Conceptualising the Development and Delivery of Interprofessional Health Care Education in Malta

Margaret Bonello

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This thesis is concerned with the concept of undergraduate Interprofessional Education (IPE) as a possible model of practice for the education of health care professionals at the Faculty of Health Sciences, University of Malta. In 2010, the World Health Organisation published its Framework for Action on IPE and Collaborative Practice outlining a vision for a “collaborative practice-ready workforce” emphasising the importance of the health and educational systems as supporting pillars of IPE and collaborative practices (WHO, 2010, p.7). The concept of IPE had been mentioned in policy documents in Malta but no such model had ever been tried or tested at the University. This study aimed to explore stakeholders’ perspectives and perceptions of IPE and to encourage debate of adopting such an approach at the Faculty of Health Sciences.

This thesis starts by tracing a history of IPE internationally, teasing out the diversity of policy drivers and motivating factors behind its inception and highlighting the lessons learnt for its development and sustainability into curricula; which, inter alia, include the importance of political drivers, national coherent policies, organisational support and earmarked central funding. This was crucial to underscore as it brought to the fore the paucity of such triggers for IPE within this research study. The study then adopts a qualitative case study approach underpinned by a social constructionist and interpretative stance designed to explore the possibility of IPE at the University of Malta. The purposive sample totalled sixty four participants and these included academics at the Faculty of Health Sciences, key informants from the education/health sectors and newly qualified health professionals. Data was gathered through a combination of focus group discussions and one-to-one interviews, and analysed using Ritchie and Spencer’s (1994) ‘Framework’ analysis supported by NVivo software. Findings yielded rich insights into participants’ perceptions of IPE; while they lauded the notion in principle, they identified a multiplicity of factors that would pose barriers to its enactment in practice. Some barriers might be described as symbolic while others were rooted in the practical domain of operational systems and structures. On a symbolic level, participants were particularly concerned that IPE would pose a threat to their professional identities and to the maintenance of boundaries that define the conceptual territories of the various professions. Participants also pointed to traits and behaviours they perceived as endemic in Maltese culture that would conflict with
the enactment of IPE; these were especially relevant as the influence of macro cultural determinants has been largely overlooked in the interprofessional literature.

These findings were interpreted through an interdisciplinary conceptual framework drawing on sociological discourses of professionalism and Bourdieu’s theories of societies and social practices. The framework also drew on concepts in anthropological discourses, focusing in particular on Hofstede’s theory of cultural dimensions as a means of theorising about the role that national culture can play in shaping perceptions and behaviours.

The originality of this study lies in its a priori approach by exploring perceptions of an interprofessional model of practice when this philosophy had not yet been considered, and which in the process, identified contextual variables which could impact on the design and delivery of IPE. It is unique in employing various theoretical perspectives so as to transcend the factual findings and engage in higher order reconceptualisation. It is also the first study of IPE to be conducted in Malta; significant to consider for any potential interprofessional initiatives. This research contributes to the body of evidence underpinning IPE in two ways. It highlights again the existence of embedded hierarchies and power struggles across health systems and how these impact on IPE, and it uncovers the potential impact of national culture as a tangible determinant in the planning, development and delivery of IPE initiatives.
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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>AIHC</td>
<td>American Interprofessional Health Collaborative</td>
</tr>
<tr>
<td>AIPPEN</td>
<td>Australasian Interprofessional Practice and Education Network</td>
</tr>
<tr>
<td>ATBH</td>
<td>All Together Better Health Conference</td>
</tr>
<tr>
<td>CAIPE</td>
<td>Centre for the Advancement of Interprofessional Education</td>
</tr>
<tr>
<td>CIHC</td>
<td>Canadian Interprofessional Health Collaborative</td>
</tr>
<tr>
<td>CIPW</td>
<td>Creating an Interprofessional Workforce</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
</tr>
<tr>
<td>EIPEN</td>
<td>European Interprofessional Education Network</td>
</tr>
<tr>
<td>EMPE</td>
<td>European Network for the Development of Multiprofessional Education in Health Sciences</td>
</tr>
<tr>
<td>FHS</td>
<td>Faculty of Health Sciences</td>
</tr>
<tr>
<td>GPN</td>
<td>Global Healthcare Professional Network</td>
</tr>
<tr>
<td>HMSO</td>
<td>Her Majesty’s Stationery Office</td>
</tr>
<tr>
<td>IECPCP</td>
<td>Interprofessional Education for Collaborative Patient-Centred Practice.</td>
</tr>
<tr>
<td>IHC</td>
<td>Institute of Health Care, Malta</td>
</tr>
<tr>
<td>IHI</td>
<td>Institute of Healthcare Improvement</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine, U.S.A.</td>
</tr>
<tr>
<td>IPC</td>
<td>Interprofessional Collaboration</td>
</tr>
<tr>
<td>IPE</td>
<td>Interprofessional Education</td>
</tr>
<tr>
<td>IPEC</td>
<td>Interdisciplinary Professional Education Collaborative</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>IPL</td>
<td>Interprofessional Learning</td>
</tr>
<tr>
<td>IPLC</td>
<td>Interprofessional Learning Continuum Model</td>
</tr>
<tr>
<td>IPTW</td>
<td>Interprofessional Training Ward</td>
</tr>
<tr>
<td>JAIPE</td>
<td>Japan Association for Interprofessional Association</td>
</tr>
<tr>
<td>JIPWEN</td>
<td>Japan Working and Education Network</td>
</tr>
<tr>
<td>MHSA</td>
<td>Malta Health Students Association</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health System, UK</td>
</tr>
<tr>
<td>NIPNET</td>
<td>Nordic Interprofessional Network</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PBL</td>
<td>Problem-based Learning</td>
</tr>
<tr>
<td>RIPEN</td>
<td>Rural Interprofessional Education Network</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats.</td>
</tr>
<tr>
<td>TUFH</td>
<td>The Network: Towards Unity for Health</td>
</tr>
<tr>
<td>UoM</td>
<td>University of Malta</td>
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<tr>
<td>WFME</td>
<td>World Federation of Medical Education</td>
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Glossary

**Hegemonies** refers to influence or control over a group of people.

**Hierarchies** refers to systems in which people are placed in a series of levels with difference importance or status.

**Interprofessionality** is defined as the “process by which professionals reflect on and develop ways of practicing that provides an integration and cohesive answer to the needs of the client/family/population (D’Amour & Oandasan, 2005 p. 9).

**Interprofessional collaboration (IPC)** is defined as “the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients, clients, families and communities to enable optimal health outcomes” (Canadian Interprofessional Health Collaborative (CIHC), 2010, p. 8).

**Interprofessional collaborative practice** occurs “when multiple workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care” (WHO, 2010, p. 13).

**Interprofessional education (IPE)** is defined as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 2002, p. 1).

**Interprofessional learning (IPL)** is defined as “learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happens spontaneously in the workplace or in education settings” (Freeth et al., 2005, p. xv).

**Multiprofessional learning (or education)** is described as “occasions when two or more professions learn side-by-side for whatever reason” (CAIPE, 1997 p. 1).
Problem-based learning (PBL) “is a way of delivering a curriculum in order to develop problem-solving skills as well as assisting learning with the acquisition of necessary knowledge and skills. Students work cooperatively in groups to seek solutions to real world problems, set to engage students’ curiosity and initiate learning of the subject matter” (Freeth, Hammick, Reeves, Koppel and Barr, 2005, p.xvi).

Shared learning is frequently used interchangeably with multiprofessional and interprofessional learning (Goble, 1994) and implies occasions when participants are learning together in a multi-disciplinary context (Leathard, 1994).

Uni-professional teaching is members (or students) of a single profession learning together (Freeth, Hammick, Reeves, Koppel and Barr, 2005, p.xvii).
Acknowledgements

I would like to acknowledge a number of people who have made the completion of this research study possible. Firstly my heartfelt appreciation goes to Professor Gaynor Sadlo, Dr. Jane Morris and Dr. Jon Wright who provided me with the necessary advice and guidance all throughout this research study. Their constant belief in my abilities gave me the confidence to go on during challenging times and of course, to see me completing this thesis.

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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

[Signature]

Margaret Bonello (k/a Marjorie)

Dated: 2\textsuperscript{nd} March, 2016
Chapter 1  Introduction

Most simply put, stories are a way of knowing ... Telling stories is essentially a meaning-making process. When people tell stories, they select details of their experience from their stream of consciousness ... It is this process of selecting constitutive details of experience, reflecting on them, giving them order, and thereby making sense of them that makes telling stories a meaning-making experience (Seidman, 2006, p. 7).

1.1  Introduction

This thesis presents the story of my research. The story started out as an exploration of possible interprofessional education (IPE) at the newly constituted Faculty of Health Sciences within the University of Malta. As the research unfolded it also became a story about my organisation, the professions which constitute the Faculty, as well as contextual factors outside the organisation.

1.2  Background Context and Rationale

Although the start of my story can be traced back to the late 2000’s, my professional and personal backgrounds helped to set the scene. I graduated as an occupational therapist in 1989 and after a number of years working in hand rehabilitation, I commenced my postgraduate studies in the United Kingdom. My Master’s thesis focused on clinical education and it was during that time that I became interested in the discourse of higher education. On my return to Malta in 1998, I took up the role of Health Policy Coordinator within the Ministry of Health, a position which involved continual collaboration and coordination with other professions, both from the health ministry and from other sectors.

As part of my work in 2008, I was nominated to sit on a National Committee tasked with developing a National Dementia Strategy for Malta. One of my remits on this committee comprised conducting a scoping study to map out the level, content and duration of dementia education for health and social care professionals across the
University of Malta. I found the results disappointing - education for dementia care across all university departments was sparse. Further, the few departments that had complete modules addressing one of the most challenging diseases threatening health care systems worldwide seemed to replicate the same basic knowledge to different groups of students. In my view this seemed like a huge waste of scarce resources. Could there be another way to educate health professionals? For example, perhaps giving a baseline of dementia care training to all health and social care professionals and then in a more specialised format to the different professions? Dementia was such a complex condition that it required the collaboration of many health (and other) professionals. My concern for this field also stemmed from personal experience. My maternal grandmother, a beacon in my family, had been diagnosed with this terrible disease in 2007 and from first-hand experience, I knew how collaboration (or the lack of it) could make all the difference in managing this complex condition. Introducing interprofessional dementia training studies across a number of professional courses could be one way of creating dialogue between professions and thereby, perhaps, paving the way for future collaborations across the different care settings. I raised this issue with various colleagues and although people thought it made logical sense, there seemed to be an air of complacency about the proposition of health care students learning together so as to eventually be able to work together.

A few years later, I took up the role of full time assistant lecturer at the Occupational Therapy Department at the Institute of Health Care. In 2010, this Institute was upgraded to faculty status and renamed the Faculty of Health Sciences. This was an important development which implied the possibility for change and reform. There was the election of a new Dean who was elected by the academics themselves; a Dean for whom collaboration between the various departments and faculties was high on the agenda (Xuereb-Anastasi, 2011). New academics were recruited for the newly constituted departments (as opposed to the former divisions). This upgrading coincided with the Faculty of Health Sciences moving to new premises adjacent to the, then just inaugurated, acute general hospital. Could this be the time to start understanding and seeing our world of educating future health care professionals from a different perspective? From personal and professional experience, I was well aware that the realities of collaboration between academic departments and faculties
within our University were generally poor. My scoping study in dementia care education had been just one example. Also, from my working experience, it seemed to me that at a health service level, collaboration between health professions was even more lacking and in some instances, totally nonexistent. The assumption and expectation, from both the educational and health service providers, was that health graduates would ‘naturally’ learn to work together.

As a clinician and educator, I slowly became more and more interested in the idea of students learning together so as to be able to work together and my involvement in clinical education with other health care students other than those from my own profession fuelled this interest. I began reading literature on IPE and the notion of initiating dialogue within the local context on this topic seemed timely as I was about to commence my doctoral studies.

Moving away from my personal and professional rationale to the international arena, it may be said that calls for stakeholders in the health and education sectors to recognise the need for IPE as fundamental to forging collaborative practice have been gaining momentum over the past four decades. Among such calls two international documents are noteworthy: the Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010), and an article commissioned by one of the world's oldest and best known general medical journals, The Lancet (Frenk et al., 2010).

The World Health Organisation has for decades been proactive and supportive of IPE (WHO, 1976; 1978; 1988). The Framework for Action on Interprofessional Education and Collaborative Practice outlined a strategic vision for a “collaborative practice-ready workforce” with IPE forming the cornerstone of this strategy. This report also emphasised the importance of the health and educational systems as being supporting pillars for IPE and collaborative practices (WHO, 2010, p. 7).
Also in 2010, The Lancet Commission\(^1\), contended that “health systems worldwide are struggling to keep up, as they become more complex and costly, placing additional demands on health workers” (Frenk et al, 2010, p. 1923). One of the reasons attributed to this was a mismatch of professional competencies to patient and population needs, mostly due to “fragmented, outdated, and static curricula that produce ill-equipped graduates”\(^2\) (p. 4). Professional health education reforms were urgently called for and IPE was identified as part of these reforms. It was argued that the inclusion of IPE in health curricula could contribute towards a professional workforce which was more competent to meet the complex realities of health system demands (Frenk et al., 2010).

In view of such international appeals for development of IPE as a means of preparing a collaborative ready workforce, the absence of IPE from curricula\(^3\) at the Faculty of Health Sciences, University of Malta, reinforced my rationale for undertaking this study. While the concept of interprofessional education had been addressed in local educational policy documents, no IPE initiative had ever been designed or implemented. A study was therefore needed which would create knowledge about understandings and perceptions of IPE from relevant stakeholders and which would encourage debate about adopting such an approach at the University of Malta. It may be added that the recently published, National Health Systems Strategy for Malta, 2014-2020 (Ministry for Health, 2014), makes numerous references to the importance of promoting practices so as to ensure teamwork and collaboration across disciplines. Indeed, this document makes direct reference to a need for investment in health professional education so as to promote multidisciplinary teamwork. Although multidisciplinary teamwork is different from interprofessional collaboration, such affirmations in the National Health Strategy are promising and this study’s findings could go some way towards providing insights into how this investment in health professional education could best be developed.

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\(^1\) This was a worldwide commission made up of twenty professional and academic leaders from diverse countries who were assembled so as to develop a shared vision and strategy for the education of health professionals.

\(^2\) Other authors apart from the Lancet Commission are credited to this statement namely the Institute of Medicine (2002), UK General Medical Council (2009) and WHO (2006).

\(^3\) There is a degree of shared learning in undergraduate curricula and multiprofessional learning in a few postgraduate courses and these are discussed in Chapter 2: Part 1.
1.3 Study Aims and Research Questions

The qualitative research methodology adopted in this study is described, explained and justified in Chapter 4 and 5: The Research Process. Since this form of inquiry does not begin with an *a priori* hypothesis but seeks to explore an enquiry as it is constructed by the study participants, the research question is framed as a ‘focus-of-inquiry statement.’ The focus-of-inquiry statement, which provides initial direction on entering the field under study, may be refined by the researcher as data collection progresses and salient themes in the participants’ world begin to emerge. The focus-of-inquiry statement for this study was framed as follows:

This study aims to explore participants’ understandings and perceptions of IPE including the possibility of developing and sustaining an undergraduate IPE initiative at the Faculty of Health Sciences, University of Malta and therefore poses the following research questions:

- Are academics at the Faculty of Health Sciences (and other stakeholders) aware of IPE?
- If they are, what do they understand by it?
- What are their perceptions about IPE being implemented at the Faculty?
- Is this a timely endeavour considering we have recently become a Faculty?
- Are there any barriers and enhancers to such an initiative? And if so, what are they?
- How would it work in practice?
- When, how and where could it be introduced?

As data collection and analysis progressed, and as my reading and thinking evolved, I started to appreciate how the issues I was interested to explore were intricately bound to wider contexts beyond the Faculty of Health Sciences. The evolution and development of the research focus and re-framing of the research questions are explained at the end of Chapter 3: Literature Review.
1.4 Research Approach and the Study Sample

The research adopted a qualitative case study approach. Data was collected through focus group discussions and one-to-one interviews. The purposive sample consisted of the large majority of academics at the Faculty of Health Sciences, newly qualified health professionals and key stakeholders from the health and educational sectors. Chapter 4: The Research Process - Methodology and Methods, describes and justifies the case study approach, as well as examines my ontological and epistemological positions informing and underpinning my research.

1.5 Significance of the Study

This study is different from other international IPE studies which, in the main, focus on exploring, describing and evaluating various aspects of existing IPE initiatives, processes and curricula (including various systematic reviews); there is also a wealth of literature concerning advocacy, policy and theorisation for IPE, as well as the identification of barriers and enablers influencing IPE. By contrast, this study appears to be a first empirical study to explore understandings and perceptions of IPE before an IPE initiative is actually implemented. Apart from exploring potential barriers and enablers for IPE, it also seeks to understand key contextual influences which could possibly impinge on a local IPE initiative. It is also the first study of IPE to be conducted in Malta.

1.6 Clarifying Semantics

The literature uses different terms interchangeably to express the concept of students learning together. Particularly in earlier days, this seemed to be a major barrier to the development of IPE (Gilbert, 2005; Reeves, Goldman, & Zwarenstein, 2009a; Thistlethwaite & Moran, 2010). Leathard (1994) referred to this problem a “semantic quagmire” (p. 5); a problem which largely remained unchanged years later (Leathard, 2003). The interprofessional field was also one “bedevilled by terminological inexactitude” with prefixes such as multi, inter, cross and trans conjoined to adjectives and nouns and used interchangeably (Barr, Koppel, Reeves, Hammick, & Freeth, 2005, p. xvii). The outcomes of these variations were distinctly different adding to the ambiguity and misconceptions around the subject (Barr,

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2002). For example, the diversity in learning encompassed students who were merely sitting and learning together (usually referred to as multiprofessional education, shared learning or common studies), to students who were involved in interactive and planned learning opportunities with the goal of improving collaborative practices (interprofessional education, interprofessional learning or joint-working). Along the spectrum, there was also multiprofessional, multidisciplinary or cross-disciplinary learning, all of which implied learning with other professionals and which collectively seemed to be valuable in improving collaborative practices (Freeth, Hammick, Reeves, Koppel, & Barr, 2005).

In 1997 (with a later revision in 2002), the UK Centre for the Advancement of Interprofessional Education (CAIPE), clarified the field by developing a definition for IPE and this has been extensively adopted worldwide. A recent survey in the UK has reported that “ambiguity between the terms common learning and interprofessional learning has been largely resolved” (Barr, Helme & D’Avray, 2014, p. 11) and this augurs well for improving the clarity of purpose for IPE. In the light of this, this thesis adheres to the following definitions and abbreviations:

- Interprofessional education (IPE) is defined as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 2002, p. 1).

Emphasis on the words with, from and about show that IPE is conceptually distinct due to its requirement for interaction among and between the professions.

- Interprofessional collaboration (IPC) is defined as “the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients, clients, families and communities to enable optimal health outcomes” (Canadian Interprofessional Health Collaborative (CIHC), 2010, p. 8).

- Interprofessional collaborative practice occurs “when multiple workers from different professional backgrounds work together with patients, families,
Interprofessionality is defined as the “process by which professionals reflect on and develop ways of practicing that provides an integration and cohesive answer to the needs of the client/family/population (D’Amour & Oandasan, 2005 p. 9).

- Interprofessional learning (IPL) is defined as “learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happens spontaneously in the workplace or in education settings” (Freeth et al., 2005, p. xv).

Interprofessional learning (IPL) is often used interchangeably with interprofessional education (IPE) in the literature. The main difference is that IPL focuses more on micro learning processes whilst IPE tends to refer to a more overarching educational framework (Thistlethwaite & Moran, 2010).

- Multiprofessional learning (or education) is described as “occasions when two or more professions learn side-by-side for whatever reason” (CAIPE, 1997 p. 1).

A glossary of frequently used terms employed within this field is included on page xiv.

1.7 Thesis Outline

Whilst this opening chapter has provided the rationale for my research and the context in which it is set, a synopsis for chapters which follow is presented below.

Chapter 2: Setting the Scene, provides the backdrop of the story of my research. Part 1, The Maltese Context, discusses relevant aspects of Maltese historical and cultural background, the health care system and the Faculty of Health Sciences at the University of Malta, as a means of illuminating the context in which participants’ discourses were situated. Part 2: The Global Context offers a historical and
geographical overview of IPE, that is, it presents a snapshot of the development of IPE in different countries across the globe, thereby situating this study within the international context of IPE.

**Chapter 3: Literature Review** explores key issues in IPE and critically engages with theoretical perspectives in the literature, making use of an adapted version of Freeth and Reeves’ (2004) 3P Curriculum Model (Presage-Process-Product) as the vehicle to do so. It considers the various influences discussed in the literature at micro (individual), meso (institutional/organisational), and macro (political and socio-cultural) levels.

**Chapter 4 and 5: The Research Process**, collectively, explain and justify the overall research methodological framework guiding this research. **Chapter 4: Part 1, Methodology and Methods** describes the strategy I undertook to realise the vision for this research, explaining how my theoretically founded assumptions underpinned the selection of a qualitative case study methodology. It discusses how I utilised a systematic and explicit way of inductive reasoning throughout the research process so as to address the research questions, as well as to ensure the quality needed from such research. **Chapter 5, Part 2: Data Analysis** presents a well-defined analytical strategy consistent with the philosophical underpinnings of my methodology. This strategy involved various stages of analysis making use of the ‘Framework’ approach (Ritchie & Spencer, 1994). I also used a software package, QSR NVivo 10, as a tool for conducting my analysis and conceptualising the data. This enabled me to produce an audit trail, demonstrating the high levels of rigour I applied throughout the process.

**Chapter 6** presents the **Findings** of the study. It discusses the two overarching master themes entitled ‘The Idea of IPE’ and ‘The Reality of IPE.’ These master themes encapsulate participants’ discourses and represent, metaphorically speaking, the central plot of the IPE story. Under these themes, each aspect of the story illustrating participants’ understandings and perceptions of IPE is further subdivided into subthemes, and the analysis of each theme is supported by quotations from the study participants.
Chapter 7: Discussion, builds on the findings identified in Chapter 6, and places key themes, issues and concerns raised by the study’s participants in dialogue with relevant discourses in the literature on IPE and beyond. It adopts an interdisciplinary framework drawing on sociological discourses of professionalism and Bourdieu’s theories of societies and social practices, as a means of illuminating and analysing the key themes; it also draws on concepts in anthropological discourses, focusing in particular on Hofstede’s theory of cultural dimensions as a means of teasing out the role of culture in shaping perceptions and behaviours (Hofstede, Hofstede & Minov, 2010). By means of this explanatory framework, the chapter presents an in-depth discussion of the meanings and implications of the study findings.

Chapter 8 entitled Conclusion: Looking back and ahead returns to the original context that gave rise to my rationale for conducting this research, summarises and concludes the case-study, then it looks ahead to the context in which the findings may be positioned and considers how learnings and insights gained from the study may be useful in a changed and changing context. The chapter also considers the originality of the study and the contribution it makes to knowledge; the implications for education, practice and further research. It also outlines the study limitations and presents a strategy for dissemination. The thesis concludes with a reflexive epilogue on the entire research process.

Notes:

i. Reflexive analysis in research can be defined as “thoughtful, conscious self-awareness” and “encompasses the continual evaluation of subjective responses, intersubjective dynamics and the research itself” (Finlay, 2002a, p. 532). This was central to this work most especially since I was a researcher researching my own institution. I have thus presented a running commentary throughout the thesis representing significant excerpts from my reflexive journal. These are entitled The Inward Eye; a term used by Wordsworth in his poem Daffodils (Wordsworth, 1807/1994) implying deep insights reflected upon when in solitude. These excerpts go further than documenting my reflections on this thesis; they represent my process in engaging with this research which, in practice, was “full of muddy ambiguity and multiple trails” (Finlay, 2002b, p. 212). Nonetheless, reflexivity provided me with the
space where I could explore and question my position “in producing (imperfect, partial) knowledge” (Finlay, 2002b, p. 227). It also served to “unpack notions of scientific neutrality, universal truths and researcher dispassion” (Fine, 1994, p. 71). I envisage that the continuing thread of these Inward Eye excerpts together with others measures which will be discussed in Chapters 4 and 5, will help readers assess the quality and trustworthiness of this thesis, as well as providing glimpses of the “ambiguities of becoming” (Dall’Alba, 2009, p. 34) a qualitative researcher.

ii. This thesis is written in the first person which is in keeping with my social constructionist and interpretative underpinnings. It also makes significant use of footnotes that offer explanatory comments without interrupting the flow of the main discussion.

iii. Whilst the importance of up-to-date literature is indisputable, this thesis also contains older sources as these provided valuable and therefore current insights into the story and the development of IPE.

This introduction now closes with the first in the series of The Inward Eye reflections, followed by Chapter 2 which contextualises the case in this study; both from a local and an international perspective.

1.8 The Inward Eye

My choice in adopting a qualitative approach meant that I had to recognise, acknowledge and embrace how my own story might inform the processes and outcomes of this particular study. These reflective and reflexive thoughts were selected from my five year reflexive diary and describe my rite of passage into the process of engaging with the research, making the research process as transparent as possible so as to finally present a coherent and scholarly document demonstrating mastery in the field, as well as making a modest contribution to knowledge in the field.

5 Dall’Alba (2009) suggests that learning to become a professional, in this case, a researcher, involves not only knowledge and skills but also who we are (becoming).
In the first months of my journey, I realised that my interest and enthusiasm for IPE could bias the whole research process starting from the way I reviewed the literature, to data collection and data analysis. I needed to distance myself ... however suppressing my interest into IPE was unrealistic. I made every effort to be continually vigilant of my biases and found myself creating a mental mantra which helped me sustain this stance ... I was exploring the possibility of IPE in Malta and this did not necessarily make me an immediate advocate for it. This helped me develop a more neutral and healthy position towards IPE.

The process of being a researcher within my own organisation was a major issue which had to be acknowledged and addressed through my reflexive writings. As hard as I tried to adopt a neutral perspective, in letting go, in questioning and challenging my preconceived ideas and beliefs, I was always going to play a major role in the world within which I was studying. In short, it was a case of standing in my own truth. Slowly, I came to celebrate and appreciate this truth ... however I needed to reflect on that and how that would colour the entire research process.

These excerpts provide insights into some of my innermost processes and struggles by exploring my own identity in relation to the data and in trying to make sense of new understandings and interpretations. They also encapsulate a degree of artistry and introspection which I experienced throughout the whole process. Many questions are posed ... some of which are left unanswered; but that, I have learnt is the nature of inquiry contextualised in our postmodern world imbued with multiple truths and multiple identities. I hope that these reflexive thoughts will enrich the story of my thesis as well as provide glimpses into my journey towards doctoral level thinking.
Chapter 2  Setting the Scene

2.1  Introduction

Following the introduction of this thesis, this chapter presents the background for this study. Part 1 focuses on the Maltese context; it discusses relevant aspects of Malta’s historical and cultural background, explains the structure and development of the health care system and considers professional health education at the Faculty of Health Sciences, University of Malta. This three-stranded approach aims to illustrate the context in which participants’ discourses were situated. Part 2 situates this study within an international context and traces a historical and geographical map of the emergence and development of undergraduate IPE worldwide.

2.2  Part 1: The Maltese Context

2.2.1  Historical and Cultural Background

The Maltese archipelago comprises of three small islands: Malta, Gozo and Comino (Malta being the largest) making it one of the smallest countries in Europe. As shown in Figure 2.1, these islands are located in the centre of the Mediterranean Sea. Sicily is located 93km to the north, Africa 288km to the south, Gibraltar 1826km to the west, and Alexandria 1,510 km to the east.

Malta's position and size seems to encapsulate its cultural disposition echoing Mitchell’s (2002) view on Malta as being “caught on the margins of Europe, between tradition and modernity” (p. 239) (Figure 2.2). The total land area is 315km² and, with a population of 417,520, Malta is the most densely populated country in the European Union (National Statistics Office, 2013).
Figure 2.1 Location of Malta within a European context

Figure 2.2 Figurative map of Malta
Historically, Malta’s strategic position made it an attractive base for naval powers, mostly due to its excellent harbours. Over the ages, it has been occupied by the Phoenicians, Carthaginians, Romans, Arabs, Normans, the Knights of the Order of St. John, the French and the British (Pace Asciak, Camilleri & Azzopardi-Muscat, 2002). In 1800, Malta voluntarily became a colony under the British Empire. Under British rule, the island housed the headquarters of the British Mediterranean fleet, and became a military and naval fortress. In 1921, the British granted self-government to Malta. However, due to several constitutional upheavals, it was only in 1964 that Malta obtained its independence and became a sovereign state. Malta became a republic in 1974 (whilst retaining membership in the Commonwealth of Nations) and the British Forces left the island in 1979 (Blouet, 1993). In 2004, Malta became a full member of the European Union as one of its small state members. While English and Maltese are both official languages, the predominant language used in secondary and tertiary education is English.

The various dominations of Malta over the course of history have bestowed a rich and colourful tapestry on Maltese culture, which is said to be broadly Mediterranean or Latin European. At the same time, it is very distinctive with its own blend of historical and economic traditions which, in turn, have influenced our values and practices as a nation (Baldacchino, 2000). There is an apparent confluence between the micro status and insularity of Malta versus Malta’s position in the shadow of European influences and value systems (Sultana & Baldacchino, 1994). This theme, which is particularly relevant to this study, is examined by Mitchell (2002) in an ethnographic study on the Maltese people. He explored the Maltese national identity during the accession process to European membership, suggesting that the idea of Europe was perceived as both a promise and a threat: a promise of increased security and modernity but simultaneously a possible threat to morality, family and tradition. Although Mitchell’s (2002) study was carried out in the context of possible EU membership, it could be suggested that such ambivalent traits and consequent anxieties about the present and the future may be applicable to other areas, especially where changes are proposed. The official religion in Malta is Roman Catholicism and religion has been, and still is, an important influence in the culture and identity of the Maltese people (Baldacchino, 2000).
It is noteworthy that the effect of the British influence on Malta (1800 to 1964), which transformed the Maltese language, culture and politics, resonates long after this rule has ended (Blouet, 1993). Multiple overt British legacies may be witnessed in, for example, a parliamentary structure based on Westminster, a legal system founded on common law, and a civil service enacted on the British model (Cassar, 2000). Malta’s public health national system is loosely based on the British National Health Service (NHS) and there are close links between Malta’s Medical School, the Faculty of Health Sciences, and several British hospitals and academic institutions (Azzopardi-Muscat, Grech, Cachia & Xuereb, 2006). There is also an implicit affinity and role modelling in relation to, primarily British but also increasingly American, academia. Indeed, foreign consultants, examiners, conference guest speakers, and other experts are more commonly invited from Britain or America as opposed to mainland Europe. Furthermore, many Maltese wishing to pursue postgraduate studies overseas do so in these same countries, hence perpetuating this cycle of “cultural cloning” (Sultana & Baldacchino, 1994, p. 11).

2.2.2 Health Care in Malta

2.2.2.1 Health Status

The health status indicators in Malta are generally favourable. The total health expenditure in relation to GDP was 8.7% in 2012, falling below the EU average of 9.6% (WHO, 2013a). Healthy life years, which is a European structural indicator of a nation’s health status, compares favourably to the EU-27 average. In 2010, the major causes of mortality and morbidity in Malta were coronary heart disease and stroke, followed by accidents for individuals under 65 years, whilst cancers accounted for 24% of all deaths. Diabetes is a significant national health problem with 10% of the Maltese population having diabetes mellitus, as compared to 2% to 3% of European countries (Rocchiccioli, O’Donoghue & Buttigieg, 2005).

2.2.2.2 Health System

The Maltese public health care system is funded through taxation and national insurance and operates through public hospitals and health care centres. Established in 1948, this system has been in place for over thirty years and has been influenced by the British National Health Service (NHS) (Azzopardi-Muscat, Calleja, Calleja &
Cylus, 2014). The Maltese health care system covers all residents and offers primary, secondary and tertiary health care services which are free of charge at the point of use. Private health care plays a complementary role for health care coverage and coexists with the state system with out-of-pocket payments and private health insurance (Cordina & Borg, 2012).

Primary care in Malta is covered by both the public and private systems and these function independently of one another. Within the public sector, primary health care covers general practice, community care, immunisation and school health service. In 2009, the Government launched a consultative document on the future of primary health care services in Malta and one of the policy objectives aimed to provide more comprehensive and collaborative services to the population at large (Ministry for Social Policy, 2009). This document was not fully endorsed by the necessary stakeholders (Azzopardi-Muscat et al., 2014) and to date, discussions on it have been stalled. Secondary and tertiary care are mainly provided by specialised public hospitals of varying sizes and functions. Mater Dei Hospital, the main acute general teaching hospital, was inaugurated in 2007 and is located adjacent to the University of Malta.

During recent years, rehabilitation services have been undergoing a process of restructuring and consolidation (Cordina & Borg, 2012). In 2007, a political decision was taken to migrate a 60-bed geriatric hospital, Zammit Clapp Hospital, to Karin Grech Rehabilitation Hospital as part of a wider rehabilitation plan for Malta. This is of particular interest to this study in that Zammit Clapp Hospital was the only public hospital in Malta providing a multidisciplinary team approach to geriatrics (Ferry & Fiorini, 2005). Indeed, Rizzo Naudi, former Chairman of the Institute of Health Care (now known as Faculty of Health Sciences) referred to the ‘Zammit Clapp Hospital Concept’ (Appendix 1) highlighting the importance of interdisciplinary cooperation (Rizzo Naudi, 2010a). However, since the 2007 migration necessitated increased demand for services to cater for 280 patients (without the concomitant increase of staff), multidisciplinary working as had been

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6 The premises chosen for these migrated rehabilitation services were the old acute hospital. This was a great disincentive for staff.
practiced at Zammit Clapp Hospital became increasingly difficult to sustain (C. Scerri, personal communication, February 1, 2012).

Long-term care has benefited from an expansion of community-based services and residential care facilities. This has been in response to the growing number of older citizens (due to demographic trends of ageing population) and persons with disability. The Community Care Outreach Programme, part of the community care services, is significant here because it consists of a six-week programme delivered by a multidisciplinary team whose objective is to support the informal carers of dependant persons so as to enable the latter to continue living in the community (Cordina & Borg, 2012).

The health sector is one of the largest employers in Malta. Malta’s 2004 accession to the European Union was a strong determining factor affecting human resources in health care (Buttigieg, 2013), mostly due to an expected increase in professional mobility between Malta and other EU member states (Vassallo, 2005). Following EU accession, Malta experienced a severe outflow of newly qualified doctors, mainly to the United Kingdom where it was customary that Maltese doctors continue their specialist training. However, this shortfall was effectively managed by establishing a mutual recognition agreement with the United Kingdom General Medical Council and introducing formal specialisation training programmes in Malta (Azzopardi-Muscat et al., 2014). The insufficient number of nurses to meet local demands was also addressed by active sourcing and recruitment from overseas (Cordina & Borg, 2011). Within the allied health field, there have been ongoing discussions between the Ministry for Health and the Faculty of Health Sciences to ensure that the ongoing professional educational programmes will meet current and future local health care demands (J. Chetcuti, personal communication, September 2012).

Provision of comprehensive health services, recruitment, training and retention of health care professions remains one of the major challenges for policy makers (Azzopardi-Muscat & Grech, 2006). Health Vision 2000, the first national strategic health plan, offered a road map for achieving the highest standard of health and health care for Malta (Ministry for Social Development, 1995). This policy is of
special interest to this study because it was the first to emphasise intersectorial
participation between government departments, agencies, voluntary organisations,
and other sectors, such as business, industry, labour unions, local councils and
professional groups. However, the reality unfolded differently and collaboration
both within and outside the Health Department remains an ongoing struggle (R.
Xerri, personal communication, June 7, 2011). The objectives set out in this national
strategic plan, many years ago, have been at the heart of subsequent health policies
and reforms, and intersectorality remains one of them (Azzopardi-Muscat et al.,
2014).

Similar to other countries, the local health system faces many challenges including
an ageing population, which impacts the sustainability of public finances. In
response to these challenges, over the last decade there have been major health
reforms and the enactment of new legislations. The focus has been on maximising
efficiency, together with investment in primary and community-based health and
social care (Azzopardi-Muscat et al., 2014). In February 2014, A National Health
Systems Strategy for Malta for the period 2014-2020 (Ministry for Health, 2014)
was presented; the main thrust of this strategy is a people-centred approach which
recognises the importance of informing and empowering patients so as to promote
and protect their own health. This document makes numerous references to the
importance of promoting practices which encourage teamwork and collaboration
across disciplines. Indeed, under Section 6.3 of this document entitled ‘The values,
principles and characteristic of a people-centre health system approach,’ health
authorities are tasked with:

Investment in health professional education that promotes multidisciplinary
teamwork, good communication skills, an orientation towards prevention,
and integrates evidence about psychosocial dimensions of health care
(Ministry of Health, Malta, 2014, p. 67).

This document includes other references related to promoting multidisciplinary
approaches and multidisciplinary teams in all services given by the national health

7 The cost of treating an ageing population was identified as the major challenge facing local health
systems as the average cost of illness rises significantly per capita in higher age categories
(PricewaterhouseCoopers Malta, 2012).
system. Regrettably though, it falls short of outlining how these multidisciplinary approaches and teams are to be fostered.

2.2.3 Health Education at the Faculty of Health Sciences

The University of Malta, a state-funded university, has a four hundred year old history with a long tradition of scholarship and research in most disciplines. There are some 11,000 students, including 700 foreign students from 77 countries, following various degree or diploma programmes. In recent years, the University has reviewed its structures so as to be in conformity with the Bologna Process⁸ and the European Higher Education Area. The University has fourteen faculties and a number of interdisciplinary institutes and centres (University of Malta, http://www.um.edu.mt/about/com).

Within the field of health and social care, the faculties/departments include the Faculty of Medicine and Surgery, Faculty of Dental Surgery, Department of Psychology, Department of Social Policy and Social Work, and the Faculty of Health Sciences (responsible for the education of nursing, midwifery and allied health professionals). Due to the research objectives of this thesis, the following sections focus on the last of these faculties, the Faculty of Health Sciences.

The current Faculty of Health Sciences was originally set up as the Institute of Health Care (IHC) in 1987 for the education and training of health care professionals (nurses, midwives and allied health care practitioners).⁹ As illustrated in Appendix 2, although this Institute was under the academic responsibility of the University of Malta, it was heavily dependent on the Ministry for Health, Elderly and Community Care for financing of personal emoluments, training budgets, facilities and courses (Rizzo Naudi, 2002). When the Institute become a Faculty in 2010, financial autonomy from the Ministry for Health, Elderly and Community Care was negotiated (J. Camilleri, personal communication, January 4, 2013).

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⁸ The Bologna Process is a series of ministerial meetings and agreements between European countries to ensure comparability in the standards and quality of higher education qualifications (Christensen, 2004).

⁹ Prior to the setting up of the Institute of Health Care in 1987, all nursing, midwifery and allied health related courses were run by the Department of Health at St. Luke’s Hospital Training School for Nursing (Rizzo Naudi, 2014).
The first undergraduate programme which was offered by the IHC was the BSc (Hons.) in Nursing and Midwifery in 1988. Other divisions slowly followed. Initially, there was a heavy reliance on foreign lecturers, however this dependence slowly decreased and, by the end of 2000, all teaching staff were local lecturers, with the vast majority possessing a Master’s degree in their disciplines and a small number having a PhD. Over the years, various diploma, degree and postgraduate health care programmes were introduced at the IHC, reflecting the health care needs of the nation; this became one of the drivers for academic staff to read for their doctorates (Rizzo Naudi, 2010b).

Since the mid-1990’s, the concept of collaboration between professions represented at the Institute and other university faculties seemed to be important for policy makers. For example, as shown in Appendix 2, during the first IHC strategic conference in 1995, the importance of forging alliances with other faculties was considered:

The IHC was to enter into discussions with the medical, dental and possibly, the pharmacy faculties to create a structure for an Allied Health Sciences grouping within the University that recognised the contribution and autonomy of each of the professionals represented in the group (Galea, 6th June, 1995 cited in Rizzo Naudi, 2002).

Seven years later, while presenting a Draft Development Plan document outlining the strategy to be adopted by the Institute of Health Care (2002-2006), Professor Rizzo Naudi, then Chairman of the Institute of Health Care, referred to this issue by reiterating the above goal and outlining what had been done to address it:

The IHC is characterised by a number of very different disciplines and courses in the various divisions. After many meetings of the coordinators, a broadly coherent set of courses across and within these professions has been created although there are still some persistent differences inherent to the IHC (Rizzo Naudi, 2002, p. 4).
These “broadly coherent set of courses across and within these professions” mentioned above referred to the ‘common core teaching’ modules which, according to the definitions presented in the glossary, fall under ‘shared learning’ initiatives. The students attending these modules are undergraduate IHC students (now the Faculty) with occasionally other students from diverse faculties, such as Psychology and Education. During these lectures, students from different professions sit together in classes or large auditoriums to listen to a series of lectures about core subjects, such as Anatomy, Physiology, Pathology, Developmental Psychology and Nutrition. The lecturers for these common core teaching modules are usually clinicians with part time academic appointments affiliated to university departments within other faculties such as the Medical School, Department of Pharmacy or Department of Psychology. Administrators scheduling these modules are challenged with a myriad of logistical problems, including finding spacious auditoriums to accommodate large numbers of students, finding common times in the various students’ time tables, and securing lecturers willing to teach such large groups (over and above their clinical work commitments). Collaboration between students is an aspect which is not a requisite and thus is not explicitly addressed.

This common core teaching is carried out in the first two years of undergraduate degree programmes. Recently, two common core modules concerning research (Reviewing the Health Science Literature and Research Methods in the Health Sciences) have been included in the second and third year undergraduate faculty programmes. These modules, unlike the other common core curriculum lectures, have been developed and delivered by academic staff from the Faculty of Health Sciences, itself.

In 2005, the Director of the then Institute of Health Care, reiterated the importance of interdisciplinary collaborations between university faculties in an editorial in the Malta Medical Journal:

It has also become very important that the Institute of Health Care and the Faculties of Medicine and Surgery and that of Dentistry should enter a new phase of dialogue and collaboration ... the introduction of interdisciplinary credits in the undergraduate curriculum and more postgraduate courses will
further help in achieving team building as from student days (Buttigieg, 2005, p. 8).

