

ORIGINAL ARTICLE

Personal Attitudes Toward, Use of Perceived Benefits and Limitations of Evidence Based Practice

Dilani Perera¹, ERC Sandamali², Faiz MMT Marikar³

ABSTRACT

This study explored personal attitudes, usage patterns, and perceived benefits and limitations of evidence-based practice (EBP) among academic professionals in Sri Lanka's health education sector. EBP is a key approach in training health professionals to deliver collaborative, patient-centered care. The success of EBP education depends on multiple factors, including individual perceptions, institutional support, and integration into teaching methods. This study aimed to assess readiness for EBP education and its influence on clinical skills, decision-making, and interdisciplinary collaboration within post-secondary health professional programs in medicine, nursing, and physical therapy. A structured questionnaire was distributed via email and post to academic staff across Sri Lanka in January 2024, with a satisfactory response rate of 46%. The survey measured attitudes using an adapted readiness for EBP scale. Results showed strong support for EBP principles, with 100% of respondents agreeing that patients ultimately benefit when health professionals collaborate through interdisciplinary learning. While overall attitudes were favorable, one noted limitation was the perceived variation in knowledge and skill acquisition across faculties – 36.5% agreed and 25% disagreed that students gain significantly more within their own disciplines, suggesting a potential barrier to integrated EBP learning. In conclusion, the findings indicate a positive perception of EBP among academic staff, with strong support for interdisciplinary collaboration. These results suggest that Sri Lanka's health education system is well-positioned to implement EBP initiatives that foster teamwork, critical thinking, and patient-centered care across professional boundaries.

Keywords: Evidence-Based Practice (EBP); Interdisciplinary Education; Health Professional Attitudes; Collaborative Care

International Journal of Human and Health Sciences Vol. 10 No. 01 January'26

DOI: <https://doi.org/10.31344/ijhhs.v10i1.899>

INTRODUCTION

The delivery of high-quality patient care increasingly relies on evidence-based strategies that emphasize collaborative practice among healthcare professionals.¹ Personal attitudes toward such collaboration play a significant role in the adoption and use of evidence-based practice (EBP). Effective teamwork, clear communication, and mutual understanding of professional roles are all essential elements of EBP as supported by the existing literature.^{1,2} Despite strong evidence for

its effectiveness, traditional profession-specific training models have hindered the widespread implementation of interprofessional collaboration. In response, Interprofessional Education (IPE) was introduced to foster a workforce capable of collaborative, evidence-informed practice. The World Health Organization (WHO) defines IPE as a learning approach where students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes. This approach aligns

1. Department of Physiotherapy & Occupational Therapy, Faculty of Allied Sciences, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka.
2. Department of Computational Mathematics, Faculty of Computing, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka
3. Staff Development Centre, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka.

Correspondence to:

Dr. Faiz MMT Marikar, Staff Development Centre, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka.
Email: faiz@kdu.ac.lk

with the core values of EBP by promoting shared decision-making and comprehensive patient care.² Research highlights several perceived benefits of IPE, such as improved quality of care, reduced patient length of stay, fewer medical errors, and cost savings.³ However, limitations remain in fully integrating IPE and EBP into curricula due to institutional and cultural barriers. Nonetheless, by reshaping traditional teaching methods, IPE encourages the development of interprofessional competencies that support evidence-based, patient-centered care.^{3,4} According to the Centre for the Advancement of Interprofessional Education (CAIPE) in UK, “interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care”.⁵

The recognition of IPE as a vital component of healthcare dates back to the late 1970s. The World Health Organization (WHO) was among the first to acknowledge its importance in 1978, highlighting the growing trend toward multi-professional teamwork in healthcare, supported by an expanding evidence base.¹ This momentum led to the establishment of the Centre for the Advancement of Interprofessional Education (CAIPE) in the United Kingdom in 1987 and the launch of the Journal of Interprofessional Care in 1986.⁵ Today, the integration of IPE into healthcare training programs has become a key goal for universities and governments globally. In the UK, for instance, the Department of Health supports IPE initiatives at both undergraduate and post-qualification levels.⁶

Extensive research underscores IPE as both an innovative and essential approach to preparing healthcare professionals for collaborative, evidence-based practice. The 2003 report *Health Professions Education: A Bridge to Quality* emphasized that all healthcare professionals should be trained to deliver patient-centered care as members of interprofessional teams, grounded in evidence-based practice, quality improvement, and informatics.^{3,7} Despite widespread consensus on its value, the implementation of IPE remains inconsistent and gradual. Numerous barriers hinder its adoption, including institutional limitations, academic resistance, and student-level challenges.^{8,9} A major impediment lies in the attitudinal divide among faculty members, where differences in perception and a lack of engagement often prevent full integration of IPE

into curricula. Effective implementation requires collaboration among educators from various disciplines to foster an environment conducive to interprofessional learning. However, challenges such as increased faculty workload and time constraints continue to limit progress.

