

**Table 4. Multiple linear regression model for the prediction of the RIPLS total score**

| Unstandardized coefficient | Standardized coefficient |
|---------------------------|-------------------------|
| Nestandardizovani koeficijent | Standardizovani koeficijent |
| $\beta$ | SE | $\tau$ | Beta |
| Constant/Konstanta | 55.243 | 2.535 | 24.794 | 0.000 |
| Gender/Pol | 5.269 | 1.107 | 0.224 | 4.761 | 0.000 |
| Study group/Studijska grupa | 2.387 | 0.347 | 0.325 | 6.875 | 0.000 |
| Previously completed education/Prethodno završena škola | 2.143 | 0.996 | 0.100 | 2.151 | 0.032 |
mean RIPLS total score and both subscales were statistically significant. Cohen’s indicator points to a medium or small effect of these variables.

In Table 4, the results of standard multiple linear regressions show that all three independent variables were significantly related to the total RIPLS score. Based on the values of beta coefficients, it is noted that the study program (beta = 0.325, p = 0.000) individually contributes the most to the explanation of the RIPLS score. The multiple regression analysis model explains 19.8% (adjusted $R^2 = 19.2\%$) variance of the overall RIPLS score. A further analysis calculated semi partial correlation coefficients, which was the basis to determine the unique contribution of each independent variable. The obtained results indicate that 12.5%, 4.9 and only 1% of the variance value of the total RIPLS score was accounted for by the study program, gender, and previously completed school, respectively.

Discussion

The implementation of IPE as an educational strategy requires overcoming many structural and organizational barriers, but it is difficult to alter ambivalent or negative students’ attitudes [2, 4, 5]. Making this alteration is also one of the primary objectives in planning IPE outcomes aimed at improving teamwork and developing collaborative practice [4, 5, 7]. Therefore, the assessment of the students’ baseline attitudes is significant for the initial steps towards integration of this educational strategy into curricula [4, 5].

Students’ attitudes among five educational profiles in this study, assessed by RIPLS, indicate students’ readiness for IPE. Similar results were obtained in previous studies as well [4–9, 11–18]. Accordingly, there were differences among students’ attitudes based on their study profile both in our study and studies conducted in other countries [4, 6, 7, 11–20]. Namely, medical students were less open towards IPE, while nursing, pharmacy, and physiotherapy students demonstrated greater readiness for IPE.

The results of this study show that female students are more ready to accept shared learning. Some authors suggest that these results reflect different learning styles between men and women. Namely, women are more inclined to listen, understand and accept attitudes of other people [6, 11, 18].

Students who previously completed secondary medical school are more prepared for IPE, probably due to longer contact with the actual setting during schooling. However, our results are not comparable with the results of studies conducted in most countries, because their education system is different from the one in Serbia. In these countries, studies at faculties of health and social care are preceded only by general and not vocational medical education.

One of the prerequisites for this research was that students started lectures on clinical subjects, i.e. in a real clinical setting. This is important because teamwork prevails in such a setting, whereby a team comprises different professionals, with varying number of members, a collaboration time frame, circumstances under which they were formed and the way they solve their common task. It is important to emphasize that most students of all profiles fully agreed with statements which indicated the shared learning benefits from teamwork.

The largest number of students believed that trust and mutual respect developed through small group shared learning. Such results are not surprising as the students had the opportunity to feel the benefits of this work during their previous education. Namely, while the education system in Serbia is still dominantly traditional, group work as teaching and learning methodology has been included in education since elementary school. Students also occasionally work and study together in groups. However, these are uni-professional groups comprising at least 10 students, and problem-solving tasks are a major characteristic of their professional domain.

There is a question in literature whether it is better to introduce inter-professional education before or after graduation. Our students seem to like the idea of acquiring the skills necessary for the team work during their studies, i.e. before graduation. The initiators of the implementation of the IPE education strategy consider it to be a part of professional development of students, which begins with acquiring qualifications/diplomas and continues throughout their professional career [21]. According to a WHO report, the IPE enables students to acquire knowledge and skills required to become a collaborative practice-ready health worker [2].

The lowest mean score in this study was recorded for the statement indicating that students did not consider learning together with students of different study profiles to be a waste of time. On the contrary, they generally consider shared learning to be necessary, specifically emphasizing its importance for acquiring the skills to solve clinical problems. However, students of medicine and dentistry are still more focused on uni-professional learning, especially when it comes to acquiring the skills to solve clinical problems. In several previous studies, similar results were obtained, which could be explained by the realistic conflict theory according to which, hostile and discriminatory inter-group relationships are the result of negative attitudes [22]. A similar interpretation is also found by Hind, who analyzed the interpersonal perceptions of students of medical faculties and found that individuals who identified strongly and positively with their own professional group tended to be more negative towards students of other groups [20]. Certainly, the aim of the IPE strategy is not to equate students’ attitudes and opinions, but to approach the problem/task from different perspectives and positions, while respecting different attitudes of students of different and/or the same profile [2, 5, 21]. Barr points out that inter-professional education is assumed to provide students an opportunity to see that intervention by one profession at one “point of the system will affect the functioning of the system as a whole” [21].
Compared to the previous research conducted at the Faculty of Medicine in Novi Sad [12], students of nursing are now more confident about their professional tasks. However, although academic studies of nursing in Serbia were established fifteen years ago, current legislation within the health care system has not yet fully “recognized” this profile. The least confident in their future professional tasks in our study are students of physiotherapy, which is one of the latest academic study profiles, also “unrecognized”. The uncertainty of pharmacy students regarding their future tasks in our study is not a solitary case in the literature. The authors of comprehensive review studies explain similar results by the fact that the traditional occupational tasks of pharmacists (drug issuing and compounding) are changing due to the rapid development of pharmaceutical practice [23]. The contribution of pharmacists in clinical practice in the form of providing professional advice to patients and members of the health team, preventing adverse drug effects and monitoring drug use considerably increases the safety and efficacy of drug administration, which further decrease treatment expenses and results in changes in clinical teamwork. This significantly increases the safety and efficacy of drug use, which contributes to reducing the cost of treatment, but also leads to changes in clinical teamwork. Due to these changes, team members have to change attitudes towards traditional tasks of pharmacists and accept new ones [15, 23]. In contrast, dentistry students know very well what their future professional tasks will be.

Students of medicine, in our and several previous studies, were least opposed to the statement that the role of nursing technicians was to provide full support to doctors. However, students of nursing and other study profiles had significantly different attitudes not only in our study but in previous studies as well as [Horsburg, el Zub]. Such results indicate that the roles of nurses continue to be accepted stereotypically (as subordinate members of the health team who mostly act merely as persons who carry out doctors’ orders) [16]. Certainly, IPE is not a panacea for every challenge that the healthcare system encounters [2]. However, an effective implementation that respects the basic provisions is based on mutual respect of students of various study profiles and provides the possibility of reducing negative stereotypes, as well as eliminating them [2, 8, 21].

**Conclusion**

The attitudes of most students of all study profiles, participating in this study, indicate that our students are ready to accept IPE as a new educational strategy. In addition, a more detailed analysis of responses of the students’ of each profile allows us to perceive all potential barriers and find solutions in due time in order to integrate IPE into the curriculum of all study profiles of the Faculty of Medicine, specified in the ReFEEHS project activities. The effective integration of IPE would contribute to the development and acceptance of collaborative practice as the underlying model of healthcare workers in Serbia as well.

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