Some years later, in 2008, this same Director spearheaded a joint interprofessional pilot project between the Institute of Health Care and the Medical School involving fourth year students from Medicine, Communication Therapy, Occupational Therapy, Nursing, Physiotherapy, Podiatry and Radiography. These students were presented with a case study of a patient who had sustained a cerebral vascular accident (stroke) with complex and multiple pathologies and were encouraged to collaborate on the case and develop a common patient assessment together with a treatment plan. The final outcomes of the project were presented during a one day interprofessional symposium held in June, 2008 which was open to all students and academic staff at the Institute of Health Care and the Medical School. The project was evaluated though the analysis of students’ feedback forms and fifteen individual interviews which were held after this one day symposium. The results suggested that the introduction of this kind of common teaching, as opposed to the common core teaching, could be beneficial to health care students (Sacco, 2008). However, despite providing interesting insights, Sacco’s study was limited by a failure to provide certain crucial specifics in relation to the development and delivery of this pilot initiative. For example, relevant information, such as how the initiative was structured, facilitated and supported were absent from his account. This study’s participants’ perceptions of this symposium are discussed in Chapter 6: Findings.

In 2009, the IHC Board initiated discussions exploring the possibility of the Institute moving towards faculty status. These discussions mainly focused on strategic analysis of each division and the formulation of a future strategy that would define each department within a faculty (Rizzo Naudi, 2010b) (Appendix 3). Each divisional head, together with members of staff, carried out a SWOT analysis (strengths, weaknesses, opportunities, threats) of their particular division. The final strategic plan document (including a SWOT inventory, based on the collation of the divisional SWOT analysis) can be found in Appendix 4. It is worth pointing out that the term ‘interprofessional’ was mentioned several times throughout the document and this is highlighted in Appendix 5. These references to IPE and/or collaboration provide evidence that the concept of IPE was discussed during divisional meetings,
as well as during the more formal Board of Studies meetings. This is substantiated by formal minutes taken during these Board of Studies meetings which, for confidentiality reasons, cannot be included in this dissertation.

A letter written by the Chairman of the IHC (Rizzo Naudi, 2010a) to the Rector of the University (as part of the changeover process from institute to faculty) underscored the importance of interdisciplinary cooperation within a faculty context stating that although the original mission statement of the Institute of Health Care was to be retained, there should be an additional emphasis on interdisciplinary cooperation. The full letter can be found in Appendix 1. The multidisciplinary approach practiced at Zammit Clapp Hospital and discussed above was also referred to as a model of care to which the Faculty should aspire (excerpt below):

The Care aspect of this Faculty of Health Sciences will be emphasised by keeping the original mission statement of the Institute: ‘To achieve excellence in the education and training of reflective, caring, accountable health professionals in response to the health and health service needs of the population’ that was formulated in 1992 and reflected the needs and the social climate of the Maltese Islands at that time but is still very relevant today. This will remain the basic mission of the Faculty. However, research on the effectiveness of our Health Services at the point of delivery and the health of the population will also remain a highly important goal of our Faculty together with active and continuous efforts towards more and more interdisciplinary cooperation similar to the Zammit Clapp Hospital Concept approach with team working among the various departments for a holistic and more effective approach towards patient care and the health of the population in general (Rizzo Naudi, 2010a, p. 2).

In August 2010, the Institute of Health Care was formally conferred faculty status (Faculty of Health Sciences), necessitating major organisational and administrative restructuring including the election of a dean from the academic staff themselves (Ferrito, 2010). Upgrading to a faculty status coincided with the physical relocation of the Institute. The site earmarked for the new Faculty was originally close to the main university campus, however, due to escalating costs for the construction and
furnishing of the main hospital, these plans had to be abandoned. Consequently, the Faculty of Health Sciences, the Medical School and the Faculty of Dental Surgery were located at the periphery of the new main hospital (R. Xerri, personal communication, April, 2011). Although these buildings are in close proximity to each other, they are distinct faculties. Other related faculties, such as the Faculty of Social Wellbeing and the Faculty of Education, are located in separate buildings on the main campus.

The Faculty of Health Sciences comprises eleven departments (rather than the former divisions) namely: Applied Biomedical Science, Food Studies and Environmental Health, Health Services Management, Midwifery, Nursing (which includes Mental Health Nursing), Medical Physics, Occupational Therapy, Physiotherapy, Podiatry, Radiography and Speech Language Pathology. In addition to undergraduate programmes, most of these departments offer postgraduate degrees. The Health Services Management and the Medical Physics Department are the only departments that offer degrees at postgraduate level only. The number of full time resident academic staff at the Faculty is 65 and the number of part time academic staff holding a Council appointment stands as 62 (as per academic year 2015-2016). Almost all of the academics have a professional health care background and many of the part time academic staff are still working within the health service sector. The Faculty is currently the second largest faculty at the University, with over 1,300 students participating in various undergraduate and postgraduate years programmes\(^{10}\) (Rizzo Naudi, 2014).

Although currently there are no formal IPE initiatives at the Faculty, the following programmes exemplify multidisciplinary or shared learning at undergraduate and postgraduate levels respectively.

- Bachelor of Science (Hons.) Health Science - Distance Learning is aimed at facilitating accessible education for those health professionals possessing a diploma and wishing to upgrade their qualification to a degree (Rizzo Naudi, 2010b) (Appendix 3). Since this degree is offered for various health

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\(^{10}\) Appendix 6 shows detailed student population as per each Faculty of Health Sciences programme of studies (2015-2016).
professionals it has a multidisciplinary element, especially within its virtual learning platform.

- The Common Core teaching curriculum (discussed above). A more advanced version of these modules is also delivered in a multidisciplinary manner to postgraduate students at the Faculty.

- Master of Science in Health Services Management is a postqualification programme attracting a multidisciplinary cohort from qualified health professions. The teaching is carried out in a multidisciplinary manner intended to encourage students to communicate and work together.

- The Clinical Education in Practice is a postqualification course targeted at state-registered health professionals and is described as “interprofessional in its philosophy and delivery ... Various platforms are used to encourage participation and communication between candidates of different professional backgrounds and these include seminars, workshops, online debates, problem-solving and placement” (University of Malta, http://www.um.edu.mt/healthsciences/studyunit/HSC4061) This course is usually heavily subscribed as it has replaced all clinical mentorship and clinical education courses held by each department.

2.3 Summary of the Maltese Context

Mccallin (2001) contends that IPE must be contextualised within the socio-political context where it unfolds and should be oriented towards meeting the needs of the particular audience. Part 1 of this chapter has partly addressed this concern and has raised a metaphorical curtain to make explicit and understand the stage on which this research will unfold - the various facets of the Maltese context. It has shown that Malta, a small but highly populated European state, has a relatively good health status underpinned by a strong public health care system. However, similar to many other countries, Malta faces challenges in the financial and operational sustainability of its entire health care system and these could eventually challenge the possibility of IPE.
Although the concept of multidisciplinarity within the health service has always been endorsed: Health Vision, 2000 – Ministry for Social Development (1995); Consultative Document on the Future of Primary Health Care Services – Ministry for Social Policy (2009); National Health Systems Strategy (2014 – 2020) - Ministry for Health (2014), it seems to remain more at policy level or else curtailed in contexts where it was practiced (Zammit Clapp Hospital). Within professional health education, a similar pattern emerges. Discussions of collaboration at the Institute of Health Care have taken place since the mid-1990s and the concept of interprofessionality seemed to be significant while planning the strategic direction of the new faculty. To date, tangible efforts of multidisciplinary/shared learning at the Faculty are the common core teaching curriculum, the 2008 interprofessional symposium and the few examples outlined above. In the light of rapid demographic transitions and challenges for health systems in Malta and worldwide, a study exploring new ways whereby health care professionals could be educated and equipped to respond to these changing health care needs is, to my mind, timely. Part 2 of this chapter, the Global Context, follows The Inward Eye and explores the emergence of IPE worldwide highlighting national, policy, cultural, institutional and resource developments and challenges that have precipitated and shaped the global interprofessional movement; developments and challenges which invariably will be of relevance to this research.

2.4 The Inward Eye

And where do I fit in within the story of the Faculty? My story started in 1996 when I joined the then Institute of Health Care as a part time lecturer in Occupational Therapy and then as from 2010 as a full time academic. My move to full time academia meant that I had to shed my Policy Coordinator (Ministry of Health) role which I had held for more than ten years to become an Occupational Therapy lecturer. I was comfortable with this transition as moving towards academia was something that I had wished.

Assuming a full time role at the Faculty made me acutely aware of my new surroundings. This coincided with the start of my doctoral programme so my critical perceptions were even more heightened. Being part of the Faculty brought me in touch with the different health care backgrounds of the professions which were
represented at the Faculty and the way that each professional had to
metamorphosise himself to become a lecturer ... including myself. The process of
becoming a lecturer was largely expected to happen naturally, possibly facilitated by
the acquisition of Master’s and Doctoral degrees. But in reality did it? This
reminded me of expecting newly qualified graduates to work collaboratively once
they started practising.

I started to become aware and observe the pervasiveness of professional cultures
and the cultural discourses that shaped everyday life and interactions at the Faculty.
Ultimately, the Faculty was a group of professions with different ideologies all
working separately within their domains ... but under one roof. Nonetheless, I saw
many commonalities in our health professional education. From my documentary
search, both from the Faculty as well as from the Ministry of Health, the concept of
working together and teamwork seemed to be espoused to ... however was this just
rhetoric? All the Heads of Departments and Lecturers at the Faculty seemed to be
drowning in their teaching commitments, research and administrative bureaucracy,
leaving no time to discuss or reflect on any pedagogical innovations or at the least,
successful pedagogical practices. But was pedagogical research or innovations ever
high on the agenda? Or were we always trying to cram more specialised knowledge
into our curricula? Informative learning at its best. Could this be one of the
reasons why the concept of collaboration was always espoused but never actually
practiced? Within such a context, interprofessional initiatives would always be
considered peripheral and possibly dispensable to professional interests.

This made me question again why I, as an Occupational Therapist, became
interested in this area? Working within a broader health policy context at the
Ministry for Health, Elderly and Community Care, I became more appreciative of
the bigger picture of health care within our local, social and cultural context; I
recognised and accepted divergent views, attitudes and values, possibly to create
something bigger. This did not make me less of an occupational therapist but
increasingly, I saw myself as part of a team working towards a common goal (for
example, the national dementia health strategy). Whilst acknowledging that health
policy and planning was not clinical practice and hence devoid of hospital realities,
there was a great professional satisfaction of working towards common patients’
goals together with different professions. This personally resonated with the raison d’etre of IPE which is learning together, to be able to work together ... however, as much as it is simple to understand, it seems to be so elusive to develop and implement.

2.5 Part 2: The Global IPE Context

2.5.1 Introduction
Part 2 of this chapter presents a geographical and historical overview of the development of pre-registration IPE in different countries across the globe. It is neither intended as a definitive nor an exhaustive review; rather it offers a descriptive ‘potted’ history of the growth and development of IPE in a number of countries as a means of situating my study within its international context, thereby providing a background to considering IPE within the Maltese context in later chapters.

Collating this chronological narrative proved to be labyrinthine due to the overlapping nature of IPE and IPC literature encompassing undergraduate (pre-registration), postqualifying and work-based initiatives set against a backdrop of changing government policies and drivers. IPE as has been highlighted earlier, is also associated with a number of terms used interchangeably across the literature, further adding on the challenge in charting its emergence and development worldwide.

2.5.2 Global Drivers for IPE
More than forty years ago, the World Health Organisation identified interprofessional education as an important component of primary health care (WHO, 1973). Some years later in 1978, inspired by the Alma-Ata Declaration (WHO, 1978), the WHO European Region published the seminal book Targets for Health for All in which it identified thirty eight health-related targets for the fifty one countries to achieve by the year 2000. This policy document mapped out a number of targets, which emphasised the need for increased collaboration in education, training and practice between the health professions (WHO, 1985). A WHO study group on Multiprofessional Education of Health Personnel then issued the
authoritative statement on IPE: *Learning together to work together for health* (WHO, 1988). This report called upon the development of multiprofessional education and collaborative practices as a means of improving health outcomes. It recognised those higher educational institutes that included such learning in their curricula and urged others to follow suit (WHO, 1988). It also recommended that the various health professions should have common learning experiences occurring at different times during their education. This common learning, it was anticipated, would encourage students to acquire the necessary skills for team competencies whilst addressing the health care needs of the communities.

Almost two decades later, in 2006, the WHO reaffirmed its interest in IPE when it convened a Study Group focused on Interprofessional Education and Collaborative Practice tasked to conduct an international environmental IPE scan and to develop a conceptual framework for IPE (WHO, 2006; Yan, Gilbert, Hoffman, Rodger & Ishikawa, 2007). The ensuing report, *Framework for Action on Interprofessional Education and Collaborative Practice* outlined a strategic vision for a “collaborative practice-ready workforce” and provided strategies for health and education policy makers to develop and implement IPE and collaborative practices particular to their local contexts (WHO, 2010, p. 7). During this time, the interprofessional movement supported by various networks and collaboratives was also slowly gaining momentum (Thistlethwaite, 2010). More recently, the WHO published its first ever guidelines calling for new approaches in health professionals’ education and training; IPE was included as one of the recommendations, albeit with caution pending more robust evidence (WHO, 2013b).

The Organisation for Economic Cooperation and Development (OECD) also promoted IPE. In 1977, an OECD conference served as a discussion forum to show examples of IPE between different programmes in different countries (OECD, 1977). The World Federation of Medical Education (WFME) formally acknowledged IPE in 1988, and a year later called upon nations to train their doctors in a collaborative manner (WFME, 1988), reinforcing this appeal in 1993 during the World Summit on Medical Education (Walton, 1994).
In 2010, The Lancet published a paper arguing for a major shift in professional health education so as to be able to influence health systems worldwide. It was envisaged that learning should change from merely being formative and informative to one which was transformative. Within this vision, IPE was recognised as being an integral part of a continuum of all health professionals’ learning so that eventually it becomes embedded in their professional development (Frenk et al., 2010).

The collective message from these authoritative documents is that health systems face serious challenges mostly due to rapid demographic changes, health care worker shortages, increased incidence of long term and complex conditions, new infectious diseases, environmental and behavioural risks, increasing specialisation of health professional practices, patient safety and the quality agenda (Frenk et al., 2010; Thistlethwaite, 2012; WHO, 1985; 1988; 2010). Education and health are interdependent and it is argued that IPE, as opposed to the traditional silo-based health education, could contribute towards an interprofessional workforce better equipped to meet current and further health care demands (Hughes, 2007; WHO, 2010). The call for IPE was heard and addressed in various countries and sections to follow give a broad overview of these developments.

2.5.3 IPE in Europe

2.5.3.1 United Kingdom

In the United Kingdom, early small-scale, work-based and postqualifying initiatives started in the late 1960’s and early 1970’s. There were also the beginnings of certain movements within social work and nursing professions, as well as professions which were associated with medicine and complementary therapies who collectively and in various ways were developing common academic frameworks. The intentions behind these movements were to improve practice and patient care, to gain collective strength and to secure a place in higher education. These seemed to be the initial proponents of ‘generic’ studies and were the first developments towards integrated learning for the different professions. It is

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31 As has been highlighted in Part 1 of this chapter, although Malta is an independent republic, the British legacy still lives on. Thus the story of IPE in the U.K. is chronicled in far more detail than other European countries.
contested whether these initiatives were essentially interprofessional or just coincidentally occurring in tandem with the contemporary movements then (Barr, 2007a). This was also the time when community services and teamwork were being introduced and developed in areas such as mental health and learning disabilities (Barr, 2000a).

It seems that the first explicit IPE activities were fragmented endeavours in the 1970s and took place in shared undergraduate studies in Southampton, Liverpool, Newcastle, Cantebury and Keele (Mortimer, 1980). Other early developments included: a mandatory shared learning week at the former Bristol Polytechnic (Parsell & Bligh, 1998); a common course for allied health professions in Salford set up by Lucas in 1990 (as cited in Leathard, 1994); various multiprofessional opportunities (lunchtime meetings, joint home visits and residential weekends) in Thamesmead presented by Jacques in 1986 (as cited in Barr 2007a); obligatory practice weeks between medical, nursing and physiotherapy students at Middlesex Hospital (Hutt, 1980); joint training programmes for practice teachers (Anderson, Bell, Eno, Littleford & Walter, 1992) and workshops between doctors and nurses (Carpenter, 1995). Other initiatives may have occurred that were never documented or published.

The growing interest in IPE was the impetus for the establishment of the Centre for the Advancement of Interprofessional Education in Primary Health and Community Care, (CAIPE), in 1987 (Pietroni, 1994). This was an independent expert organisation, created to promote research and development of IPE and to foster IPC in practice. Over the years, CAIPE has strived to become a coherent body for promoting, developing and supporting IPE, and today it has achieved national and worldwide recognition, both as a focal point and as a source of expertise for IPE (Barr, 2007a; Gray, 2015).

The Education and Training Unit at the Marylebone Centre Trust which was established in 1988 was another significant organisation in the United Kingdom. This Trust was responsible for the establishment of the Journal of Interprofessional

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12 IPE in the U.K. and worldwide is synonymously intertwined with Emeritus Professor Hugh Barr, President of CAIPE. He has chronicled IPE in innumerable publications and this chapter in particular has drawn heavily on many of his publications.
Care (in 1992) promoting worldwide collaboration between education, practice and research in health and social care. A smaller organisation, the Health Care Professions’ Education Forum, was also set up in 1989 beginning as a multiprofessional group aspiring to forge links in developing and implementing changes in education and training. Over the years, other small organisations, such as Continuing Care at Home, Commission on Primary Care and the Alliance of Primary Care also sought to promote collaborative practice. However, by 1993, these small organisations found working together difficult (Leathard, 1994) which is paradoxical since collaboration was the task that they themselves were championing. This seems to reflect the rhetoric of team working which, although espoused to be the ideal solution, “sits alongside power relations, status differences, resource limitation, blurred role definitions and time pressures” (Stark, Stronach & Warne, 2002, p. 411).

The public at that time was slowly becoming aware of national public inquires and reports concerning appalling and grievous occurrences happening within the health and social care sectors. Reports, such as the inquiry into the death of Maria Colwell\(^{13}\) (Department of Health and Social Security, U.K. 1974) and the Cleveland child abuse cases\(^{14}\) (Butler-Sloss, 1988), highlighted a lack of effective communication and collaboration between the agencies involved, and this inadvertently supported the case for IPE (Barr, 2007a).

The government was also at the time encouraging professions to work together. Testament to this were the numerous policy documents commending joint training or shared/common learning as being crucial for teamwork and collaboration (Barr, 2007a). The chronology and scope of these policy documents can be found in Appendix 7. However, one particular report, the Schofield Report (1996), is relevant here. Whilst the focus in the other documents was on postqualifying education so as to improve coordination between professions and agencies, the Schofield Report recommended a multi-skilled workforce with common core training, generic carers

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\(^{13}\) Maria Colwell was an eight-year old child who had been starved and beaten to death by her stepfather in 1973. The case was extensively covered and led to a Department of Health and Social Security inquiry (DHSS, 1974).

\(^{14}\) In 1987, the Cleveland child abuse scandal involved two paediatricians who diagnosed sexual abuse in one hundred and twenty one children from fifty-seven families in the area. Most of the children were removed from their homes and placed under safety orders. The Butler-Sloss Report (1988) concluded that most of the diagnoses were incorrect.
and flexible working (Schofield, 1996). This report, which was mostly penned by service managers and human resource directors, raised a lot of fears amongst health professionals in that IPE was being used as a scapegoat so as to legitimise a “veiled attack” on their professional identity (Barr, 2007a, p. 2) and this consequently instigated resistance to IPE (Pittilo & Ross, 1998). These ideas were in contrast to what IPE meant and, in fact, Barr (1996) has repeatedly clarified that IPE is about respecting the differences between professions, rather than producing a flexible or a generic workforce.

On the whole, there seemed to be a gap between existing IPE practices and the policy enthusiasm promoted by the government (Barr, 2007a; Ross & Southgate, 2000). Ongoing IPE initiatives were isolated and fragmented and frequently entangled in a bureaucratic system of accreditation, funding and educational commissioning. It was evident that IPE was still a long way off from being integrated in the majority of university curricula; nonetheless, the groundwork was laid for the reforms which were to unfold in the ensuing years (Barr, 2007a).

The year 1997 was a milestone for IPE in the United Kingdom. A new Labour government, as part of its health and social care workforce modernising agenda, called for collaboration at all levels, including undergraduate programmes. The vision was to integrate ‘common learning’ into mainstream health and social care undergraduate professional education, giving impetus to IPE. The first international interprofessional conference entitled ‘All Together Better Health’ (ATBH) was hosted by the United Kingdom and, after ten years in existence, CAIPE’s efforts were endorsed by government policy (Barr, 2007a). This enthusiasm was reflected in a plethora of health care reforms; amongst which one of the common threads was a radical review of health care education (Appendix 8 lists the more salient of these reform documents). IPE, most especially postqualification IPE and Continuing Professional Development, seemed to be regarded as a panacea for workforce shortages. In contrast, these policies were largely silent on undergraduate IPE which was seen to be the remit of universities, the professions or validating bodies (Barr, 2000b).
One of these policy documents, *A Health Service of all Talents: Developing the NHS Workforce* (Department of Health, 2000a), advocated a multidisciplinary workforce with new types of health care workers, and this rekindled disputes amongst professionals evocative of the 1996 Schofield Report. Misunderstandings also arose from inconsistencies in terminology when referring to educational activities involving two or more professions as terms such as multiprofessional, multidisciplinary, interprofessional, transdisciplinary and common learning were used interchangeably (Barr, 2002; Glen, 2004).

In the midst of this climate, public outcry was to eclipse all other concerns. Despite Labour’s policies and rhetoric calling for joint and integrated working, appalling events and tragedies, such as the death of children undergoing cardiac surgery (Kennedy, 2001) and the death of Victoria Climbie at the hands of her guardians (Laming, 2003), were still occurring. These events were reminiscent of the 1970’s and 1980’s and again public inquiries into these tragedies highlighted the lack of communication between the professions and the need for a radical reform in the education and training of a range of professionals so as to promote patient-focused collaborative care (Humphris & Hean, 2004; Kennedy, 2001; Laming, 2003). This influenced the IPE agenda yet again (Barr, 2007a) and resulted in the policy response *Every Child Matters: Change for Children* (Department for Education and Skills, UK, 2004). This policy emphasised the importance of multi-agency work and the restructuring of services around teams.

Gradually, IPE was becoming an integral part of pre-registration education. Regulatory bodies, such as those for allied health professions, nursing and midwifery, social work and medicine included IPE in their requirements. In 2001, the Higher Education Institutes and Workforce Development Confederations were invited by the Department of Health to develop common learning programmes. Four national leading edge pilot sites for IPE were selected for funding with the premise to disseminate their evaluated findings (Barr, 2007b). Evaluation of these sites highlighted many key lessons for IPE including the need for IPE to be supported at the micro, meso and macro levels (Miller, Woolf & Mackintosh, 2006). There was also the setting up of *The Combined Universities Interprofessional Learning Unit* between the University of Sheffield and Sheffield Hallam University, leading to the
development of the most widely adopted pre-registration framework in the U.K.: the *Interprofessional Capability Framework*. This framework articulated the learning outcomes that students were required to achieve to develop their capacity as interprofessional workers (Walsh, Gordon, Marshall, Wilson & Hunt, 2005).

By 2004, pre-registration IPE in universities across the United Kingdom was largely established (Barr, 2007a). Diverse interprofessional models both from the pedagogical, as well as from the operational perspectives proliferated (Barr, Helme & D’Avray, 2011). The way in which IPE was interwoven in the various curricula differed from “well-planned implants” to “longitudinal and incremental IPE sequences” (Barr & Ross, 2006, p. 98). In 2007, there was another major initiative. The Department of Health funded a three year project entitled ‘Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care’ (CIPW) so as to develop an education and training framework for health and social care in England (Hughes, 2007). Recommendations from this project were significant and served to raise the profile of IPE (Barr *et al.*, 2011; Meads, 2007). During 2005-2010, seventy four Centres of Excellence in Teaching and Learning were funded from the Higher Education Funding Council England. IPE formed a substantial part of the courses offered by these Centres and this further supported its cause (Barr *et al.*, 2011). A recent survey commissioned by CAIPE assessing the current provision of IPE showed that as a minimum, two thirds of universities across the United Kingdom have integrated IPE into their health and social care qualifying courses (Barr *et al.*, 2014).

These developments reflect the unfolding of the IPE story in the UK. Although it is noted that “generalisations....are best made with caution” (Barr *et al.*, 2011, p. 42), it seems fair to suggest that IPE in the UK has found its place within undergraduate curricula.

**2.5.3.2  Other European Developments**

Whilst IPE developments across Europe have been somewhat patchy, the common denominators and drivers that stand out in enabling and sustaining IPE encompass internal and external drivers, supported by the necessary financial backing. The sections below outline a number of European countries which have, to varying
degrees, developed (or attempted to develop) IPE within their undergraduate curricula.\footnote{Together with the U.K., many European countries mentioned in the forthcoming section are members of the European Interprofessional Education Network (EIPEN). The aim of this network is to develop and sustain a presence in Europe so as to share and develop effective interprofessional training curricula, methods and materials for improving collaborative practices and multi-agency working between health and social care. The EIPEN partnership has been developing since 2004 through a common interest in IPE between partners from the U.K., Sweden, Hungary, Finland, Poland and Greece. In 2008, partnership was extended to Ireland, Belgium, and Slovenia. An even earlier network, the European Network for the Development of Multi Professional Education in Health Sciences (EMPE) was launched in 1987 (Goble, 1994). This was managed until 2001 when it merged with The Network of Community-Oriented Educational Institutions for Health Sciences covering a wider geographical remit. In 2002, this Network again merged with WHO’s ‘Towards Unity for Health’ project and became known as the ‘Network: Towards Unity for Health’, TUFH (Boelen, 2004). In 2009, the Health Professionals’ Global Network (HGPN), under the auspices of WHO was established in Geneva (Nisbet, Lee, Kumar, Thistlethwaite & Dunston, 2011). The Nordic countries of Denmark, Finland, Norway and Sweden also form part of another network termed NIPNET which aims to foster interprofessional collaboration in education, practice and research across the Nordic countries (NIPNET, 2013).}

Sweden, within the European context, was at the forefront of IPE. Pioneering work into IPE started as early as the 1970’s (Goble, 1994) and in 1986, the University of Linköping initiated an IPE model which was later to be named the Linköping IPE Model. During this original initiative, the Faculty of Health Sciences in Sweden devoted parts of its curricula to interprofessional problem-based learning between various educational programmes (Areskog, 1994). Over the years, this initiative was developed into a fully-fledged problem-based IPE curriculum culminating in the establishment of an interprofessional training ward (Wilhelmsson \textit{et al.}, 2009). The success of these interprofessional student training wards have been emulated in other parts of Sweden (Lidskog, Lofmark & Ahlström, 2008) as well as across Europe (Jacobsen, Fink, Marcussen, Larsen & Hansen, 2009; Reeves & Freeth, 2002). Linköping was also the site where the European Network for the Development of Multiprofessional Education in Health Sciences (EMPE) was constituted in 1997.

Another renowned Swedish educational institution, Karolinska Institutet, a medical university spanning twenty educational programmes in medicine and health care has also been at the forefront of IPE. Since 1998, this Institutet has promoted collaboration between teachers and students across professions and this has been beneficial in preparing the groundwork for future professional teams. There was also the setting up of a clinical interprofessional training ward and this has also been
running since 1998. In the last years, Karolinska Institutet has founded the Centre for Clinical Education whose vision is to prepare health care professionals to be able to work in highly challenging and interprofessional contexts (Karolinska Institutet, http://ki.se/en/kisos/clinical-education; Vyt, 2009).

In Norway, interprofessional work was considered to be a key feature of high quality health care. In 1995, the Norwegian government, through the General Plans for Health Care Education, recommended a common core curriculum for undergraduate health and social university programmes. These recommendations were open to interpretation by the higher educational institutes vis a vis the structure that this common core curriculum should take (Bjorke & Haavie, 2006). In fact, although all university colleges adopted this common core curriculum, some universities paradoxically introduced it as uni-professional learning (Vyt, 2009). In 1998, the Faculty of Science at Oslo University College introduced an innovative interprofessional model for eight different professional programmes utilising a problem-based and project-oriented format so as to enhance collaborative learning between the programmes. This was a radical model challenging traditional academic structures and uni-professional attitudes (Bjorke & Haavie, 2006).

In Denmark, the tradition of collaboration between health, social work and teaching professions dates back from 1960s. However, formal IPE for health care undergraduate programmes has only been required by law since 2001 for nurses, midwives, physiotherapists and occupational therapists, since 2002 for social work students and since 2007 for school teaching and social education students. Similar to Norway, the law did not prescribe the interprofessional curriculum and it was left up to each profession to decide on the format (Nielsen & Hamming, 2008). Between 2004 and 2007, two higher education institutes in Denmark developed an Interprofessional Training Unit manned by students from various health care professions. Evaluation of this project showed that the students learnt how to work interprofessionally in a patient-centred way (Jacobsen et al., 2009).

In Finland, despite the lack of a central framework for IPE, a number of IPE initiatives were still developed. In the early 2000s, four Finnish polytechnics developed a pilot e-learning module dealing with teaching interprofessional care of
the elderly. This web-based environment enabled discussions and collaborations between different health and rehabilitation professionals in different polytechnics across Finland (Juntunen & Heikkinen, 2004). In 2007, the University of Oulu and the Oulu University of Applied Sciences developed a course on public health and interprofessional health promotion aimed at medical and other health care students. Although evaluation of this course elicited mixed results (there was diversity of opinion regarding the e-learning discussions), students seemed to acquire new understandings of interprofessional work. This course has since become a permanent component of the curricula in both universities (Vyt, 2009).

The Netherlands is considered to be a frontrunner within the IPE European field. In 1980, the Faculty of Health Sciences at the University of Limburg, Maastricht, developed a multiprofessional programme based on problem-based learning principles. During this programme students’ learning processes were complemented by real work practice situations. At the same time, there was also the introduction of a ‘social medicine’ programme which gave the opportunity for students to graduate in nursing science, health education and health administration. Over the years, this programme was developed in a health science programme leading to similar programmes all across the Netherlands (Goble, 1994).

In Belgium, in the late 1980s, one of the Ghent University Association’s colleges, College Arteveldehogeschool, embarked on IPE with small group discussions amongst students from different study programmes. By 1994, this project developed into InterDis: a multiprofessional teaching and a learning trajectory aimed at interdisciplinary collaboration in health care. In 2001, it received a grant from the Flemish government and, in collaboration with the Faculty of Medicine and Health Sciences at the University of Ghent, developed the project. Since 2007, InterDis became a mandatory course in several departments of the Arteveldehogeschool (Vyt, 2009).

In France, the beginnings of IPE date back to as early as 1984 when the University Paris Nord, Bobigny, introduced a two-year multiprofessional programme. This modular programme aimed to offer health science students the opportunity to recognise which field of health care studies were the most appropriate for them,
while simultaneously providing them with a multiprofessional experience (Parsell & Bligh, 1998). Regrettably, information about more recent IPE initiatives was not located in the literature.

In the Republic of Ireland, it has only been in the last number of years that IPE has been introduced. In 2001, the Irish National Health Strategy set out a vision for multidisciplinary primary care teams and networks through the publication *Quality and Fairness: A Health System for you and a Primary Care Strategy* (Department of Health and Children, Irl, 2001a; 2001b); this document emphasised the pivotal role that IPE could play in fostering an interprofessional culture. There were also the publication of two seminal government reports urging reforms in medical education and these included, *inter alia*, the need to foster and develop appropriate linkages between the various professional training systems (Department of Health and Children, Irl, 2005a; 2005b). However, it was the move towards community mental health teams (necessitating more collaboration between professionals) which seemed to push the IPE agenda forward (Mental Health Commission, 2008). In 2009, the Irish Health Service Executive identified IPE as essential to the effective collaboration between health and social care staff (Health Service Executive, 2009). In response to these policy directives, a number of universities developed their interprofessional base, albeit to varying degrees.

In Southern Europe, the literature reveals little evidence of IPE. In Spain, in the early 2000’s, the possibility of undergraduate IPE was explored in the light of the European Higher Education Requirements for reform. However, with the IPE knowledge available then, it was suggested that it might be more appropriate to develop IPE at a postgraduate level (Mendez *et al.*, 2008). Recently, the European University of Madrid developed a collaborative practice programme for first year medical residents (Beunza, 2013). Although not targeted at undergraduate students, this programme could still auger well for the development of IPE in Spain; however, evaluation of this programme is, as yet, unavailable.

Greece’s involvement in IPE during the mid-2000’s seemed to be an isolated initiative. It concerned a European Interprofessional Education Network (EIPEN) project whose objective was to develop an IPE strategy for Greece in the field of
Health Informatics. This was partially funded by the European Commission in the Leonardo da Vinci Community Action Programme on Vocational Training (2005-2007) (Liaskos et al., 2009). To date, health and social care IPE in Greece has not been developed (D. Zikos, personal communication, September 4th, 2012).

The three countries which have just been discussed, Ireland, Spain and Greece have been counted amongst European states which were most adversely hit by the global economic crisis of recent years and consequent austerity measures imposed by the Troika (European Central Bank, European Commission, and International Monetary Fund) as conditions for bailout programmes. It is therefore likely that investment in IPE may not be deemed high priority in countries characterised by economic instability resulting in severe cutbacks across all sectors of society.

2.5.4 IPE Outside Europe

2.5.4.1 United States of America

The USA has a chequered IPE history with varied and disparate initiatives reflecting diverse administrations and political drivers, and the way the health care industry has evolved (Lavin et al., 2001). Notwithstanding this, from the late 1970s until the early 2000’s, the United States was internationally recognised as being a leader in IPE (Brandt, 2014).

The earliest documented undergraduate IPE activity occurred in the late 1940s with the Clinical Health Care Team Programme at the University of Washington Child Health Centre (Casto, 1994). As the years progressed, IPE initiatives included the provision of interdisciplinary education in various settings by Saint Louis University Health Sciences Centre in the late 1960’s (Lavin et al., 2001), the development of an Interdisciplinary Health Science Programme at University of Nevada in 1971 (Baldwin, 2007a; D’Avray, 2007), interdisciplinary clinical experiences at the University of Miami (Tanner, Linn & Carmicheal, 1972) and elective IPE courses at the University of Minnesota (Rosenberg & Anderson, 1973 as cited in Baldwin, 2007a). In 1972, the publication of the progressive report, Educating for the Health Team by the Institute of Medicine (IOM) generated enthusiasm for the concept of learning together and highlighted an urgency to educate health professional students.
in preparation for team-based health care\textsuperscript{16} (Brandt & Schmitt, 2011). One year later, there was the establishment of the oldest and most well-documented interprofessional collaborative initiative in the USA: \textit{The Interprofessional Commission of Ohio} which facilitated comprehensive interprofessional graduate courses across nine participating academic units (Casto, 1994).

In 1974, the Federal Government created the Office of Interdisciplinary Programmes allocating funds to interdisciplinary team training of health professional students in primary care. Between 1975 and 1978, a substantial number of medical schools and universities received funding to develop interdisciplinary student health team programmes (Baldwin, 2007a; D’Avray, 2007). However, despite efforts to establish IPE in health curricula (Hogness & Akin, 1977) most of the federal funding for these programmes subsided and only a few of these projects could be sustained. Collaborative education and practice were regarded as an “expensive luxury” and few of the projects of the 1970s made it to the early 1980s (Baldwin, 2007a, p. 28; D’Avray, 2007). Notwithstanding, the annual disciplinary health care team conference was organised in 1979 and since then has been a consistent annual assembly of collaborative practice and education in the United States (Casto, 1994).

An interesting thread to the story of IPE in the USA concerns the Veterans’ Health Administration (previously known as Veterans’ Affairs). Together with other private philanthropic foundations these groups played an important role in the development of IPE in the USA. They started with inaugurating interdisciplinary programmes for aging veterans, however, over the years, ended up supporting many other IPE programmes, such as geriatric care. Indeed, it has been argued that geriatric care has strengthened the case for IPE due to the necessity of providing team-based approaches both for the education, as well as for the care of this client group (Baldwin, 2007a).

The 1990’s witnessed renewed interest for IPE and IPC, mostly brought about by a growing awareness of the inadequacies in the US health systems (Baldwin, 2007a). The Centre for Collaboration for Children was founded in 1991 and its remit included revision of university curricula so as to promote interdisciplinary work

\textsuperscript{16} At the time this concept was referred to as ‘Interdisciplinary Education’ (IDE).
(Casto, 1994). In that year, the US Public Health Service also funded the Primary Care Policy Fellowship Programme whose aim was to enhance IPE and collaboration (Hassmiller, 1995). There was also strong support for community-university collaboration for the design, implementation and evaluation of interdisciplinary programmes (Crouse, Mueller & Uden, 1998). The Pew Health Professionals Commission appealed for a reform in health professions education and by 1994, the Institute of Healthcare Improvement (IHI) launched the Interdisciplinary Professional Education Collaborative (IPEC) (Barnsteiner, Disch, Hall, Mayer & Moore, 2007). In 1998, the Pew initiative also served as the impetus for eight nationally funded projects concerning geriatric interdisciplinary team training (Fulmer, Flaherty & Hyer, 2003). Similarly, in that year, the fourth and final report of the Pew Health Professions Commission, *Recreating Health Professional Practice for a New Century*, listed interdisciplinary team competences as one of its twenty one health professional competencies. It also advocated that academic health centres should target twenty five per cent of their educational curricula to interdisciplinary learning (Pew Health Professions Commission & O’Neil, 1998).

The late 1990’s and early 2000’s saw the Robert Wood Johnson Foundation funding the Collaborative Interdisciplinary Team Education and Achieving Competence Today, projects aiming to teach teamwork to the various health professionals working in managed care organisations (Ladden, Bednash, Stevens & Moore, 2006). Other philanthropic foundations, such as The Kellogg Foundation, have also been significant in supporting IPE and, over the years, have funded a number of IPE related projects (Baldwin, 2007a). In 2000, the Josiah Macy Jr. Foundations organised a summit during which nurse and physician leaders were urged to address the need for more collaboration in the quest for better patient outcomes. Most of the recommendations emanating from this summit reflected a strong emphasis on the promotion, development and researching of IPE (Barnsteiner et al., 2007). A year later, the Institute of Medicine (IOM) published the seminal report *Crossing the Quality Chasm: A New Health System for the 21st Century* which inter alia stressed the importance of teams in delivering health care and recommended that health professionals’ training be redesigned so as to emphasise multidisciplinary
approaches (Institute of Medicine Committee on Quality of Health Care in America, 2001).

At the turn of the century, fiscal driven pressures, services inadequacies and the move towards community care again influenced the way IPE initiatives unfolded. The focus in the United States health care was on improving the quality, efficiency and effectiveness of the service through interdisciplinary Continuous Quality Improvement (CQI) teams encompassing both the education and service sectors (Baldwin, 2007a). In 2003, the Institute of Medicine published a further report, *Health Professions Education: A Bridge to Quality*, in which it again urged IPE to be included in all United States health professions education (Institute of Medicine, 2003). There was also a significant thrust to promote IPE through national collaborative meetings, such as the Institute for Healthcare Improvement Health Professions Education Collaborative in 2003 and the Telluride, CO, Health Science Educators meetings in 2005 (Barnsteiner *et al.*, 2007). The late 2000’s also saw the establishment of the American Interprofessional Health Collaborative (AIHC), a United States based international organisation, with the aim to transform learning, policies and practice towards an improved health system (Blue, Brandt, & Schmitt, 2010).

There has been resurgence in IPE in recent years (Brandt & Schmitt, 2011). Of note was the Josiah Macy Jr. Foundation Conference in 2012 which brought together twenty IPE teams from twenty four higher education institutions so as to discuss ways forward for IPE in the USA (Thibault, 2012). There was also the landmark establishment of a national coordinating centre for IPE and IPC: the National Centre for Interprofessional Practice and Education. This centre, funded by four private foundations and the central administration (Brandt, 2014), “is discovering and sharing ways to improve health, engage people and communities, enhance patient care and control costs by integrating health professions education and practice into a transformative Nexus” National Center for Interprofessional Practice and Education, University of Minnesota (https://nexusipe.org/informing/about-nexus).

It would be interesting to foresee the implications for IPE emanating from the Patient Protection and Affordable Act (2010), commonly known as Obama’s US health care
reform. Reeves (2012) recognises the significance of this Act, due to the fact that the new health care system will yield an increase of more than 30 million people which, most likely, will necessitate health professionals to work differently together.

2.5.4.2 Canada

In Canada, the main motivation for IPE and IPC stemmed from the rise in health care expenditure (Spitzer, 1975). The literature shows that, as early as forty years ago, there were a number of elective interdisciplinary courses for health science students at the University of British Columbia (Szasz, 1970). The 1980’s saw early initiatives in the form of two-day optional human sexuality workshops which were held at the McMaster University and Mohawk College (Solomon & Baptiste, 2005). During the early 1990’s, there was the development of a number of collaborative care initiatives, all supported by Health Canada17 (Health Canada, 2004). In 2002, the Head of the Commission on the Future of Health Care in Canada, Roy Romanow, presented the seminal report *Building on Values: The Future of Health Care in Canada* in which he argued that if health care providers were expected to work in teams, then training should follow suit (Romanow, 2002). In the wake of such support, the University of British Columbia established an interprofessional model spanning seven faculties (Gilbert & Bainbridge, 2004).

In 2004, Health Canada invested 80 million dollars over five years to support the development and implementation of Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP). This investment was a mechanism to address current and emerging health and human resource issues, as well as to ensure that health professionals could practise in a collaborative manner (Oandasan & Reeves, 2005a). Subsequently, Health Canada (2004) issued proposals aimed at encouraging Canadian Universities to develop, implement and sustain IPE experiences (Allison, 2007). Phase 1 (2003-2004) of the initiative consisted of a team of health researchers tasked with formulating the strategy for IPE in Canada; one of the outcomes of this strategy was the development of a conceptual framework for the development of IPE initiatives. Phase 1 (2004-2008) called for proposals to fund a variety of IPE projects, as well other specific programmes (Herbert, 2005; D’Amour & Oandasan, 2005). There was also the creation of the Canadian Interprofessional

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17 Health Canada is the government department responsible for national public health.
Health Collaborative (CIHC) whose aim was to work at the interface of health, education and the professions so as to implement and advance IECPCP (Thistlethwaite, 2013). This led to the development of the National Interprofessional Competency Framework which provided an integrative approach to describing the competencies required for effective IPC (CIHC, 2010).