Considering these issues, the present study aims to explore the perceptions of faculty members from diverse health professions in Sri Lanka regarding Interprofessional Learning. Understanding their attitudes, perceived benefits, and limitations is essential to developing strategies for meaningful and sustainable EBP integration.

METHODS

This cross-sectional, descriptive study was done with representation of all Medical and Allied health faculties – all academic staff of Medicine, Physiotherapy and Nursing of above representation from all faculties in Sri Lanka. Sample size a total of 16 academic members were included. The whole cohort of academic staff members in the mentioned study settings was invited to complete the questionnaire. Based on previous studies as the inclusion and exclusion criteria all the academic staff members who consent to participate in the study will be included in the Personal Attitudes Toward, Use of, Perceived Benefits and Limitations of Evidence-Based Practice.

Data was collected using a self-administered questionnaire. The questionnaires, consent forms and information sheet were provided in English language only since the academic staff members are proficient at speaking and writing in English. Data was obtained using that self-administered questionnaire.

The Readiness for Inter-professional Learning Scale (RIPLS) was used as measuring tool in this study. RIPLS is a simple, self-administered questionnaire which has been originally developed in 1999 by Parsel & Bligh.¹⁰ This 19 ties scale examines the attitude of health and social care students and professionals towards inter professional learning. Using a five-point Likert type scale, it assesses the attitudinal differences with open ended questions on educational interactions, preferred contents and activities for IPE. In addition to that further comments regarding inter professional education will also be gathered. The test-retest reliability, validity and sensitivity of

RIPLS have been evaluated and well documented in Personal Attitudes Toward, Use of, Perceived Benefits and Limitations of Evidence-Based Practice. The questionnaires were sent through post or emails to the consenting participants as per their suggestions of most convenient ways. Our questionnaire mainly consisted of the Readiness for Personal Attitudes Toward, Use of, Perceived Benefits and Limitations of Evidence-Based Practice.¹⁰ The questionnaire was anonymous and identified only by a unique identifier. The personal information such as age, name, gender etc. which were used in this survey to analyze results demographically was only accessed by the principal investigator. Confidentiality of all data and samples are guaranteed/ensured and any information by which individual participants will be kept securely only with the researchers.

Analysis of data was done using SPSS version 20.0 for windows. Data was initially analyzed using descriptive statistics. Analytical statistical methods were used to compare responses of different groups. The free comments were also content analyzed.

RESULTS

A total of 16 participants completed baseline and follow-up questionnaires. Demographic data were collected only for the 16 current study participants. Participants' age, gender, listed in Table 1. There were no significant differences between groups in terms of age and gender. Table 2 presents the response rate by academic program type. A total of 16 responses were received from the 120 academic administrators forwarded an e-mail request to complete the survey, a 13% response rate. Schools of Medicine (60%), School of Nursing (40%), and School of Physical Therapy (40%) recorded the response rates. Table 3 presents a detailed overview of potential barriers to the implementation of interdisciplinary learning through the lens of evidence-based practice (EBP) among physical therapists. Overall, the responses indicate a generally positive attitude toward EBP, with the majority acknowledging its importance and relevance in clinical settings. For instance, a significant proportion of respondents either agreed (56%) or strongly agreed (38%) that the application of EBP is necessary in physical therapy practice. Similarly, 63% strongly agreed and 31% agreed that literature and research findings are useful in