2.5.4.3 Australia

The concept of multidisciplinary education in Australia dates back to 1976 when the Foundation for Multidisciplinary Education in Community Health in Adelaide ran multiprofessional programmes both for students and practising health professionals undergoing further education. However, due to a myriad of challenges faced by multiprofessional teaching, these programmes were not retained. During the 1980’s multiprofessional education in community health was offered to health sciences students in South Australia. In 1987, this multiprofessional programme was transferred to the University of Adelaide, yet, despite running into federal funding difficulties, it was continued and extended to other institutions (Meads & Ashcroft, 2005).

In the early 1990’s, the University of Newcastle developed shared undergraduate studies for health and social care professionals (Meads & Ashcroft, 2005). Similarly, a number of other Australian universities, such as Curtin, La Trobe, South Australia, Sydney and Queensland, adopted a common curriculum (Graham & Wealthall, 1999). At that time, the University of Newcastle also developed shared undergraduate studies for health and social care professionals (Meads & Ashcroft, 2005).

The year 2005 was significant in the development of Australian IPE; it was the year when the Australian Capital Territory (ACT), University of South Wales, and local service providers initiated a four year multilateral partnership in which IPE was considered as the core of an interprofessional health system. Other developments included a national conference focusing on interdisciplinary learning, robust initiatives to incorporate “IPE-enabling” components within the various curricula.

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18 Although such information was retrieved from Meads and Ashcroft (2005), the particular chapter in question is based on a longer review by Hugh Barr and can be found on www.caipe.org.uk
(Stone, 2007, p. 335), and the amalgamation of the Australasian Interprofessional Practice and Education Network (AIPPEN) with the Rural Interprofessional Education Network (RIPEN) (Thistlethwaite, 2007).

However, despite all these developments, a scoping study carried out in 2006, revealed that although IPE had increased, most particularly in rural settings, initiatives were often short and isolated. This seemed to be reflective of the Australian situation in that, although there were a considerable number of multiprofessional and/or IPE activities, there was still the lack of the concomitant support needed for their development and sustainability (Thistlethwaite, 2007). This appeared to be due to a dearth of national coherent policies backed up by a solid financial infrastructure (Stone, 2007; Thistlethwaite, 2007). In 2007, a partnership of academics, educators and health professionals took cognisance of these factors and undertook a scoping and developmental study so as to establish a national research and development agenda for IPE across the continent. The project entitled Learning and Teaching for Interprofessional Practice in Australia, gave the impetus for a nationally coordinated approach to IPE in Australia which to date, continues its work though a multi institution project (Dunston et al., 2009; Thistlethwaite, 2007; 2012; Thistlethwaite et al., 2009).

In recent years, there have been a number of additional factors which collectively led to the strengthening of IPE in Australia. There was the recognition that the continent needed to ‘catch up’ with what was happening in health care, mostly in Canada and the USA. Studies also showed that lack of communication between health professionals contributed to medical errors, furthering the case for collaboration between health professionals. The impetus for IPE by central government resulted in improved communication and the co-ordination of particular programmes.\footnote{For example, the health workforce reform was driven by federal ministers of health via an organisation they funded called Health Workforce Australia (Productivity Commission, 2005).} There was also the support of key influential people, such as the Chief Medical Officer in Western Australia, who championed IPE and encouraged IPE groups to form across Australia. Moreover, clinicians collaborated in interdisciplinary teams to develop new models of interprofessional care (M. Brewer, personal communication, 5\textsuperscript{th} October, 2011).
2.5.4.4  Japan
Interprofessional working is not new to Japan; initiatives of interprofessional working have been present albeit unsupported by national policies (Hosoda et al., 2005). However, it was demographical trends over the last decade which were the main drivers that account for rapid developments in IPE. The elderly population has been steadily increasing since the 21st century, making Japan the country with the world’s highest longevity and this has required that health professionals improve “quality of life” and “healthy life expectancy” of patients, rather than just “mean life expectancy”. To this end, collaboration between medical and social care has become crucial and IPE is seen as being the vehicle through which this could happen (Takahashi & Sato, 2009, p. 554).

Of note was the approval of a clinical community pathway by the medical insurance system in 2005 and this seemed to strengthen interprofessional working (Takahashi, 2007). There was also the establishment of two national institutions promoting IPE and IPC in 2008: the Japan Association for Interprofessional Association (JAIPE) and Japan Working and Education Network (JIPWEN). Amongst its many remits, the JAIPE plans to promote a common IPE curriculum between medical and social welfare departments across universities. JIPWEN, on the other hand, is a network of eleven universities that advocate for and support IPE in Japan (Takahashi & Sato, 2009). In 2012, the sixth ‘All Together Better Health’ conference was held in Kobe, further catapulting Japan and IPE towards centre stage.

2.5.4.5  Developing Countries
Despite the paucity of publications from developing countries, IPE, or in most cases, shared learning, has been reported in a number of countries such as the Dominican Republic (Vinal, 1987), Iran (Irajpour, 2009), Fiji (Tope, 1994), Lebanon (Makaram, 1995), Malaysia and South Africa (Rodger & Hoffman, 2010). Meads and Ashcroft (2005) note that, in contrast to the developed countries where preparation for interprofessional practice has largely focused on individuals and families, developing countries have mobilised resources for community development and public works. The unique settings and cultures of these developing countries have also shaped the nature of IPE. For example, in some Latin American countries, inequalities between health care providers were generally low and the entire team assumed responsibility
for health care outcomes (Vinal, 1987). This highlights how systemic factors, such as diversity in settings and the socio-cultural values of health providers are significant in the development and delivery of IPE; a perspective that is considered extensively across this study.

2.6 Summary of the Global Context

Professional organisations and authoritative voices worldwide such as the World Health Organisation (WHO 2013b; 2010), the World Federation of Medical Education (WFME, 1988) and the Lancet Commission (2010), have made the case for IPE by arguing that it can play a significant role in alleviating some of the challenges faced by global health care systems; especially those challenges that require an interprofessional workface such as an ageing population, complex care concerns, technological advances and new behavioural and environmental risks. This global overview, explored how various countries have responded to these international calls and considered why and how IPE commenced across a spectrum of developed and developing countries.  

This review showed that irrespective of the diversity of drivers and motivating factors for IPE, the tide has turned in favour of IPE across many countries, albeit to varying degrees. The global policy levers and motivating factors included direct external drivers, such as government policies, higher political requirements and dedicated funding, and indirect external drivers such as inquiries into medical errors, demographic changes, specialisation of health professional practices, health workforce shortages, geriatric care demands and targeted collaborative efforts at local levels between community, primary care teams and mental health teams. There were also other internal drivers, such as university top level support and other contextual opportunities; all crucial for the development and sustainability of IPE.

20 The opening paragraph explained that this chapter comprises but a descriptive ‘potted’ history of IPE and does not claim to be a definitive nor exhaustive account; this was beyond the scope of this work. It may be noted though, just as the write up of this theses was in its final stage in June 2015, Barr published a comprehensive account entitled ‘IPE: The Genesis of a Global Movement’ (Barr, 2015) that would have been of immense value to my research had it been published earlier as it pieces together the story of global IPE based on documentary sources and personal accounts. For those interested in the detailed historical and global development of IPE, Barr’s (2015) review is an excellent and timely source (in addition to other documents preceding it, most of which were used for this chapter).
The global differences in mandates and resources available to change existing systems of education stood out; and this is crucial to underscore as such imperatives for IPE are mostly unrecognised within the context of this research study (as seen in Part 1 of this chapter).

This review has also identified those overriding key factors crucial for the success in implementing and sustaining progress in IPE. These included the importance of political drivers, national coherent policies, institutional and organisational support, earmarked central funding and as Barr (2015) notes “the readiness of interprofessional exponents to set aside professional protectionism and academic rivalry as they support each other across borders and boundaries” (p.2).

Despite the strong imperatives for IPE, implementaion remains problematic (Clark, 2011; Nisbet et al., 2011; Rodger & Hoffman, 2010). Baldwin (2007a), a key scholar in IPE compares its development to the mythical Sisyphus21 in which “each forward push seems to end with a return to a new point of origin, with little tangible evidence of impact or permanence” (p. 32). The reasons for this are multifaceted: IPE appears to be bedevilled by academic, professional, organisational, structural, philosophical and sociological barriers (Chesters & Burley, 2011; Hall & Weaver, 2001; Harris, 2006; Reeves, Macmillan & Van Soeren, 2010a); there are also complexities of definition, purpose and methods associated with its development and delivery (Cooper, Braye & Geyer, 2004); and there remains a need to build a sound evidence-based body of knowledge on IPE (Ireland, Gibb & West, 2008; Payler, Meyer & Humphris, 2008). Inevitably this leads to continued misunderstandings and misconceptions surrounding IPE giving rise to different interpretations and hence different ways of implementation.

To move IPE forward much needs to be done; amongst the many challenges and demands “faculty and administration must understand what IPE is (and is not), as well as how to move from merely adding IPE content to a few courses ... to a comprehensive, integrative, curricular approach” (Masten et al., 2013, p.323). CAIPE’s (2002) definition is conceptually clear and is an excellent operational

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21 In Greek mythology, Sisyphus, King of Ephyra, was punished for chronic deceitfulness by being compelled to roll an immense boulder up a hill, only to watch it roll back down, and to repeat this action forever.
starting point. All this points to the importance of recognising the multi-dimensional task of developing, embedding and sustaining integrated IPE which in Matthews et al’s (2011) words “will require a national and research informed approach to build momentum and scale” (p.137). And as this review has shown, countries that today are considered to be world leaders in IPE have thrived in the presence of such multi-targeted approaches for developing IPE. Nonetheless, IPE is also a progressive journey (Masten et al., 2013) and the findings from this study could be first steps towards creating a road map for IPE in Malta.

2.7 Conclusion

Part 1 and Part 2 of this chapter have collectively explored and examined the antecedents and context in which IPE has emerged globally and possibly could emerge from a local perspective; in so doing it has set the scene and contextualised the story of this case study. The next chapter attempts to provide clarity and direction to the conceptual underpinnings of IPE by presenting and critically reviewing the literature on the key concepts and processes related to the development and delivery of undergraduate IPE.

2.8 The Inward Eye

The process of unearthing and presenting such a vast amount of literature in a chronological and synthesised manner was challenging and labyrinthine. However, it was simultaneously enriching to slowly discover why, when, where and how undergraduate IPE emerged across the globe. Each country was particular ... yet there were so many common threads. IPE did not happen in a vacuum but needed the combination of many drivers pushing it forward. And that was not enough ... it necessitated voracious amounts of ongoing support so as not to die, prematurely.

In reality, at the time of writing this study, there were no explicit drivers pushing for IPE at the Faculty of Health Sciences or elsewhere at University of Malta. However, paradoxically, collaborative practices in health care delivery were encouraged both anecdotally, as well as in various health policy documents. It seemed that collaboration within local academic and health contexts was espoused to, however,
expected to happen automatically. Cognisant of some of the global developments of IPE, the local situation was disheartening for me. Could professional health education in Malta remain unaware of international calls to re-examine health care education so as to be in a better position to meet the health care needs of the future? This would be foolhardy at the very least. And although we are an island, in reality no man is an island! There were so many existential questions which, for a while, seemed to threaten the underpinnings of my research study.

Being an eternal optimist, I reckoned that exploring the context and the background, the ground from which IPE could emerge were sound preliminary steps and this gave me the impetus to go on. Understanding the roots of IPE and charting its arduous development in the various countries and continents helped me appreciate the bigger picture of IPE; a picture of potential IPE in Malta reframed against the realities worldwide.
Chapter 3  Literature Review

3.1  Introduction

This chapter presents a review of the literature in relation to developing and delivering IPE. It builds on Chapter 2 which was more a descriptive review, to include empirical and conceptual studies revealing the determining attributes and characteristics of this activity. It borrows and adapts the 3P (Presage-Process-Product) Model of learning and teaching (Biggs, 1993; Freeth & Reeves, 2004) as an organising framework for examining the concepts that have shaped IPE, as well as highlighting key debates in the field. Within this framework, the complex, multi-layered and interrelated factors and/or determinants of IPE are teased out thereby improving the overall conceptual clarity for this work.

Literature pertaining to undergraduate (or pre-registration) IPE, the focus of this study, has increased exponentially during the past two decades (Dimoliatis & Roff, 2007). In collating this review, I employed a systematic search process so as to ensure comprehensive understanding of this area. I identified literature from various electronic databases and the specific steps I undertook for this strategy are described in Appendix 9. As my studies progressed and my ideas became more focused and refined, I used the snowball technique. This process was guided by themes evolving from the literature which then lead me to consider areas which are outside the IPE field per se, such as Sociology, Education, Psychology, Anthropology and Organisational Literature.

3.2  Current Trends in IPE Literature

The majority of IPE studies are published in the United States of America, Canada, the United Kingdom (Abu-Rish et al., 2012). A large part of this literature rests on descriptive and/or empirical studies employing small single-site studies of pilot IPE initiatives; and these are based on self-reported learner outcomes reflecting changes in attitudes, perceptions, knowledge and skills (Reeves, 2010). A number of

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22 This is a technique referring to following up references from bibliographies of books and articles as they arise (Ridley, 2012).
systematic and general scoping reviews have been carried out; largely these address the conceptual basis of IPE (CIHC, 2010; D’Amour & Oandasan, 2005; Mann et al., 2009; Reeves et al., 2011), examining and strengthening the evidence base of IPE (Barr, Freeth, Hammick, Koppel & Reeves, 2006; Lapkin, Levett-Jones & Gilligan, 2013; Reeves, Goldman, Burton & Sawatzky-Girling, 2010b) and developing conceptually clear and sustainable models of IPE (Barr et al., 2006; Freeth & Reeves, 2004; Reeves et al., 2011). Although these conceptual and empirical studies (to a greater degree than the more descriptive accounts outlined in Chapter 2), have collectively contributed to the current knowledge base of IPE (as will be presented in this chapter), the literature is still beleaguered by many inconsistencies and weaknesses including lack of theoretical underpinnings guiding the programmes, inconsistencies in describing study contexts, population samples and outcomes, paucity of longitudinal follow-up of IPE outcomes, and lack of attention to issues concerning faculty development23 (Abu-Rish et al., 2012). These shortcomings, inter alia, weaken evidence-based arguments, decrease understandings into processes underpinning IPE and render replication studies difficult; such research issues tend to limit advancement in the field.

A variety of forms and models have also been adopted to implement IPE. These demonstrate the diversity of interpretations and conceptualisations of IPE which as seen in Chapter 2, ranged from uniprofessional learning modules to fully integrated curricula. A deeper understanding of the attributes, characteristics and influences that impact on IPE is required to move IPE forward. For this study, the conceptualisation of IPE adheres to CAIPE’s (2002) definition presented in Chapter 1. Freeth and Reeves (2004) examine the nature of educational opportunities designed to promote collaborative practices such as IPE, by using the Presage, Process and Product (3P) model of learning as a tool to “untangle the web of influences on learning to work together” (p. 43); and it is towards this model that this review now turns.

23 These inconsistencies were identified through a systematic literature review which builds on previous work and includes reports of qualitative, quantitative and mixed method educational intervention published in peer-reviewed journals between 2005 and 2010 (Abu-Rish et al., 2012).
3.3 Rationale for using the 3P Product Model

The Presage, Process and Product (3P) Model of learning and teaching was originally developed by Biggs (1993) and represented different and interlinking learning factor levels: presage factors, context in which learning takes place, process factors, various ways in which learning may unfold, and product factors, outcomes of this learning (Appendix 10). This model adapted by Freeth and Reeves (2004) so as to “provide a structure to analyse influences upon and within learning opportunities whose purpose is to promote collaborative working” (p. 44) seemed particularly apt for this work as I was looking for a coherent framework in which I could organise my discussion of the complex, multi-layered and interrelated factors affecting IPE. Moreover, using a framework to review and analyse the literature into the development and delivery of IPE further contributed towards improving my conceptual clarity of this field, which as has been highlighted is ridden by conceptual and semantic challenges.

Whilst Biggs’ model had subsumed the role of teachers and facilitators within the learning context, Freeth and Reeves’ model added their role as a distinct presage factor and this places more emphasis on the significance of teachers and facilitators within the IPE process. Figure 3.1 shows Freeth and Reeves’ 3P model of learning to collaborate.
Figure 3.1 Freeth and Reeves’ components of the 3P model of learning to collaborate

Source: Freeth & Reeves (2004). Reproduced with permission from the authors.
Although this model is illustrated with examples from the UK context, Freeth and Reeves (2004) hope that the central arguments will “trigger reflection on similar and contrasting aspects of readers’ local contexts” (p. 44); and this was another reason for using and adapting their model for this work. It needs to be emphasised that my adaption of their model was a loose adaptation, meaning that rather than adhering closely to the Freeth and Reeves’ (2004) model, I used the main concept of the systems-form 3P (presage-process-product) and went on to create my own organising framework for discussion of the complexity of IPE within this thesis. Furthermore, whereas in both Biggs’ (1993) and Freeth and Reeves’ (2004) models, the focus is on learning to collaborate, my emphasis was IPE, reflecting the scope of this work.

In Biggs’ (1993) and Freeth and Reeves’ (2004) models, there is a natural flow from left to right: presage factors are the backdrop for any learning experience and can influence the product directly. However, as Freeth and Reeves (2004) highlight, this is a complex and dynamic system made up of interlinking components and it might be “too simplistic to assume that knowledge of presage will permit the manipulation of process to produce the desired outcomes” (p.44); hence the significance of the double sided arrows in both theirs and Biggs’ models (Figure 3.1 and Appendix 10).

After considering my research questions and critically appraising the literature, I decided to use the model in reverse; my model thus starts from product factors, through process factors, ending with presage factors. I adopted this approach, because as a first step I wanted to unpack the product; IPE per se by discussing the foci of IPE and the evidence of its effectiveness, followed by a consideration of process with its possible approaches and theoretical underpinnings, and ending with presage, where I considered various ways in which context, at various levels, could influence both the development and delivery of IPE. Presage factors, which provide the context in which the learning experiences are conducted, have already been partly discussed in Chapter 2 in the form of political levers and funding; in my model (Figure 3.2) they are further developed at micro, meso and macro levels and further underscore the central importance of understanding the contextual factors underpinning this case study. Their emphasis is reflected in the last column of my adapted model (Figure 3.2) and ensuing discussions.
Figure 3.2 presents my adaptation of the 3P model and provides a roadmap for the review. It is important to emphasise that these components are not perceived in isolation from each other, rather, they are more akin to a “dense web of interacting factors” (Freeth & Reeves, 2004, p. 54) with the majority of influences capable of being juxtaposed at the various levels.
Figure 3.2  My adaptation of the Freeth and Reeves’ (2004) 3P Model
### 3.4 Product

#### 3.4.1 Product: Foci and Learning Outcomes of IPE

This section discusses the *product* of IPE which in Freeth and Reeves’ (2004) model concern collaborative competencies. In my adapted model (Figure 3.2) the *product* is IPE and thus this section encompasses the significance (foci) and the intended (and unintended) outcomes of this educational activity. It also analyses the evidence that has been collected and reported on the impact of IPE.

The overall aim of IPE is to improve patient outcomes and quality of care (Thistlethwaite, 2015); in reality though, IPE faces obscurity around its intended foci, outcomes and competencies. Barr *et al.*, (2005) attempt to clarify this picture by presenting three overlapping and mutually reinforcing foci distilled from over a hundred evaluations of IPE (Figure 3.3).

![Figure 3.3 Interlinking relationships of the three foci of IPE](image)

*Source: Barr *et al.* (2005). Reproduced with permission from the authors.*

The first focus, individual preparation, which is most often emphasised in pre-qualifying IPE, is on equipping individuals with the knowledge, skills and attitudes for collaborating in practice. The second focus is on cultivating collaborative group practices within and between professional groups, organisations, clients and...
The third focus is on service development and care improvement, and reflects the collaborative competencies presented in Freeth and Reeves’ (2004) 3P model. All foci are mutually reinforcing and each cycle supports the other; success in one cycle is assumed to add momentum to the next, and failure in one cycle could decrease or even stall progress in the others (Barr et al., 2005).

Learning outcomes for IPE are presented variously in the literature. For example, they are referred to as objectives at the University of British Columbia (Charles, Bainbridge & Gilbert, 2010), competencies at the Australian Capital Territory Health (Braithwaite & Travaglia, 2005) and capabilities at the Combined Universities Interprofessional Learning Unit, Sheffield, UK (Gordon & Walsh, 2005).

As part of a wider exercise reviewing the current position of IPE worldwide, the WHO study group on IPE and Collaborative Practice synthesised IPE learning outcomes cited in the literature over a twenty one year period (1988 to 2009). These outcomes are organised into six categories of common learning outcomes: teamwork, roles and responsibilities, communication, learning/reflection, the patient and ethical/attitudinal implications. The complete list of themes and subthemes is collated in Appendix 11 (Thistlethwaite & Moran, 2010).

In a somewhat similar but broader aimed review, Reeves, Tassone, Parker, Wagner and Simmons (2012) synthesised the key developments of IPE presented in the literature over the last thirty years. However, unlike Thistlethwaite and Moran’s findings (2010) which focused on defined learning outcomes cited in the literature, Reeves et al., (2012) synthesised reported outcomes of IPE. Generally, they found that outcomes from prequalification IPE programmes include changes in students’ attitudes, beliefs, knowledge and collaborative skills; which correspond with Barr’s et al., (2005) first and second focus. Postqualification learning outcomes of IPE show similar outcomes and compare well to Barr et al.’s (2005) third focus: changes in organisational practice and improvement in patient care. However, as the authors acknowledge these latter reported outcomes could be attributable to the fact that

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24 For the interested reader in collaborative practices and/or competencies, Barr, (1998; 2000a) and Freeth and Reeves (2004) are excellent sources.
improvement in patient care is a normal outcome for qualified practitioners (Reeves et al., 2012).

The literature also refers to the unintended products or outcomes of IPE. These are less positive and include: students’ perceptions that IPE is not central to professional development due to it not being assessed, the idea that it is just carried out to meet institutional requirements (Freeth et al., 2005), and possible reinforcement of negative stereotypes (Leaviss, 2000; Mandy, Milton & Mandy, 2004). Such issues illustrate the difficulties of IPE and understanding the interdependency between these concerns could offer some insights into reasons for these inadvertent outcomes. For example, it has been suggested that allocating limited resources to IPE could make it seem secondary to the profession-specific curriculum (Freeth et al., 2005); IPE facilitators’ lack of enthusiasm and specific training could be another barrier (Freeth et al., 2005; Gray, 2009); and selecting an inappropriate time for an IPE initiative could also be a factor in yielding negative outcomes (Mandy et al., 2004). There is no magic wand to dispel the possibility of these negative outcomes but, clearly, a first step is to recognise their likeliness to occur and to see how best to contain them within the structures of current health professionals’ curricula. As discussed in Chapter 2: Part 2, strong policy direction in driving IPE forward is vital for without it, IPE will always remain peripheral.

### 3.4.2 Product: The Current Evidence Base for IPE

Having considered foci and learning outcomes which are associated with IPE, this section discusses the evidence underpinning these products. In the light of contemporary health care where evidence-based practice has become an expectation (Booth & Brice, 2004; Curran, 2004), simply assuming that IPE could eventually lead to improved collaborations and better patient outcomes does not suffice. Proposed curricula upheavals need to be supported by the evidence that such changes are, in fact, beneficial (Clifton, Dale & Bradshaw, 2006; Koppel, Barr, Reeves, Freeth & Hammick, 2001). However, demonstration of such evidence poses major logistical and inherent challenges for a multitude of methodological reasons.

It is difficult to control the many variables that are involved, including institutional and individual characteristics, duration, curriculum variations and many other factors
that influence student learning (Payler et al., 2008; Stone, 2006). Such variables challenge ‘cause and effect’ evidence, especially concerning long-term benefits such as patient outcomes (Freeth, Hammick, Koppel, Reeves & Barr, 2002). During practice-based IPE these variables multiply, adding to the interplay between the organisation, the student and the patient (Steven, Dickinson & Pearson, 2007). Research instruments designed for controlled environments are also unsuitable for such educational initiatives (Ireland et al., 2008). Additionally, IPE cannot realistically be evaluated against the ‘gold standard’ of randomised controlled designs; such positivist methodology is inappropriate because a large degree of adult learning is contextual and cannot be accommodated within the strict parameters of such a framework (Barr & Ross, 2006; Koppel et al., 2001).

Despite these confounding variables obscuring evaluation results, several systematic reviews of IPE have been undertaken (Reeves et al., 2010b; 2010c). The earliest was a Cochrane systematic review carried out in 1999 whose strict criteria required that only those studies based on a positivistic paradigm could be included (Zwarenstein et al., 1999). These studies employed quantitative methodologies in the form of randomised controlled trials, controlled before and after studies or interrupted time series studies which would demonstrate changes in delivery of services or benefits to patients/clients. No studies were found that met these strict criteria yet this was not interpreted as an indication of a lack of effectiveness of IPE but, rather, as a lack in the appropriate research which is available. This highlighted the link between process and outcome in IPE (Zwarenstein et al., 1999) and thus, a second IPE review used broader inclusion criteria including qualitative, quantitative and multi-method approaches showing a continuum of outcomes. These extended criteria showed more positive results in the form of reactions to the learning experience, changes in perceptions, acquisition of knowledge/skills, and changes to organisational practice/patient care, the latter for work-based programmes (Barr, Freeth, Hammick, Koppel & Reeves, 2000).

Other systematic reviews explored a wide spectrum of pre-licensure and post licensure programmes, mostly from North America and the United Kingdom, involving different professional groups, having varied duration and employing various interactive learning methods. The predominant evidence from these reviews
shows that IPE is generally well-received by participants, can have short-term benefits in attitude change, can enable students to learn the knowledge and skills necessary for collaborative working, and can improve organisational practice by employing better practices in the organisation of care. However, it is important to note that methodological limitations are prevalent in all these studies (Barr et al., 2000; Barr et al., 2005; Cooper, Carlisle, Gibbs & Watkins, 2001; Hammick, Freeth, Koppel, Reeves & Barr, 2007; Reeves, 2001) diminishing the trustworthiness of the findings.  

A later Cochrane Review (Reeves et al., 2008a), located six relevant studies (in contrast to the first review where no eligible studies were identified) and analysed the effects of IPE on professional practice and patient care. Four of these studies indicated positive changes for professional practice and patient satisfaction, while two studies reported that IPE interventions had no impact on either professional practice or patient care. Whilst the positive results were encouraging, generalisations could not be made due to small sample sizes, single sites and poor quality controls. An update to this Cochrane Review (Reeves, Perrier, Goldman, Freeth & Zwarenstein, 2013), located nine new studies, seven of which reported positive outcomes showing that “IPE produced positive outcomes in the following areas: diabetes care, emergency department culture and patient satisfaction; collaborative team behaviour in operating rooms; management of care in domestic violence; and mental health practitioner competencies related to the delivery of patient care” (p. 2). Nevertheless, the authors of this review note that it was once more not possible to draw ‘generalisable interpretations’ of the effectiveness of IPE due to methodological limitations which, this time, included small number of studies and heterogeneity of interventions and outcome measures.

In summary, key methodological limitations across these IPE studies include: ambiguous and weak research designs; employment of very small numbers of participants; lack of detail about specific IPE interventions; instruments which have not been validated; lack of control or comparison groups; post test evaluations only (i.e. no baseline data) and short duration or follow-up on the IPE initiative (Clifton et al., 2000; Freeth et al., 2002 and Reeves, Goldman, Sawatzky-Girling and Burton, 2008b).

The specific methodological limitations of each of these reviews can be found in the articles themselves, as well as in other sources, such as Barr et al., (2000), Freeth et al., (2002) and Reeves, Goldman, Sawatzky-Girling and Burton (2008b).
In most of these evaluations, changes in individual behaviours made use of single evaluation methods, such as self-reporting scales (Freeth et al., 2002; Nisbet, Hendry, Rolls & Field, 2008) which are not highly regarded because they recognise perceived change, rather than actual change (Reeves et al., 2008b). Moreover, few authors describe the educational philosophy informing the design of their IPE intervention (Freeth et al., 2002) and often there is a lack of association between theoretical underpinnings and the intervention chosen (Cooper et al., 2000); this will be discussed in the sections to follow. A number of studies also fail to discuss their methodological limitations, making it difficult to objectively understand the nature of their biases (Reeves et al., 2008b). All these limitations, although contextualised to IPE, seem to be commonly faced by the larger educational research community (Pollard, 2006).

One way in which evaluation of IPE could be more rigorous is the increased use of randomised controlled studies (Reeves et al., 2013). However, as discussed earlier, this is very challenging within the complex context of IPE; thus a wider range of methodologies, such as mixed-methods, multi-site/multi-institutional, longitudinal, interpretive and critical studies need to be employed to encompass the multifaceted nature of IPE and to improve the generalisability of the studies. These designs could lead to findings that would illuminate processes as well as expected outcomes of IPE (Freeth et al., 2002; Ireland et al., 2008; Reeves et al., 2010b; 2010c). Freeth et al. (2002) emphasise the importance of a smaller number of evaluations of different and innovative kinds of IPE (both in their pedagogy and their evaluation), and prospective studies with long follow up periods. It is also imperative that IPE evaluations should be underpinned by sound theoretical frameworks and take into consideration the pedagogy employed (Payler et al., 2008).

During the past decade, the IPE community has taken heed of some of these recommendations; evaluations of IPE have gradually employed more rigorous methodologies (including categorising the outcomes using a modified form of the four-level Kirkpatrick typology used in evaluating training outcomes)26 and this has generally improved the level of evidence available for IPE (Freeth et al., 2005).

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26 Barr et al.’s (2005) adaptation of Kirkpatrick’s typology (1967) can be found in Appendix 12.
However, more robust research needs to be undertaken so as to underpin IPE with clear and unequivocal evidence.

Having considered potential outcomes of IPE (product) and linking them to the existing evidence, the next section discusses process factors. Various approaches to learning and teaching of IPE influence the development and delivery of an IPE programme and, within my adapted 3P framework, process factors focus in particular on curriculum models, timing of IPE, and theoretical perspectives informing the development and delivery of IPE.

3.5 Process

3.5.1 Process: Possible Curriculum Models for IPE

As seen in Chapter 2, IPE has developed in response to different drivers, in different settings, between different organisations and between different professions. These initiatives fall along a continuum spanning discrete and isolated IPE modules to integrated IPE curricula. One of the existing typologies of IPE formats is offered by Langton (2009) who provides examples of a range of curriculum models. These are:

1. One or more modules inserted into new or existing curricula.
2. Within clinical practice as one element.
3. A common curriculum across all professions (for all or part of a programme).
4. E-learning in parallel with other courses.
5. Work-based.

There may also be a combination of two or more of these formats. Langton’s (2009) classification bears similarities to an earlier classification developed by Barr et al., (2005) which is based on a systemic review database leading to the identification of six domains of IPE as it is commonly practiced; these domains are intended to complement each other along a continuum of learning spanning pre-qualification to postqualification IPE. Table 3.1 presents this classification collated in a tabulated

27 I acknowledge that in Freeth and Reeves’ (2004) model the process component includes many other strands for learning associated with collaborative practice (Figure 3.1). My model (Figure 3.2) highlights the most important strands which were considered to be more relevant for this case study.
format but only the first three domains are presented here as my research primarily concerns issues around pre-qualification IPE.

<table>
<thead>
<tr>
<th>Domains in pre-qualification IPE</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>College-led IPE</strong></td>
<td><strong>Model: The extracurricular model</strong>&lt;br&gt;&lt;br&gt;<strong>Form:</strong> IPE initiative is assigned to outside class contact hours.&lt;br&gt;&lt;br&gt;<strong>Comments:</strong> Simple ways to implement IPE when institute is not ready for more integration.</td>
</tr>
<tr>
<td><strong>College-led IPE</strong></td>
<td><strong>Model: The crossbar model</strong>&lt;br&gt;&lt;br&gt;<strong>Form:</strong> The introduction of one or more shared learning sequences across curricula. These are seen as cross cutting bands of studies binding the uniprofessional programmes together. Can include multiprofessional and/or interprofessional studies.&lt;br&gt;&lt;br&gt;<strong>Comments:</strong> This model might be challenging to implement due to logistical difficulties.</td>
</tr>
<tr>
<td><strong>Service-led IPE</strong></td>
<td><strong>Form:</strong> Apprenticeship type of model during which IPE is offered to different professions during concurrent placements in the same location.&lt;br&gt;&lt;br&gt;<strong>Comments:</strong> Usually offered between two or more groups of apprentices during placements.</td>
</tr>
<tr>
<td><strong>Jointly-led IPE</strong></td>
<td><strong>Form:</strong> IPE initiatives led by education as well as the service providers (such as training ward initiatives).&lt;br&gt;&lt;br&gt;<strong>Comments:</strong> Very beneficial, but needs sustained support from both parties. Becoming more common due to increased partnership agreements between service and education providers.</td>
</tr>
</tbody>
</table>

Table 3.1 Pre-qualifying domains of IPE<br><br>Source: Barr *et al.* (2005). Reproduced with the permission of the authors.
Although both models pertain to formal IPE, which is an explicitly designed curriculum occurring at various levels and in various settings (Freeth et al, 2005), Barr et al’s domains emphasise the definite settings which will lead the initiative and be responsible for its development and quality assurance. It is interesting to note that Barr et al’s domains include jointly-led IPE, the latter reflecting increased tendencies on joint working between service and education providers. In addition to this type of education, there is also informal IPE, where IPE occurs in the process of another planned activity, and serendipitous IPE, which implies encounters between different professionals providing opportunity for exchange of interprofessional learning (Freeth et al., 2005).

One possible structure for IPE, e-learning, seems timely in today’s information age. E-learning has grown considerably over the past years and numerous authors suggest that such initiatives could be integrated into the curricula and could circumvent the myriad logistical barriers inherent in IPE (Barr et al., 2014; Juntunen & Heikkinen, 2004; Miers et al, 2007; Skorga, 2002). However, e-learning is not without its concerns and these include lack of engagement, lack of trust, and superficiality of critical debates (Miers et al., 2007; Moule, 2006). The safety of the computer screen could also be used as a virtual shield for avoiding the ‘difficult conversations’ that IPE can bring up. The key, it seems, is not to rely exclusively on e-learning to deliver IPE. Indeed, in Langton’s (2009) classification, Type 4, e-learning occurs in parallel with other courses; recently it has also been affirmed that for best practice, e-learning should be complemented by face-to-face learning (Barr et al., 2014).

As my adapted 3P Model indicates, the process of unfolding IPE is dependent on many interlinking and inter-related factors, a number of which are addressed throughout this review. And as seen in Chapter 2, it can also take many forms. Although some educational activities classified as IPE might not meet all of the criteria in CAIPE’s (2002) definition (which emphasises learning with, from and about each other) the idea of having planned shared learning activities in higher education which have the potential to develop into IPE seems a positive starting point. Nonetheless, an integrated and sustainable initiative spanning education and
service sectors exemplifies the most successful IPE experience. Thistlethwaite and Nisbet (2007) suggest that IPE should be akin to an “interprofessional stream” (p. 69) running through the courses and beyond. Likewise, Herbert (2005) argues that IPE needs to move beyond “single classroom” (p. 3) thinking towards more collaborative experiences across the continuum of education. In practice such comprehensive approaches are less common, possibly because they necessitate radical thinking and unequivocal higher level policies which might not be timely or possible in many contexts and, within the constraints of a curriculum or practice placement, it might be acceptable to start off with a small but manageable initiative aligning its content to outcomes. As Freeth et al., (2005) suggest, small could also be beautiful.

3.5.2 Process: Timing of IPE

The question of when best to introduce IPE has attracted its fair share of debate (Freeth et al., 2005). Until the 1990’s, the prevalent thinking was to leave IPE until after qualification because students were then assumed to have developed their professional identity, necessary for effective learning with other professions (Barr, 2000a; Dombeck, 1997). The counter argument posited that IPE would be more effective if delivered early during undergraduate years when, it was assumed, negative attitudes and stereotypes towards other students were not yet developed (Areskog, 1994; Areskog, 1988; Hall, 2005; Leaviss, 2000). Such a view was challenged in that negative attitudes and/or stereotyping were shown to be present, even at undergraduate (or pre-registration) levels and students arrive at university with distinct stereotypes of other professions (Adams, Hean, Sturgis & Macleod Clark, 2006; Hean, Clarke, Adams & Humphris, 2006; Lewitt, Ehrenborg, Scheja & Brauner, 2010; Pietroni, 1991). Gray (2009) also notes that early IPE can be confusing for some students and could sabotage future interprofessional competencies; it seems that introducing concepts of team working are more appropriate at such levels.

During the last decade, the overriding thinking favours IPE as a learning continuum starting early in undergraduate years and sustained throughout the working life of

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28 Examples would be the Leicester Model of Interprofessional Education (Anderson & Lennox, 2009) and the New Generation Project in Southampton, UK (O'Halloran, Hean, Humphris, & Macleod-Clark, 2006).
professionals (Barr et al., 2005; Freeth et al., 2005; McPherson, Headrick & Moss, 2001; Walsh et al., 2005). However, as has been discussed, such an integrated approach necessitates major changes in curricula, changes which not all universities might be ready or willing to implement.

3.5.3 **Process: Theoretical Perspectives on IPE**

The use of explicit theory underpinning IPE encourages “systematic, disciplined and critical thinking” (Barr et al., 2005, p. 120) and advances research and practice in the field (Clark, 2006). Theory plays a key role during planning, implementation and evaluation of IPE (Reeves et al., 2007) generating complex understandings of the processes involved (Reeves & Hean, 2013). Early published accounts of IPE initiatives were “descriptive, anecdotal and atheoretical” (Clark, 2006, p. 1) and, in effect, IPE was largely under theorised (Reeves & Hean, 2013). In recent years, this has changed and there is a keen interest in strengthening the theoretical base for IPE, attested to by the growing number of published works (Hean, Craddock & O’Halloran, 2009; Reeves & Hean, 2013).

Theories guiding the development and delivery of IPE originate from various perspectives ranging from learning theories, psychodynamic theories, social psychology, sociology, systems theories and organisational theories (Reeves et al., 2007). Such perspectives have the potential to guide and inform the various facets of IPE (Barr et al., 2005) and the following sections discusses a number of theories that have informed IPE; the aim is not to give details of individual theories but to highlight the breadth of perspectives employed within the field.  

3.5.3.1 **Learning Theories**

Hean et al., (2009) identify two families of learning theories used in IPE: behaviourism and constructivism. Behaviourists adopt a positivistic analytical approach in that they focus on measurable learning outcomes (Bigge & Shermis, 1999 cited in Hean et al., 2009). Within IPE, these outcomes translate into interprofessional competencies which, as has been considered in previous sections, include those skills associated with learning for collaboration. Conversely,

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29 It was beyond the scope of this study to review all genres of theories with the potential to inform IPE. However, for the interested reader, Barr et al., (2005); Colyer, Helme and Jones (2005) and Reeves et al., (2007) have penned excellent reports.
constructivists (cognitive) address processes the learner has experienced, such as how the learner understands things in relation to their own developmental stages, as well as their own learning styles. Although such a process-driven orientation is not explicitly used within IPE, adult learning theory, which is constructivist in origin and emphasises the value of the process of learning, is frequently employed for IPE.\(^{30}\) Hean et al., (2009) argue against this stance as adult learning theory applied to IPE is not a theory in its own right but one which provides the context on which constructivist learning is applied. These researchers assert that adult learning theory bereft of its wider cognitive constructivist family provides only limited understandings of “how” an IPE initiative is delivered rather than “why” it is delivered (p. 256).

Reeves et al., (2007) also note that whilst many authors claim to use adult learning theory, they generally tend to draw upon its principles implicitly. For example, Freeth and Nicol (1998) cite Knowles and Kolb briefly during a small interprofessional initiative between medical students and nurses, when they suggest that realistic patient scenarios “would aid meaningful learning and allow participants to draw upon their practical experience” (Knowles, 1990; Kolb, 1984) (p. 457). The presence of this and another similar reference to adult learning tends to limit the reader’s ability to appraise the extent to which Knowles’ and Kolb’s input supported the learning that occurred.

Continuing on the process of learning (constructivism) discussions, Almås (2007) explores how Bourdieu’s theory of the educational system is relevant for IPE, in particular for the implementation process of a common core curriculum in Norway (Bourdieu, 1989).\(^{31}\) Findings reveal that such a common core curriculum is not sufficient to improve students’ professional habitus (personal disposition and professional identity); rather, what is central for a change in students’ professional habitus is the interaction made possible during IPE. This further confirms earlier discussions on the importance of face-to-face interactions as being necessary to supplement e-learning. Almås (2007) also shows how the duration and mode of IPE

\(^{30}\) The theory and model of adult learning was pioneered in the 1970’s by Malcolm Knowles.

\(^{31}\) Bourdieu’s theory of educational system was addressed within this section of learning theories as he referred to his approaches as “constructivist structuralism” or “structural constructivism” (Bourdieu, 1989, p. 14).
(process components) have implications for students’ interprofessional cultural capital,\(^{32}\) which in her work includes interprofessional capability. Bourdieu’s concepts, most especially his work on the conceptualisation of field dynamics, are discussed in later chapters.

Another branch of constructivism (within the overall umbrella of learning theories) is social constructivism. In contrast to cognitive constructivism, social constructivism focuses on social encounters as being crucial within the individual’s experiences of learning: learning is intricately bound with the social-cultural context (Atherton, 2011; Wenger, 1998). Developmental psychologist, Vygotsky (1978), is one of the main proponents of this approach; his social-development theory stresses the fundamental role of social interactions in the development of cognition and in the process of making meaning. He also taps into collaborative learning, placing much emphasis on the social and cultural aspects of learning. Although these are seemingly key factors within IPE, there is a dearth of IPE studies utilising such learning approaches. However, of note is Hughes, Ventura and Dando’s (2004) study which refers to Vygotsky’s zone of proximal development\(^{33}\) during online undergraduate interprofessional module interactions.

Wenger’s (1998) theory of ‘communities of practice’ is another social learning theory which has been utilised for IPE. This theory looks at the development of an identity as a member of a community of practice taking place when people are engaged in active participation and collective learning. Sterret (2008) explores if and how postgraduate participants in interprofessional settings develop elements of community of practice, and her findings support Wenger’s (1998) theory in that her participants developed an interprofessional community of practice through mutual engagement and joint enterprise. It could be argued that the notion of situated learning, one of the tenets underpinning ‘communities of practice,’ could be difficult to achieve in academic-based undergraduate IPE. Nevertheless, the idea of

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\(^{32}\) Cultural capital is one of Bourdieu’s central concepts and refers to resources which could be useful for power and which could generate privilege for certain groups (Bourdieu, 1989).

\(^{33}\) Zone of proximal development is defined as “the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance, or in collaboration with more capable peers” (Vygotsky, 1978, p. 86).
‘communities of practice’ could perhaps be transposed to faculty academics, whereby the practices espoused by the social community could be facilitative of the development of their interprofessional identity.

3.5.3.2 Psychodynamic Theories
Psychodynamic approaches are also utilised in IPE. Holman and Jackson’s (2001) research using Marris’ (1986) loss and change theory is of interest as it was used as an underpinning argument to evaluate a series of IPE workshops for staff caring for older adults. Findings revealed that although participants enjoyed the workshops, they did not change any of their work practices. On one hand, they were enthusiastic for multidisciplinary involvement, yet, on the other hand, they were resistant to the new initiatives. This could be reflective of bereavement theories in which the impact of the loss, in this case change and possible perceptions of loss of identity, requires individuals to make adjustments (Marris, 1986). Holman and Jackson (2001) suggested that there was an unconscious agenda at play and stressed the importance of identifying the emotions at the root of the resistant behaviour. Although application of Marris’ (1986) theory is helpful in offering some explanations for the study participants’ lack of tangible action, the authors do not offer any information regarding how the unconscious agenda could be considered within the context of IPE development. Nevertheless, the idea of applying bereavement theories (and their concomitant effects on individual emotions) to understand change initiatives is interesting and indeed several organisational researchers have applied Kubler-Ross’ (1973) ‘stages of grief’ to change management, especially when new beliefs and practices are required by the employees (Adrienne, 2003; Schoolfield & Orduña, 1994).
3.5.3.3 Social Psychology Theories

Social psychology which is often regarded as bridging the gap between psychology and sociology, is another theoretical lens which within the realm of IPE concerns intergroup behaviour and attitude change. Of note is the Contact Theory or Contact Hypothesis (Allport, 1979), which postulates that although bringing people together is an effective way of reducing tension between groups, it is insufficient to produce attitude change and influence stereotypical views. Specific conditions, such as equality of status, cooperation between groups and the existence of common goals need to be met (Allport, 1979). Hewstone and Brown (1986) developed this work further and included positive expectations, success in joint group work, and willingness to understand similarities, as well as differences between the groups.

There have been a number of evaluation studies on IPE programmes which have incorporated ‘contact variables’ in their design. Of note are three empirical investigations of attitude change in IPE for social work, medical and nursing students at Bristol University (Carpenter, 1995; Carpenter & Hewstone, 1996; Hewstone, Carpenter, Routh & Franklyn-Stokes, 1994). Although these studies generally show positive attitude change in interprofessional stereotypes, the permanence, most especially the degree to which these positive outcomes were translated into better attitudes once these students became practitioners, is unknown. Carpenter and Hewstone (1996) also highlight that 19 per cent of the participants’ attitudes towards other professions actually worsened and this generally was allegedly due to the programme itself, putting into question the whole idea of ‘contact variables.’ Another evaluation study based on a longer programme of IPE between qualified mental health professions found little evidence of change in stereotypes (Barnes, Carpenter & Dickinson, 2000). These researchers suggest that, although the ‘contact variables’ were met, the lack of change in attitudes could be due to the uneven representation of professionals, the fact that professionals did not perceive fellow programme members as ‘typical’ members of other mental health professions, and the perceptions that ‘contact variables’ were not all met. Such results underscore the difficulty of stereotype change during IPE, which cannot be merely squared by including ‘contact variables.’
Hind et al., (2003) explored students’ attitudes towards their own and other professional groups by utilising a questionnaire survey on 933 undergraduate health care students from five different professional groups. They underpinned their study with various social psychology theories to explain the complex intergroup dynamics and relationships between these students. These included: contact theory (discussed above) together with realistic conflict theory, social identity theory and self-categorisation theory. Realistic conflict theory suggests that the existence of intergroup conflicts stems from competition over limited resources (Brown, Condor, Matthews, Wade & Williams, 1986). Social identity theory introduces the concept of social identity as a way to explain intergroup behaviours during which a group will support their own group over another, in terms of individual and collective identities (Ellemers, Spears & Doose, 1999). Self-categorisation theory, which forms part of social identity theory, suggests that intergroup relations are governed by an interaction of cognitive, motivational, and socio-historical considerations (Hornsey, 2008). Hind et al.’s (2003) study again confirms the complexity and nonlinearity of interpersonal and intergroup dynamics and supports the introduction of IPE early on so as to take advantage of students’ positive attitudes towards their own and other professional groups. However, as has been discussed, starting IPE early is not without its concerns partly due to the evidence of distinct stereotypes in novice students (Adams et al., 2006; Hean et al., 2006; Lewitt et al., 2010; Pietroni, 1991). This calls for more exploration of the broader influencing determinants of stereotypes and possible stereotype change through IPE.

Another social psychology theory, cognitive dissonance theory, is pertinent to attitude change. This theory suggests that people hold a number of cognitions (beliefs, opinions) about the world and about themselves and when these cognitions are inconsistent, discrepancies are evoked, resulting in a state of tension. This tension is cognitive dissonance, which normally we are motivated to reduce or eliminate in order to achieve consonance. The three main ways of reducing dissonance include change in attitudes, acquiring new information, and reducing the importance of cognitions (Festinger, 1962). In their prospective study, Anderson, Thorpe and Hammick (2011), analysed data from thirteen educators (unfamiliar with IPE) through a cognitive dissonance lens; their results suggest that exposure to just
one quality IPE initiative supported by good role models could be sufficient in fostering positive attitudes towards IPE. Although these results were promising, the sample size was small and it seems somewhat insufficient to attribute such change to this quality initiative. Indeed, the authors acknowledged the complexity of exploring people’s attitudes and beliefs in their limitations.

### 3.5.3.4 Sociological Theories

Sociological theories provide novel insights into IPE. Of note are Foucault’s theories of social power and discourse which fit in the realm of IPE with its issues of understanding complex cultures (Foucault, 1972). De Bere (2003) suggests that Foucault’s discourse analytical theory (Foucault, 1972) can help make sense of the personal, professional, occupational and organisational discourses arising from IPE. She argues that such a lens highlights how IPE maintains, challenges or transforms these discourses. In his doctoral dissertation, Koppel (2003) uses Foucault’s work to explore the distribution of power between stakeholders of IPE and of interest here is the rhetoric of cooperation existing between the managers, educators and professionals which, although referring to the NHS (UK), resonates with other health care contexts.

Hammick (1998) also uses the constructs of power and control while creating a framework for IPE. She draws on Bernstein’s pedagogic discourse, specifically his concepts of knowledge, power and control, so as to understand knowledge production and reproduction, as well as exploring discourses during IPE (Bernstein, 1996). Her final IPE model is noteworthy in that it incorporates Bernstein’s concepts in practice.

Negotiation theory (Strauss, 1978) is another sociological perspective applied to IPE. This perspective argues that all social order is negotiated and people mainly negotiate with each other so as to accomplish tasks in social settings. Using a negotiated-order perspective, Svensson (1996) analyses interprofessional interplay between Swedish nurses and doctors across five hospitals. Processes of negotiation take place and these reframe the interplay between doctors and nurses, as well as

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35 For these authors, a quality IPE initiative meant that the IPE initiative would have addressed the presage, process and product factors (Freeth & Reeves, 2004) and upheld collaborative values as outlined by CIPW (Hughes, 2007).
establishing social order on hospital wards. The emergent issues concerned the way decisions were made, how the ward rules were changed and the way control was maintained. Other studies which draw upon a negotiated order perspective include a multi-method action research investigating power relations across acute and non-acute health services in Australia (Nugus, Greenfield, Travaglia, Westbrook & Braithwaite, 2010), and an ethnographic study exploring the nature of interprofessional interactions within general and internal medicine settings in Canada (Reeves et al., 2009b). Nugus et al.’s (2010) findings reveal a co-existence between “competitive power” and “collaborative power” which could provide new ways of looking at power conflicts between professions (p. 899). Reeves et al.’s (2009b) study also provides insights into the nature of negotiated interactions between different health professionals, and highlights the non-negotiated order of physicians who engaged minimally with other professions, usually those occupying lower power bases. Such knowledge could be beneficial in understanding and possibly addressing such familiar phenomena in practice.

3.5.3.5 Systems Theories

Systems theories highlight the multifaceted nature of IPE. This approach focuses on the whole (system) rather than parts, and on processes rather than structures (Von Bertalanffy, 1972). The interprofessional community introduces these ideas through complexity theory (Cooper et al., 2004), Presage-Process-Product model (Freeth & Reeves, 2004), chaos theory (Velde, Greer, Lynch & Escott-Stump, 2002), and Engeström’s activity theory (Reeves & Lewin, 2004).

The common thread between these approaches is the consideration of both orderly and disorderly IPE processes taking place at the different levels (micro, meso and macro). IPE is a complex dynamic system in which “the focus is on patterns and relationships rather than on objects and structures, on wholes rather than on parts” (D’Avray, 2007 p. 16). Indeed, IPE needs to be “understood in terms of the complexity of the responsive processes of relating that are involved in such interactive, multilevel, multidimensional, activities of learning” (D’Avray, 2007, p. 16, 17). A messy and non-linear perspective, such as complexity theory, seems to

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36 Competitive power refers to a professional from one occupation dominating another. Collaborative power refers to interdependent participation and decision making with staff holding themselves accountable to team members (Nugus et al., 2010).
provide IPE with coherent theoretical underpinnings, freeing it from the constraints of other traditional models (Cooper et al., 2004). Price (2005) also argues for ‘complexity’ as a relevant theoretical framework for IPE (and IPC), as it could provide novel insights into how agents in systems may interact. In essence, Price postulates that the notions of change, uncertainty and anxiety (all possible experiences during IPE) can be used favourably as a means of prompting a system to allow emergent behaviour. There is unpredictability surrounding this emergent behaviour which prima facie, weakens Price’s argument for complexity and IPE. However, this unpredictability also suggests that it could be plausible to accept ambivalent outcomes if the whole paradigm rests on appreciation of this uncertainty. Presumably, as Price contends, transformative learning could occur at such junctures.

3.5.3.6 Organisational Theories
Organisational theories are also utilised for IPE. For example, the notion of an organisation as a learning organisation is an approach used within IPE (Barr et al., 2005; Wilcock, Campion-Smith & Head, 2002). This approach assumes that a learning organisation is one in which individuals work and learn together so as to collectively improve the quality of the work environment, as well as the services they provide, in this case, education (Reeves et al., 2007).

IPE could also signify great changes within organisations. Ginsburg and Tregunno (2005) consider the relevance of organisational change literature to the implementation of IPE. Their work is pertinent to this study as it addresses issues related to change management at an individual, organisational and system level. These authors employ Gersick’s (1991) punctuated equilibrium model, arguing that although mild incremental changes can and will occur, such changes will not challenge the deep structures of the organisation; it is only radical changes facing more substantial barriers which will entrench IPE within a system.

The breadth of theoretical perspectives outlined in these last sections and used as underpinnings for IPE aims towards aligning theory to practice (Reeves & Hean, 2013). Some theories address the individual learner (such as adult learning theories), others address group collaboration (such as communities of practice), and others
address the entire system (such as complexity and organisational theories) (Barr et al., 2005). Although these diverse foci make the utilisation of theory more accessible, they could nonetheless suggest a lack of a unifying IPE theory addressing complexities between the learner, the relational and contextual factors. However, a comprehensive theory of IPE is difficult to achieve as IPE, by its very nature, unifies a lot of realities necessitating multiple perspectives (Barr et al., 2005). The critical point is that the choice of theory underpinning any IPE activity is not an afterthought but is made explicit during the initial planning phases; this could offer conceptual clarity so that IPE could become “truly informed practice” (Craddock, O’Halloran, Borthwick, & McPherson, 2006, p. 237).

Having considered process factors, focusing on curriculum models, timing of IPE, and theoretical perspectives informing the development and delivery of IPE, the next section discusses presage factors, which, within my adapted 3P framework, focuses on various ways in which context, at various levels, could influence or impact on IPE.

### 3.6 Presage

Within my adapted 3P model, presage factors are conceptualised as those contextual factors which foreshadow IPE. These factors exist before the learning experience and influence its creation, development and delivery (Freeth et al., 2005). In Freeth and Reeves’ (2004) model, these concern context, teacher/programme developer characteristics and learner characteristics (Figure 3.1). In my adapted model, presage factors have been considered at ‘micro’, ‘meso’ and ‘macro’ levels further reflecting my emphasis on understanding and analysing context in this case study. ‘Micro level’ refers to the learner and the socialisation process: ‘meso level’ refers to institutional and organisational factors, teacher characteristics and preparation for IPE, and the broader professionalism context: and ‘macro level’ refers to national culture.  

These contextual factors can be thought of as a dynamic and inter-related web of determinants, prevalent either singularly or collectively, which “influence and inform each other and may act as catalysts or barriers” (D’Amour & Oandasan, 2005, p. 13).

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37 This taxonomy of factors influencing the success (or otherwise) of an IPE initiative was influenced by Oandasan and Reeves’s (2005b) work on IPE factors, processes and outcomes.
3.6.1 Presage: Micro Level Context

Micro level factors at the level of the individual learner mostly pertain to the many ways in which the learner acquires, not only the skills and values of the profession (educational experiences), but also assumes the occupational identity of that profession (Hall, 2005); in other words, professional identity. The development of professional identity has been described as a complex process which involves the internalisation of the group’s values and norms in the person’s own behaviour and self-concept (Adams et al., 2006). It thus follows that although professional identity is construed individually, it is influenced and forms part of the collective whole: the professional culture of the particular profession. Wackerhausen (2009) differentiates between “macro level” and “micro level” professional identity. Macro level is the “public face” (p. 459) of a profession; that is, how the profession is seen and recognised by the public and by other professions which includes, inter alia, the regulation and authorisation of the profession as well as the self-image that its leaders campaign for. “Micro level” professional identity refers to the level of the practitioner and includes everything that would enable that professional to practice in that field, such as qualifications and training, as well as the cultural socialisation process of the profession; this would ensure that the practitioner will “be one of our kind” and “stay one of our kind ... ever after” (Wackerhausen, 2009, p. 461).

The acquisition of professional identity develops and is the result of professional socialisation through which learners develop a concept of what it means to belong to their chosen profession, and to differentiate themselves from other professions (Adams et al., 2006). Hence, the construction of a student’s professional identity is inextricably linked to the complex process of professional socialisation, particular to each profession. This socialisation process evolves during each professions’ programme of studies with each profession educated separately within its own ‘silo,’ experiencing a common language, common knowledge base, common values and common problem-solving approaches (Hall, 2005). Students’ worldviews are further influenced by enforced norms, such as the rules, language, concepts, perspectives, knowledge and skills of that particular profession (D’Avray, 2007), as well as by the culture of their profession with its underlying philosophies, values, beliefs, attitudes, customs and behaviours (Hall, 2005).
Petrie (1976) suggests that this separatist socialisation process contributes to professions acquiring different “cognitive maps” (p. 35) which consists of the entire paradigmatic and conceptual knowledge of that particular profession. In practice, this means that different professions are looking at the same thing differently. Clark (2006) refers to health care professionals and students as “seeing the world as they are, not as it is” (p. 578). In today’s health care educational climate, in which students are increasingly immersed in specialised knowledge, their worldview becomes even more circumscribed and territorial to their profession (Hall & Weaver, 2001), and this accentuates separateness rather than collaboration between professions (Ginsburg & Tregunno, 2005).

Given this background, it is hardly surprising that stereotypes, negative perceptions and deep-seated boundaries should challenge interprofessional relations. As has been suggested, novice students might arrive at university with already established stereotypes (Hean et al., 2006; Tunstall-Pedoe, Rink & Hilton, 2003) which, following participation in IPE, could change into more positive perceptions (Ateah et al., 2011). However, these attitudes could also remain unchanged (Barnes et al., 2000; Curran, Sharpe, Flynn & Button, 2010), reinforced or indeed worsened (Carpenter & Hewstone, 1996; Leaviss, 2000; Mandy et al., 2004). Despite the limitations observed in the above studies38 which inter alia, include the various profiles of the professions, the length and nature of IPE, voluntary participation, small sample sizes and uneven number of represented professions, the presence of stereotypes and their influence on IPE is undisputable.

Indeed, it is not uncommon to find words and phrases, such as tribes, rivalries, hegemonies, negative stereotyping and territoriality, used in discussions and analyses of interprofessional relations in health and social care (Beattie, 1995; Braithwaite, 2005; Mandy et al., 2004; Nugus et al., 2010; Pirrie, 1999). As Baldwin (D’Avray, 2007) aptly states, “the liberating philosophies and practices of egalitarianism, openness, empowerment and cooperation, implicit in both IPE and interprofessional

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38 The overarching aim of these studies was to explore the influence of IPE on the perceptions and attitudes of health professions.
practice, are a direct challenge to the existing establishment because they threaten to level the playing field and to empower other health professionals (p. 13).”

Finding ways through which the various professions educated in such silos could cross professional boundaries and rise above these ontological barriers poses different challenges: professions with strong identities could lose their dominance and power, whereas professions with weaker identities could feel threatened by the idea of learning and working in a new and interprofessional manner. Lorenz (2009) suggests that understanding and acknowledging differences between the professions is paramount. And as Barr (1996) emphasises, the starting point of IPE is from a position of a strong professional identity and not from one which tries to gloss over and blend the differences.

In addition to these factors associated with the development of professional identity in students, other studies suggest that further micro level factors could influence the presage of IPE. These include personal qualities and attitudes (Parsell & Bligh, 1998), gender and gender imbalances of students (Baldwin, 2007b; Gardner, Chamberlin, Heestand & Stowe, 2002), and ethnic and age differences (Miers et al, 2007).

Having considered a number of micro level factors in relation to the learner’s professional identity and the professional socialisation process, the next section considers meso level contextual factors.

3.6.2 Presage: Meso Level Context

The key presage factors at meso level included in my adapted model concern ways in which IPE could be influenced by institutional and organisational factors, by teacher characteristics and their preparation for IPE, as well as by the socio-historical context of professionalism. The focus is on understanding the educational, health professional and cultural ‘eco-system’ of higher educational contexts planning for IPE.

39 These terms are used interchangeably in the literature. For this work, ‘institutional’ refers to the meso level higher educational context at faculty level, whilst ‘organisational’ refers to a higher meso level such as the administration and management at university.
3.6.2.1 Institutional and Organisational Influences

There is consensus that a combination of vision, commitment, leadership, administrative and financial support is crucial for successful IPE (Bridges, Davidson, Odegard, Maki & Tomkowiak, 2011; Harriett, Cummings & Dreyfus, 2003; Goble, 1994; Oandasan & Reeves, 2005a; 2005b; Parsell & Bligh, 1998; Pirrie, Wilson, Harden & Elsegood, 1998). Examples of some of these antecedents for IPE have been highlighted in Chapter 2.

Leadership has always been a major force in curricular change and innovation, and within IPE, leadership and vision at the highest levels are paramount (Oandasan & Reeves, 2005b). Clark (2004) puts forward an analogy of Newton’s first and second laws as he explores the difficulties of developing and sustaining IPE programmes. The first law, the Law of Academic Inertia, states that academia “will resist change unless they experience an external force, such as grant funding or accreditation requirements” (p. 254). The second law, the Law of Permanency of Academic Change, states that the “degree of permanency of interdisciplinary change in academic programmes is directly proportional to the size of the pressure acting upon them and inversely proportional to the structural and financial resistance to change within the institution” (p. 257). Clark’s (2004) ‘laws’ resonate with many IPE initiatives worldwide (as seen in Chapter 2: Part 2) which start off enthusiastically, only to come to an untimely and premature death; they also reflect the realities of IPE which, as has been emphasised, is lauded in theory but challenging and complex to implement.

Strong visionary leaders can address some of this complexity because they can control resources, decide on educational policies and mobilise faculty support (Goble, 1994; Oandasan & Reeves, 2005b), and they can ensure the sustainability of such a pedagogy (Clark, 2004). At lower levels, leadership is also crucial. Ginsburg and Tregguno (2005) highlight the importance of developing “diffuse local leadership” (p. 182): a critical mass of IPE enthusiasts willing to engage in the change process. Freeth et al., (2005) further emphasise the significance of leadership and management for IPE at various levels; this includes IPE champions, as well as managers at different levels who would have the capability of working closely with the planning team. It has been noted that frequently, IPE initiatives are
led by enthusiastic individuals over and above their workloads with little or no support (Hall, 2005; Sommer, Silagy & Rose, 1992); and this puts the whole IPE process in jeopardy if or when these IPE champions move on or have to relinquish their IPE commitments due to competing agendas (Freeth, 2001).

In addition to having the support of executive top level administration and IPE faculty champions, initiatives need to address and overcome a myriad of other presage factor inhibitors associated with the organisation. These factors include “internal inhibitors,” such as inequalities in the number of students per profession, differences in curricula, time table differences, curriculum overload (known as curriculum cram) and geographical isolation (Pirrie et al., 1998, p. 413). There are also “external inhibitors” such as validation, accreditation and funding (Freeth et al., 2005; Pirrie et al., 1998, p. 413). As Gilbert (2005) observes “changing a college curriculum is like moving a graveyard: you never know how many friends the dead have until you try to move them” (varyingly attributed to Cooledge or Wilson, cited in Gilbert, 2005, p. 97).

Of note within ‘internal inhibitors’ is geographic isolation; this refers to the separate lecture halls/facilities for the various students again reinforcing the separate nature of the professions (Hall, 2005, Pirrie et al., 1998). As a result of their work on social and spatial influences on interdisciplinary research, Scott and Hofmeyer (2007) suggest that interdisciplinary research addressing complex health and social issues is “facilitated by explicitly constructing social and spatial contexts that encourage transformation of disciplinary boundaries to achieve new knowledge integration” (p. 491). Similarly, Nordquist, Kitto, Peller, Ygge and Reeves (2011) point to the centrality of the environment for IPE, suggesting that it is the connection between space, place and interprofessional learning that is central to understanding the professional cultures and identities via the hidden curriculum. In this vein, Karolinska Institutet and Stockholm County Council have been running a project called Future Learning Environments since 2009. This project, which is grounded on research in learning and higher education, explores the impact of space on learning and Karolinska Institutet hosted a conference in 2012, ‘Future Learning

The hidden curriculum refers to influences that function at the level of organisational structures as well as cultures and which could contribute to the development of appropriate professional attitudes (Hafferty & Hafler, 2011).
Environments: How Space Impacts on Learning’ as a forum for debating such issues (Karolinska Institutet, http://ki.se/en/about/future-learning-environments). Although this may seem a somewhat utopian vision for IPE, understanding conceptual and practical relationships between space, place and learning could be an impetus for developing contexts aimed at encouraging collaborative learning environments.

3.6.2.2 Teacher Characteristics and their Preparation for IPE

The concept of IPE as defined by CAIPE (2002) contains attributes that makes it unique to any other educational activity, hence requiring a different kind of educator beyond those necessary when working uniprofessionally; educators that inter alia would assume more the role of facilitators (rather than that of teachers delivering didactic learning), be reflective practitioners, have a positive attitude towards IPE and would be able to lead group process towards effective interprofessional performance (Gray, 2009; Howkins and Bray, 2008). The literature is unequivocal that effective IPE facilitation is critical and essential to its success and should be an integral part of IPE development (Anderson et al., 2011; Freeth et al., 2005; Gray, 200); hence the next organisational tier crucial for IPE at a meso level are the teachers and/or facilitators for IPE, resonating in this instance with Freeth and Reeves’ (2004) central category in the presage factors (Figure 3.1).

Evidence shows that the educational value of IPE is strongly associated with the quality, content and delivery of teaching and/or facilitation (Barker, Bosco & Oandasan, 2005; Cooper, Spencer-Dawe & Mclean, 2005; Freeth et al., 2005; Gray, 2009; Miller et al., 2006). However, there is a dearth of research on faculty development and IPE (Steinert, 2005) specifically as to whether educators are prepared to facilitate IPE and what kind of preparation would be needed to develop discipline-specific educators as IPE facilitators (Anderson, Cox & Thorpe, 2009; Barr et al., 2014; Gray, 2009). Reeves (2010) notes that “we have a limited understanding of the learning/teaching processes that occur within IPE, which means we still struggle to know empirically, for example, what elements contribute to effective interprofessional facilitation” (p. 217).
This paucity of research could possibly be based on a naive assumption that facilitation of IPE does not require any different skills other than normal lecturing skills. Various authors suggest that it is precisely this assumption, plus lack of time, which is at the basis of the lack of staff development for IPE (Anderson et al., 2009; Gray, 2009; Priest, Sawyer, Roberts & Rhodes, 2005). It has also been found that lecturers entrusted with IPE facilitation find it very challenging (Anderson et al., 2009; Gray, 2009; Oandasan & Reeves, 2005b). Gray’s (2009) doctoral study suggests that IPE facilitators have minimal insight into interprofessional issues resulting in “internal confrontation between known mono-professional teaching identities and the unanticipated but required interprofessional teaching identities” (p. 171). A number of research studies have attempted to identify the various causes for this (Anderson & Thorpe, 2008; Gray, 2009; Howkins & Bray, 2008). For instance, there is the loyalty and commitment to one’s own profession (Gray, 2009; Hean et al., 2006), anxiety about working with students with a different body of knowledge and being expected to answer queries beyond their level of expertise, coping with prejudices and competing behaviours (Barr, Helme and D’Avray, 2011), negativity, inexperience, uncertainty and the lack of an interprofessional identity; all aspects which may be unintentionally communicated to the students undermining the success of IPE (Gray, 2009). Gilbert (2005) and Gray (2009) add that academics who are educated in traditional professional silos themselves, could be uncomfortable with collaborative learning approaches, for clearly it requires them to focus less on their status as experts and more on their ability to facilitate and maintain group dynamics. This brings to the fore the complex relationship between teachers’ ideas, beliefs, practices and attitudes and possible innovations in higher education. It is indeed paradoxical that teachers in higher education, for example in health professional education, could be experts in their own areas yet, in many cases, would have limited pedagogical training.

Research has strongly suggested that compulsory facilitator training is critical for IPE (Gray, 2009; Hammick, Olekers & Campion-Smith, 2009) and during the last decade, the IPE community has attempted to address this lacuna. CAIPE, in the United Kingdom, has been at the forefront in organising workshops for educators involved in IPE delivery. Howkins and Bray (2008) provided a critical exploration of the theory and practice related to teacher preparation for interprofessional
On a more pragmatic level, Banfield and Lackie (2009) developed an interprofessional facilitator-collaborator competency tool, which is used to design a culturally sensitive interprofessional facilitator programme. Anderson et al., (2009) developed a Master’s level two day course for IPE facilitators which gave a great deal of importance to group processes of the course, such as reflection and dialogue. Gray (2009) also identified salient themes necessary for the pedagogy of IPE and developed a model designed for the preparation and support of IPE teachers.

Nevertheless, preparing teachers for IPE is such a complex and demanding activity that apart from high quality preparation, other factors addressing teachers’ characteristics per se need to be in place. These inter alia include choosing teachers who are committed and enthusiastic for the concept of IPE itself (Freeth & Reeves, 2004; Gray, 2009): making explicit teachers’ critical awareness of their beliefs towards collaborative learning and practices (Freeth & Reeves, 2004): acknowledging teachers’ behaviours and expectations which could influence the complex process of institutional change (Ho et al., 2008); facilitating the development of teachers’ interprofessional identity (Gray, 2009): working towards establishing an adult and reflective learning approach between student and teacher (Gray, 2009); and cyclical training and ongoing teacher support (such as regular teacher induction and de-briefing sessions) (Anderson et al., 2009; Freeth & Reeves, 2004; Lindqvist & Reeves, 2007). Combined with skilful facilitation, these factors can collectively work towards aiming at and possibly sustaining a good level of interprofessional collegiality and commitment during IPE.

3.6.2.3 Professions and their Historical Context

All health and social care professions have diverse origins; it is important here to examine how the socio-historical and political roots of these professions in western societies could help develop deeper insights into their collaborative behaviours both in clinical practice and in higher education contexts. This refers particularly to how professions’ embedded hierarchical, stereotypical and territorial behaviours and practices (discussed earlier at an individual micro level) appear to be deeply rooted in the socialisation processes and professionalisation discourses of health care.

These included expertise in facilitation skills, expertise in the interprofessional process of teaching, appreciation of reflective practices and the effective use of problem-based learning principles and processes (Gray, 2009).
professions (Khalili, Hall & DeLuca, 2014) and how these behaviours could impact on IPE.

Until the late 1960’s, sociologists tended to analyse the traits or characteristics that distinguished professions from other groups. This ‘trait approach’ suggested that professions could be defined in terms of core characteristics, such as a prolonged period of training pertaining to a body of abstract knowledge and a service orientated approach (Goode, 1960). This approach was associated with a functionalist perspective in which professions (such as medical professions) fulfilled a social need and represented guardians of collective societal well-being for modern society. In this perspective students were seen as passive recipients of a professional identity that was shaped by their chosen profession (Khalili et al., 2014).

Adopting a social constructionist stance, Freidson (1973, 1988a), was critical of the functionalist perspective since it suggested that professions, especially the medical professions, worked altruistically for the benefit of society and their patients. Freidson argued that it was not the knowledge base of an occupation which granted that particular occupation its professional status but society’s judgement that the occupation had superior attributes and skills. He contended that the process by which occupations become professions, termed professionalisation, is characterised by the development of power structures within these professions resulting in domination, autonomy and control, as opposed to collegiality and trust.

Building on the work of Freidson, Larson (1977) described the process of professionalisation as the ‘professional project’; a concept which resonated with the ideas of Weber (1978), particularly his stratification of occupations as a framework for demonstrating how knowledge-based occupations set about becoming established professions within a society (cited in MacDonald, 1995). Larson (1977) proposed that the creation of occupational groups, most notably the medical profession, was, in effect, the outcome of critical engineering by the professions in translating their

42 There are various perspectives on the sociology of the professions and these include structuralists, neo-Weberian, Marxist and interactionist approaches. Although Chapter 7 will revisit the analysis of socio-historical discourse of professionalism, the reader is invited to refer to such works as Abbot (1988); Evetts (2003; 2005); Larson (1977, 2013) and MacDonald, (1995) for a comprehensive examination of the different perspectives and interpretations.
special knowledge and skills into social mobility (thus higher status) and economic rewards (thus higher remuneration); a process akin to market closure securing economic and status rewards. Indeed, Freidson (1988a, 1994) argued that occupations engaged in what Weber termed ‘social closure,’ the practice of preserving their privileges by restricting access to resources and rewards to the specialised few: those who would have undergone extended years of schooling and acquired knowledge that was too complex and scientific for the layman to execute and evaluate. These professions then negotiated a special relationship with the state and the public so as to ensure that their specialised knowledge and skills remained solely within their control. The successful outcome of this relationship was state registration or licence to practice. It was also a means of controlling the profession by the professionals’ own self-governing organisations and by their members. Ultimately, Coburn (2006) contends that being a member of a profession was a societal contract granting that professional a monopoly of its services and the privilege of self-regulation. In return, society would be assured of professional competence in services rendered.

Such insights provide some understandings of how the socio-historical and political processes underpinning the processes of professionalisation could run counter to the philosophical ideal of an egalitarian foundation on which IPE can be built; a paradox that has been largely overlooked in IPE and IPC. It is only in recent years that this sociological lens has come into use, highlighting the roots of interprofessional hierarchies and imbalances and how these continue to be perpetuated (Baker, Egan-Lee, Martimianakis & Reeves, 2011; Cameron, 2011; Khalili, Orchard, Laschinger & Farah, 2013; Kitto, Chesters, Thistlethwaite & Reeves, 2011). Eraut (1996), who explicitly regards professionalism as an ideology (thus reiterating the majority of the arguments outlined above), further highlights the possible effects of this ideology within higher education arguing that academic educators trained within the various historical, political and sociological contexts could eventually find themselves at odds with the norms of higher education, as the latter take precedence over those of the professions. For example, he notes that the fragmentation of knowledge necessary for credit based systems might be unsuitable for developing the professional knowledge and competencies necessary for professional practice.
A small number of research studies have used sociological theories to inform their analysis; of note is an ethnographic study (Reeves et al., 2009b) exploring the nature of interprofessional interactions within two ward settings in Canada which, amongst others, drew on Strauss (1978) negotiated order perspective and Freidson’s (1970; 1988a) concepts of professional power and medical dominance to explain the observed differences (dynamics) in interprofessional interactions. Baker et al. (2011), in their multisite IPE initiative evaluation, emphasised how the different professions perceived and experienced power. These researchers used Witz’s (1992) model of professional closure to underscore how traditional professional dynamics could be powerful barriers to collaborative approaches. Such studies provide insights into territorial behaviours, common to all professions, and representing one of the major challenges facing IPE and IPC.

These organisational and professional presage meso level factors raise key questions. How are professions expected to work within ‘permeable boundaries’ after years of struggling to define and protect these boundaries? Can an organisational and professional culture which would appreciate and support interprofessional learning ever be cultivated? The literature offers some pointers in this regard and the next section discusses some suggestions for creating a climate in which professions would value the concept of learning together in order to eventually work together effectively.

3.6.2.4 Creating the Culture for IPE

Kipp, Pimlott and Satzinger (2007) suggest that the academic culture of the institution should provide the right balance between discipline-specific socialisation and socialisation with other professions. This would provide students with opportunities to become aware of realities other than their own (Jarvis, 2004) and realise that the team could be greater than the sum of its parts. However, such socialisation processes would need to be underpinned by a culture of reflective learning which, as Niemi (1997) suggests, is key to committing to and achieving an interprofessional identity and is imperative for preparation of educators involved in IPE (Anderson et al., 2009; Gray, 2009). Clark (2009) emphasises that IPE requires the development of self-insight and understanding, and necessitates achieving metacognitive competencies regarding oneself, the other professions on the team and
the team itself. This is akin to students’ development of “their identity within the collective” (McGregor, Hooker, Wise & Devlin, 2010, p. 184) which, within early IPE, could be the first steps towards students positioning themselves within the team. Iliadi (2010) suggests a number of pragmatic principles to counteract attitudinal barriers which are rife within professional communities, one of which is having a “neutral frame of reference” which possibly counteracts issues of power and territoriality. She suggests that the person “who provides leadership” would have to be included in this “neutrality” (p. 133). Iliadi (2010) offers little explanation of her ideas and her notion remains elusive. If by “neutrality” she means bracketing off one’s own professional identity, this might be unrealistic to sustain in practice, since professional identity is “embodied in the practitioners’ habitual, everyday practice” (Wackerhausen, 2009, p. 455). Alternatively, she could be suggesting that the leader of an IPE initiative would come from an administrative background, rather than a professional one.

The ideas of “team learning” presented by Senge in his classic text, *The Fifth Discipline* (Senge, 1990, p. 10) are taken up by Stinson, Pearson and Lucas (2006) who suggest ways to develop a learning culture which, *inter alia*, would cultivate teamwork. Within the process of “team learning,” a group of individuals suspend personal assumptions about each other and enter into a genuine “thinking together” mode (p. 310) underscoring the subtle differences between discussion and dialogue. In discussion, people long for their own views to be accepted by the group and the emphasis is on winning rather than learning; whereas in dialogue, the emphasis is on temporarily suspending personal judgements and exploring each and every point in search of common ground. Whilst this approach reflects the core concepts of IPE and IPC, its success depends on whether the various professions are open and know how to engage in dialogue rather than discussion. And if not, what are the ways in which such communication skills could be encouraged?

Fitzsimmons and White (1997) attempted to create a climate of dialogue with social services and nursing teams in the United Kingdom by setting up an innovative workshop. They firstly identified and acknowledged important themes, such as

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43 Although these authors are not writing within the IPE context, their arguments concern developing a learning culture which is relevant here.
different priorities, political dynamics and organisational constraints. They then made use of behavioural contracting in which the groups were able to recognise how their behaviour impacted on the other group. After using such strategies, these researchers noted a significant effect on the quality of the service provided by each agency. Such collaborative processes could be well worth considering during the delivery of IPE both in academia and in practice.

Having considered institutional/organisational factors, teacher characteristics and their preparation for IPE and the socio-historical backdrop of the professional cultures at meso level presage factors influencing IPE, and having considered possible ideas for creating a culture for IPE, the next section discusses macro level contextual factors.

3.6.3 Presage: Macro Level Context

While within Oandasan and Reeves’ (2005b) classification, macro level factors refer to the political (government) and institutional support required for IPE, macro presage factors discussed here are extended to include determinants acting outside the institution, such as the cultural influences of a country. This discussion also goes beyond Freeth and Reeves’ (2004) model (Figure 3.1) which centres on the main presage factors associated with the learning context. My rationale in highlighting collaboration determinants at a macrostructural level again reflects the research questions. It also draws attention to the paucity of research studies exploring determinants on IPE at this level.

3.6.3.1 Political Influences

The introduction and sustainability of IPE necessitates wider catalysts than appropriate leadership and support within the institution/organisation (Goble, 1994; Pirrie et al., 1998, Oandasan & Reeves, 2005b); political support is crucial. For example, in the UK, the political pledge to achieve seamless service for patient-centred care supported universities and higher education colleges in introducing new core curricula (Barr, 2000a; 2000b; 2007a). There were also high profile inquiries which put collaborative practices on the political agenda (Butler-Sloss, 1988;

44 These challenges are not exhaustive of all the meso level barriers, however they were deemed to be the most important for this work.
Department of Health and Social Security, UK, 1974; Francis, 2013; Laming, 2003). Similarly, in the USA, the complexity of care necessary for the ageing World War II Veterans led to the Veterans Administration (part of Central Government) supporting interprofessional geriatrics team training and care (D’Avray, 2007).

The literature also considers professional institutes/associations, regulatory bodies and service agencies as other key stakeholders for IPE (Barr & Ross, 2006). The leverage of these bodies varies in every country depending on factors such as historical traditions, legislative frameworks and workforce trends. In the UK, Barr (2002) notes that collaboration between these stakeholders provided the bedrock for IPE policies.

In Malta, as has been discussed earlier (Chapter 2: Part 1), there is a thrust for developing a multidisciplinary approach in all services provided by the national health service (Ministry for Social Policy, 2009; Ministry for Health, Malta, 2014). To what extent and in what ways this aspiration will be translated into reality still remains to be seen. This case study, an in-depth exploration from multiple perspectives of the complexity and uniqueness of possible IPE at the Faculty of Health Sciences in Malta, will, hopefully, generate valuable knowledge and understandings illuminating and supporting possible future multiprofessional and interprofessional developments in Malta.

3.6.3.2 National Cultural Considerations

Meso level presage factors discussed earlier illustrate how socialisation processes embedded in the professional cultures of health care professions and intertwined with the socio-historical discourses of the professions promote competition rather than collaboration. Nonetheless, these influences are only part of the picture. Another factor, which operates at a yet deeper level, is the way national cultures affect deep rooted beliefs which unconsciously or subconsciously guide our thinking and behaviours. Culture refers to those intangible factors which permeate all our social interactions both on a personal and a professional level.\(^{45}\) The essence of a

\(^{45}\) This work does not address the notion of cultural diversity referring to the possible variety of cultural or ethnic groups in interprofessional education. This is not because it is an irrelevant aspect (most especially since we are increasingly living in multicultural societies) but because it was beyond the scope of this work.
culture are those unconscious and shared beliefs, actions, norms and values held by the individual within an organisation, community or society and which influence the way things are carried out (Hofstede, Hofstede & Minov, 2010). Culture is defined as a “collective identity composed of shared understandings which are communicated through a common language and will influence to a greater or lesser degree what individuals think and do” (Charles, Gafni, Whelan & O’Brien, 2006, p. 263). It also refers to “the collective programming of the mind that distinguishes the members of one group or category of people from others” (Hofstede et al., 2010, p. 6).

Hofstede, a professor in organisational anthropology, emphasises that, despite numerous forces for change, societies have a remarkable capacity for conserving their characteristic cultures. His extensive research concerning comparative intercultural research suggests that people carry ‘mental programmes’ which are developed in early childhood and represent patterns of thinking, feeling and acting. These programmes exist within the social contexts in which a person grows up and are reinforced in families, schools, church and organisations. National cultures are programmed first and represent the most profound values; occupational cultures are acquired later on during adolescence; and organisational cultures are acquired in adulthood during employment. Although organisational/institutional cultures are given much importance both in management literature and in IPE literature, these cultures are relatively superficial: it is national culture which operates at the deepest level of our mental programmes (Hofstede, 1989; Hofstede et al., 2010), hence its importance is unequivocal for this work.

There is a dearth of research or literature concerning how national cultural determinants could influence IPE. Only a few researchers explore and/or provide conceptual accounts of how wider cultural factors or social structures can constrain or enable IPE. An example is Irajpour (2009) who, through a mixed-study approach, explores the development of shared learning in medical sciences education in the Islamic Republic of Iran. His findings point to an interesting cultural paradox: that Iranian culture with its religious emphasis on being together could facilitate collaborative practices, yet innate cultural inabilities to work in teams and fear of innovation could work against shared learning. Mariano (1989) also postulates that a
strong cultural affinity for autonomy could challenge collaborative practices. More recently, Rieck (2014) employs the concept of Hofstede’s power distance\textsuperscript{46} to explain barriers to collaboration between general practitioners and community pharmacists in Australia.

Another example is a comparative research study testing three hypotheses concerning attitudes to physician-nurse collaboration across genders, disciplines and cultures in the United States and Mexico; the results highlight how cultural differences between the two countries influenced the way professionals looked at collaborative work (Hojat \textit{et al.}, 2001). Although this study provides interesting information about the classic physician-nurse relationship, the research instrument, an attitude scale,\textsuperscript{47} makes it difficult to explore other and possibly deeper cultural values. Cross cultural differences were also explored between Slovenia and Sweden using an interprofessional palliative care course as the platform for data collection. Again the findings, although limited by small sample sizes and subjectivity, brought to the fore cultural variances regarding teamwork and interprofessional relationships between the two countries (Pahor & Rasmussen, 2009).

### 3.7 Refinement of Research Questions

The focus of inquiry and research questions identified at the outset of my study, are presented in the introduction to this thesis. Whilst reviewing the literature, I came to appreciate that the issues I wanted to explore were intricately bound to wider contexts beyond the Faculty of Health Sciences at the University of Malta, that is, the micro, meso and macro contexts discussed in this Literature Review and the chapter preceding it (Chapter 2: Setting the Scene). The focus of the research thus had to change from merely exploring participants’ perceptions of IPE and a possible initiative, to one which would include contextual determinants; it was thus crucial that my research questions be worded in such a way so as to allow any of these influences to emerge, and so the original research questions were reframed as follows:

\textsuperscript{46} Power distance is one of the six cultural dimensions developed by Hofstede (Hofstede \textit{et al.}, 2010) and refers to how a society handles inequalities among people. This will be discussed in more detail in Chapter 7.