their daily practice, showing that most therapists value evidence in guiding clinical decisions. Despite this support, many therapists (50% agree, 38% strongly agree) admitted that they need to increase their use of evidence in daily practice, suggesting a recognized gap between knowledge and implementation. However, several perceived barriers were also noted. A combined 57% of respondents agreed or strongly agreed that the adoption of EBP places an unreasonable demand on physical therapists, indicating concerns about time, workload, or available resources. Likewise, while a strong interest was expressed in improving EBP-related skills (50% agree, 44% strongly agree), some respondents expressed skepticism about the practicality of EBP in their settings. Notably, 25% agreed and 19% strongly agreed that EBP does not fully consider the limitations of their clinical practice environment. Furthermore, although many respondents (63% agree, 25% strongly agree) stated that EBP helps in making patient care decisions, 31% agreed and 6% strongly agreed that EBP does not take into account patient preferences—highlighting a potential conflict between standardized guidelines and individualized care. Financial incentives for EBP adoption were also uncertain; while 56% agreed their reimbursement rate might increase with EBP, 31% remained neutral. Lastly, the perception that strong evidence is lacking for most interventions (56% agree, 31% strongly agree) could undermine confidence in EBP and reduce motivation to apply it. In conclusion, while physical therapists largely recognize the value of EBP and express a willingness to enhance their skills, concerns about its practicality, relevance, and real-world constraints continue to pose barriers to full implementation within interdisciplinary learning contexts. Table 4 provides insight into the frequency and extent to which physical therapists engage with research literature and practice guidelines over a typical month. The data suggests that engagement with research is moderate but shows room for improvement. When asked about reading research or literature related to their clinical practice, responses were varied: 38% disagreed and 25% were neutral, while only 25% agreed and 6% strongly agreed. This suggests that a significant portion of therapists may not regularly read research articles, possibly due to time constraints, accessibility issues, or lack of habit. Similarly, when it comes to using professional literature and

research findings in clinical decision-making, 44% disagreed, and only a combined 37% (31% agree, 6% strongly agree) reported doing so – indicating that research may not be consistently integrated into their decision-making processes. In contrast, the use of databases like MEDLINE for finding practice-relevant literature showed a somewhat more encouraging trend, with 44% agreeing and 13% strongly agreeing, though 31% still disagreed. This suggests that while some therapists are proactive in seeking research, others may lack the skills or motivation to do so. Regarding practice guidelines, 44% agreed that they actively seek such resources, and 38% were neutral—pointing to a growing interest but not yet widespread adoption. Encouragingly, actual use of practice guidelines in clinical practice appears more common, with 44% agreeing and 66% strongly agreeing, indicating that once guidelines are accessed, they are likely to be implemented. Overall, the data reflects a gradual but incomplete integration of evidence-based resources into clinical practice. While the majority recognize the value of guidelines and some actively seek out literature, a considerable number of respondents still do not regularly read or apply research findings, highlighting a key area for improvement in promoting evidence-based practice among physical therapists. Table 5 explores the extent to which physical therapists are supported and prepared to engage with research and utilize search engines in their clinical practice. The data reveals a mixed picture of institutional support and individual preparedness. When asked whether their facility supports the use of current research in practice, responses were split, with 38% agreeing and another 38% disagreeing, suggesting inconsistent organizational backing. On a more positive note, 56% of respondents agreed that they learned the foundations of evidence-based practice (EBP) during their academic training, though 13% strongly disagreed, indicating that not all educational programs may have emphasized EBP equally. Formal training in research search strategies was reported by a majority, with 50% agreeing and 13% strongly agreeing, though 25% remained neutral, and a small portion (13%) strongly disagreed, hinting at disparities in professional development opportunities. Familiarity with medical search engines like MEDLINE and CINAHL appears high, with 56% agreeing and 25% strongly agreeing. Similarly, 63% of respondents

indicated they had received formal training in the critical appraisal of research literature, reinforcing the presence of academic preparation in this area. Confidence levels in applying these skills are relatively strong. A combined 81% of respondents expressed confidence in their ability to critically review professional literature, and 87% felt confident in finding relevant research to answer clinical questions. These findings suggest that while institutional support may vary, many physical therapists feel personally prepared and capable of engaging with research, largely due to their academic background and formal training. However, the data also underscores the need for more consistent support and professional development across clinical settings to ensure research-informed practice is sustained.

Table 1: Demographic Data for Participants in the Current Study

Sex and Age	Number	Percentage
Male	06	32
Female	10	68
Total	16	100
Age	16 (24-70)	Mean 36.64 Median 32

Table 2: Response rate by academic program type

Academic program type	No of potential response	No of actual response	Response rate
School of Medicine	40	6	60%
School of Nursing	40	5	40%
School of Physical therapy	40	5	40%
Total	120	16	13%

DISCUSSION

Evidence-based practice (EBP) has been widely acknowledged as a cornerstone of quality patient care in physical therapy, yet its successful integration into routine clinical work is often influenced by the attitudes and experiences of individual practitioners.¹¹ This study sheds light on personal attitudes toward EBP, highlighting both the enthusiasm and the hesitations that shape its use in practice. While most respondents demonstrated a positive perception of EBP – recognizing its value in improving patient care and expressing confidence in their ability to find and