\textsuperscript{47} The instrument used was a modified version of the Jefferson Scale of Attitudes towards Physician-Nurse collaboration (Hojat & Herman, 1985).
• What are the perceptions of IPE held by Faculty of Health Sciences, University of Malta academic staff and other key stakeholders?
• What are the factors that could possibly influence their perceptions of IPE?

It was anticipated that exploring these questions would stimulate discussion on the often neglected determinants outside the organisation, such as the social, cultural, educational and professional systems. In light of this, the revised or widened study aims may be summarised as follows:

• To explore how academic staff and other stakeholders at the newly upgraded Faculty of Health Sciences perceive and understand IPE.
• To explore and understand the perceived barriers and/or enhancers of a possible IPE undergraduate initiative at the Faculty of Health Sciences.
• To explore and understand how micro, meso and macro contextual factors could possibly influence IPE in Malta.

It was timely that in April 2015, the Institute of Medicine (IOM) in the U.S.A. published recommendations put forth by a committee it had convened to identify and propose research methods best suited to enhancing understandings of IPE and its longer term implications for practitioners and patients (IOM, 2015). The report appeals to stakeholders, funders and policy-makers in the field of IPE to commit resources and expertise “to a coordinated series of well-designed studies of the association between IPE” (IOM 2015, p. 1). The IOM Committee proposes comprehensive methodologies, recommending that “when possible, such studies should include an economic analysis and be carried out by teams of experts that include educational evaluators, health services researchers, and economists, along with educators and others engaged in IPE” (IOM, 2015, p. 1). Such grand-scale, comprehensive proposals and recommendations illustrate the depth and breadth of studies needed if the field of IPE is to be truly understood, developed and sustained. The IOM Report proposes a conceptual model for evaluating IPE outcomes reproduced below in Figure 3.4:
This model consists of a broad array of learning, health, and systems outcomes and major enabling and interfering factors which, although not yet empirically tested, can be adapted to suit local or national contexts (IOM, 2015). Although my study is not an evaluation of IPE but an exploration of stakeholders’ perceptions of IPE as a precursor to its possible implementation, what is timely and relevant about the IOM Report is that two elements of the model coincide with the analytical framework I had developed during the data analysis process and on-going engagement with the literature, in particular with the ‘learning continuum’ (which refers to Process factors such as possible curriculum models and timing of IPE) and the enabling or interfering factors, embracing not just the Faculty but micro, meso and macro factors that may influence IPE directly or indirectly.

3.8 Conclusion
This chapter presented a review of the literature in relation to the nature of developing and delivering IPE and highlighted the key concepts essential to its
success. It borrowed and loosely adapted the 3P (Presage-Process-Product) Model of learning and teaching (Biggs, 1993; Freeth & Reeves, 2004) as an organising framework to discuss the complex, multi-layered and interrelated factors that may enhance or impede IPE. The first pillar in this model considered potential outcomes of IPE, *product*, and linked them to the existing evidence. The second pillar, *process* factors, focused on potential curriculum models, timing of IPE, and theoretical perspectives informing the development and delivery of IPE. The third pillar, *presage* factors, discussed interrelated contextual factors that influence IPE at micro, meso and macro levels. At micro level, it considered the learner and the socialisation process, at meso level it discussed institutional and organisational factors, teacher characteristics and their preparation for IPE, as well as the professions and their socio-historical context, and at macro level it looked towards political influences and national culture.

The review identified a number of gaps in the literature pertaining to IPE, but most notably a gap concerning scholarship on the influence of national cultures on IPE. This study aims to address this lacuna by exploring these influences and thereby contributing to the building of a much-needed body of knowledge on contextual understandings of IPE. Chapter 4 describes, explains and justifies, the methodological approach I adopted to address the research question and study aims.

### 3.9 The Inward Eye

The organising, synthesis and critical appraisal of the IPE literature pertinent for this review reminded me of Etherington’s (2004) thoughts on arranging her book on reflexivity ... I had read this book early on in my PhD process but this excerpt had resonated with me in a particular way.

> Trying to arrange this book has been like trying to dress an over-active baby in a Babygro! No sooner had I pushed one leg in, then the other came out; as soon as I tucked that leg back in, an arm was free and so on (Etherington, 2004, p. 23).

The process of engaging in a dialogue with the ever-growing IPE literature which was relevant to my needs, included many moments of uncertainty - uncertainty that
in telling the story of IPE I would overlook some important material, uncertainty that I would not find my voice amidst the IPE researchers and scholars, uncertainty that my immersion in the field would make it more difficult for me to stand back from the literature and the entire research process. Indeed, there was a point when I became aware that in exploring the literature, I was more drawn to studies which exalted IPE. When I became aware of this, I started being more critical of my choices and the studies and papers I had originally considered for this review. My saving grace was my continual awareness to focus on the ‘conceptual thread.’ Way back, I had heard this wonderful piece of advice from an eminent educationalist and always kept it in mind whilst wrestling with difficult moments in my PhD journey. As the months progressed into years, my confidence slowly grew and I could navigate around the vast terrain of IPE literature even adapting existing models to ‘scaffold’ my literature. I could also use experts’ ideas and arguments to clarify my own story and see where my work sits in that story ... a story however which still needed to be unravelled against the beliefs, values and practices prevalent in the local culture. The literature was unequivocal; IPE is a complex and demanding field with challenges of context, implementation and sustainability. Cognisant of this complexity, I could not de-contextualise my IPE story from my personal beliefs and surroundings ... I could only write about it by my continual explicit questioning of my own interpretations.
Chapter 4  The Research Process  
Part 1: Methodology and Methods

“There is no such thing as a logical method of having new ideas or a logical reconstruction of this process” (Popper, 1959/2005, p. 8).

4.1  Introduction

This chapter presents the research design I adopted for this study. It provides the methodological “map” (Finlay, 2006a, p. 9) for my research explaining how my ontological, epistemological and theoretical perspectives guided the research design, methods of data collection and analysis. It also shows how a systematic and explicit way of inductive reasoning was employed so as to seek a high degree of methodological rigour. Further, this chapter acknowledges the central role I played in this research by engaging in and making explicit my reflective and reflexive process of being an insider researcher.

4.2  Mapping Methodology

The research questions and aims stated at the close of the previous chapter provided the strategic direction for my methodological ‘map’ (Finlay, 2006a, p. 9) requiring that I adopt an approach which would enable me to understand participants’ meanings and interpretations of IPE situated within their social, cultural and temporal contexts. This called for consideration of qualitative philosophical assumptions and interpretative frameworks.

4.2.1  Ontological and Epistemological Positions

Ontology concerns perceptions of the nature of reality and being in the world (Crotty, 1998). It attempts to answer the question “What is the form and nature of reality, and therefore what is there that can be known about it” (Guba & Lincoln, 1994, p. 108). Ontology is closely related to epistemology which concerns the nature and production of knowledge (Crotty, 1998). The fundamental question regarding epistemology is “what is the nature of the relationship between the knower and what can be known?” (Guba & Lincoln, 1994, p. 108). Discussing epistemology
and ontology separately seemed artificial since epistemological questions arise from ontological concerns (Carpenter & Suto, 2008). My assumption was that participants’ understandings of IPE would be based on their own realities, experiences and interpretations. This assumption, referred to as relativism, implies that the same phenomenon would be interpreted differently by different people in different times and contexts (Crotty, 1998). These multiple realities could be seen as socio-psychological constructions forming an interconnected whole (Lincoln & Guba, 1985; Maykut & Morehouse, 1994). Hence, this research study assumed a relativist ontology and understanding this reality (epistemology) led me to assume a social constructionist worldview (Crotty, 1998; Lincoln & Guba, 1985). Figure 4.1 shows my interrelated philosophical and methodological ‘map’ determined by my research purpose and questions.

**Figure 4.1 The Research Framework**

Source: Adapted from Crotty, 1998

Constructionism posits that “all knowledge and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their worlds, and developed and transmitted within an essentially social context” (Crotty, 1998, p. 42). Meaning is not inherent in objects and waiting to be discovered but is constructed through a dynamic interplay between
the person and the objects in a world in which they live and interact (Crotty, 1998). Hence, my research, rather than assuming to explain one reality, was orientated towards understanding different perspectives and different realities. For example, each participant would interpret IPE differently and with each new interpretation, new knowledge would be constructed (Stake & Kerr, 1995). Meanings of IPE would be constructed by participants themselves, by participants in relation to each other and to the researcher, in a constant and dynamic interplay within the different worlds including my own. When such knowledge is constructed, the knower (researcher) “cannot be totally separated from what is known: the world is co-constituted” (Maykut & Morehouse, 1994 p. 11). The emergent knowledge would be my interpretations of the co-constituted knowledge influenced by my position and stance; although this was acceptable within this worldview it underscored the importance of continual reflexivity.

As a social constructionist, I believe that cultural influences are pivotal to the way people experience reality and make sense of their world. Crotty (1998) asserts that as human beings we depend on culture “to direct our behaviours and organise our experiences” (p. 53). Understanding culture was pertinent to this work and added to the richness of the story. Etherington (2004) notes that social constructionism “challenges us to view grand narratives” (p. 21) and this was congruent with my intention to explore factors inside and outside the organisation which could possibly influence the development and delivery of IPE.

4.2.2 Theoretical Orientation: Interpretivism

The theoretical orientation within a study refers to the philosophical choices and assumptions behind the methodology (Crotty, 1998). My research aimed to explore, understand and interpret how participants made sense of IPE in a world in which people assume different perspectives and different realities. These ontological and epistemological positions were consistent with an interpretative orientation which seeks understanding of a particular phenomenon recognising that the context in which the research is carried out is paramount to the interpretation of the data (Willis, 2007). Interpretivism has its origins in hermeneutics and phenomenology and situating this research within this paradigm required me to understand the social
world that people have constructed and reproduced, and one which is constantly being interpreted and reinterpreted (Blaikie, 2007).

My interpretative position stems from my personal worldview of holism, and my professional background as an occupational therapist and later as a health policy coordinator. These worldviews orientated me in looking at ways in which individuals within a particular context (and time) interpret the world around them, and that people’s different perspectives need to be taken into account and understood within their social and cultural contexts.

Crotty (1998) suggests that the researcher adopting such an approach needs to look for culturally derived and historically situated interpretations of the social-life world. These interpretations are multiple and complex and form through interaction with the researcher, others, as well as through participants’ historical and cultural contexts (Creswell, 2007). My aim was to understand participants’ meanings and interpretations of IPE within the newly formed faculty and wider cultural realities. There were multiple truths, and I wanted to explore and understand these truths both above and ‘beneath the surface’ of participants’ discourses.

Choosing interpretivism as a theoretical orientation brought to the fore my position as a researcher studying my own organisation. I was an insider researcher and one occupying the dual roles of researcher and academic. Finlay points out that the researcher’s identity and position shapes the research process and findings in a fundamental way. And as a researcher exploring my own organisation, interpretivism celebrated that I was “part of the world that I was studying rather than external to it” (Finlay, 2006b, p. 19). I felt I was uniquely positioned to study the possibility of IPE at the Faculty of Health Sciences and this echoed the literature underscoring opportunities for insider researchers (Coghlan, 2007; Taylor, 2011; Trowler, 2011). For example, being an insider researcher, I had an in-depth understanding of the culture being studied giving me greater insights on how to best map out the entire research process. It was also easier for me to gain access to the context including securing approval to conduct the focus groups, recruitment of participants and access to documents. I could also understand “the hermeneutics of everyday life” (Trowler, 2011, p. 2) and the “politics of the institution” (Unluer,
2012, p. 1) helping me to make sense of the complexity behind participants’ discourses.

Nevertheless, I was acutely aware that I needed to understand how my multiple roles fitted within this research and how my views, subjectivities, agendas and experiences would influence the entire process. Reflexivity became central to this work, requiring me to acknowledge and understand how my thoughts, feelings, culture, environment, social and personal history would influence the research process (Etherington, 2004). This process was captured by Maykut and Morehouse (1994) who write that:

the qualitative researcher’s perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning system of others-to indwell-and at the same time to be aware of how ones’ biases and preconceptions may be influencing what one is trying to understand (p. 123).

The duality in my extricable roles as the researcher researching my own educational institution necessitated me to occupy a space in which I could explore and be explicit about my positionality. This space was my reflexive diary, parts of which are presented in the numerous Inward Eye excerpts interspersed throughout this thesis, which I feel was invaluable to give a voice to my insider researcher.

4.3 Methodological Approach

The next choice in my methodological ‘map’ (Finlay, 2006a, p. 9) was drawn from my epistemological orientation and the response to the question “how can the inquirer go about finding what they believe can be known?” (Guba & Lincoln, 1994, p. 108). This meant choosing the most appropriate methodology for this study. Since the main aim of this research was to develop in-depth understandings about the development and delivery of IPE in Malta, the essence of my findings was expected to transcend the constructed meanings of participants’ discourses and explore broader issues, dimensions and perspectives. I therefore adopted a qualitative research approach which would allow me to explore, understand and make sense of this breadth of perspectives.
Choosing such an approach hinged on the fact that qualitative research looks for answers to questions that explore how a social experience is created and given meaning (Denzin & Lincoln, 2008). It can also inductively generate understandings from the field (Patton, 2002), as well as facilitate the meaning-making process (Krauss, 2005). These were all concerns which addressed my focus in understanding participants’ multiple meanings, interpretations and constructions of IPE. The inherent characteristics of qualitative research were also appropriate which included *inter alia* using myself as the key instrument of data collection, gathering of data sources in their natural setting, relying on text rather than numerical data and developing a holistic account of this phenomenon (Creswell, 2007).

Within my chosen philosophical and interpretative framework, I considered many qualitative approaches that might address my research questions. I was looking for a sound methodology which could offer me a strategy to explore a complex concept which might not be familiar to participants. Case study research offered the methodological approach to understand IPE (with all its deeper and wider implications) from the point of view of participants set within the culture of the new faculty and beyond. Its emphasis on understanding both the complexity and uniqueness of a bounded system encompassing its contextual determinants seemed compatible with the purpose and questions of the study (Merriam, 1998; Simons, 2009; Stake; 1995). Moreover, Stake’s (1995) notion of a qualitative case study researcher as being an interpreter and presenting constructions of participants’ constructed reality, reflected my epistemological stance. As the researcher, a case study methodology also afforded me with a degree of flexibility which is not readily offered by other qualitative approaches (Hyett, Kenny & Dickson-Swift, 2014).

Other approaches congruent with my philosophical and theoretical ideas were also considered. Phenomenology, which focuses on deep understandings of participants’ lived experiences of IPE (Creswell, 2007), was not appropriate because I could not assume that participants in the study would have experienced IPE. Narrative research could not be used as I was not attempting to explore the lived and told stories of individuals (Creswell, 2007). Grounded theory necessitated the studying of a process, action or interaction (beyond description) so as to generate a theory grounded in the data (Strauss & Corbin, 1988). This approach was not suitable as
IPE had not yet been developed at the Faculty. I looked at ethnography, more specifically critical ethnography, however as an insider researcher, observing my colleagues on a day-to-day basis would be considered unethical. Moreover, the aim was not to bring about social change through reconstructive analysis and dialogical data generation which are the main goals espoused by critical ethnography (Carspecken & Walford, 2001). I also explored action research, which involves learning through action and reflection (McNiff & Whitehead, 2002). This was also considered inappropriate as current logistical and organisational barriers would preclude me from introducing an IPE initiative even in the form of action research.

4.3.1 The Nature and Critiques of Case Study Research
Case study research has a chequered history within the social sciences and has antecedents in a variety of disciplines, such as Sociology, Anthropology, History, Psychology, Law and Medicine (Simons, 2009). Although it is said to be one of the main forms of inquiry in the social sciences (Thomas, 2011a), it is a “contested terrain” (Yazan, 2015, p. 134) characterised by ambiguity and misinterpretations over its meaning (Crossley & Vulliamy, 1984). For example, Creswell (2007) refers to it as “a methodology, a type of design in qualitative research, or an object of study, as well as the product of inquiry” (p. 73), while Stake (1995) defines it as “the study of the particularity and complexity of the single case, coming to understand its activity within important circumstances” (p. xi), and Yin (2009) refers to it the preferred method when the “focus is on contemporary phenomena within a real-life context” (p. 2). Case study research can also be positioned within different epistemological paradigms (Hyett et al., 2014) or designed with “a palette of methods” (Stake, 1995, p. xii). Amidst the main descriptions of case study approaches found in the literature, it was Simons’ (2009) definition of a case study as “an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a ‘real life’ context” (p. 21) which seemed to encapsulate the essence of my epistemological underpinnings and research questions. The process was anticipated to generate in-depth perceptions, understandings and constructions of knowledge about IPE from the different stakeholders within the Maltese context. The ultimate aim was not to reach a consensus but to present a rich portrayal about the possibility of IPE in Malta.
Case study research is compatible with complexity science (Anderson, Crabtree, Steele & McDaniel, 2005) and this resonated with complexity theory and one which could offer a potentially useful approach to help understand the underpinnings of the development and delivery of IPE (Chapter 3: Literature Review). A case study approach within the perspective of complexity theory would help provide insights into the organisation, such as revealing the nature and the dynamics of the organisation, seeing patterns across the different levels and learning about the system’s interdependencies (Anderson et al., 2005).

Simons (2009) emphasises that case studies could have epistemological and political benefits; deep immersion in a case could lead to a thorough understanding of the complexity of social situations which could eventually improve the soundness of future policy decisions. Although this was not the primary objective of this study, findings emerging from the co-construction of knowledge about IPE in Malta could provide new insights which might inform strategic development or policy-making in the longer term.

There are various kinds of classifications of case study research. Within Stake’s classification, this case study could be categorised as an instrumental case study implying that the particular case would be used to develop understandings of a subject with a view to illuminating a wider context (Stake, 1995). This referred to exploring the concept of IPE within the Faculty of Health Sciences, reflecting realities both within, as well as outside the Faculty. This approach made it possible to document multiple and multifaceted perspectives and place them all within the wider extrinsic context. Yin (2009), on the other hand, identifies three types of case study research: exploratory, descriptive and explanatory. Within the realm of this study, my approach was initially exploratory as I was interested to study participants’ perceptions of IPE. However, as the research progressed, the case study became more explanatory as I was trying to make sense of participants’ discourses.

As it has been mentioned previously, case study research has been widely criticised and still lacks a full consensus on its design and implementation, possibly hampering its full evolution (Simons, 2009; Yazan, 2015; Yin, 2009). Nevertheless, the concept
of case study research has greatly evolved during the last forty years, as may be attested by a significant body of work utilising it (Simons, 2009).

The main critiques of case study stem from “misunderstandings” (Flyvbjerg, 2006, p. 420) which *inter alia* concern generalisability, subjectivity, lack of rigour and whether case study is a general approach or a distinct methodology in itself (Flyvbjerg, 2006; Simons, 2009; Stake, 1995; Yin, 2009). De Vaus (2001) speaks of case study research as being in a “methodological limbo” (p. 219) in that it is either ignored or confused with other types of social research.

One of the greatest concerns in case study research has been the concept of generalisability. It has been repeatedly argued that one cannot generalise from a single case (Flyvbjerg, 2006; Thomas, 2010; Yin, 2009). However, it has also been counter argued that it is not generalisability which is crucial to case study research nor endeavours to prove it (Flyvbjerg, 2006; Thomas, 2011b; Yin 2009); rather, the core of the matter depends on the case and how it is chosen (Flyvbjerg, 2006). For Yin (2009), generalising from a case study (analytical generalisations) means using a previously developed theory as a template with which to compare the empirical results of the case study; replication may be suggested if two or more cases support the same theory. Thomas (2011b) speaks of “phronesis” (p. 23) which is practical knowledge based on personal experience and which helps one make sense of particular situations. He argues that a “case study offers understanding presented from another’s horizon of meaning, but understood from one’s own” (p. 32). Stake and Trumbull (1982) speak of naturalistic generalisations, the process during which readers could find descriptions in the study which resonate with their own experiences, thus making them consider whether their situations would be similar enough to merit generalisations.

This case study was not carried out to generalise the findings, but to explore and discover holistic understandings and meanings of IPE defined by a temporal, cultural, political and social context. The purpose was “not to represent the world but to represent the case” (Stake, 2005, p. 460). My intention was not to study the whole organisation (University of Malta) but the Faculty of Health Sciences positioned within its own micro socio-cultural context possibly reflecting the
Maltese macro socio-cultural realities. Such close examination of a specific case acknowledges the significance of abduction which Hammersley (2007) notes is the development of a theoretical idea emanating from close inquiry of particular cases. The final onus would be on the reader to understand and possibly make a connection between the case and his/her own experience and the organisational setting (Thomas, 2011b). As the researcher, I facilitated this process by documenting the case in a detailed way to provide in-depth descriptions about the context, the unit, the data and myself as both the researcher and the research instrument (Lincoln & Guba, 1985; Stake, 1995).

Another criticism of case study centres on the notion of researchers’ subjectivity. Flyvbjerg (2006) suggests that the closeness of the researcher to the research setting could entail deeper understandings, thereby helping the researcher to move away from preconceived assumptions. Similarly, Eisenhardt (1989) purports that the constant closeness and correlation of conflicting realities tends to free up thinking, thus having the potential of lessening researcher bias. And Simons (2009) notes, that subjectivity is an inevitable part of the case study, however when appropriately acknowledged and disciplined, is vital for understanding the case. Being an insider researcher in this case study, I assumed I could understand participants’ social worlds, experiences and constructions about IPE. Nevertheless, I needed to ensure constant vigilance of my personal and professional subjectivities and this I endeavoured through regular entries in my reflexive journal.

The lack of rigour in data collection and analysis is another criticism levelled at case study research, usually arising because the researcher would not have followed systematic procedures and would have been biased in his/her conclusions (Yin, 2009). Amis and Silk (2007) argue that this critique can be directed towards qualitative research in general which largely consists of much less standardised procedures for assessing rigour. Within this entire research process, I aspired to the highest standards of rigour and drew upon Lincoln and Guba’s (1985) procedures for ensuring trustworthiness. I have also demonstrated rigour in my data analysis and have produced a well-defined analytical strategy entirely consistent with the philosophical underpinnings that support this methodology. This will be discussed in more depth in the forthcoming chapter.
There is a degree of ambiguity in the literature as to whether case study research is a distinct research methodology as advocated by Creswell (2007) and Yin (2009), or a more fluid and open concept of a methodological approach espoused to by Simons (2009) and Stake (1995). The latter (Stake), also uses the terms ‘research method’ and ‘approach’ interchangeably when discussing case study research. In keeping with my epistemological and ontological positions, I found myself more consonant with Simon’s (2009) and Stake’s (1995) concept of case study research and considered this case study as an introspective methodological approach falling under a qualitative paradigm; this approach would guide the methods chosen for data collection so as to conduct, analyse and interpret the case.

Given this context, I recognised and reflected on these traditional prejudices and I understood the core assumptions and principles of case study research. This allowed me to make the informed and defensible choice that such a methodology was suitable for this research.

4.3.2 Case Selection: The Unit of Analysis and Boundaries

Thomas (2011c) notes that a case study is especially useful for grasping and portraying a rich picture of a phenomenon and gaining analytical insights from it. Hence, defining the boundaries of the case or the unit of analysis becomes fundamental. The unit of analysis in this case study started out to be “IPE at the Faculty of Health Sciences within the University of Malta.” The main reason for focusing on the Faculty of Health Sciences, as opposed to including other faculties was that whilst being governed by the same generic rules and regulations of the University, other faculties are likely to have diverse ways of organising their curricula to reflect the needs of the subject matter, resources, as well as students and academic staff. Attempting to explore IPE within such a broad and heterogeneous context would be disadvantaged from the start. Secondly, the starting point of this research was to explore IPE within the Faculty of Health Sciences between the nursing, midwifery and allied health professionals. Opening up the study further afield would have possibly resulted in more breadth but less depth.
When data collection was underway and my reading into the IPE literature deepened, I realised that the boundaries of my case went beyond the Faculty of Health Sciences and the University of Malta. The influences of IPE determinants outside the institution and the organisation were apparent throughout participants’ discourses. Initially, this was of concern, however once I had referred back to the literature on case study research, I realised that it was acceptable to shift boundaries in the light of emergent findings and analysis (Simons, 2009; Stake, 1995). According to Stake (1995), whilst defining the case, it was also important to regard the interrelationships between the phenomenon and its contexts. I therefore revised my choice of unit of analysis to include elements outside the Faculty and the University of Malta and which could possibly encompass the social, cultural, educational and professional systems. Thus, the unit of analysis which was originally “IPE at the Faculty of Health Sciences” became “IPE at the Faculty of Health Sciences positioned within the Maltese context.”

These underpinnings were reminiscent of Heidegger’s ‘hermeneutical circle’ which refers to the idea of understanding the whole in terms of its individual parts and understanding the parts through reference to the whole (Heidegger, 2008). Within the context of hermeneutical texts, Heidegger asserts that neither the whole text nor any individual parts could be understood without reference to one another. Although fully acknowledging that my work was not grounded in a phenomenological ontological perspective, the idea of understanding the possible concept of IPE in Malta by understanding stakeholders’ experiences, perceptions and constructions and then relating (and interpreting) these to wider determinants and vice versa (interdependency between parts and patterns that emerge and the whole) became the raison d’être of this work.

The temporal boundaries of this case study were designed to capture the transitional process from an Institute of Health Care to the Faculty of Health Sciences in 2010. Data collection was thus undertaken from May 2011 until May 2012. Documentary data search in the form of minutes of meetings, discussion papers and other grey literature was carried out between January 2012 and December 2013.
4.4 The Inward Eye

After navigating through the swamps of methodological possibilities for my study, I realised the naivety of my initial thinking. I was under the impression that the choices in my research planning would necessitate me to choose the right methodological approach so as to address the research questions. Essentially true, but the reality was so much more complex. There was a plethora of philosophical and theoretical elements that I first had to come to grips with prior to choosing the methodology and methods to address my research questions. There was also my position of an insider researcher which was a term laden with subjective involvement. It was necessary for me to unravel and examine my motivations and assumptions so as to be aware and acknowledge my biases and my preconceptions which I realised could weaken my research if unaccounted ... and all this would invariably be influenced by my view of the world.

This was an elusive process; although I was initially unfamiliar with the actual terms, such as ontology and epistemology, I could still understand their ‘being’ and their value (albeit in a somewhat implicit manner). And when eventually I could understand them, I still found difficulty in articulating them. Frustration at its best! On a pragmatic level, understanding the infinite forms of reality and the nature of my relationship between what needed to be known, encouraged me to move away from knee-jerk thinking and appreciate the many different ways I could look at my study.

And then there was my choice of case study research as the methodology. Although I was confident that it was the right fit for the research, its reputation did not precede it. It was referred to as “the weak sibling” (Yin, 2009, p. xiii) of other rigorous approaches and seemed to be used when other qualitative descriptive studies did not fit in with other traditional approaches (Merriam, 2009). This was disheartening for a novice researcher ... the last thing I wanted to do was to use an inferior methodology for my doctorate. Before making any firm decisions, I made sure to understand case study research well so that I would be able to argue for and defend any position which I ultimately took. This I did by arming myself with accessible works, as well as engaging in discussions with my supervisors and peers. Slowly, I became more and more confident that this was the right methodological
approach for me and realised that all of the concerns and criticisms highlighted in the literature did not need to be limitations. Thomas’s (2011c) take on a case study as portraying a rich picture with various kinds of insights coming from different angles and from different sources of information seemed to embrace the story of this case.

4.5 Research Design and Methods

A case study approach makes use of multiple sources and techniques in the data gathering process. This flexibility is a unique strength of a case study as it is able to deal with a variety of data, such as documentation, archival records, interviews, observations, participant observation and physical artefacts. These sources all have their strengths and weaknesses and during case study research, it is considered good practice to use as many as possible so as to also enable the researcher to gain a holistic view of the phenomenon in focus (Stake, 1995; Yin, 2009). In this study, interviews (focus group and individual key informant interviews) and a focused documentary search were my main methods of data collection.\(^{48}\) Participants were:

- Academics from the ten academic professions represented at the Faculty of Health Sciences.
- Newly qualified health professionals who would have followed their professional health education at this same Faculty.
- Key informants from the health ministry and higher education sector (University of Malta).

Data collection and analyses processes were carried out in two phases to allow me to take an inductive approach to data analysis (Figure 4.2).

\(^{48}\) The justification for using these data collection tools are discussed in more detail in later sections.
Data collected and analysed during Phase 1A and 1B of the research therefore provided me with knowledge so as to validate existent findings, explore unanswered questions and develop new topic guides for Phase 2 of the study. Table 4.1 presents this iterative process.
Phase No. | Description
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Phase 1 | 1A: A series of ten focus groups was held with academics from each Department at the Faculty of Health Sciences (excluding the two departments which only cater for postgraduate students). Total number of participant academics was fifty three as one participant withdrew from the study.
1B: One focus group was held with newly qualified health professionals who had followed their programme of studies at the Faculty of Health Sciences and had graduated in the year, 2011. Total number of participants was 6.
Primary documentary search: Location and exploration of seemingly relevant documentary sources from the Faculty of Health Sciences and Ministry of Health.
Phase 2 | 2A: A series of five one-to-one open ended interviews were held with key informants.
Focused documentary search: Aim was to:
- locate relevant documents brought up in both phases.
- explore in more depth issues brought up from other sources so as to augment, corroborate and/or contradict information.
- follow certain organisational decisions, innovation or issues through a series of documents.

Table 4.1 Descriptions of the various stages in the research process

The three data collection sources (focus groups, individual key informant interviews, and a focused documentary search) provided the opportunity to explore IPE at the three levels that this case study attempted to address: the micro level (faculty members and newly qualified health professionals perceptions), the meso level (faculty members within their own professional and organisational cultures, supplemented with information from documentary sources) and macro levels (key informants who represented university policy makers and Ministry of Health senior officials, supplemented with information from documentary sources).

4.5.1 Phase 1A and Phase 1B; Data Collection – Focus Groups

4.5.1.1 Justification
Focus groups are used for generating information on collective views and the meanings that lie behind those views (Gill, Stewart, Treasure & Chadwick, 2008). They are useful in understanding and explaining “the meanings, beliefs and cultures
that influence the feelings, attitudes and behaviours of individuals” (Rabiee, 2004, p. 1). Moreover, “because of their synergistic potentials, focus groups often produce data that are seldom produced through individual interviewing and observation and that result in especially powerful interpretative insights” allowing the “proliferation of multiple meanings and perspectives” (Kamberelis & Dimitriadis, 2005, p. 903, 904). These theorists’ perspectives encapsulate my rationale for choosing focus groups as one of the data collection sources, giving me the opportunity to understand participants’ worldviews, explore and discuss a complex and multifaceted subject, such as IPE. The discourses and dynamics emerging from the focus groups also allowed me to see the different ways in which the various professions positioned themselves in relation to other health professionals.

Phase 1 of the study consisted of ten focus groups with academics and one focus group with newly qualified health professionals. The first ten homogenous focus groups (Phase 1A) were carried out with academics and included heads of departments, senior lecturers, lecturers and assistant lecturers.

At the start of the research process, the total population of academic staff at the Faculty of Health Sciences consisted of 65 full time academics and 62 part time academics (with a Council appointment). Besides those working within the Department of Nursing (due to the large number of academic staff within this Department), all academic staff across the ten departments (both full time and part time) were officially invited to participate in this study (Phase 1A). The total number of participants who accepted to participate within these focus groups was 54 participants; 45 participants in a full time position and 9 participants in a part time position. This is significant since it represented a very high percentage of the Faculty’s full time academic staff, satisfying the requirements of this study. Phase 1B consisted of a heterogeneous focus group with newly qualified health professionals.

Since all participants in this study consisted of professionals with a tertiary level of education, the language used in the focus groups and interviews was English. This was considered to be appropriate.

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49 This was a permanent appointment albeit on a part time basis.
4.5.1.2 Sampling Procedures

4.5.1.2.1 Ten Focus Groups with Academics [Phase 1A]

Purposeful sampling, a strategy widely used in qualitative research, refers to the selection of “information-rich cases whose study will illuminate the questions under study” (Patton, 2002, p. 46). This procedure was adopted in this study. Krueger (1994) argues that it is ultimately the purpose of the research which should drive the study. In this case study, the research questions could be partly addressed by exploring academics’ perceptions of IPE; hence academics formed a large part of the participant pool. The ten focus groups with academics were homogenous, that is, each focus group consisted of academics representing just one profession. Krueger (1994) notes that it is only if participants are prepared to fully engage in the discussion that meaningful data can best emerge and advocates that the selection of focus group participants should be based on commonality rather than diversity; it is vital for participants to feel comfortable, respected and free to give their opinions without fear of being judged. Rabiee (2004) contends that an element of trust amongst group members implies a freer expression of views.

Selecting homogenous groups for Phase 1A was significant as discussions about IPE could have raised sensitive issues, such as professional boundaries and resource conflicts. And with my insider’s knowledge of the various departments, I decided that faculty members would feel more at ease to engage in self-disclosure and discuss certain sensitive issues with their own departmental colleagues. Discussing such issues within a heterogeneous milieu might have possibly introduced negative attitudes sabotaging the entire focus group dynamics. During each of these focus groups, I also invited and recommended that each head of department would attend the focus group of his/her own profession because although I valued the individuality of each participant, I perceived it was important to explore each head of department’s stance. Krueger (1994) writes about the danger of existing groups and of superior-subordinate relationships amongst participants. In this case study, I considered that the risks of superior-subordinate relationships within the professional groups were low and the benefits of having the head of department in each focus
group would outweigh the potential risks. Nevertheless, during all the focus groups, I was mindful of any hierarchical presentations and possible power issues.

4.5.1.2.2 One Focus Group with Newly Qualified Health Professionals [Phase 1B]

Participants were again selected using purposive sampling, however this time the focus group was a heterogeneous one because newly qualified health professionals included representatives from various professions. Although I was cognisant that sensitive issues as discussed above might possibly emerge, I was interested to explore to what extent newly qualified health professionals working in ‘real life’ practice experienced and valued the idea of collaborative working. Moreover, I perceived that following Phase 1A, I would be in a better position to handle sensitive issues if they arose. The other option of recruiting newly qualified health professionals to organise ten homogenous focus groups was not possible, mostly due to logistical difficulties.

The homogeneity in this group was that all participants were former students of the Faculty of Health Sciences who had finished their programme of studies in 2011. The significance of graduating in 2011 was that by the time the focus group was carried out, these health professionals would have just finished their first working experiences (within the public health sector). Indeed, one of the inclusion criteria for this group was that the health professionals were required to have worked in their respective professions for at least six months. Hence, health professionals graduating from the Departments of Medical Laboratory Science, Midwifery, Nursing (including Mental Health Nursing), Occupational Therapy, Physiotherapy and Radiography during 2011 were invited to take part in this focus group. These professions were selected because they represented all the departments which had graduate cohorts during 2011.

4.5.1.3 Access and Recruitment Strategy

Lincoln and Guba (1985) stress the importance of having a definitive focus guiding naturalistic inquiry as this determines where and from whom the data will be collected. In this study, data collection was guided by the following criteria:
4.5.1.3.1 Ten Focus Groups with Academics
[Phase 1A]

Inclusion Criteria:
- Faculty of Health Sciences
  - full time academic staff
  - part time academic staff with a Council appointment

Exclusion Criteria:
- Faculty of Health Sciences part time visiting academic staff without a Council appointment (that is, lecturers having occasional commitments at the Faculty).

Following ethical approval from the Faculty Research Ethics and Governance Committee at the University of Brighton and the University Research Ethics Committee, University of Malta (discussed in Section 4.7 below), a meeting was convened with the Dean of the Faculty of Health Sciences to explain the nature of the research and to request access to the participants and to relevant documents within the Faculty (institutional access); and access was granted shortly after (Appendix 13). Following approval from the Dean, meetings were held with each Head of Department within the Faculty of Health Sciences to discuss the invitation letter inviting him/her to participate in a focus group, as well as requesting access to his/her departmental staff. This was accompanied by an information sheet outlining details of the study (Appendix 14). All heads of departments at the Faculty consented to my request and indicated tentative dates when their professions’ focus group could be held. They forwarded me e-mail addresses of all eligible full time and part time academic staff members within their particular department following which I sent an invitation letter plus an information sheet to these participants (Appendix 15). The University’s e-mail system was deemed to be a better route than a formal postal letter as this is an accepted mode of efficient communication between all faculty staff at the Faculty of Health Sciences and throughout the University. Moreover, it made it easier for participants to reply to my mail once they had made up their minds to participate (or not) in the study.
Almost all of the full-time faculty academics accepted my request to participate in the focus groups and their acceptance was duly acknowledged. There was one particular large department that I had to accept participants on a ‘first reply, first acceptance’ basis as accepting all of the academic staff would have made that focus group unmanageable. All focus groups took place in the Committee Room at the Faculty of Health Sciences which was ideal, as it was a familiar setting for the participants and was free from distractions. Details about the position and years of employment of these academics can be found in Appendix 16.

4.5.1.3.2 One Focus Group with Newly Qualified Health Professionals [Phase 1B]

*Inclusion Criteria:*

Faculty of Health Sciences graduate health professionals who:

- Had finished their training programmes in 2011.
- Had been successful in their final examinations.
- Had been working in their respective profession for at least six months.

*Exclusion Criteria:*

Faculty of Health Sciences graduate health professionals who:

- Had finished their training programmes prior to 2011.
- Had not been successful in their final examination.
- Had been working in their respective profession for less than six months.

Access to these health professionals was originally proposed to be requested from the Medical Director/s of the hospitals where the health professionals were working at the time of recruitment. However, after discussions with my supervisors, it seemed more appropriate within my case study approach to invite these focus group participants in their capacity as past students of the Faculty of Health Sciences and as successful graduates of the year, 2011. Permission for this slight amendment to my recruitment criteria was requested to the Faculty Research Committee, University of Malta and for which I received a favourable reply (Appendix 17). The following steps were undertaken to gain access to these participants:
A letter was sent to the University of Malta Registrar requesting access to the list and addresses of undergraduate students who had graduated from the Faculty of Health Sciences during 2011 (Appendix 18).

An invitation letter plus an information sheet outlining the main focus of the study was sent to the first ten former Faculty of Health Sciences students in each department (Appendix 19). I decided on the number ten as I envisaged that I would not have a very high response rate for this focus group based on past experience of response rates to questionnaires and surveys; if I would have no replies from the first ten former Faculty of Health Sciences students, I planned to send more invitation letters to the next ten former students. There were certain cases, where the numbers of students were less than ten and invitation letters were sent to all students in that department for that year. I was aiming to have one or two representative/s from each profession and hence, the selection of participants was carried out in order that their acceptance was received; this was made clear in the invitation letter. These invitation letters were sent by normal post since participants’ university e-mail addresses were no longer operational. All acceptances to my invitation were duly acknowledged.

Sixty seven letters were sent by normal post to newly qualified health professionals from seven different professions on Friday, 6th January, 2012.

Two replies out of these sixty seven letters were received; one concerned a health professional who could not make it on the allocated day and another participant who was not eligible since she had not been working for the stipulated six months.

Sixty five reminder letters were sent on Tuesday, 17th January, 2012.

Eight positive responses were received from these reminder letters.

The focus group was held on the 15th February 2012 and participants included one midwife, three occupational therapists and two physiotherapists; two prospective
participants phoned me on the day to say that they were unable to attend. As with the academics’ focus groups, the group was held in the Committee Room at the Faculty of Health Sciences; a familiar and non-threatening environment to the participants.

4.5.1.4 Questioning Route

4.5.1.4.1 Ten Focus Groups with Academics
[Phase 1A]

The power of the focus groups is in their focus (Patton, 2002) and in this case, the focus was on exploring and understanding academics’ perceptions and constructions of IPE; the nature of their experiences, the perceived barriers and/or enhancers to it and the factors that could ultimately influence it. I thus developed an open-ended, non-leading questioning route based on the research questions and pertinent literature in the field. As suggested by Krueger and Casey (2009), this questioning route consisted of an opening, introductory, transition, key and concluding questions. It was also flexible enough to allow me to probe and follow up on related issues as they arose during the discussion. The final version could not be pilot tested with a large group as I would have otherwise lost valuable faculty participants, however I still tested it with three colleagues who are occupational therapists and are faculty staff. The questioning route was slightly amended following their comments; the final questioning route used can be found as Appendix 20.

4.5.1.4.2 One Focus Group with Newly Qualified Health Professionals
[Phase 1B]

The main objective of this focus group was to explore and understand newly qualified health professionals’ perceptions of what it meant to be a newly qualified health professional working in ‘real’ life practice, the degree of collaborative practices in their current practice settings and their perceived preparedness for collaborative practices. I also wanted to find out what they understood by IPE and their perceptions of it. Development of the questioning route was carried out in a similar fashion to Phase 1A. I retained the relevant core set of questions so as to

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50 These members of staff could not be included in the actual occupational therapy focus group because although they had part time lecturing duties, they did not hold a permanent senate appointment with University.
allow for consistency in the research tools. The first draft of this questioning route was pilot tested on a small number of occupational therapists who work within the public health service. Although these occupational therapists qualified in 2010, they could still identify with their relatively recent professional training and the realities of their current work practices. Again, the questioning route was slightly amended following their comments and the final version can be found in Appendix 21.

4.5.1.5 Facilitating the Focus Groups: General Perspectives

During the process of conducting the focus groups, I held the role of facilitator, moderator, listener and observer. The original plan to ask a colleague to act as my research assistant and as an *aide-memoire* during the transcription process was changed as I felt that the presence of another person would influence the discussion and interactions of the groups. Although some authors suggest that audio recording the focus groups may alter the quality of the discussion (Robinson, 1999), all focus groups in this study were nonetheless recorded; memorising what the participants were saying was unrealistic and would detract from my role as facilitator. Moreover, the recordings of participants’ voices were the basis of my data analysis process and formed part of my audit trail.

At the start of each focus group, I introduced myself, the research process and communicated a number of ground rules. Since I was aware that some participants might be unfamiliar with the term and concept of IPE, I prepared a one page flip chart outlining some basic points about IPE consisting of a definition, the policy drivers behind IPE, worldwide uptake, and the current evidence base (Appendix 22). I then read this information, mindful of my verbal and nonverbal communication (so as to try and avoid any bias on my part either in favour or against IPE). Throughout the focus groups, I tried to maintain this stance and actively avoided signs which showed whether I agreed or disagreed with participants’ views.

A study’s credibility could be threatened when participants respond to what they think is the preferred social response (Krefting, 1991). I was aware that I might have been perceived as exploring the possibility of a desirable and ‘modern’ concept in

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51 I video-taped myself rehearsing this introduction so as to be able to study and consequently improve my delivery and stance.
higher education (IPE). With our island mentality of looking at international trends in a favourable way, this might have influenced some of the responses, especially those of the newly qualified health professionals. I, therefore, reiterated the exploratory nature of my study to all participants.

As an insider researcher, the world which I was exploring was my professional world. For this reason, I chose to adopt a postmodern approach by making the ‘baggage’ I brought to the research explicit and visible (Scheurich, 2014). Immediately before each focus group, I reflected on my thoughts towards that particular professional group and how my biases could affect that group. This self-reflection helped me get in touch with my unexpressed subjective views about the collective nature of the particular professional group. Following each focus group, I wrote field notes so as to capture my observations of the important aspects of the discussion which would not have been captured by either the recorder or by simple observation (such as body language, intonations and different attitudes). These were documented in a ‘Reflections just-out-of-the-field’ template (Appendix 23) which encouraged me to think deeply on participants’ discourses and the way the focus group developed. These reflections, which were carried out before and after these focus groups, helped me become aware of how my experiences, values and multiple identities (as researcher, academic, occupational therapist, ex-policy co-ordinator, doctoral student) influenced the research process.

4.5.1.5.1 Facilitation of Ten Focus Groups with Academics [Phase 1A]

The six month period in which the ten focus groups were conducted was considered to be short enough to recognise the similarities and the diversities between the groups and long enough to be able to have time to reflect on the content and the process. Participants interacted with each other and although there were periods where I was no longer the centre of the discussion, I felt free to probe and ask questions spontaneously as they arose. I also used prompts which encouraged reactions to discourses from fellow participants. It has been suggested that the nature of the discussion during focus groups might shift the opinions of some individuals (Krueger, 1994) and this did occur in some of these focus groups, during which I picked up subtle shifts in perceptions of IPE and attitudes towards it.
There are a number of documented difficulties and limitations associated with focus groups. One disadvantage is the variation between focus groups (Krueger, 1994) and this was well addressed in my study as I held ten focus groups, each with different professions. There is also the issue that within a focus group the moderator might have less control than an individual interview (Krueger, 1994). I found that moderation in one particular focus group was more challenging than the others due to an internal professional situation to which a few participants continually referred. Fortunately, this session was conducted towards the end of the data collection process and by then, my moderator skills were stronger and I managed to steer the group back on track. Another criticism of focus groups is that dominant individuals could influence results (Krueger & Casey, 2009) and indeed throughout these focus groups, I observed that generally, the more experienced academics tended to dominate the discussions. During those occasions, I made it a point of encouraging other participants to offer their views and ask if they saw the situation differently. There were also a few instances when I asked dominant participants to refrain from speaking for a short time during the discussions so as to give space to other focus group participants to express their views.

4.5.1.5.2 Facilitation of One Focus Group with Newly Qualified Health Professionals [Phase 1B]

This heterogeneous focus group consisted of six participants: three occupational therapists, one midwife and two physiotherapists.52 The group started out in a very enthusiastic manner possibly because the newly qualified occupational therapists felt quite comfortable with me since I had been one of their lecturers during their course programme. As the group progressed, the discussion became rather weak, possibly due to their unfamiliarity with each other, their lack of confidence in their own contributions, their difficulty to conceptualise the possibility of IPE, their unease to speak about sensitive issues in front of the other professions and the hierarchical difference between myself as an academic and themselves as entry-level health professionals.

52 Although this number was not ideal, it was the response that I received following the mailing of sixty-seven invitation letters to seven different professions plus another sixty five reminder letters.
4.5.2  Phase 2: Data Collection:  
In-depth Semi-Structured Interviews with Key Informants

4.5.2.1  Justification
Key informants are a select group of people who would be knowledgeable or experienced about certain issues or problems and who would be willing to share their knowledge. They are often considered critical to the success of a case study due to their invaluable insights into the matter (Yin, 2009), as well as being able to provide an overall view of the organisation, its activities, policies and future directions (Luborsky & Lysack, 2006). They could also be a source of explanation in helping the researcher understand what is really happening and finding out how and why people frame their views (Patton, 2002). In this study, interviews with key informants were crucial in providing me with insights from different perspectives.

4.5.2.2  Sampling Procedure
Purposive sampling was again employed to select individuals who were crucial to any IPE initiative ever being conceptualised and implemented within the Faculty of Health Sciences. I thus created a list of potential candidates who were considered experts in their own field, were policy/practice decision makers and who, because of their position, could contribute towards knowledge and insights into potential IPE in Malta.

I used key informant diversity so as to avoid one-sided or biased results and eventually short-listed five key informants from the health and higher education sectors (including policy, practice and management); the two sectors of paramount importance for any potential IPE initiative (WHO, 2010). Further, all these key informants were involved first hand in professional health education. Inclusion or exclusion criteria for selecting these key informants were not relevant.

4.5.2.3  Access and Recruitment Strategy
The research was an inductive one and so these one-to-one key informant interviews were carried out following the completion of Phase 1 focus groups. This was the “focused exploration” stage (Lincoln & Guba, 1985, p. 265) which allowed me to build on the results of the preceding phase. An invitation letter, plus an information
sheet was sent to all five key informants (Appendix 24). All five of them consented to my request and an interview was held at a time and a place which was convenient for them.

4.5.2.4 Questioning Route
The development of the interview guide was based on:

- Pertinent literature.
- A core set of questions (similar to Phase 1A, 1B).
- Themes emanating from Phase 1A, 1B - preliminary data analysis.
- Concern with ‘exploiting’ each key informant’s unique position.
- Concern with determinants which could influence potential IPE both within the organisation and beyond it.

The five interview guides were developed successively so that each guide built on the preceding one seeking clarification of the broader issues, building on information that was previously addressed and exploring new directions. This gave me time to reflect between the interviews, examine my own responses to the data obtained and be responsive to the diversity of the key informants. Each interview guide was discussed with my supervisors and the first draft was piloted on a senior colleague who gave me feedback on the content and the flow of the questions. Appendix 25 shows the questioning route utilised for the first key informant.

4.5.2.5 Conducting the Interviews
These key informants held very senior positions within the health and educational organisations and this suggested hierarchical issues between me as the researcher and them as participants. However, the fact that I was well known to all key informants throughout my years working within the health policy field helped to dilute these issues and made it easier for me to gain access and to establish a good rapport during the interview. Nevertheless, I chose not to commence the interviews with a review of the outline of salient issues pertaining to IPE (as I had done with the eleven focus groups and presented in Appendix 22) since I perceived that it would seem slightly condescending and ‘unnatural’ in a one-to-one interview. In these interviews, I just read the definition of IPE found in their information sheet. As with
my approach to the focus groups, I was cognisant of my preconceptions of the key informants and thus, before and after each interview I used reflexivity to get in touch with these biases. This helped me adopt what Snape and Spencer (2003) refer to as “emphatic neutrality” (p. 4), during which the researcher, fully aware that complete neutrality and objectivity are illusory, uses personal insights whilst trying to adopt a non-judgmental stance. In practice, this meant that in addition to me being fully present (mindfulness), open, sensitive and responsive during these interviews, I allowed my personal experiences and engagement with the key informants to inform and complement my understanding of their perspectives.

4.5.3 Data Collection: Documentary Data
[Phase 1A, Phase 1B & Phase 2]

The main objective of using documentary sources within this case study was to provide the historical and current contexts of the case. This was vital in addressing the research questions and in understanding the entirety of story of the case. Documents were also used to supplement information, compensate for any limitations and cross validate information such as primary data (Noor, 2008). Scott’s (1990) four control criteria for handling and assessing the quality of evidence emanating from these documents were employed. These were ‘authenticity’ (whether the evidence is genuine), ‘credibility’ (whether evidence is typical of its kind), ‘representativeness’ (whether documents retrieved represent the totality of documents) and ‘meaning’ (whether evidence is clear and compatible).

A documentary search was carried out at the end of Phase 1A, throughout Phase 1B and Phase 2 and continued well after the completion of Phase 2 data collection. The main documentation which was accessed for this study, were official and unofficial documents and records from administrative offices at the Faculty of Health Science and the Department of Health. The majority of these documents were mostly grey literature and included memos, annual reports and historical documents produced by the Institute of Health Care (now the Faculty of Health Sciences) during the late 1990’s up until current times. Other data sources included health policy documents and reports. This search was carried out iteratively over many months giving me the opportunity to uncover and revisit relevant information.
The process of spending many hours trawling through these documents provided me with a deeper perspective of the Faculty. During and after this cyclical process, I could better appreciate and understand the history of the Faculty and its interdependence on the Ministry of Health for many years. Becoming a faculty in 2010, was a milestone and being privy to the narrative leading to it added richness to this case study.

4.6 Seeking Rigour

One of the main criticisms of qualitative research is its supposed lack of rigour (Rolfe, 2006; Thomas & Magilvy, 2011) making it unable to achieve what Kvale (1996) refers to as “the status of the scientific holy trinity of validity, reliability and generalisability” (p. 229). Lincoln & Guba (1985) argue that qualitative research, which concerns multiple truths and multiple ways of knowing, cannot be measured or defined in terms of these positivist criteria and instead they propose alternative terms of ‘credibility’, ‘transferability’, ‘dependability’ and ‘confirmability’ as being more appropriate to show the rigour or ‘trustworthiness’ of naturalistic research. Within this study, I have employed these criteria to show the quality and integrity of my research and this was congruent with my philosophical and theoretical underpinnings guiding this work.53 The next section considers these criteria and their operational procedures within this study.

4.6.1 Truth Value … Credibility

‘Truth value’ questions whether the researcher has confidence in the truth of the findings both for the subjects and for the context of the study. There were many truths and many constructions and reconstructions embedded in participants’ discourses. Lincoln & Guba (1985) speak of credibility as the naturalist’s alternative to truth value which may be enhanced by various techniques, which inter alia include ‘prolonged engagement and persistent observation, ‘triangulation;’ ‘peer debriefing;’ and ‘member-checking.’ Each technique will be explained in turn.

53 Although these criteria are three decades old, they are still regarded as the “gold standard” in qualitative research practice (Whittemore, Chase & Mandle, 2001).
4.6.1.1 Prolonged Engagement and Persistent Observation

‘Prolonged engagement’ refers to the researcher spending enough time in the field to ensure that certain criteria have been met. These include building a trusting relationship with the participants, familiarisation with the culture, checking for possible distortions and deciding what is relevant to the study (Creswell & Miller, 2000; Lincoln & Guba, 1985; Merriam, 1998). These were all addressed within this study as the field of study was my place of work; I knew and was known to the participants and hence, was in the privileged position of being familiar with the research context. The focus groups and informant interviews also increased my understanding of the organisational culture prevailing at the Faculty.

Participant observation is meant to provide more depth to the research context (Lincoln & Guba, 1985). Initially, I envisaged that observation would form part of my formal data collection methods. However, this was not possible due to my position as an insider researcher and the ethical implications associated with this. ‘Persistent ongoing observations’ could have introduced an element of awkwardness between myself and the participants and might have been seen as an invasion of their privacy. Nevertheless, since the Faculty is my workplace, informal and unstructured observations were an inescapable part of my everyday routine. Some of these observations, although not formally recorded, were reflected upon in my reflexive journal and this eventually led to a richer understanding of the context.

4.6.1.2 Triangulation

‘Triangulation’ refers to the use of multiple data sources so as to enhance credibility and the accuracy of the findings (Krefting, 1991). Some authors argue that triangulation is insufficient to verify the findings (Denzin, 1970; Silverman, 2013) and others suggest that triangulation extends understanding of the phenomenon by providing a rich and more complex picture (Fielding & Fielding, 1986; Ritchie, 2003). In this study, triangulation was achieved by using triangulation of data sources and triangulation of data methods (Denzin, 1970). Triangulation across sources involved collection and interpretation of data from several types of informants mirroring the practice, educational and policy perspectives in both the health and education systems in Malta. These included faculty academics, newly qualified health professionals, health and education policy makers. Triangulation
across methods included the use of cross-sectional/non cross-sectional analysis of data emerging from focus groups, key informant interviews and documentary data; these processes, discussed in the forthcoming chapter, helped me gain different viewpoints and make better sense of the data.

4.6.1.3 Peer Debriefing

‘Peer debriefing,’ which is another technique useful to establishing credibility refers to the process during which the researcher calls on a disinterested peer so as to explore aspects of the inquiry (such as over or under emphasised points, biases or assumptions) that would have otherwise remained implicit in the researcher’s mind. The role of these external peers would be to challenge the researcher with regard to methods, meanings and interpretations of the data (Lincoln & Guba, 1985).

Prescheduled peer debriefing sessions with my supervisors were organised after focus groups and key informant interviews during which my supervisors listened to my perceptions of the groups and interviews, challenged me to think deeper (or in a different way) about the multiple facets of the discussion and reflect on my position as an insider researcher. Lincoln & Guba (1985) suggest that peers should not be in an authoritative relationship with the researcher however in my case, this was not possible because as an insider researcher, most of my colleagues who could have acted in this capacity were participants in the study.

4.6.1.4 Member Checking

‘Member checking’ refers to the process in which data, analytic categories, interpretations and conclusions are given to the participants for their comments ensuring that the final work reflects the participants’ experiences (Lincoln & Guba, 1985). Although this is ideal practice, it is also acknowledged that going back to the participants with higher conceptual analysis and insights could be difficult, mostly due to ethical implications (Krefting, 1991). In this case study, I perceived that it was not appropriate to discuss my interpretations and conclusions with the participants, due to the sensitive nature of the emerging analysis. Moreover, due to the cross-sectional analysis of my data (across professions), my interpretations could have jeopardised anonymity of certain participants/professions. I, therefore, carried out member checking of the raw data in the following ways:
At the end of each focus group and interview, I gave a succinct oral summary of the discussion that had just occurred and was vigilant to review the key points, as well as my preliminary ‘on the spot’ interpretation of these views.

I then asked participants to verify this summary and to comment if there was something that I had misinterpreted or had left out. There were no instances when participants asked me to change anything.

Following the transcription of each audio recording, I sent each of the participants a copy of their group’s/individual transcript in which all names were deleted and instead, there was a common and gender-free term, ‘Respondent.’ In my covering e-mail with this transcript, I asked the participants to contact me if they felt that the transcript was not truthful to what they said. No participant ever requested any changes and this reassured me that all the participants were satisfied with the manner in which their contributions were presented in the transcripts.

4.6.2 Applicability ... Transferability

‘Applicability’ refers to the ability to generalise the findings of a study to a larger population or the degree to which the findings of a study can be applied to other contexts or settings. Lincoln and Guba (1985) argue that in qualitative research this concept is not relevant as studies are carried out in naturalistic and particular settings with few controlling variables. They suggest transferability as an alternative in which the aim is to give readers detailed information about the research setting so as to enable them to judge whether the research findings would be transferable to other settings (Lincoln & Guba, 1985). As discussed earlier in this chapter, this case study was never concerned with generalisations but with “tacit and situated understandings” (Simons, 2009, p. 24). It is for the reader to judge whether these understandings could be generalised and this could only be made on the proviso that the case study presented enough “opportunity for vicarious experience”54 that the reader would feel a personal connection to the story (Stake, 1995, p. 87).

54 According to Stake (1995), ‘vicarious experiences’ refer to accounts that need “to be personal, describing the things of our sensory experiences, not failing to attend to the matters that personal curiosity dictates. A narrative account, a story, a chronological presentation, personalistic description, emphasis on time and place provide rich ingredients for vicarious experience” (p. 87).
This was addressed by providing rich and thick descriptions of the research context (through data gleaned from the documentary sources such as the historical narrative leading up to the Institute of Health Care becoming the Faculty of Health Sciences and the nature of the public health system in Malta), as well as the research approach, design, process, implementation and analysis (including my role within it). Documentary sources were particularly valuable to facilitate possible transferability as they provided rich and distinct descriptions of the context and its culture. I also presented my preliminary interpretations during a conference in Slovenia and this provided me with positive feedback regarding possible transferability of my findings (Bonello, 2013).

Nevertheless, there were two issues which precluded me from presenting full ‘vicarious experiences’ which Stake (1995) refers to. Primarily, I was constantly mindful that due to my position as an insider researcher I needed to exercise vigilance in my writing so as to respect the anonymity of the participants and the various professional groups. This meant that certain excerpts or interpretations highlighting certain issues could not be included in the final thesis. There was also the word count limit of this thesis which meant that certain accounts had to be abridged.

4.6.3 Consistency ... Dependability

The third criterion of ‘trustworthiness’ is consistency, which refers to whether the findings would be consistent if the study were to be replicated with the same participants or in a similar context (Lincoln & Guba, 1985). This construct was not applicable because my case study was contextualised within organisational, cultural and temporal boundaries. However, the alternative concept of dependability which encourages researchers to provide an “inquiry audit” or audit trail was relevant (Lincoln & Guba, 1985, p. 319).

This ‘inquiry audit’ was carried out by meticulously describing and laying open to external scrutiny the exact methods of data gathering, analysis and interpretation. The fact that I used a well-established analytical framework executed by the use of a computer software programme facilitated this process and allowed me to produce a transparent audit trail showing how my data, findings, interpretations and subsequent
conclusions were all tracked and grounded in the raw data. Further details are provided in the forthcoming chapter. Dependability is also enhanced with dense (or thick) descriptions, triangulation and peer examination (Krefting, 1991) all of which have been discussed within the context of credibility and transferability.

4.6.4 Neutrality … Confirmability

Lincoln and Guba (1985) proposed that neutrality or objectivity within quantitative research should be replaced by confirmability which shifts the objectivity from the researcher’s characteristics to the characteristics of the data itself asking the question “are the results confirmable?” (p. 300). The major technique for addressing this is a confirmability audit which inter alia should include raw data, instrument development information, data reduction and analysis procedures, data reconstruction and synthesis products (Lincoln & Guba, 1985). In this study, all these categories of data including the data managed through NVivo software were physically kept in my office at home and will be all destroyed three years after the completion of the study. Moreover, triangulation and reflexivity, two other strategies which can help establish confirmability, were used in the same manner as for establishing credibility.

Whilst the measures described above sought to establish trustworthiness of this study, two further measures which are worthy of note were used: guidance for conducting focus groups and interviews, and use of reflexivity.

4.6.5 Improvement of Interviewing Skills

Interviewing skills, which include both technical and interpersonal skills, influence the quality of the data (Lysack, Luborsky & Dillaway, 2006); hence the manner in which interviews are conducted is crucial to consider. Cognisant of my relative inexperience, I endeavoured to acquire the prerequisite skills prior to the data collection stage and I attended focus group training sessions, both at the University of Malta, as well as at the University of Brighton. This training helped me understand group processes and ways to improve my moderation skills. I also made

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55 Due to my insider position, researcher neutrality could never be applicable. Reflexive analysis within the entire research process helped me acknowledge and account for how my perspective impacted both data collection and analysis.
use of online training workshops to become familiar with the common pitfalls encountered during interviews. Finally, I practiced my interviewing techniques with two colleagues whose feedback allowed me to reflect on my interviewing style.

4.6.6 Reflexivity in Practice

In claiming trustworthiness, researchers need to evaluate how “intersubjective elements influence data collection and analysis. Reflexivity offers one tool for such evaluation” (Finlay, 2002a, p. 531). Throughout this case study, practicing reflexivity was multi-layered and the experience was captured in my reflexive journal. These journals are useful in ensuring trustworthiness as they provide a means of monitoring the rationale, personal biases and strategies applied during the research process (Lincoln & Guba, 1985). At a basic level, engaging in reflexive analysis meant being aware of my subjectivities, at another level it meant examining the dynamics of the relationship between myself and my participants, and at yet another level, exploring how my position would influence data collection and analysis (Finlay, 2002a). This was an enriching personal and professional process reflecting Etherington’s (2004) depiction:

Keeping a journal as part of reflexive research can help us focus on our internal responses to being a researcher and to capture our changing and developing understanding of method and content. We reflect on our roles, on the impact of the research upon our personal and professional lives, on our relationship with participants, on our perceptions on the impact we may be making on their lives and on our negative and/or positive feeling about what is happening during the research process. We can capture our dreams that might inform the research even while sleeping, or poems that reflect the essence of something barely known to us and provide new insights or conversations with colleagues about the research ... (Etherington, 2004, p. 127-128).

My journal helped me be aware and make explicit how my professional and personal background, my conceptualisation and understanding of IPE, my data collection and data analyses all influenced the final outcomes of this research. Various excerpts and reflections from my reflexive diary in the form of The Inward Eye have been
interspersed throughout this thesis, providing the reader with a brief insight into these internal processes.

In conclusion to this section which outlines techniques used to establish trustworthiness in this study, Table 4.2 provides a succinct summary of the measures employed.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Measures</th>
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<tbody>
<tr>
<td><strong>Credibility</strong></td>
<td>Prolonged engagement in the field and persistent observations</td>
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<td></td>
<td>Triangulation</td>
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<tr>
<td></td>
<td>Peer debriefing</td>
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<tr>
<td></td>
<td>Member checking</td>
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<tr>
<td><strong>Transferability</strong></td>
<td>Dense descriptions of the context and methodological approach,</td>
</tr>
<tr>
<td></td>
<td>process, design, implementation and analysis.</td>
</tr>
<tr>
<td><strong>Dependability</strong></td>
<td>Inquiry audit</td>
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<td></td>
<td>Audit trail</td>
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<tr>
<td></td>
<td>Dense descriptions</td>
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<tr>
<td></td>
<td>Triangulation</td>
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<td></td>
<td>Peer debriefing</td>
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<tr>
<td><strong>Confirmability</strong></td>
<td>Confirmability audit</td>
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<tr>
<td></td>
<td>Triangulation</td>
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<tr>
<td></td>
<td>Reflexivity</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td>Personal training to conduct focus groups and interviews</td>
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<tr>
<td></td>
<td>Reflexive journal</td>
</tr>
</tbody>
</table>

Table 4.2 List of measures taken to establish trustworthiness in this study
Source: Adapted from Lincoln and Guba (1985)
4.7 Ethical Considerations

Whilst ethical issues and dilemmas are present in all kinds of research, these become more significant when researching your own institution. An insider researcher could raise issues of power and risk, both to the researcher and to the participants, calling into question the quality and meaningfulness of the data (Creswell, 2007; Orb, Eisenhauer & Wynaden, 2001). Although these challenges were acknowledged and appreciated, I took the informed decision to conduct this case study from an insider’s perspective as the case study was not a free-floating critical account of the Faculty but an instrumental case study with the objective of exploring the possibility of IPE at the Faculty of Health Science in Malta; a topic which, although could have wide ramifications and implications, was not a dangerous one in its own right.

Nevertheless, it was imperative that I would reflect on all the possible ethical issues involved. Approval was received for this study from the Faculty Research Ethics and Governance Committee at the University of Brighton (Appendix 26), as well as from the University of Malta’s Research Ethics Committee (Appendix 27). I was also assigned a local ethical supervisor, a faculty academic, whose role was to ensure that all ethical principles detailed below were being adhered to throughout the entire research process.

4.7.1 Access

The process of negotiating access to the setting and the participants was done through the formal channels and is summarised in Table 4.3.
<table>
<thead>
<tr>
<th>Phase of Research</th>
<th>Access Permission</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Overall research study | Data Clearance from the Data Protection Officer, Mater Dei Hospital. Ethical approval from UREC and access to participants and documentary data at the Faculty of Health Sciences.                                                                                           | 1. Granted (Appendix 28)  
2. Granted (Appendix 13 & 27) |
| Phase 1A          | Heads of Departments, FHS                                                                                                                                                                                          | Granted by email.                                                                                   |
| Phase 1B          | UREC Registrar, University of Malta                                                                                                                                                                                  | Granted (Appendix 18 & 27)                                                                        |
| Phase 2           | Due to the nature of the position of all key informants, no access arrangements or permissions were necessary. An invitation letter plus information sheet was sent to the key informants personally and they were free to accept in their own right.  |

Table 4.3 Access procedures to the setting

4.7.2 Informed Consent

The process of recruiting the various participants for this study has been detailed in previous sections. Prior to the start of every focus group and/or interview, each participant was given a second copy of the study’s information sheet which included an explanation of the details of the research study. They were also given an informed consent form and asked to sign it if they agreed with all the points given (Appendix 29). All participants signed this and by signing this form, they confirmed that they were fully informed about the purpose of the study, the voluntary nature of participation, confidentiality, storage of data, anonymisation of the data and the fact that some data could be used in published material. They were also given the opportunity to ask questions regarding this consent form or any other matter that was of concern to them.

4.7.3 Confidentiality and Anonymity

All participants were asked to sign the consent form which *inter alia* assured participants that as the researcher, I would respect the confidentiality of the group/interview by not divulging anything that was discussed during the session outside the focus group and that the data collected would be only seen by myself and
my three supervisors (in an anonymised form). All soft records of collected data were stored on a password protected hard drive. Hard copies of raw data, field notes, memos and other personal notes recorded throughout the research process were all kept in a locked cupboard. Furthermore, the local ethical supervisor was never granted access to any raw material since he knew most of the participants.

Prior to each focus group, I also drew the attention of all participants to respect the confidentiality of the group since confidentiality could be compromised, either accidentally or deliberately by any one of the group members. This is a weakness of focus group interviews in which the researcher can never assure total confidentiality. Confidentiality through the process of anonymity requires particular care and some argue that, in most qualitative research, it cannot be totally guaranteed. For example, participants’ stories in small communities could be so particular that simple anonymisation would not be sufficient to avoid their identity being discovered (Wiles, Crow, Heath, & Charles, 2008). In this case study, participants were either Faculty of Health Sciences academics or key informants from the Health or Education Departments - a small community where there was a remote possibility that local readers could, on occasion, identify certain participants in the final thesis (or any publications and presentations emanating from the study) due to their role or their expressed views.\

I, therefore, employed the following measures to ensure, as much as was possible, the anonymity and confidentiality of all participants.

- Real names of faculty academics and newly qualified health professionals were changed to a participant code during transcription so as to mitigate the recognition of these participants. This was also carried out when direct quotations were used throughout this thesis (for example - Academic 1 and Newly Qualified Health Professional 1).

- Key informants were likewise enumerated during transcription and data analysis (e.g. Key Informant 1) however not pursued when using their direct quotations in the final thesis. This was because the number of key informants was small (5) and it was possible that a local reader might have

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For clarity’s sake, this research was formally affiliated to the University of Brighton where the identification of the participants would be very difficult. However, data collection was carried out in Malta necessitating strict adherence to confidentiality and anonymity measures.
identified a particular key informant’s discourse throughout the text. Although I was aware that this practice might introduce an element of ambiguity to the reader (as to the reader being unsure about the dominance or otherwise of certain key informants’ discourses), I still took the informed decision to protect the key informants’ anonymity as much as possible and presented their quotations with simply ‘Key Informant.’

- Prior to each focus group and interview, I sought written acknowledgement (detailed on the consent form) that, although all measures would be taken to ensure anonymity in the final theses, publications or presentations, there could still be the possibility that certain quotes might be identifiable. I considered that by clarifying my position and seeking participants’ approval I had found a fair solution, especially when one considers that the aggregate number of participants (64) would make this possibility remote. Moreover, I was also confident that the topic of discussion, IPE, would not entail disclosure of intimate or extreme stories.

- I took all measures necessary to ensure the security of all data storage pertaining to this study. All electronic data was stored in a password protected personal hard drive accessible only to me, as the researcher (rather than on the University’s computer mainframe). All other documents which were printed during the process of the research were kept in a locked cupboard in the Researcher’s office at the Faculty of Health Sciences. Other hard data material, such as written notes/records, audiotape recordings and computer pen drives were also stored in this cupboard.

- I took great care to safeguard the participants’ identities during the writing up of the whole thesis, with particular reference to the Findings and Discussion chapters. I also made sure that excerpts from my reflexive diary (The Inward Eye) would not disclose any reflections which could be traceable to the participants. This obviously constrained me from presenting ‘particular’ reflections and I kept my observations at quite a ‘generic’ level. I also chose not to include a sample copy of a focus group or a key informant transcript for these reasons.
4.7.4 Protecting Participants from Harm

Protecting participants from harm was another ethical principle which I addressed (Lewis, 2003). One aspect which might have ‘harmed’ faculty academics was that they might have felt uncomfortable discussing certain issues due to the fact that their head of department was present. Justification for this has been discussed above in Section 4.5.1.2.1. In my invitation letter to faculty academics, I clearly expressed that their head of department was going to be present and they were therefore free to decline my invitation to take part in the group if they felt uncomfortable with this arrangement. At no time, did I try to coerce or put pressure on any academic to take part in the study. I also ensured that the integrity of the participants was upheld by accurately representing their contributions in the Findings Chapter.

During the course of the focus groups, there was one minor ethical incident and this is described in greater detail in Appendix 30. The research process was otherwise uneventful and to my knowledge, all ethical considerations were fully respected throughout.

4.7.5 Researching my own Institution

“The hardest thing is to study your own culture” (Napier, 2004, p. 39).

While there were many advantages from being an insider researcher conducting this case study, I was also confronted with a number of challenges (Coghlan, 2007). Primarily, I was aware that my familiarity with the context could possibly have prevented me from seeing all the dimensions of the situation and/or my judgments could be clouded based on my personal knowledge and experience.

The presence of the Faculty heads of departments in the focus groups conducted with academic staff could possibly have prevented some academics from divulging certain perspectives. There were potential power issues concerning interviewing stakeholders who were more senior than I am (heads of departments, senior academics, key informants), interviewing my peers (academics, occupational therapy
colleagues) and interviewing those who were indirect subordinates (newly qualified health professionals and past students). Moreover, the participants might have replied in ways which they perceived to have been either more acceptable or more ‘politically correct’. Participants might have also felt uncomfortable with the idea that their perceptions were being studied by an internal researcher and that these perceptions could eventually form the basis of a doctoral thesis. There was also the issue of promising anonymity and confidentiality to colleagues and key informants which, as already outlined, can be contentious in small communities.

There was no magic wand to dispel all these concerns. I tried to maximise the advantages of my insider researcher role and to minimise the potential for disadvantages (Breen, 2007) by adopting a preventative, reflexive and self-critical approach throughout the entire research design, implementation and writing up processes (Coghlan, 2007; Unluer, 2012). Coghlan, (2007) notes that such an approach challenges insider researchers to “transcend their own subjectivity through the quality of how they are attentive to the data, intelligent in their understanding, reasonable in their judgements and responsible in their actions” (p. 341).

Applying this approach in practice was multifaceted. I considered and respected key ethical principles including maintaining a constant critical self-awareness of my position, returning transcripts to participants and finding best ways to represent my organisation, practices and my findings. I was explicit in my orientation throughout by keeping a reflexive diary for five and half years and presenting some of its excerpts throughout this thesis. I ensured that all participants and institutional bodies were ethically protected, both during data collection, as well as in the final writing up of the dissertation. I also presented (in the next chapter) a detailed audit trail of the data analysis process to help the reader understand how I came to my conceptual conclusions. Finally, my thesis was read by two independent readers so as to assess

57 This refers to the focus group with the newly qualified health professionals. Although I had no jurisdiction over these health professionals, I might have been perceived as occupying a senior position relative to theirs. Three of these participants had also been my students during the previous year.

58 In reality, this fact was diluted as there were other colleagues who were in the process of reading for their doctorates. Hence, I found a lot of support from participants who were eager to share their views.
the level of “traceability” (Trowler, 2011, p. 3). Considering and adhering to these ethical safeguards and providing a transparent account of the entire research process should help satisfy the reader as to the robustness of this study.

4.8 Conclusion

In this chapter, The Research Process, Part 1, I have discussed the philosophical and theoretical underpinnings of this study, through which the methodology and methods were mapped out. I have presented my rationale for situating this study within an interpretivist paradigm recognising my role as an insider researcher throughout the entire research process. I have also justified my reasons for using a case study approach to guide data collection and analysis, as well as critiquing its strengths and weaknesses. Furthermore, I have discussed the selection, operations and processes of data collection including measures taken to ensure trustworthiness and ethical considerations of this study. The process of collating my methodological “map” (Finlay, 2006b, p. 9) has enabled me to consider and understand the myriad of possibilities in engaging with research and has made me more confident that my methodological choices underpinned by my philosophical and theoretical ideas were the most appropriate for this study. The next chapter, explains my data analysis process adopting ‘Framework’ approach (Ritchie & Spencer, 1994) as a hierarchical thematic method to guide this phase.

4.9 The Inward Eye

While conducting the first few focus groups, I tried to hold back my personal opinions and views so as to ‘bracket out’ my influences. I also reflected intently before the start of each group so as to be mindful of my perceptions and possible biases. I then started each focus group by saying that there were no right or wrong answers and the scope of the study was to explore IPE within the local context. However, as the research process progressed, I became more and more aware that despite my efforts to be seen as ‘neutral,’ I was still being perceived to be partial towards IPE. I started to question this supposed ‘neutrality’ and whether identifying and setting aside one’s own biases and inclinations, as some literature suggests, could ever be completely possible. It was clear that I was the main influencing

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59 This is yet another practice to moderate against the identification of participants’ identities.
protagonist in the entire research process. As data collection proceeded, I became more and more appreciative of the difficulties of implementing and sustaining potential IPE at the Faculty. I embraced this reality and addressed it by shifting my earlier adopted ‘neutral’ stance towards one which necessitated me to look inward, as well as outward. I explored how my own behaviours and responses could be used to gain insights from my participants. I also became more mindful during the groups and the key informant interviews; this felt somewhat more liberating in that paradoxically I could be more open towards my participants and their discourses.

My thoughts as an insider researcher in this study alternated between celebrating the opportunity of conducting this research myself versus that of trying to minimise its effect. In the beginning, I was rather complacent about the implications of researching my own organisation thinking that it was mainly my familiarity which was the main challenge. However, on becoming aware of all the possible methodological and ethical issues surrounding an ‘insider’ researcher I became more and more concerned. How could I write about my own colleagues, my own organisation and my own culture? How would I be seen as a recent full time recruit and novice researcher exploring academics’ views ... some of which, now professors had been there for years? And how would I represent them in a fair and just manner? Would the participants agree with my interpretation of their discourses? I was ridden with doubts and uncertainties.

In an attempt to overcome these uncertainties, I thoroughly familiarised myself with works which tackled ethical decision making and this helped me clarify some of the above dilemmas. Moreover, it was by situating this research within a relativist ontology and adopting an interpretivist perspective that helped me accept that this was the story of my research; and this was through exploring, recognising and understanding the nature of participants’ construction of the data intertwined with my own constructions and realities - our very own and unique co-constructions. There were different truths for everyone; the important thing for this research was to acknowledge these multiple truths and choose the most respectful way how to represent them.
“The ultimate excitement and terror of a qualitative project is that you can’t know at the start where you will end” (Richards, 2009, p. 133).

5.1 Introduction

This qualitative study did not set out to seek one single truth. Following many months trawling through the data, multiple truths converged into significant understandings of the study participants’ perceptions of IPE in Malta. This chapter describes the analytical process starting with preliminary coding of the raw data to making sense of patterns emerging from the data and to identifying themes. It shows how my data was put through rigorous analytical procedures so as to come up with findings deeply rooted in the data.

5.2 ‘Framework’ used to Synthesise and Interpret Data

This case study generated rich data which emanated from eleven focus groups (ten with academics and one with newly qualified health professionals) and five key informant interviews. The transcript for each focus group was approximately twenty eight pages long whilst the transcript for each key informant interview was approximately thirteen pages long. The challenge was to reduce this large volume of information (data reduction), identify significant patterns and to construct a framework for communicating the essence of the data (Patton, 2002) underpinned by my philosophical ideas. This was done through a ‘Framework’ analysis approach which is a qualitative data analysis method developed during the 1980’s by the UK’s largest, independent non-profit research institute, the National Centre for Social Research (Ritchie & Lewis, 2003). This method employs a hierarchical thematic

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60 Although documentary sources, as outlined in Chapter 4, constituted another data collection method, their value in this case study was to support and cross check primary data and to provide the descriptive and historical contexts of the case. They were thus not subject to the above mentioned analytical processes but handled using a quality control formula (Section 4.5.3).

61 Duration of focus groups were approximately 90-120 minutes long, whilst interviews were approximately 60-90 minutes long.
framework that is used to classify and organise data according to key themes, concepts and emergent categories. It identifies a series of main themes subdivided by a succession of related subtopics and, once deemed to be comprehensive, each main theme is charted by completing a matrix or table where each case, respondent or participant has its own row while the columns represent the subtopics. These charts are used to examine the data for patterns and illustrate the relationships, both by participant and by theme. ‘Framework’ is not aligned to a particular epistemological viewpoint or theoretical approach but is flexible enough to be used for many qualitative data analysis approaches. It is used by hundreds of researchers in areas such as health research, policy development and programme evaluation (Gale, Heath, Cameron, Rashid & Redwood, 2013); and although it may generate theories, the prime concern is to describe and interpret what is happening in a particular setting (Ritchie & Spencer, 1994). As Srivastava and Thomson (2009) point out:

[‘Framework’ analysis] can be said to be quite similar to grounded theory; however, ‘Framework’ analysis differs in that it is better adapted to research that has specific questions, a limited time frame, a predesigned sample (e.g. professional participants) and a priori issues (e.g. organisational and integration issues) that need to be dealt with (Srivastava & Thomson, 2009, p. 73).

‘Framework’ can be used for both inductive and deductive thematic analysis and the final decision rests on the research questions (Gale et al., 2013). In this study, I did not have an a priori theory but anticipated that meanings would emerge out of the data (Lincoln & Guba, 1985). Hence, my questions required an inductive approach to data analysis, allowing me to explore the unexpected and to generate themes from open coding of the data. This meant that, in the early stages, I used thematic non-cross-sectional analysis during which I looked in-depth at each focus group and interview separately assigning different conceptualisations of categories. This approach is particularly useful in case studies as a vehicle to gain a sense of uniqueness of the data and to understand complex narratives (Mason, 2002; Spencer, Ritchie, Ormston, O’Connor & Barnard, 2014a). My other option of using a cross-sectional analysis approach in which a common system of categories would have
been developed and applied across the whole data set (Spencer et al., 2014a) was not appropriate at the initial stage. This was because it would have gone against my inductive philosophy of the early stages of data analysis.

As data analyses proceeded through the several stages of coding and processes described by Ritchie and Spencer (1994) as indexing, charting, mapping and interpretation, I shifted the process to cross-sectional analysis. Combining both strategies is an acceptable strategy within ‘Framework’ analysis (Spencer et al., 2014a); and in this study meant that I was searching for common meanings and patterns, as well as differences and divergences within and across the data.

5.3 Managing the Data using Electronic Software

The original specialist software designed by NatCen to support ‘Framework’ analysis was called FrameWork. This software is no longer developed, and through a partnership between NatCen and QSR, NVivo 9 and NVivo 10 provide functionality to support the ‘Framework’ method. I had used a manual method for qualitative data analysis for my Master’s degree, devoting much time to tasks such as cutting, pasting, mapping and charting. For my doctoral study, I wanted to use a computer software package so as to ensure rigour and absolute transparency of the research process (without compromising creative and reflective analysis). I thus decided to make use of a software package which supported ‘Framework;’ hence QSR NVivo (Version 9 & 10). Nevertheless, I was aware that the use of computer software for qualitative data analysis has been critiqued; especially on the degree of closeness between the researcher and the data, domination of the code and retrieve method and mechanisation of the whole data analysis process (Bazeley, 2007).

Contrary to these concerns, my experience of using NVivo proved to be otherwise. The programme supported my analysis by enabling me to drive my data through a complex, systematic and iterative data interrogation process (Bazeley, 2007). Such thoroughness would not have been possible with a manual process of data analysis. The software programme never takes over the cerebral and intensive process of data analysis.

62 These are just a few of the debates surrounding issues of computer assisted analysis. For further arguments and counter arguments, the reader is invited to read, among others, Bazeley (2007); Spencer, Ritchie & O’Connor (2003); Spencer et al., (2014a) and Weitzman and Miles, (1995).
analysis; it is merely a tool for making the analysis process more robust, efficient and transparent. Whilst it is beyond the scope of this thesis to describe the intricate details of NVivo workings, I am including some personal reflections about using NVivo.

- It facilitated my overall data management throughout the entire project. This included management of data sources (primary data, linked memos, participant demographics), data coding, data retrieval, data reduction and visual displays of conceptual hierarchies. It provided the opportunity for cross-referencing with other non-primary data sources, such as pertinent literature and my reflective writings.

- It allowed me to have instant access to participants’ transcripts (written and audio) and my evolving coding hierarchies. This immediate retrieval enabled me to continuously go back and forth in my data, within its original context, as well as to confirm or discard intuitive thoughts. This could be a simple task, such as checking the context of a participant’s discourse or a complex one, such as asking particular questions of the data.

- The immediate access to my data expedited both making comparisons and identifying divergences. It facilitated abstraction from the data, especially in the later stages of data analysis during which I used various conceptual models and theoretical orientations.

- It allowed me to view the entirety of a given participant’s discourses, thus helping me to be in a better position to understand the essence of that particular participant’s perspective (for focus group participants).

- It facilitated the coding process as the many categories generated could be visually displayed and arranged/re-arranged according to my evolving thinking.

- Using NVivo allowed me to work more methodically and thoroughly than would ever have been possible with manual methods. It recorded every
movement of my data, making traceable each and every stage of the data analysis process. This included simple data logging to more complex processes, such as reinterpreting my data with new insights and mapping of conceptual categories; these features finally led to the production of a methodological audit trail which establishes analytical credibility, transparency and rigour.

Notwithstanding all these benefits, learning how to use NVivo was a limitation in that it required a steep learning curve which necessitated setting time and resources aside to become conversant with the software and its jargon.

5.4 ‘Framework’ in Practice

The idea of the ‘Framework’ approach as a hierarchical conceptual scaffolding allowed me to gain an overview and make sense of the raw data, to then describing and questioning the data and to finally conceptualising and explaining the data. This was not a linear process and necessitated going backwards and forwards between the data and my analytical concepts to reconsider, rework and refine ideas (Spencer, Ritchie, O’Connor, Morell, & Ormston, 2014b). It required that I carried out several stages of coding to ensure a rigorous analytical method.

Table 5.1 shows how the five key stages outlined in ‘Framework’ were applied with NVivo stages of analysis so as to build knowledge out of the data. Each stage is then described in more detail in the sections to follow.