Table 3: Potential barriers to the implementation of interdisciplinary learning in their skills

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	N	%	n	%	n	%	n	%	n	%
Application of EBP in necessary in the practice of physical therapy.					1	6	9	56	6	38
Literature and research findings are useful in my day-to-day practice.					1	6	5	31	10	63
I need to increase the use of evidence in my daily practice.			2	13			8	50	6	38
The adoption of EBP places an unreasonable demand on physical therapists.			1	6	6	38	7	44	2	13
I am interested in learning or improving the skills necessary to incorporate EBP into my practice.					1	6	8	50	7	44
EBP improves the quality of patient care.					5	31	5	31	6	38
EBP does not take into account the limitations of my clinical practice setting.			2	13	7	44	4	25	3	19
My reimbursement rate will increase if I incorporate EBP into my practice.					5	31	9	56	2	13
Strong evidence is lacking to support most of the interventions I use with my patients.			1	6	1	6	9	56	5	31
EBP helps me make decision about patient care.					2	13	10	63	4	25
EBP dose not take into account patient preference.	1	6	6	38	4	25	4	25	1	6

Table 4: Response for a typical month for literature search

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	N	%	n	%	n	%	n	%	n	%
Read research/literature related to my clinical practice (no of articles)	1	6	6	38	4	25	4	25	1	6
Use professional literature and research findings in the process of clinical decision making.			7	44	3	19	5	31	1	6
Use MEDLINE or other databases to search for practice-relevant literature/research.			5	31	2	13	7	44	2	13
I actively seek practice guidelines pertaining to areas of my practice			3	19	6	38	7	44		
I use practice guidelines in my practice.					7	44	9	66		

Table 5: Response for a typical research and search engines

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	N	%	n	%	n	%	n	%	n	%
My facility supports the use of current research in practice.	2	13	6	38	2	13	6	38		0
I learned the foundations for EBP as part of my academic preparation.	2	13	1	6	4	25	9	56		0
I have received formal training in search strategies for finding research relevant to my practice.	2	13			4	25	8	50	2	13
I am familiar with the medical search engines (eg. MEDLINE, CINAHL)	3	19					9	56	4	25
I received formal training in critical appraisal of research literature as part of my academic preparation.	2	13	1	6	3	19	6	38	4	25
I am confident in my ability to critically review professional literature.	2	13			1	6	9	56	4	25
I am confident in my ability to find relevant research to answer my clinical questions.	2	13					9	56	5	31

appraise relevant literature – there remain notable barriers that impact its full implementation.

Many therapists reported receiving formal academic preparation in EBP and search strategies, suggesting that foundational knowledge exists.¹² However, this knowledge does not always translate into regular use. The data revealed that despite a general willingness to apply EBP, there are inconsistencies in the frequency of literature searches and the routine application of research findings. This disconnect may be linked to challenges such as lack of time, limited access to research databases, or uncertainty about how to integrate evidence into individualized patient care.

The perception of institutional support also plays a crucial role in shaping personal attitudes toward EBP. While some respondents felt supported by their workplaces in using research to inform practice, others did not, pointing to variability in the organizational culture surrounding EBP.¹³ This inconsistency may influence motivation and the perceived feasibility of maintaining evidence-informed approaches in a busy clinical environment.

Moreover, while confidence in critical appraisal and research retrieval skills was generally high, the survey highlighted an ongoing need

for professional development and continuous learning.^{14,15} Therapists showed a strong interest in improving their EBP skills, which indicates openness to growth but also signals that current practices and support systems may not be sufficient to meet this demand.

The findings from Tables 3, 4, and 5 collectively provide a nuanced understanding of the attitudes, behaviors, and challenges faced by physical therapists in integrating evidence-based practice (EBP) into their clinical settings. While there is a strong overall recognition of the importance and value of EBP most notably, its role in improving patient care and informing clinical decisions barriers such as time constraints, limited institutional support, and concerns about the applicability of research to real-world practice persist.

In Table 3, most participants agreed that EBP is necessary and beneficial, yet many acknowledged they do not consistently use it in their daily routines. Concerns that EBP may not always consider clinical limitations or patient preferences highlight potential gaps between research and practice. Additionally, therapists expressed a strong desire to improve their EBP-related skills, indicating an openness to professional development despite perceived obstacles.

Table 4 further reinforces the mixed application of EBP in daily practice. Although most respondents use practice guidelines, fewer actively read or apply research literature regularly. This may be due to limited time, lack of access, or insufficient confidence in navigating databases. The relatively low frequency of literature searches points to a need for better integration of research engagement into routine clinical workflows.