63 This process requires three kinds of activity: data management, descriptive accounts and explanatory accounts (Ritchie, Spencer & O’Connor, 2003).
<table>
<thead>
<tr>
<th>Analytical Process (Ritchie &amp; Spencer, 1994)</th>
<th>Practical Application in NVivo</th>
<th>Strategic Objective</th>
<th>Iterative process throughout analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarisation</td>
<td>Stage 1: Open (free) Coding</td>
<td>Data Management</td>
<td>Assigning data to refined concepts to portray meaning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Open and hierarchical free coding of raw data through NVivo.)</td>
<td>Refining and distilling more abstract concepts.</td>
</tr>
<tr>
<td>2. Identifying a thematic framework</td>
<td>Stage 2: Categorisation of Codes and Propositional Statements</td>
<td>Descriptive Accounts</td>
<td>Assigning data to themes/concepts to portray meaning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Re-ordering, ‘coding on’ and annotating through NVivo.)</td>
<td>Assigning meaning.</td>
</tr>
<tr>
<td>3. Indexing</td>
<td>Stage 3: Coding on</td>
<td>Explanatory Accounts</td>
<td>Generating themes and concepts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Extrapolating deeper meaning, drafting summary statements and analytical memos through NVivo.)</td>
<td></td>
</tr>
<tr>
<td>4. Charting</td>
<td>Stage 4: Triangulation with Key Informants and Conceptual Mapping using NVivo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Mapping and interpretation</td>
<td>Stage 5: Analytical Memos and Abstraction of Data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.1  Stages and processes involved in qualitative analysis
[Analytical hierarchy to data analysis]

Source: Adapted from Ritchie & Spencer (1994)
5.4.1 Familiarisation

At this stage, I familiarised myself with the data gathered from Phase 1 by reading the transcripts, the observational/field notes, and listening to the tapes innumerable times. I immersed myself in the voices of the participants and the overall discourse of the academics slowly becoming aware of recurrent themes and ideas. I also started to compile my database in NVivo by importing the demographic details of all the participants (so as to track the contribution to source), the transcripts of the ten focus groups with academic members of faculty staff, the focus group with the newly qualified health professionals and my reflection notes on each focus group notes (Visual 5.1 on the next page).

NVivo had the potential to link these sources thus facilitating quick retrieval and contextualisation of cases. At this early phase, I started preliminary provisional coding which is akin to deconstructing and classifying the data. A code could refer to a broad descriptive category or to a more interpretative or analytical concept (Richards, 2009). In this first stage, coding involved ‘broad-brush’ or open coding giving rise to free codes. Free codes are free in that they are non-hierarchical, and free in that they are not bound by the research question but allow for emergent themes to arise out of the data. In NVivo language, codes are also referred to as ‘nodes’ and similarly to ‘codes,’ provide the storage areas for references to coded text (Bazeley, 2007). Throughout this study, I have adopted the term ‘codes’ in the text, however, the term ‘nodes’ is still evident in certain visuals and appendices.

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64 Although focus groups and informant interviews were transcribed independently, I was deeply involved in the process by going through each audio recording and cross checking with the draft transcripts so to ensure accuracy of the participants’ contributions.

65 As explained in the previous chapter, these notes were drawn up prior to and following each focus group/interview and were the vehicle for exploring my subjectivities and biases during the data collection process.
This was the stage in which I started to recognise recurrent themes and ideas arising from the data and thinking about these themes in a more abstract way. It was a cyclical process of listing key ideas, making notes, going back to the sources and starting the process over and over again. I was mindful that this was an inductive process and so derived the *in vivo* codes directly from the data (Strauss, 1987).

As an interpretative researcher, I also made use of the “constant comparative method” (Maykut & Morehouse, 1994, p. 126). This is a nonlinear and iterative process in which each new ‘unit of meaning’ or text segment selected for analysis was compared to all other units of meaning and categorised and coded with similar

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66 The basis of this approach approach stems from Glaser and Strauss’s (1967) method of data analysis for theory building and later modified by Lincoln and Guba (1985). Today, it is a widely used approach in grounded theory (Charmaz, 2014).
codes. This process allowed me to compare data looking for similarities and/or differences eventually emerging with the essence of my data (through themes). I also wrote annotations and electronically attached them to the relevant documents. These annotations were my own comments, reminders and/or reflections on the text which captured my thinking at that moment in time reminding me of particular observation/s. Visual 5.2 is an example of such an annotation.

Visual 5.2 Example of an annotation in NVivo
By this stage, I had finished the preliminary coding of the ten transcripts ending up with a substantial number of free codes. This involved lifting the data from its original textual context (transcripts) and placing it in these free codes which were largely descriptive, broad, participant-driven and stand-alone categories (units of meaning) with no evident relationships or connections to each other.

Due to the subjective nature of this process, each free code was defined and detailed with a descriptive ‘rule of inclusion’ which was a rule outlining the basis for including (or excluding) particular text segments (Maykut & Morehouse, 1994). Figure 5.1 is an example of the first generation of these free codes and Visual 5.3 shows this same process of free coding in NVivo.

![Example of Open free Codes](image)

**Figure 5.1** Example of first generation of open free codes

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67 At this stage, free codes evolved rapidly, however the process as Lincoln and Guba (1985) note, slowly levels off.
This process was taken further by writing this ‘rule of inclusion’ as a ‘propositional statement’ summarising the essence of each code as a “statement of fact the researcher tentatively proposes, based on the data” (Maykut & Morehouse, 1994, p. 140). My thinking was shifting from “categorising units of meaning to preparing a statement that reflects the collective meaning” within each free code (Maykut & Morehouse, 1994, p. 140); this involved refinement and/or collapsing of free codes by making numerous assumptions as to the meaning and significance of the data (Bazeley, 2007; Maykut & Morehouse, 1994). I also started to identify key issues, concepts and themes from the data and this signified the emergence of an early thematic framework. NVivo facilitated this process as I had instant access to read and cross compare transcripts from the different departments at the Faculty.

5.4.3 Indexing
This was the process during which the evolving thematic framework consisting of free codes was systematically applied to all the textual data. This meant going through all the data, questioning the data, highlighting and making comparisons, both within and between cases and this formed the thematic framework to which data could be referenced.
Although largely descriptive, this framework was showing the beginnings of a hierarchical structure (classifying related concepts in a set). Visual 5.4 shows indexing using NVivo. The right-hand panel in this visual is an example of transcript excerpts that were indexed under a particular subtheme.

Gradually, my emerging ideas derived from the data were being refined (reconstruction of the data) and the flat structured free codes developed into a more complex hierarchical structure (tree codes). Organisational and theoretical patterns were becoming apparent. This was work-in-progress and involved re-naming, merging, distilling, culling and/or clustering of related categories generating several generations of codes.

Through NVivo, I was checking on my ideas and assumptions by going back and forth between transcripts, audio and observational note sources (Visual 5.5). This process reflected my social constructionist epistemology to see how, and in what context participants were constructing meanings of IPE.

Visual 5.4  Example of indexing in NVivo
Visual 5.5 Example of linking and identifying sources in NVivo
5.4.4 Charting

At the charting stage, data from all participants that had been indexed in the previous stage (*free* codes) was arranged in the appropriate *tree* codes with headings and subheadings (thematic cross-sectional analysis) and situated in the ‘Framework’ matrix. This process created a degree of conceptual order to my coding system. I continued to make use of ‘propositional statements’ to help me understand the codes’ contents and refine relationships between them. This stage of code refinement for all eleven transcripts coincided with the stage of revisiting and finalising the topic guide for the five key informant interviews (Phase 2). This was timely as I could be highly responsive towards those areas that emerged or needed further elaboration from Phase 1A and Phase 1B, further reflecting my research approach that each phase would build on the preceding one. This stage was also one in which a picture of the data as a whole was starting to emerge. Figure 5.2 shows an example of code refinement; in this case it is showing how some of my *free* codes were gradually grouped into a charting framework consistent with ‘Framework’ approach.

![Figure 5.2 Organisation of some free codes into tree codes [An example]](image_url)
Appendix 31 is a work-in-progress Word document tabulation exported from NVivo showing brief contents of a number of tree codes (nodes), each with its number of sources (the number of participants) and references (how many times it was mentioned). A number of these codes were later reorganised and reclassified to reflect emergent conceptual relationships.

At this point, all five key informant interviews had been conducted and transcribed and so the stages of ‘familiarisation’, ‘identifying a thematic framework’ and ‘indexing’ outlined above were carried out on this data set. Although this was a new data set, I started off by coding on the free codes which I had drawn up for Phase 1A and Phase 1B adding on new codes as required. I did this because there were many common issues, albeit raised by the different stakeholder groups (at this stage, the key informants).

Once this process was completed (which by then encompassed both the focus group transcripts and key informant interviews), all free codes were rechecked for their content, rules for inclusion and re-organised into a re-structured tree code hierarchy (or in ‘Framework’ terminology, ‘charts’). This was a ‘messy’ stage of analysis extracted from triangulation of all data and methods, and one which consolidated and reduced the data. Divergent views were captured, challenging my ideas of emergent patterns.

This stage of ‘Framework’ involved placing the indexed coded data into a grid or matrix. Visual 5.6 shows an example of Ritchie and Spencer’s (1994) ‘Framework’ Grid in NVivo. The first column contains the participant’s demographic and profiling information whilst the last column contains coded content of that particular participant to that particular theme. I then systematically synthesised content for each participant, theme by theme, by writing overall summaries or memos about the particular theme into the grid. This process helped me move beyond what was said in the transcripts (factual descriptions) to deeper aspects of the discourses (interpretative analysis) (Bazeley, 2007). Reading the grid crossways offers a participant analysis for each theme, while reading the grid downward offers a cross participant analysis of each theme.
Visual 5.6 Example of Ritchie & Spencer’s ‘Framework’ Grid [As applied to my data]
5.4.5 Mapping and Interpretation

This stage involved analysis of the key issues as laid out in the charts. It was an iterative, intuitive and creative process in which I tried to interpret the data set as a whole “searching for a structure rather than a multiplicity of evidence” (Ritchie & Spencer, 1994, p. 186). This phase was dominated by long periods of working deeply and sensitively with the data so as to try and identify patterns in the data which were at a higher level than participants’ discourses. It was only by going through this process that I could understand how “textual level of work” was interlinked to “conceptual level work” (Richards & Richards, 1994, p. 448). The former refers to data management methods, such as ‘code and retrieve’ methods to identify key concepts and map the phenomena, whilst the latter refers to higher order abstraction during which evidence and arguments are brought to the fore (Richards & Richards, 1994). There were no hard distinctions between these levels and Richard and Richard’s (1994) explanation of how conceptualisation takes place is worthy of note.

And so the web-of code, explore, relate, study the text-grows, resulting in little explorations, little tests, little ideas hardly worth calling theory but need to be hung as wholes ... Together they link together with other theories and make the story, the understanding of the text. The strength of this growing interpretation lies to a considerable extent in the fine grain size and tight interknittedness of all these steps: and the job of qualitative data handling (and software) is to help in the development of such growing interpretations (Richards & Richards, 1994, p. 448).

Using NVivo at this stage involved going through the data, propositional statements and memos, verifying whether each code was a true representation of participants’ discourses, so as to eventually work towards synthesis. This ‘bottom-up’ approach ensured that all the codes created in previous stages reflected higher order themes. NVivo has a number of tools that facilitate this process whilst at the same time providing a comprehensive audit trail of decision-making processes; one of these is writing memos (or thick descriptions) at code level linked to the conceptual hierarchies and this is illustrated in Visuals 5.7 and 5.8.
Visual displays of conceptual hierarchies - code definitions - linked and related memos
Another tool is a ‘coding query’ and this helped me to: explore patterns and ensure that excessive emphasis was not placed on isolated findings: see the connections between the themes and participants: and searching and displaying content coded at multiple codes (intersecting coding). Visual 5.9 shows how a coding query in NVivo can help make the connections between the data.
There are also ‘search’ tools with which I could ask questions or interrogate the data and during which I considered various factors, such as examining the code in context, pattern analysis and using divergent views and/or negative cases to
safeguard against drawing generalisations. I also engaged deeply with the literature and this encouraged me to ask complex questions of the data followed by reflection on how I might interpret the results of such questions (Bazeley, 2007).

During this stage, I looked at the data in new ways exploring both its breadth and depth (Richards, 2009). I was making connections and seeking explanations for these connections (Ritchie & Spencer, 1994). Documentary data helped me in exploring some of these connections so as to appreciate their significance and deeper purpose. This was particularly pertinent for my third revised research aim (p.96) which sought to explore and understand how micro, meso and macro contextual factors could possibly influence IPE in Malta; and predominantly documentary data helped me understand the nature of the meso and macro level contextual factors. For example, I looked at archived minutes of meetings of the then Institute of Health Care Boards so as to make sense of the narrative leading to the possibility of IPE being included in the mission statement of the Faculty of Health Sciences (discussed in Chapter 6, Findings). I also examined various local and international official documents and position papers (such as health strategies/policies, consultation documents and reform documents) so as to understand the context of some of the participants’ discourses. A typical example was when I looked at various European Union health strategies/policies so as to comprehend a participant’s arguments which concerned harmonisation of local health workforce planning with European health and social targets. His discussions centred on improving the efficiency of the local health system by ensuring a balanced mix of staff skills and looking at different ways of working and collaborating.

Documentary sources also played a valuable role in providing background information to particular events/issues brought up during data collection as well as augmenting details to confirm/contradict data from the different sources (Yin, 2009). For example, during two of the key informant interviews there was reference to Training and Development post-qualification programmes delivered to health care professionals working in the public sector. Following these interviews, I looked at the content of these training programmes so as to explore if and to what extent, collaboration, an essential feature of professional practice in health care, was addressed in these programmes. I also looked at documents associated with the
‘interprofessional symposium’ mentioned in Chapter 2: Part 1 (Sacco, 2008), as well as the Faculty of Health Sciences professions’ preregistration course programmes so as to be aware of the nature and extent (if any) to which the different student groups had multiprofessional experiences during their entire courses. Furthermore, I reviewed the general regulations governing the design of undergraduate programmes at the University of Malta so as to have knowledge of the various administrative and regulatory issues that participants brought up during their discussions about the possibly of IPE at the Faculty of Health Sciences. During this mapping and interpretation stage, I wrote analytical memos (conceptual synthesis of my findings) for higher order themes and hand drew concept maps and models to help me go further with my ideas and arguments and to identify the overriding core themes and patterns which permeated the data. For example, I first conceptualised the data into positive, neutral and negative determinants for IPE as demonstrated in Visual 5.10.

Initial models were hand drawn to encapsulate my thinking process of how I envisaged the introduction of IPE in our curriculum: a hypothetical change process reflecting positive and restraining orientations.

Visual 5.10  Example of early conceptual mapping
As my thoughts progressed and my ideas gradually shifted, my initial concepts were reinterpreted and I developed different ways how to make sense of patterns and relationships in the data; the initial themes seemed narrow and restrictive. I considered literature from various academic disciplines and this was useful in interpreting what was possibly going on. For instance, at one point, I made use of the Transtheoretical Model of Change developed by Prochaska and DiClemente (1986) and adapted to IPE by Clark (2013) so as to understand the processes and forces that can facilitate or challenge an innovation, such as IPE (Appendix 32). These models were at a later stage, discarded as I felt they were too focused on the decision-making abilities of the individual and consequently this did not capture the entirety of my data. However, the concepts of the model, specifically the principles and processes of intentional change proved to be very insightful to my overall thinking.

With stages of deeper thinking, synthesis and revisiting of the data with new perspectives, I became confident in knowing which were consistent issues and patterns in the data and which were not. Eventually, I felt I was “above the noise of the data” (Richards, 2009, p. 143) and was able to see the “bigger picture” (Richards, 2009, p. 173). In so doing, I could present coherent findings and tentative interpretations of the meaning of those findings for possible IPE in Malta.

Visuals 5.11 and 5.12 are simplified examples of higher order theme development from initial deconstruction of the transcripts, through open coding (identifying a thematic framework), to developing categories (indexing), to refining categories (charting) and to abstraction (mapping and interpretation). The final overarching themes and their subthemes are presented in the Findings Chapter and placed in dialogue with the literature in the Discussion Chapter.
Visual 5.11  A simplified audit trail for higher order theme development [Example 1]
### Visual 5.12 A simplified audit trail for higher order theme development [Example 2]

<table>
<thead>
<tr>
<th>Coding</th>
<th>Collapsing</th>
<th>Collapsing</th>
<th>Abstraction to Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcripts</td>
<td>Sample Open Free Codes</td>
<td>Categories: Collapsed in Multiple Stages</td>
<td>Abstracting to Themes</td>
</tr>
<tr>
<td>Power relationships</td>
<td>Lack of drivers</td>
<td>Institutional &amp; structural barriers</td>
<td>Our organisation cannot take it</td>
</tr>
<tr>
<td>Private practice</td>
<td></td>
<td>Logistical barriers</td>
<td></td>
</tr>
<tr>
<td>Health Service realities</td>
<td>Policy and logistical barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic realities</td>
<td>Administrative rigidity</td>
<td>Reals of teamwork</td>
<td></td>
</tr>
<tr>
<td>Inequality between professions</td>
<td>Logistical barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>Competition at the Faculty and University at large</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space/structural</td>
<td>Attitudinal barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ingrained attitudes</td>
<td>Service delivery realities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curriculum cram</td>
<td>Lack of teamwork</td>
<td></td>
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**Various Levels of Coding**

Higher order theme: 
The Reality of IPE

Hegemonies and territoriality at the Faculty

Our way of doing things

Medical model reigns supreme
5.5 Reflections on using NVivo

While thinking about and working with the data, I often asked myself how my analysis could have been different if I had not used NVivo. Although this remains a hypothetical question, I believe that using this software improved the rigour and quality of my research. Critics of NVivo argue that using NVivo could potentially fragment the data and thus alienate the researcher from the data; another argument is that the combination of transcripts and the software can cause the researcher to become too immersed in the data resulting in the inability to see the bigger picture (Bazeley, 2007). I would argue that the closeness and distance of the data could equally be compromised by the use of basic word processing software, other than NVivo, which is commonplace in data analysis. During the entire data analysis process, I felt close to the data as, with a simple click, I could have an overview of the data, as well as read and hear particular participants’ excerpts in context. There was also a continual connection and visibility between the original data and the classification taking place. In the later stages of the analysis, I continued using NVivo to confirm and/or question my interpretations in preparation for further synthesis. Eventually, the closeness to the data became more abstract and distant enabling me to see the findings from a broader perspective. My experience reflected current thinking in software analysis design where closeness is required for familiarity, distance is required for abstraction and synthesis, and the ability to switch between the two perspectives is recommended (Bazeley, 2007).

Using NVivo software provided me with an audit trail which is visual evidence of the processes employed during data analysis, such as coding, managing codes through various iterations, annotation and memoing content, as well as mapping concepts and themes developed during analysis. This audit trail shows how my analytical strategy was entirely consistent with the philosophical underpinnings of my methodology and its practical application (rather than a manual map of a complicated process).

I also reflected how my emerging core themes might have been different had I not used NVivo as an analytical tool. Within my relativist ontological position, I could certainly never, nor would ever wish to claim that my analysis of the data is the only

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68 Evidence of this can be seen throughout the visuals presented in this chapter and Appendix 31.
true interpretation that may be offered. However, although the breadth and depth of my analysis could have been carried out using a manual method, the thoroughness might have been less. For example, using this software allowed me to question my data comprehensively which meant that whilst focusing on the overall picture, I also had access to the various levels of my analysis, right down to the particular context of participants’ discourses. This simultaneous viewing of the bigger picture and the more intimate and deep one allowed me to pursue ideas emerging from the data forming the basis of my conceptual and analytical ideas, which were, in turn, guided by the research questions. Furthermore, since I did not base my coding on frequency of phrases in the texts but rather on content and contextualisation of content, it is fair to conclude that my conceptual coding would have been similar had I used a manual method of data analysis.

As with all other computer technologies, NVivo needed to be learnt by doing. The fact that I was motivated and learnt how to use it during the initial stages of my data collection meant that I achieved a familiarity and a sense of ‘naturalness’ with the software. Moreover, the availability of ongoing personalised NVivo support meant that I was able to discuss the iterative data analysis process with knowledgeable experts. There was a particular limitation of NVivo which became evident in the final stages of thesis preparation. This was the exportation of NVivo visuals in the final documents which although optimised in various formats, still rendered disappointing results in printing. This, however, could have been due to my relative inexperience in using NVivo rather than due to the software itself.

5.6 Conclusion

This chapter has presented a detailed audit trail of my data analysis using the discipline of Ritchie and Spencer’s (1994) hierarchical ‘Framework’ approach. I have shown how the use of NVivo software facilitated systematic data handling and contributed to a more rigorous and transparent analysis.

The use of reflexivity throughout was akin to negotiating a “swamp of interminable deconstructions, self-analysis and self-disclosure” (Finlay, 2002a, p. 209). It was also one which helped me position myself within the research, guiding me towards deeper understandings. Analysing my data was more than just identifying themes; it
was a process of “contextualising and making connections between those themes to build a coherent argument supported by data” (Bazeley, 2009, p. 21). This ultimately gave me an intimate sense of what was going on in my data slowly working towards synthesis of this data. The remaining chapters present these findings and my interpretations of the meanings and implications of such findings, in relation to theoretical perspectives in the literature and in relation to the possible introduction of IPE at the Faculty of Health Sciences in Malta.

5.7 The Inward Eye

At this point, I felt that I was arriving at a significant place. Gerring’s (2004) words that in the real world of Social Sciences, inspiration arises from perspiration rang so true. I was stuck in the same place for so many weeks ... months. Abstraction and conceptualisation of the descriptive findings was challenging ... it was akin to prizing something open and failing every time ... I read so many ‘advanced’ data analysis texts ... I questioned and compared the data exploring various possibilities and interpretations ... I looked at diverse literature ... I engaged in endless discussions with my supervisors and with others who shared this journey with me. I was adamant that my interpretation should not be partial but should reflect participants’ deep understandings of IPE. I was getting closer and closer ... and then by some strange insight, the data seemed to lift off the page ... my mind leapt across this unchartered territory and I started to integrate all my data thinking about it in new ways. At this point, I felt I had arrived at a meaningful place and I was confident that my analysis had done justice to my data. In retrospect, it felt as if this place was always there, staring me in the face whilst I was furtively trying to get on the right path after following a few blind alleys.

My analytical journey instigated a renewed sense of self-awareness and self-confidence in which I recognised more and more how my preconceived ideas were inextricably woven with those of the participants. I tried to look at the familiar with new eyes and realised the incompleteness of what we call ‘reality.’ My research could no longer be boxed-in ... its influence was bursting at the seams.
"It is in our idleness, in our dreams, that the submerged truth sometimes comes to the top" (Woolf, 1929/1983, p. 32).

6.1 Introduction
This chapter presents the findings generated from the analysis of interviews and focus group discussions held with the academics at the Faculty of Health Sciences, with a group of newly qualified health professionals, and with a number of key informants from the University of Malta and within the health sector.

The study aimed to tease out the participants’ perceptions and understanding of IPE and the implications of a possible IPE initiative at the Faculty, in order to gain insight into factors influencing their perceptions and attitudes. The topic guide prompted participants to conceptualise a potential change and their responses revealed a range of IPE determinants at micro (individual), meso (institutional) and macro (national) levels.

The process of data analysis yielded a number of themes encapsulating the dominant issues and concerns voiced by the study participants. On further analysis and abstraction two overarching master themes emerged: ‘The Idea of IPE’ and ‘The Reality of IPE’ reflecting my understandings and interpretations of participants’ discourses. This chapter presents the findings reflected into these two master themes, while the chapter to follow explores them in-depth by abstracting from these themes those key issues that have implications for IPE and by placing them in dialogue with relevant theoretical perspectives drawn from the literature.

6.2 Outline of Master Themes
The first Master Theme: ‘The Idea of IPE’ represented participants’ discourses expressing perceptions and understandings of IPE as an idea. Participants imagined IPE as an idea through constructing largely optimistic discourses that affirmed IPE
as a good way forward. There were instances where they spoke of IPE as truly something to aspire for as it seemed to have the potential to offer many benefits to health professionals, such as improving day-to-day working relationships, making better use of scarce resources and ultimately being of especial benefit to the patient. Participants also spoke about how the newly formed faculty was slowly becoming a more collaborative environment, a factor that might help in accommodating IPE. Yet, although participants pointed to many potential benefits, discussions of IPE as an idea also elicited responses that might be said to be indicative of a certain sense of doubt and mistrust of it.

The second Master Theme: ‘The Reality of IPE,’ represented participants’ discourses on IPE but this time contextualised to their world, in other words, imagining IPE in reality or in practice. They identified seemingly insurmountable barriers to IPE that included organisational and logistical constraints, strong medical dominance and territorial behaviours that work against the principle of collaboration, and the notion that IPE might run contrary to “our way” of doing things.

The relationship between the two master themes might be described as constituting two sides of the same coin, with a degree of overlap at times and tension at other times. Some of the concepts in these themes were multifaceted, having both positive and negative aspects and therefore belonging to more than one theme or subtheme. Some discourses were also somewhat contradictory to one another and thus could be accommodated under more than one subtheme, occasionally even under both themes, for instance, as this chapter at a later stage shows, the discourses on teams and teamwork.

My intention in presenting the findings under these two master themes is to highlight this relationship and at the same time, still present the notion of a continuum between ‘The Idea of IPE’ and ‘The Reality of IPE.’ This was a complex picture which I have tried to capture through the richness, breadth and interrelatedness of the themes and their subthemes. Figure 6.1 is a diagrammatical representation of the two master themes with their subthemes, the titles of which reflect participants’ own words. Subthemes stem from the central concept of the broader master theme but with an in-depth focus on a particular element.
The left hand side of the figure represents ‘The Idea of IPE’ consisting of five subthemes, and the right hand side represents ‘The Reality of IPE’ consisting of six subthemes. The findings are presented as emanating from one data set to reflect participants’ collective perceptions of IPE, as opposed to individual or a particular participant group’s perceptions; however each category of participant is identified for transparency. Quotations from focus groups and interviews are used to provide evidence for the themes, to deepen understandings, and to clarify links between the data, analysis and my interpretations; this is a standard practice in qualitative research to support the trustworthiness of the study (Corden & Sainsbury, 2006; Long & Godfrey, 2004).

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69 Due to the possibility of identifying individuals, the pronoun ‘he’ is used. Furthermore, as noted earlier, the five key informants are not given an identification code for anonymity purposes but are simply identified as ‘Key Informant.’
6.3 The Inward Eye

Whilst attempting to unravel and portray the complexity of the findings, I was mindful of Finlay’s words that “findings are always partial, tentative, ambiguous, fluid and open to multiple interpretations and emergent meanings” (Finlay, 2006a, p. 7). Hence, I was conscious that my analysis was influenced by my own values, experiences as well as my relationship with participants; another researcher might have interpreted the findings in a different way. I was also mindful of how the literature increased my sensitivity towards the data and I openly acknowledge this influence by including preliminary reflections and interpretations on the data in this chapter; these are not meant to detract from the ‘pure’ findings but more to underscore Finlay’s idea of the “muddy ambiguity” (Finlay, 2002b, p. 209) of research which in this case rendered bracketing off the literature during data collection, analysis and representation difficult at times.

During the writing up of these findings, I was looking for meanings which surpassed the written words; my mind was moving from realistic to symbolic modes of thought. I was aware that these representations needed to be grounded in the data so as to reflect participants’ realities, as opposed to myself trying to find data to support my perspectives; perspectives which were shifting along the research journey.

At different points, I became preoccupied with how these findings will be perceived by my colleagues at the Faculty. Did the themes reflect participants’ salient discourses? Was I being judgmental and just looking at one aspect of this multifaceted phenomenon? How were my various professional roles colouring these findings? Was I blocking out or highlighting some participants’ voices at the expense of others? There were a few times when I realised that I was especially susceptible to those stories which echoed my innermost feelings, mirroring my own preconceived ideas, values and experiences. I tried to become more vigilant so that my personal views would not taint the picture of what was emerging but then, what was the reality of this picture I was trying to portray? Doesn’t the picture always depend on the viewer? There wasn’t one single truth to be explored and discovered in my data but a multifaceted kaleidoscope.
My reflective accounts written before and after each focus group and my prolonged engagement with the data helped me to ground myself and to be aware of my attitudes, prejudices and way of seeing things and interpretations. The use of NVivo also helped me to check for consistencies (and/or inconsistencies) of what people were saying about the same thing. I also engaged in a deep analytical process, comparing and contrasting the perspectives of the three groups of participants. It was only then that I felt confident that my research findings could face up to scrutiny by the wider research community.

6.4 Master Theme 1: The Idea of IPE

This section focuses on participant discourses in relation to ‘The Idea of IPE’ discussing the five subthemes that emerged from the process of data analysis. The term ‘idea’ portrays participants’ constructions of what IPE meant to them (or what it could mean) and how it ought to unfold. The five subthemes are listed below along with the relevant section number where they are discussed in greater detail:

6.4.1 We Like It
6.4.2 We Ourselves are Becoming more Collaborative
6.4.3 Teams are Ideal
6.4.4 Imagining IPE
6.4.5 We’re Suspicious

6.4.1 We Like It

In comments coded to this subtheme, participants talked about potential benefits and positive outcomes they associated with ‘The Idea of IPE.’ They suggested that IPE would be a good mechanism for building professional alliances, developing lateral thinking, improving patient care and preparing trainee professionals to work in real life contexts:

*I think it makes a lot of sense because if we expect people to work in an interprofessional way when they graduate, I mean, it’s good to start practising with that very same thing during the courses. So I agree with that* (Academic 35).

*From a philosophical perspective, the idea is very good. From the practical*
side, I think if it’s going to be a success it needs to respect the individuality of each profession. If IPE is ready to respect, and strives to respect the individuality of each profession yet strives to find ways how to support each profession in their collaboratively working together, then yes it can have a future (Academic 40).

I think it’s a wonderful idea which obviously, in principle, I’m sure we all agree upon, but … (Academic 15).

Academic 34 saw IPE as advantageous for a small island with limited resources:

I think it will be the best way forward whereby, especially if we are to acknowledge the limitations of the island and the size of the island, it will make not only ..., okay there’s a benefit, a big benefit for the patient, but also I think we would make much more effective use of resources (Academic 34).

The majority of the key informants spoke favourably about IPE:

Yes I completely believe in that, obviously, and bringing people together (Key Informant).

I am in favour of interprofessional education (Key Informant).

Newly qualified health professionals were positive about the concept of IPE and wished that, as a minimum, they could have had opportunities to get to know other professionals during their undergraduate years. They spoke positively about the potential benefits of participating in learning experiences with other professionals and saw this as possibly facilitating teamwork later on:

But if we had the chance to get to know, to have a friendship with other professionals, it would have helped, it’s a step, a first step, to get to know a person, in my opinion (Newly Qualified Health Professional 4).
Participants anticipated that IPE could be beneficial in best serving the needs of the patient and that attaining this goal would necessitate having knowledge and understanding of other professionals’ roles:

*I think one of the aims of interprofessional education is seamless care - that we don’t repeat and that we don’t leave gaps in the care – and I think knowing what other people do and how other people can contribute would help us to actually provide this seamless care* (Academic 33).

*The minimum that we’ve got to do at least is to know what a physio does and how, if we’re working together as a team* (Academic 3).

Arndt et al. (2009), use the term ‘interprofessional familiarisation’ which implies approaches aimed at introducing students to the roles and functions of other professionals. Academic 45 contextualises the benefits of this approach as a means to improve everyday work environments and his/her insight into knowing the role and functions of other professions is one which equips health professions to empathise with circumstances in which their colleagues are operating; and this empathy can only lead to smoother working relationships:

*It works both ways because when, as people working in the lab, we understand better what’s happening in the ward, at Casualty, and so on, we realise that sometimes nurses are in situations* (Academic 45).

Another participant commented that IPE could help trainee health professionals to look at patients’ problems from perspectives over and above just that of their own profession:

*And it is the human factor I think, and it is about working together, it’s about understanding who you are, what you do – so it’s having similar problems but looking at it from different perspectives, you know* (Academic 28).

This participant’s viewpoint, whether wittingly or unwittingly, resonates with Petrie’s (1976) notion of “cognitive maps” that inform and guide each profession (as
discussed in Chapter 3: Literature Review) so that “two opposing disciplinarians can look at the same thing and not see the same thing” (p. 35) and the participant highlights potential benefits of sharing, to some extent, those ‘cognitive maps’ in the interest of good practice in patient care. Other participants endorsed and amplified this idea, highlighting not just benefits for the patient but benefits for professionals too, as such interactions could make for a mutually supportive environment:

Different professionals sharing reflections about what each profession is doing for this particular person, and how they can help each other out, eventually when faced with a real case, a real patient (Academic 16).

But also in this way they are learning, what do we have in common, what do I bring myself [I myself bring]\textsuperscript{70} to the situation and what does someone else bring? So how can I bring on the particular skills and expertise of another profession? Because at the end of the day, it’s all about how the person is going to benefit from our care (Academic 43).

In addition to discussing ‘The Idea of IPE’ in terms of its potential for improving patient care and for creating learning and practice environments wherein students and practitioners could share ‘cognitive maps’ and support each other, some key informants spoke of emerging challenges to the local health system that will inevitably necessitate innovations in current work practices and systems. The main challenges these participants mentioned were demographic changes, technological innovations, specialised health care, lack of human resources and the drive for holistic health care. A key informant concluded that such challenges, and perhaps especially the drive for holistic care, render both educational and practice environments, governed by silo and separatist approaches, no longer viable:

The service that is being provided more and more is becoming, one, more specialised, and two, requiring much more the intercollaborative efforts of the different team players. Whereas in the past, people could possibly have worked in silos or isolated from each other, that today is not only not

\textsuperscript{70} […] – In quotations, this indicates a clarification of grammatical English.
acceptable anymore but it is not sustainable, it is not doable anymore, because obviously now we’re looking at the patient from a holistic point of view (Key Informant).

Overall, in comments coded to the subtheme ‘We like it,’ participants pointed to benefits they associated with ‘The Idea of IPE.’ They suggested that IPE would be a good mechanism for understanding other professional roles and improving day-to-day working relationships, for enhancing the quality of patient care and for making good use of limited resources. However, throughout these discourses, I was aware that participants’ discourses seemed slightly rhetorical and were possibly constructed in an ideal world devoid of any contextual implications.

6.4.2 We Ourselves are Becoming more Collaborative

Personally I have seen a change – maybe not in interprofessional education but in collaboration between different departments (Academic 20).

Participants agreed that the change to which Academic 20 referred, increased interdepartmental collaboration and was a direct consequence of their recently acquired status as a faculty. Referring to this change, Academic 28 depicted a vibrant image of a new and palpable shared sense of pride and enthusiasm, almost akin to the acquisition of a new collective identity as a faculty:

This Faculty seems to be proud of who they are now – they’re not an institute anymore. They’re in this really cool building, they’ve got lots of facilities, they’re taking more part in university life and when we were at St. Luke’s it hardly ever happened. I think there is this sort of shift, I think it came about when we became a faculty, as opposed to an institute and we had a change in people at the top and attitudes changed and we became more ‘university,’ more collegiate (Academic 28).

This “change in people at the top” was of significance to participants not just in terms of an accompanying “attitudes changed” but also because, as an institute, post holders of leadership posts had been appointed by higher administration, whereas, as
a faculty, such posts are now filled by personnel elected by academic staff. This new protocol has contributed to a collective sense of ownership and identity as a faculty in both symbolic and concrete terms.

Participants offered examples of collegial activities whereby faculty members, staff and students alike, were “taking more part in university life” on a professional and social level. Such activities included, for example, faculty research seminars and the founding of the Malta Health Students Association (MHSA), both of which, participants suggested, were in accordance with a key principle of IPE – the idea of professions learning from and about each other:

*The seminars delivered by different professions was a very good start and myself, and I believe my colleagues, we appreciated a lot the different aspect of research questioning us and the methodologies involved* (Academic 21).

*Learning together will make them more prone to work together and something that happened here is the MHSA which I think has started something very productive in that they go for these weekends together, they're getting to socialise together, but still within the Faculty* (Key Informant).

On a positive note, some academics suggested that the diversity of professions at the Faculty meant that it already possessed the raw materials necessary for building an IPE framework:

*I think what makes our Faculty good for IPE is that we have so many different professions within* (Academic 13).

*We already have the resources because we have the expertise in the different areas and in the different departments, so all we need to do is find a way of linking them together. So we already have them* (Academic 12).

Further, some participants saw a practical advantage for a potential IPE initiative in the reality that the diverse human resources that make up the Faculty are housed
within the same building:

Here you walk in the corridor, you meet a nurse, you walk down you speak to a physio, you go further down you go to your occupational therapist (Academic 7).

By contrast, however, despite the social interactions arising from the formation of the MHSA, Academic 27 pointed to the absence of a student common room in “this cool building with lots of facilities” as a distinct drawback in terms of a potential IPE initiative:

So how can you expect the students to intermingle if they don’t even in their recreational time, if they don’t have a place where they can go and talk to each other, meet each other – this place isn’t designed for IPE (Academic 27).

Indeed, the concept of space, encompassing physical, symbolic and virtual ‘spaces,’ emerged as a recurring theme in analysis of participants’ discourses and consequently, is a recurring motif in this chapter.

Academics highlighted some multidisciplinary initiatives already in place at the Faculty (mostly postgraduate) as potential good foundations on which IPE might be developed. These initiatives included online programmes, such as the BSc e-learning in Health Sciences, continuous professional development courses aimed at multiprofessional audiences, and postgraduate research involving more than one department.

Academic 20 suggested that the e-learning environment or ‘virtual spaces’ in which academics are furthering their education, may inadvertently, to some extent, already be serving as forums in which professionals are learning about each other:

If I may refer back to the e-learning programme. Okay, different academics from different departments are involved but probably not within the same study unit. However, the fact that different professionals, not undergraduate
students but professionals who are upgrading their qualifications, are learning together even in an online environment is perhaps indirectly making people learn about each other (Academic 20).

Some academics commented that the newly revised common core research modules delivered by faculty staff themselves (rather than by other lecturers from outside the Faculty) could also serve as good platforms for IPE. Indeed, Academic 19 referred to a recently designed module that had been specifically designed with a view to including other professions:

Research methodology run by nurses, research methodology run by radiographers, and in a way there’s a lot of common ground. And basically, in the Faculty there’s a move now and that’s something also we’ve adopted [something we have also adopted], we’ve built up a module on Ethics which basically targets not just our profession, but we set it up, built it up thinking about even, you know, including other professions (Academic 19).

Notwithstanding these positive perceptions of improved collaborations at the Faculty, participants were aware that the reality of developing and implementing collaborative projects, both between different academic departments and between students is replete with challenges and these are discussed at a later stage in relation to Master Theme 2: The Reality of IPE.

6.4.3 Teams are Ideal

Participants’ comments on the concept of teams and their observations of teams in practice, illustrates tension between their perceptions of teams in theory and their experiences of teams in reality. In short, participants lauded the idea of teams but did not seem to have many examples of good practice to draw upon, when discussing teams in relation to their everyday experiences. This section considers participants’ perspectives on the importance and significance of teams, in theory. Their experiences of teams in practice are discussed in a later section under Master Theme 2: The Reality of IPE.
A key informant noted that professionals are almost unanimous in their approach towards the importance of teamwork, in theory, but didn’t know if, perhaps, these discourses might amount to little more than slogans:

I don’t know if it’s just paying lip-service to it, but all professions, they all talk about ‘oh teamwork is important.’ Speak to any of the professions and most of them actually do mention it (Key Informant).

However, if professionals in the health sector seem to agree that ‘teams are ideal,’ a key informant warned that putting people together does not necessarily nor automatically result in good teamwork. This participant highlighted the challenges involved in trying to create health care teams, and the ‘ingredients’ necessary to forming a well-functioning team:

We’re talking about we want neuro rehab team, we’re talking about qualified staff, we want a rehabilitation team, we want a spinal team, we’re talking about a lot of teams, when in actual fact sometimes it’s very difficult, you need to get more the personalities, the right personalities together, you can’t just put people with the qualifications, you need to get people who work well with others, a lot of planning, sometimes you even have to send people along on courses - team building, communication skills (Key Informant).

Expanding on this, Academic 28 argued that critical factors that make up successful teams need to be clearly identified by educators so that those aspects could be taken on board and nurtured at student level. In other words, teamwork needs to be incorporated into educational processes and practices:

If the objective is to produce people who can work together in teams and get the best out of each other and therefore offer a better service, then you need to look at what it is within those teams and the way they might function, that you need to put into their educational preparation (Academic 28).

With regard to ‘educational preparation’, a key informant spoke of efforts to promote reform in undergraduate training that would lead to a more integrated learning
environment for trainee professionals, but regretted the failure to achieve such reform:

Another area which we have not yet managed to achieve but this is because this is not within health’s remit but we can only influence and try to push the agenda forward, is within our undergraduate training programmes. As a Ministry, we have long had the opinion that undergraduate training programmes need to be much more integrated and we’ve said this to the University and to MCAST (Malta College of Arts, Science and Technology) and to all the other training institutions many a time (Key Informant).

Arguably, successful design and implementation of more integrated undergraduate training programmes would rest on sound interprofessional teamwork; and the participating professionals’ perceptions and experiences of teamwork to date are discussed in a later section under Master Theme 2: The Reality of IPE.

6.4.4 Imagining IPE

Participants tentatively explored the most advantageous context and timing for IPE. As a starting point, academics were adamant that any IPE initiative should not compromise each department’s international and European undergraduate programme regulations and obligations. The best way forward, they suggested, would be to introduce incremental small changes over a long span of time:

We should do small things like perhaps have two credits a year to start the process going, because this isn’t something that’s going to be some kind of quantum leap from zero to hundred but if we start it little by little, I think it will accumulate with time (Academic 6).

I think we need to introduce it gradually because otherwise, I mean we can’t impose it on the course (Academic 11).

But let’s make little, little steps forward, without having to change the world (Key Informant).
These perspectives concur with the literature suggesting that small but manageable initiatives could be beneficial for initial IPE (Freeth et al., 2005). Participants also suggested that if ever IPE was to be considered by the University, it should be wider than just the Faculty of Health Sciences as most of the clinical work overlaps with other professions outside the Faculty:

*And do not be mistaken – IPE without the medics, pharmacy, et cetera is a half-baked attempt – you cannot wall up the Faculty and say we are doing IPE because if IPE is not broadened it is not IPE at all* (Key Informant).

Participants deliberated as to whether IPE should be part of the academic-based curriculum or form part of the clinical placement process. They seemed to agree that IPE within the clinical context would be more practical and in some cases might even be easier to implement than academic-based IPE. Participants spoke of introducing planned experiences during students’ clinical placements in which students would get to know about other professions’ contributions and be exposed to other professions’ points-of-view. Examples of such planned experiences included working together in clinics, using patient-centred rather than profession-centred approaches, practice placement organised activities such as bedside seminars and workshops, joint clinical assessments and participating in clinics involving different professions. However, there was one major caveat: introducing IPE within the clinical context would mean having to take account of everyday service realities, which, in the main, participants perceived as almost running counter to the concept of collaboration:

*We can’t stick our heads in the ground. The reality is that the clinical set-ups need to be prepared, because in a way, if it is not continuous then what is the scope* (Academic 32)?