Table 5 provides insight into therapists' training and confidence in utilizing research tools and evaluating literature. While many reported receiving academic preparations in EBP and expressed confidence in their ability to find and critically review research, institutional support was inconsistent. This disconnect suggests that while therapists may be individually equipped to engage in EBP, the clinical environment may not always foster or facilitate its implementation.

CONCLUSION

In conclusion, the study highlights a positive attitude toward evidence-based practice among physical therapists, accompanied by a strong interest in developing the skills necessary to implement it effectively. However, several barriers such as limited time, inconsistent use of research tools, and varying levels of organizational support impede its full integration into clinical practice.

To address these issues, targeted interventions such as continuing education, institutional encouragement, and streamlined access to research databases are essential. Strengthening both individual competencies and systemic support structures will be key to embedding EBP more deeply into interdisciplinary learning and everyday physical therapy practice.

Conflict of Interest: No personal or financial conflicts of interest.

Funding Statement: Nil.

Ethical Approval: Ethical clearance was obtained from Ethics Review Committee, Faculty of Medicine, General Sir John Kotelwala Defence University, Ratmalana, Sri Lanka. After obtaining ethical clearance, Heads of the relevant institutions will be contacted over the phone or met in person and informed about the study. Their permissions were obtained prior to the data collection. Following this, the academic staff of the departments were sent information sheets consisting of all relevant details of the study and the consent forms.

Authors' Contribution: All the authors were equally involved in conception, design, questionnaire formulation, data collection, compilation, analysis, manuscript writing, editing, review and final submission.

REFERENCES

1. World Health Organisation (WHO). Learning together to work together for health. Report of a WHO Study Group on Multiprofessional Education of Health Personnel: The team approach. Geneva: WHO; 1988.
2. World Health Organization (WHO). Framework for Action on Interprofessional Education & Collaborative Practice. Health Professions Networks Nursing & Midwifery Human Resources for Health. Geneva: WHO; 2010.
3. Buring SM, Bhushan A, Broeseker A, Conway S, Duncan-Hewitt W, Hansen L, et al. Interprofessional education: Definitions, student competencies and guidelines for implementation. *Am J Pharm Educ*. 2009;3(4):59.
4. Bridges DR, Davidson RA, Odegard PS, Maki IV, Tomkowiak J. Interprofessional collaboration: Three best practice models of interprofessional education. *Med Educ Online*. 2011;16:10.
5. Centre for the Advancement of Interprofessional Education (CAIPE). Statement of Purpose. London: CAIPE; 2016.
6. Department of Health, UK. Investment and reform for NHS staff: Taking forward the NHS Plan. London: Department of Health; 2001.
7. Marikar F, Perera, D. Perceptions of academia of different health professions towards inter professional education in Sri Lanka. *J STEAM Educ*. 2020;4(1):43-51.
8. Gilbert JHV. Interprofessional learning and higher education structural barriers. *J Interprof Care*. 2005;19(Suppl 1):87-106.
9. Vancly L. Exploring Interprofessional Education: The Advantages and Barriers. A discussion paper for the UKCC Multiprofessional Working Group of the Joint Education Committee. London: CAIPE; 1997.
10. Parsell G, Bligh J. The development of a questionnaire to assess the readiness of health care students for interprofessional learning (RIPLS). *Med Educ*. 1999;33(2):95-100.
11. Howard B, Diug B, Ilic D. Methods of teaching evidence-based practice: A systematic review. *BMC Medical Educ*. 2022;22(1):742.
12. Law M, MacDermid JC. Introduction to evidence-based practice. In: Law M, MacDermid JC. eds. *Evidence-based rehabilitation: A guide to practice*. 3rd ed. New York: Routledge; 2013.
13. Smith L, Malinowski J, Ceulemans S, Peck K, Walton N, Sheidley BR, et al. Genetic testing and counseling for the unexplained epilepsies: An evidence-based practice guideline of the National Society of Genetic Counselors. *J Genet Couns*. 2023;32(2):266-80.
14. Hume K, Steinbrenner JR, Odom SL, Morin KL, Nowell SW, Tomaszewski B, et al. Evidence-based practices for children, youth, and young adults with autism: Third generation review. *J Autism Dev Disord*. 2021;51(11):4013-32.
15. Reeves S, Perrier L, Goldman J, Freeth D, Zwarenstein M. Interprofessional education: effects on professional practice and healthcare outcomes (update). *Cochrane Database Syst Rev*. 2013;2013(3):CD002213.