*There is a dissonance between what we perceive as being inter or even multiprofessional working within this Faculty, and what takes place within clinical practice* (Academic 28).

In a similar vein, Academic 39 was unsure whether the various clinical practice
settings would have systems and structures in place that would exemplify collaborative practice and accommodate collaborative learning:

*I ask another question. Are the different practice sites interdisciplinary? Do they have a team? Do they have ward rounds? Do they have case conferences? From my experience, I think some places like Zammit Clapp were very well set up, I think other places were left to their own devices* (Academic 39).

Both the relevance of Zammit Clapp Hospital to this study and the meaning of the colloquial term ‘Zammit Clapp Hospital Concept’ have been explained in Chapter 2 in the discussion of the Maltese context.

Participants debated the timing of any potential IPE initiative, that is, whether it might be best implemented at undergraduate or postgraduate level and issues they raised in these discussions echoed issues raised in the literature concerning possible positive and negative implications of implementing IPE at pre- and/or at postqualification level. Participants’ varying views and the reasons they voiced for holding their respective views centred predominantly on issues, directly or indirectly, related to stereotyping, professional socialisation and the acquisition of professional identity, issues that have been raised in the Literature Review and are discussed in further depth and detail in Chapter 7: Discussion.

Some participants proposed that IPE should be introduced as early as possible in the formative undergraduate years as a means of possibly lessening the chances of students stereotyping, as well as understanding the roles of other professionals outside their own disciplines:

*I think the earlier you do it the better because that would prevent the stereotypes* (Newly Qualified Health Professional 1).

*So if we are to produce interprofessionally minded specialists, we need to start from Day One* (Academic 53).
Some participants were in favour of introducing IPE in the final years of the undergraduate programme by which time students would have garnered a strong sense of professional identity:

*I see a big role for IPE in the final year of the programme, particularly in clinical practice and in, you know, practically oriented study units, because by then they [would] have grown in their own self-confidence, they [would] know what you're talking about* (Academic 43).

Other participants, disagreed, suggesting that by their final year, students would already have become entrenched in their individual professional cultures, and may have formed stereotypical perceptions of their fellow students and future colleagues:

*I don’t agree, because by third and fourth year there is already this identity building quite strongly. I think right from the beginning you need to get them to work together, to accept each other* (Academic 9).

*From experience, we see that immediately upon graduation people are already ingrained in their ways, the years of formation within the university have already determined how they will be working, even at graduation let alone later on in life, so it is about the formative years of the student that is essential, yes* (Key Informant).

A number of participants favoured postgraduate level as the optimum point at which IPE might be implemented:

*I would prefer postgraduate because now they are mature, they know where they stand, they have a good standing in their profession, and they can build up and nurture more alliances* (Academic 23).

Another participant agreed that postgraduate level would be most opportune, suggesting that undergraduate students are already too burdened by intense programmes of study within their respective disciplines to engage in interprofessional learning:
I think at undergraduate level it would be too confusing for the students to learn so much, and especially if some programmes are going down to three years, everything is crammed because time is precious, we have the summers are being utilised, credits have been widened, and to introduce something at that early stage, in my mind, is not a good thing (Key Informant).

A number of participants were not categorical in their thinking about the timing of IPE; in their view IPE could straddle both camps and plausible arguments could be made for both:

You can put it into more detail on a postgraduate level, but still I think the basic groundwork should be undergraduate in my opinion (Academic 7).

I think it’s good to start from undergraduate but I think it has a place in both undergraduate and postgraduate (Academic 35).

This view of IPE as constituting a continuum concurs with the literature which suggests that IPE should be interwoven throughout students’ professional education and developmental programmes (Barr et al., 2005; Freeth et al., 2005; McPherson et al., 2001; Walsh et al., 2005).

6.4.5 We’re Suspicious

I tend to look upon it with some misgivings, the IPE issue (Academic 39).

I am not dead set against it but I’m not all for it either (Key Informant).

I think you have to be really sure about the outcomes, I mean is it worth the struggle with regard to the outcomes (Academic 23)?

As the above quotes illustrate, participants’ comments coded to this subtheme might best be described as ambiguous and ambivalent, indicative of a certain wariness or mistrust of IPE. But before considering issues identified in the analysis of data coded to this theme, it is worth noting that some participants stated that they could not really judge IPE as they did not have a clear understanding of what it is all about:
Yet, such confusion concerning the meaning of IPE is hardly surprising given that, as discussed in Chapter 1, theorists have referred to the field of IPE as “bedevilled by terminological inexactitude” (Barr et al., 2005 p. xvii). Indeed, aware of this possible situation underlying my research, I started each focus group by reading some basic notes about IPE from a flip chart and this was in addition to the brief introduction in participants’ information sheet. However, for some participants, the focus groups and the interviews still seemed to be the first opportunity during which they were attempting to understand the concept of IPE, its intricacies and also consider its implications as the discussions were unfolding. It soon became evident that IPE was a nebulous concept meaning different things to different participants and this was highlighted at various junctures in discussions when participants became aware that they were talking about multiprofessional and/or shared learning whilst thinking they were talking about IPE. Some participants suggested, that any IPE initiative could be weakened by such misconceptions and misunderstandings of IPE. And indeed, based on the analysis of the data, it could be suggested that lack of clarity on the meaning of IPE could give way to a sense of doubt, suspicion and mistrust of IPE, as may be evidenced in the quotes to follow.

For instance, a key informant expressed a general sense of doubt about the idea of IPE, portraying it as something vague, and as almost a case of ‘much ado about nothing:’

*To be honest, I haven’t seen it happen successfully anywhere, because I looked it up, last time I was looking up on the internet, I did find reference to postgraduates, and that’s at postgraduate Master’s level. But I think even, I think there isn’t much happening. We had a speaker once come to talk about interprofessional education and she didn’t really say anything. So I haven’t seen it happen successfully* (Key Informant).

Academics 23 and 16 also expressed doubts about IPE by questioning the extent to which there may be sound evidence demonstrating its value and worth, and their
search for proven precedents underscores the need (as outlined in the Literature Review) for ongoing robust research to be undertaken so as to underpin IPE with clear and unequivocal evidence:

How are we to do this famous IPE, considering that there is little concrete evidence to work upon? There might be a lot of evidence but maybe I don’t know how sound it is, considering it’s difficult to evaluate the outcomes of IPE in the long run. And should we be intuitive and go ahead and try to do it? Or are we being too idealistic (Academic 16)?

Where is the evidence that the students are better or the teaching is better (Academic 23)?

Moving from doubt to mistrust, Academics 8 and 41 exemplify some academics’ concerns that there may be a hidden agenda behind IPE in that it may mean a phasing out of some professions, in favour of developing generic and/or multi-skilled rehabilitation therapists:

So we really have to find that fine line where we don’t then overlap too much, because there is that fear that we might then come up with rehabilitation therapists (Academic 8).

There needs to be a balance between learning and being empowered by other people’s professions and developing your specialty because then we end up with a group of amateurs, in my opinion, so we have to be careful (Academic 41).

By contrast, a key informant suggested that development of such generically-skilled personnel may be of value and well justified “when funds are low:”

But when funds are low I think that is the way that we might be going. Even maybe not courses that are on at the Faculty, I mean there are other courses that have been developed to try and solve these problems of funding. Whereas say if [a] training requires five years, maybe doing something
which takes three, being more generic, so that they can use the same worker in a variety of areas. So say if we only produced say ten physios, ten OTs, ten speech, you might have say thirty of this generic person (Key Informant).

Such discourses brought to the fore a divergence of opinion between academics and key informants. Academics were adamantly opposed to any degree of flexible working which, they perceived, could jeopardise their professional autonomy and social standing; while key informants spoke favourably about a place for skill mix flexibility in today’s workforce. Indeed, one key informant talked about years of difficult negotiations in trying to reconcile these opposing viewpoints; negotiations which remain unresolved, mostly due to professionals’ fiercely protected domains and the demands of unions and professional associations. Given this background of protracted negotiations, it is perhaps understandable that some participants might be wary of IPE, possibly perceiving it as a potential platform for bringing the generic worker in ‘by the back door.’

As already discussed, if doubts about IPE are to be minimised, some participants stressed the importance of underpinning any proposals for it with sound evidence, linking it to improved student and patient outcomes. A key informant also stressed the importance of addressing costs in the context of providing evidence for the benefits of IPE, if policy makers and funders are to be won over to the idea:

I mean the only things that convince policy makers usually are either because it’s costing us more or because we’re not giving a good quality service. Now if you can put forward those two arguments, so the economic argument and the quality argument, and say listen, if we work in a different way these things will change. Otherwise, I see very little hope for changing anything around, because people will not try to change, policy makers will not try to change the way people work unless there are real tangible benefits for that change. For the sake of change, one doesn’t change anything (Key Informant).
6.4.6 Overview of Master Theme 1
In sum, the Master Theme, ‘The Idea of IPE’ generally captured broad perceptions of IPE which were perceived as beneficial and could have positive impacts on professional education, practice, and patient care. Participants were of the opinion that they themselves were slowly becoming more collaborative since they had become a faculty. They also engaged in debate about the timing and location of IPE within programmes. However, discussions on ‘The Idea of IPE’ also brought to the fore some participants’ doubts about the value of IPE and their concerns about the possibility of professional dilution as a potential negative outcome.

6.5 Master Theme 2: The Reality of IPE
The analysis of data coded to the Master Theme: ‘The Reality of IPE’ generated six subthemes which, together highlight the major challenges that participants identified when it came to discussing the realities of developing and sustaining IPE. These six subthemes are listed below along with the relevant section number where they are discussed in greater detail:

6.5.1 Our Associations with IPE
6.5.2 Our Organisation Cannot Take It
6.5.3 Realities of Teamwork
6.5.4 Medical Model Reigns Supreme
6.5.5 Hegemonies and Territoriality at the Faculty
6.5.6 Our Way of Doing Things

6.5.1 Our Associations with IPE
In effect, the study participants had limited experiences of IPE as per CAIPE’s (2002) definition, rather, experiences they associated with IPE seemed to be mostly multiprofessional learning and multidisciplinary working. Nonetheless, when asked if they had experienced IPE, some participants drew on experiences from their own student days, recalling them as positive and beneficial for professional and patient alike:
It was in clinical practice, it was in Karolinska Institutet and it's quite impressive when you see it, when you see the practice, putting it into practice (Academic 18).

I had a three-month placement actually, I was sent by [the] government where there was also this interprofessional education there. It felt good, it felt a lot of colleagueship and comradeship and it created a lot of knowledge, and improved my attitude and knowledge about how the other professions work as well (Academic 41).

So then when you finish working with the medics, like in Casualty, you realise the difference, they come to you, they speak to you, you’re like a colleague more, you know, you know each other, and I think it helps even the patient in the long run (Academic 24).

If these participants’ experiences may have occurred outside of Malta, some of the longer-serving participants remembered instances of learning together in Malta. For instance, a key informant recalled that during the 1950’s and 1960’s, medical, pharmacy and dental students shared a number of foundation courses. Although this was most likely for economies of scale (as there would not have been enough entrants at that time), this participant held the view that these shared learning experiences were instrumental in sustaining interprofessional collaborations later on in these professionals’ careers.

It is interesting to note that during the planning phase of the Institute of Health Care in the mid to late 1980’s, there had been the idea that academics should not belong to particular divisions but should contribute to the various modules depending on their expertise:

I was here from the beginning of the Faculty and originally when the Institute at the time was set up, divisions didn’t exist and it was like that on purpose, actually the original idea that the Rector had at the time was that we would not even be a member of any department or division, everybody would have a
specialisation and then there would be course coordinators who would coordinate the course taking any expertise that is available (Academic 6).

However, this idea never materialised and over the years there have been other suggestions and ideas for forging collaborations between health-related faculties, but again, such ideas have never been translated into reality:

Once there was the idea, I think it’s a few years back now, and I was consulted, I can’t remember who the Rector was, but there was this idea of creating, a college I think the idea was, a college of health sciences that would have incorporated our Faculty, the Faculty of Medicine which included pharmacy, and the thinking at the time was that they’d start a BSc where all these professions would go in together for education because the thinking was that if you learn together, you can work together (Key Informant).

There was an opportunity, when the Institute of Health Care (IHC) was going to be converted into a faculty there was, call it an opportunity, call it an idea, call it whatever you want to call it, to actually merge the Medical School or Faculty of Medicine and the IHC into one faculty. But it was an idea and it never took off for various reasons (Key Informant).

While these ideas “never took off for various reasons,” participants did not attempt to discuss or tease out those reasons, possibly because to do so might have risked raising politically sensitive issues.

Chapter 2: Part 1, discussed an event, promoted as an ‘interprofessional symposium,’ involving fourth year students from six then called Divisions at the Institute of Health Care collaborating with students from the Medical School. This was conducted in 2008 and focused on a complicated case study of a patient who had suffered a stroke, and it was this event that many participants remembered when asked if they had ever experienced IPE. The majority of the academics and the key informants (the newly qualified health professionals were not present at the time) recalled this event with disappointment as it had fallen short of its aim to foster
collaboration between professions:

*We thought it was going to be an interdisciplinary project, but it wasn’t, we all presented separately and at the end we all came out really sad and grim, because everybody presented his profession in his own way and there was no interprofessionality between it* (Academic 8).

*It was like pulling the patient apart and there was no communication between them. It was something that had struck me* (Key Informant).

*That didn’t work – I mean I was there and I saw it happen and it was a disaster* (Key Informant).

The academics and newly qualified health professionals also associated IPE with the current common core curriculum (Appendix 2), despite it not having any interprofessional elements. This was possibly because it involves various allied health students attending the same lectures together. Participants held negative views of these modules which, based on student feedback, were thought to have been developed for economies of scale rather than the enactment of an educational ideal:

*I think with this thing of shared learning here, the feedback I get from the students is that it’s a cost-cutting exercise, rather than a philosophy of trying to improve health outcomes and trying to deliver knowledge in a particular way* (Academic 46).

And the newly qualified health professionals were uncompromising in their depictions of this common core teaching as being of little value to them:

*It was only shared listening* (Newly Qualified Health Professional 1).

*You’re basically sitting next to the people on your course, you’re not really interacting much, we were a big class, we were over 250, or something like that, and it was Friday in the afternoon so that’s a class that you get tired*
more easily but I didn’t feel that I learnt a lot basically (Newly Qualified Health Professional 5).

In relation to these modules, academics talked about students forming themselves into in-groups according to their professions and avoiding any form of interprofessional collaboration. Indeed, some participants suggested that these modules (and by extension, IPE), although aimed at cultivating student interaction, may even generate negative attitudes between their own and other students:

*That was the idea, but I think in the end it backfired because our students were lost among the numbers, that’s why we mentioned the numbers. So if IPE were to be introduced now, to go back to our students complaining of again being lost and nobody knows they exist there, and eventually they end up feeling inferior because nobody gives them any notice* (Academic 40).

*So shared learning is not an ideal situation because even there they don’t really intermingle, you have the physios sitting on one end, the radiographers sitting one end, the nurses sitting together, so it’s, you know, they’re really just sitting by [next to] each other* (Academic 27).

Unlike the general negativity associated with the common core curriculum, participants held more diverse opinions on the value of the recently revised research common core modules explained in Chapter 2: Part 1. While a few academics spoke of these modules as possible grounds for IPE, those directly involved in teaching these modules returned to the issue of students’ reluctance to engage with students from professions other than their own, even deeming attempts at nurturing such interactions to be futile:

*I think it depends also on the lecturer and we’re trying to move away from it, because, for example, nowadays if I have a multidisciplinary group I make sure that if I give them an assignment that I actually mix professions, they hate you for it! They give you all kinds of excuses ‘oh we can’t meet because, you know, our lectures overlap’, blah, blah, blah* (Academic 15).
It is not unreasonable to suggest, however, that such reluctance on the part of students, most likely stems from and mirrors wider dynamics at play between the professions at the university and beyond, dynamics that tend towards a ‘silo’ approach to teaching and to practice.

Newly qualified health professionals perceived the revised research modules as even more fragmented than the earlier common core teaching because, unlike the common core teaching where they would have one lecturer delivering the entire module, these modules involve different lecturers (each delivering an individual lecture) resulting in a sense of discontinuity. With regard to shared learning modules, however, and returning to the theme of space, this time conceptual space, academics talked about practices whereby lead lecturers tend to monopolise and influence this supposedly shared conceptual space:

Very often, the lecturer who’s leading the course in that shared learning module, being a physiotherapist, being a nurse, being a doctor, being whatever, will focus his lecturing on his speciality or on his field of interest and there’s very little acknowledgement of other professions who are attending that particular methodology course. And that creates issues with the student and long term issues even with research interests or with self-development in this direction (Academic 50).

As Academic 50 pointed out, such dynamics “create issues” for both students and professionals as they work against the principles of interprofessional collaboration, and Academic 18 endorsed this view, suggesting that, rather than cooperating and supporting each other, the various professions are, in effect, each trying to advance their individual interests at the expense of the collective interest of the Faculty:

Because it’s not a question of a model that is being followed, it’s a question of, for example within our Faculty, a lot of different departments, everyone trying to pull his own string (Academic 18).

These tensions in interprofessional relations are discussed again under later subthemes in this chapter.
Moving from the micro level of individual stakeholders in the education and practice settings, the next subtheme focuses on participants’ perspectives on IPE at meso or organisational level.

### 6.5.2 Our Organisation Cannot Take It

Participants’ comments coded to this theme encapsulated many organisational barriers at both faculty and university level which they perceived would make the development of sustainable IPE very difficult. The barriers participants identified were diverse in their significance and complexity; some might be described as symbolic, while others were rooted in the practical domain of the systems and structures that govern university life.

One example of a symbolic barrier to IPE relates to the Faculty’s mission statement, as mission statements often enshrine the core principles and key practices of an organisation. Academic 6 introduced this topic:

> When we were discussing IPE with the Faculty, I had put forward a strategic plan for the Faculty at the IHC Board at the time, and one of the things I had put in was a mission statement which actually included IPE, and it was actually opposed – it was actually opposed by certain members of staff (Academic 6).

Thus, although the Faculty’s mission statement refers to IPE as an aspiration, it makes no mention of policies or plans for its development, nor of evaluation methods that might accompany its implementation, and Academic 39 was concerned about the implications of this contradiction for IPE:

> If it does not form part of our core philosophy as a Faculty, it is difficult to introduce it as being something which forms part of our normal day-to-day requirements. If it is introduced as an ‘add on’ few people may subscribe to it, I believe, one, because it is not compulsory, and two, because it will introduce scheduling problems, logistical problems, it would take a leap of faith first, and also we have to fit it in within our scheduling logistical requirements (Academic 39).
In this comment, Academic 39 identified both symbolic and practical barriers to IPE. Symbolic in that if IPE is external to the Faculty’s educational philosophy, “few people may subscribe to it” or believe in it; and practical in that it may then be seen as an optional extra incurring planning and logistic complications. Indeed, in terms of subscribing to IPE, participants stressed the importance of academics themselves believing in it, if they are to be role models for it and nurture interprofessional interaction between students:

*If we don’t believe in it how can we, you know, what message are we going to transmit to the student? We have to believe in it and, not only believe but show that we believe in what we’re saying* (Academic 34).

*Yes, because the Italians say tra il dire e ‘l fare, c’e un gran mare.* It’s nice to say things, it’s nice to assess them, it’s nice to, but are they convinced (Academic 30)?

Participants suggested that, should IPE become a reality, not only would they need to be convinced and believe in the philosophy of IPE but they would also need to receive training in the appropriate pedagogical methods:

*I think training, okay, maybe training is a bit of a broad term, I think it is necessary, because to be honest, at least for myself, if I do not have such training I wouldn’t be confident* (Academic 21).

*But we have to be educated even before we can give our input, you know? That’s very important* (Key Informant).

*We need to learn about it ourselves first* (Academic 20).

Academics were apprehensive that the possibility of organising, planning and securing the extra resources required for an IPE initiative would be fraught with the same and possibly worse logistical and resource barriers they were already facing as

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71 Italian saying: Literal translation: “there is a sea of difference between what you say and what you do.”
a faculty: lecture scheduling problems, additional teaching commitments, large numbers of students in courses and lack of adequate physical space to accommodate the delivery of IPE:

*All sorts of resources. There’s also the logistics. If you’ve got fifty students on our course and fifty nurses and fifty doctors and you go to divide them into groups of ten, two from each course, then you need enough rooms and enough people, so that you can actually, you know, one group per room, one or two academics per group, and you need the space to run this type of module because you can’t just put two hundred of them in a room and expect to get something out of it. And also a lot of co-ordination between the administration because you need to shift, fix timetables; so logistically it’s quite a nightmare and, you know, the inception and the idea of the project might be brilliant but logistically if you don’t plan for it, it won’t work (Academic 44).*

And Academic 28 echoed the viewpoint that lecturers are already operating under overladen workloads which the literature sometimes refers to as ‘curriculum cram’:

*But trying to drip-feed IPE into undergraduate is very difficult because we all have our targets, our assessments, our courses, our priorities in terms of the curricula for our own particular discipline, so trying to find commonalities is another piece of work that we would have to do on top of all the existing considerable amount of work that we have to do (Academic 28).*

A number of academics also highlighted the potential complications in terms of accrediting IPE courses:

*If we were to organise an interprofessional course it has to be given a code so under which department would that fall X or Y? Administratively we have a problem (Academic 12).*

As already discussed, in terms of physical spaces, some participants saw the number of rooms that delivery of IPE would require and the absence of a students’ common
room as drawbacks for any potential initiative; while the housing of all faculty departments within the one building was highlighted as a potential advantage. Yet, it is noteworthy that the location of the faculty building itself, positioned adjacent to the hospital but forming part of university, was seen by some participants as problematic on two counts: firstly, its distance from the main campus would be disadvantageous for any attempts at cross faculty IPE, and secondly, its positioning had symbolic implications for the professional identity of some faculty members, and this latter point is of particular interest to this study:

_I think the fact that physically we are part of the hospital is both beneficial and not, because in many ways I keep getting this thrown at me like ‘but you are part of the hospital’ – are we part of the hospital or are we really a faculty within a university_ (Key Informant)?

This Key Informant raised an interesting point because the question of professional identity is not just a strong theme in the literature but it emerged as a strong theme in analysis of the study participants’ discourses. It was raised as an issue earlier in this chapter on the possible timing of IPE and is discussed in subthemes to follow. In Chapter 7, participants’ experiences and perspectives on the theme of professional identity are analysed in dialogue with relevant theoretical perspectives in the literature.

In summary, in their comments coded to the subtheme ‘our organisation cannot take it,’ participants identified systemic, logistical and symbolic barriers or challenges to IPE at faculty and university level. Systemic and logistical barriers centred on lack of adequate and appropriate physical spaces, scheduling and accrediting challenges, and already overwhelming workloads. Participants also identified a need for further training in teaching methodologies if they are to be confident advocates and role models for IPE, should such an initiative be introduced. On a symbolic level, the absence from the faculty’s mission statement of a strategic plan for the development of IPE could, it was suggested, render it being perceived as an optional “add on” that “few people may subscribe to” or believe in as sound educational philosophy and practice. A key informant summed up the general mood of participants when considering barriers and challenges to IPE:
Well in an ideal world you could perhaps get it started at some point, but the hurdles along the way are so major that I wouldn’t even want to contemplate it (Key Informant).

6.5.3 Realities of Teamwork

As discussed under the subtheme ‘teams are ideal,’ participants placed high value on the concept of teams, in theory, and agreed that effective teamwork would be a necessary cornerstone for any potential IPE initiative. However, when talking about their everyday experiences of teamwork and of communication systems and structures in general, they did not have many examples of good practice to draw upon. By contrast, they expressed concerns about a lack of collaboration at the Faculty, between faculties, between the Faculty and the health service, in clinical practice, and across most of the health services.

Participants were critical of work practices in the clinical setting, suggesting that it would be “useless” to expose students to IPE at the Faculty when, in their clinical placements, they would observe and experience practices that run counter to the development of teamwork and interprofessional collaboration:

It is quite useless for us to encourage interprofessional education and then when they go to the clinical areas they see people who are unable to work together (Academic 43).

So our students will go out into clinical practice and in clinical practice this philosophy does not exist, although we talk about interdisciplinarity but the silo effect, everyone is in his silo, so they go out, and they come back and say ‘listen, the reality out there is a bit different’ (Academic 18).

But then when they go out there and start working, they start laughing because they say it doesn’t exist – even worse they see how people are like at loggerheads, you know (Key Informant).
And the newly qualified health professionals spoke of witnessing this lack of good coordination between professionals in the practice environment, as demonstrated in the following example of first-hand experience:

*In my case I think it lacks [it is lacking], especially when a patient is discharged, discharge planning is either absent or very poor in the medical wards. Liaison between the professionals is not very good* (Newly Qualified Health Professional 6).

But key informants pointed to such poor communication systems and structures in the provision of service as the outcome of a vicious cycle of cause and effect in terms of the relationship between the health education and the health service:

*What one sees as silos within an academic setting then obviously develops into an even bigger and more serious problem within a service delivery setting* (Key Informant).

*And unfortunately, now we are feeling the effects within the service provision side of things, the effects of years of noncollaboration at the University* (Key Informant).

While participant discussions at this level focused on the lack of interprofessional collaboration in the immediate education and practice settings and the ultimate implications in terms of patient care, some participants also expressed concern about the lack of communication between policy decision makers and academia:

*But a big driver could be or should be the Department of Health. If they tell us the policy in which they would like the Health Service to go into, then maybe it could be a driving force for our curriculum; so if they tell us that they would like to go into primary health care in a big way or preventative medicine, then we will start taking our course in that direction* (Academic 27).
This example of poor collaboration, it could be said, provides insight into potential serious implications for the education and health sectors, and for the economy, when a ‘silo’ approach becomes so entrenched that educators and policy-makers can become so far removed from each other as to be almost operating as discrete rather than interrelated entities, and, indeed, a key informant deemed this to be the case:

_We’re still very much territorial in our approach, both Health and the University, so what is mine is mine, what is yours is yours, and if we agree, we agree, if we don’t agree, we don’t agree_ (Key Informant).

If this key informant offered a correct assessment of relations between the health authorities and the University, this lack of coherence and alignment represents a serious departure from WHO guidelines which advocate seamless mechanisms between the health and education systems (WHO, 2010).

In summary, participants concluded that teamwork is generally poor in Malta, and reasons they put forth that might account for this phenomenon are considered later in this chapter under the subtheme: ‘Our way of doing things.’

### 6.5.4 Medical Model Reigns Supreme

_A major impediment to IPE, is the predominance of a medical model mentality and outlook_ (Academic 39).

_A lot of professions feel that they are not respected, that they are ruled by the medical profession_ (Key Informant).

As the above quotes illustrates, comments coded to this theme reflect participants’ strongly held sense of dissatisfaction with medical dominance in the health and academic sectors, as well as in wider society; a dynamic they perceived as incompatible with IPE.

Academic 38 proposed the concept of “professional indeterminacy” as one way of accounting for how doctors attain this dominance over other professions, depicting it as an outcome of something almost akin to a ‘sleight of hand.’
Culturally, there is something which is called professional indeterminacy, it means the doctors have it, nurses do not have it. It means that the doctor has the power to decide because he is not regulated, his profession is not regulated by ‘if the patient has this – I do that,’ in fact it is, but they give the impression that it is not (Academic 38).

Indeed, Chapter 7 considers theoretical perspectives in the literature that seek to explain processes by which the medical profession achieves its dominance. However, by whatever means this dominance may be attained and sustained, its effect, as depicted by the study participants, is profoundly felt. For instance, Academic 15 described an encounter between a medical professional and another professional group, depicting an ambiance wherein a sense of feeling intimidated is palpable amongst the members of the professional group:

And as soon as the consultant physician came in the room, we could feel it! I think one of us was assertive enough to say ‘hang on,’ he stood to be corrected; and you could see the nonverbals ‘never me’, you know, ‘you don’t dare’ – I can never see our students doing IPE with medical students (Academic 15).

And Academic 15 asserted that the medical profession had wanted to exert dominance over other professions participating in the stroke case study symposium:

And I thought this was multidisciplinary and yet the medics wanted to take over (Academic 15).

Participants suggested that, although great strides have been made in elevating the scholarship of their professions reflecting international trends in health care education, this teaching was at times sabotaged by the medics, resulting in a “tug of war” between differing approaches within health care:

It is not just the thing between us and them, it’s a whole different mentality. Over here the programme is for our students to go into individualised practice, into holistic practice and evidence-based practice, but there is a
drive within the clinical setting it’s a different drive, a different attitude, a completely different attitude. So basically, it’s not just meeting up, explaining our position, it’s literally a tug-of-war, I’d say, between two different extremes (Academic 51).

Academics suggested that wider society also supported medical dominance which meant that frequently, other professions’ expertise went unrecognised and was generally undervalued, and Academic 25 offered another example wherein medical dominance was palpable and keenly felt:

*In the field, even if you work in private practice for example, even a simple receptionist will treat you differently to the way they treat a doctor, it’s on that level and it really hurts, this is lower down, you know what I mean* (Academic 25)?

And this participant continued with an example of the enactment of deference to medical doctors at the expense of other professionals:

*Even a question of a room, if it’s a choice between a doctor and another professional, who will be given the room? – The doctor* (Academic 25).

Some participants returned to the question of professional identity, arguing that the strong medical dominance permeating the local health services has a negative impact on their students’ developing sense of autonomy, competence and worth:

*The issue of autonomy comes in here as well and it would depend upon the area of practice. So, I teach community and one of the things which students have difficulty with identifying with is the fact that in the community they are not autonomous at all, decisions amongst the multidisciplinary team are taken by the doctor and that does influence the professional identity which the students, at the end of the day, develop* (Academic 33).

*Professional identity, I think they come with a lot, but then, unfortunately, when they come here and they visit the clinical practice, it kind of winds up*
and they see that they are kind of held back and constrained by the doctors (Academic 23).

In summary, comments coded to the subtheme ‘medical model reigns supreme’ reflect participants’ sense of discontent and frustration with medical dominance in the health and education sectors and in wider society. However this was not the whole picture; the next subtheme considers the resulting power struggles, not just between the medical and other professions, but also between the various allied health, midwifery and nursing professions themselves.

6.5.5 Hegemonies and Territoriality at the Faculty

I think what’s happening is a power struggle between each and every department – which shouldn’t be (Academic 3).

Fighting and trying to prove myself all the time, it really angers me that we are not considered as important as other professionals (Academic 37).

As exemplified in the above quotes, participants’ comments coded to this subtheme predominantly centred on issues related to, interprofessional rivalry and conflict and the implications of these power struggles for the development of professional identity. Professional identity, as suggested by Wackerhausen (2009) and as seen in Chapter 3, consists of both the “macro level” or “public face” of the profession, which leaders explicitly try to promote, and “micro level” (p. 459) professional identity, which is at the level of the practitioner and which refers to what it takes to be that particular health professional.

Participants emphasised that if IPE is to work, a first step would have to entail learning about each other’s professions:

I think every one of the disciplines here, I mean, I don’t know the philosophy or role of an X, I mean what we hear is ... So I think first we have to have good knowledge of each discipline, what it involves (Academic 19).

You can’t try and make people, you know, create links and create credits or
modules together if they don’t know at least the workings of your course (Academic 44).

A key informant concurred, arguing that lack of knowledge of other professions sets in motion a chain reaction of negativity that can only culminate in interprofessional conflict:

Not knowing creates ignorance, that creates prejudice, and then prejudice creates conflict, and it escalates (Key Informant).

And indeed, Academic 3 talked of living with such conflict over the past “twenty years:”

I don’t think any allied health care professional who’s working here should have a right to stop you from developing your course; something which unfortunately has been happening since Day One I was here, and that is now twenty years. Personally it is disappointing (Academic 3).

Academic 1 had also experienced interprofessional conflict, accounting for it as perhaps arising from some professions experiencing a sense of threat:

You might actually find that your plans are being hindered by other professions. I think that they’re the professions who maybe feel threatened about what you are proposing to do (Academic 1).

And Academic 8 agreed, suggesting that this sense of threat is all pervasive at the Faculty:

I mean the professions themselves - are we looking at each other as threats? I mean yes, I do feel that at this point in time, inside this Faculty, everybody feels threatened by other departments. That is how I feel (Academic 8).

And this sense of threat, participants suggested, can lead to staunch defensiveness that can only hinder IPE:
That change will take even longer in this area because the attitude I see right now in the health professions is we are too much defensive towards our own professions (Academic 51).

Competitiveness inherent in private practice beyond the Faculty, some participants suggested, may be one of the causes of defensiveness and territoriality within the Faculty. In other words, as Academic 3 demonstrated, some professions, for example Profession X, may be wary of sharing knowledge with Profession Y during IPE for fear that such knowledge could be used by Profession Y in private practice, thereby reducing the latter’s need to refer patients to Profession X, and ultimately, a reduction in referrals could translate into a reduction in earnings:

I do not want to show another professional how I do my thing because otherwise when he goes to [into] private practice he doesn’t need it. I honestly think that private practice is a big barrier – we are afraid to refer a patient because we might lose them (Academic 3).

Academic 50 pointed to a dilemma in reconciling sharing of knowledge or ‘cognitive maps’ during IPE, with maintaining the boundaries that define and delineate individual professional territories:

People want their boundaries. It’s true no man is an island, but we need to have our boundaries, and there are boundaries which sometimes I might not want you to cross, you know; and when you have this openness, this interprofessional education, sometimes those boundaries have to be crossed, by default (Academic 50).

Participants alluded to professional territories and boundaries in terms of both physical and conceptual ‘spaces.’ Academic 46 focused on the physical aspect of maintaining “strict” boundaries:

We have our X room and we feel we’re very defensive, no-one can use it, or else with very, very strict permission, so even there we tend to not even recognise this idea of each profession being equal and can contribute to each
While Academic 41 focused on the intangible or conceptual ‘spaces’ where boundaries are far more difficult to recognise and maintain and wherein IPE would pose profound challenge:

*I, as a lecturer, when I’m facing a multi audience, what is my position? Where am I going to stop? What am I going to say? Am I going to cover everything, or am I still going to hold back some information to tell it to my group only* (Academic 41)?

Discussions about professional territories and boundaries brought to the fore the question of student awareness and the acquisition of professional identity. Academic 46, who had referred to a need for strict boundaries in terms of physical space, continued the conversation in terms of a need for fostering in students a clear and definitive sense of their individual professional identities, suggesting that failure on the part of students to attain this strong sense of identity would signify that “there is a problem.”

*We are very careful to be specific in choosing subjects and choosing ways of delivering information that is completely identifiable with the definition of X. Now, so when a student qualifies he feels, immediately feels, that he’s an X and not something else – if the student doesn’t feel that way then there is a problem* (Academic 46).

Similarly, Academic 50, echoed Wackerhausen’s (2009) perspective on micro level identity as necessitating the practitioner to “be one of our kind” and “to stay one our kind ever after” (p. 461).

*I remember telling my students, the ones that are in first year this year, that ‘from now on you’re no longer normal, you’ve been tainted, even if you never become an X, something somewhere has given you a different outlook on life’* (Academic 50).
Taking up this thread, Academic 16 suggested that the varying strengths of students’ sense of professional identity could impact on the quality and outcome of their interactions in an IPE setting, almost depicting a ‘survival of the fittest’ scenario should an IPE initiative be implemented:

But we should remember that some professions always have had more prominence than others, so when they’re in their first and second year if you put them together, some professions might be so strong with their identity, that they might instil in the others actually ... it might dishearten the professions who are younger maybe, less established, it could work out that way as well (Academic 16).

Offering another perspective on this theme, Academic 28 provided insight into a rewarding sense of achievement and professional well-being that can be felt when a solid sense of professional identity has been attained and an individual profession has won recognition and respect from its peers:

Our profession is still growing and I think the way that we function within this Faculty, is that we are now an accepted element, an accepted part of it, and as such, I think people ask our opinion, they ask our help and I would say that we’ve moved from not being anything at all, one of those nebulous ideas, to something which is very practical and positive and is regarded, I think, amongst our colleagues as being worthwhile and quite credible (Academic 28).

By contrast, Academic 41 who had spoken about a quandary in identifying conceptual boundaries when “facing a multi audience”, talked of experiencing what might be considered an identity crisis arising from the experience of participating in a multiprofessional course outside of Malta:

But then at the end, the product was ‘what am I?’ And sometimes I felt as if part of the professional identity was lost, because you gain this collaborative practice but you don’t want too much of it because then you need to specialise in your profession, as well (Academic 41).
In summary, participants’ comments coded to the subtheme ‘hegemonies and territoriality at the Faculty’ predominantly centred on issues related to interprofessional rivalry and conflict, and the implications of these power struggles for the development of professional identity, and these key issues are discussed in further depth and detail in Chapter 7: Discussion.

6.5.6 Our Way of Doing Things

The attitude is difficult to change because it demands a change of how we look at the day-by-day, if you like, situation. So we love talking about our different subjects that are common to all but then when it comes to changing the way we deliver knowledge, or transfer knowledge, we take a step back because it’s an upheaval to how we do things here (Academic 46).

I think there would [needs to] be a big culture change needed in order for IPE to work (Academic 36).

It is about changing a culture. It is about changing the way in which we have been brought up to think that we need to operate (Key Informant).

What is interesting about participants’ comments coded to this subtheme is their frequent use of the word ‘we’ in the sense of ‘we as Maltese people’ rather than ‘we as professionals’ and in this way, participants shifted their focus from professional identity to national cultural identity.

As exemplified in the above quotes, comments coded to this subtheme encompassed participants’ perspectives on macro level factors and the implications of such factors for any potential IPE initiative, with many participants suggesting that IPE would demand profound cultural change, a huge departure from “our way of doing things,” and some participants expressing doubt about the compatibility of IPE with certain cultural traits, characteristics and behaviours.

For example, Academic 41 drew on prior participation in joint clinical sessions between different professionals and, as an outcome of these experiences, identified Maltese ‘self-consciousness’ as one such cultural trait that could work against IPE:
I think it’s also our culture that we do not like to perform in front of others. I feel it that as a Maltese, we are very conscious of ourselves. I think we are not assertive enough as a nation, and we may not be sure and confident enough (Academic 41).

While Academic 9 talked about a sense of insecurity translating into a tendency to ‘watch one’s back’ in the workplace as a feature in Maltese culture that would be at odds with IPE in practice:

What we’re saying is we have this culture where everybody is afraid that we’re going to take each other’s work (Academic 8).

Indeed, using the powerful metaphor of a tidal wave to represent change, Academic 50 suggested that making changes to their inherited and long-accepted habitual work practices could be devastating if not approached with extreme caution:

We’ll have to be very careful how we’re going to look forward to the future as well. I mean, if you create a tsunami you don’t know exactly what it’s going to clear and what it’s going to destroy (Academic 50).

Some participants suggested that the Maltese tend to import ideas and practices from abroad without trying to contextualise them to the national culture, while Academic 16 referred to a certain spontaneity in Maltese culture that can give rise to inclinations to run with an idea without contemplating its implications, anticipating its outcomes or planning for its implementation:

You know, we are in Malta, sometimes things ... somebody gets an idea and says ‘let’s do this’ and they do it without real preparation (Academic 16).

A key informant agreed that there seemed to be an ingrained cultural pattern of initiating projects without thinking about the longer-term issues of continuity and sustainability:
We kind of focus very much on the present, you know, and that’s it. There doesn’t seem to be a continuity, a consistent synergy of planning, which is supposedly the policy design over decades or over a number of years (Key Informant).

Over the course of discussions on Maltese culture, participants shifted their focus beyond factors they identified as national traits and behaviours to considering national systems and structures that may inhibit the development and growth of IPE. For instance, if, as some participants suggested, implementing IPE would require a “paradigm shift,” it could be argued that bringing about such a paradigm shift would call for wide-ranging interprofessional dialogue and exchange of ideas as a vital component in developing innovative educational practices; yet, a key informant suggested that having only one university on the island limits the parameters in which such cross-discipline debate could occur:

One point which actually makes the situation more difficult is that there is only one university here so we, as academics, cannot move around, this makes our island even smaller, there is no interchange of ideas, new blood, et cetera (Key Informant).

Expanding on the theme of national systems and structures, a key informant pointed to practices in the pre-university education system that most likely groom students to be almost docile receivers of knowledge, to be passive listeners rather than active participants in the learning process:

The students, I don’t know whether you do, but I tell my students I’m going to talk about such-and-such tomorrow, I want you to read the chapter and we can have an interactive discussion,’ does it happen? No. I’m asking questions and I’m getting no answers – and that comes from our schools. Now maybe things are changing slightly, maybe they are, but in my day it was unheard of, you just had to sit there and listen (Key Informant).
And keeping on the topic of the role of the school experience in shaping behaviours, a key informant sought to explain poor teamwork standards identified earlier as a by-product of schoolyard experiences:

*Why are we Maltese not strong team players? I once read that this might be explained by the lack of team sport that our youngsters practise during their school days, starting from very young (Key Informant).*

And this key informant extended his account into the academic realm wherein a resultant “fierce independence” impedes the strong teamwork that would be essential to any possible IPE initiative:

*Obviously in an academic setting again one has to be very respectful of the context and the way in which people operate within this context. So there is a fierce independence which is enjoyed by each department but this fierce independence sometimes hinders teamwork and hinders effective communication (Key Informant).*

And if good teamwork is vital to the success of any interprofessional initiative, so too, participants suggested, is strong leadership and commitment at institutional and at faculty level, for without such vision and guidance any attempts at IPE, they argued, would fail:

*Unless we are guided and moved by the right people at the right time, IPE will not work (Academic 30).*

*The Dean has to be convinced, because it has to come from the very top (Academic 9).*

*You can’t implement something unless the policy holders accept the idea. So until the administrative bodies within the University tell us that IPE is possible, then let us design a course in which IPE or certain components of it is allowed, until then you can never have one (Academic 27).*
While participants identified good teamwork and strong leadership as central ingredients for successful IPE, analysis of their discussions has shown that they perceived poor teamwork to be a feature of Maltese culture and, in a similar vein, they, particularly key informants, talked of limited and poor experiences of leadership:

*Our experience of leadership is very limited, in my opinion* (Key Informant).

*I mean even to get what is the policy, what is the strategic direction ... I mean very often we get orders, directions, from different areas* (Key Informant).

Some participants suggested that this lack of clear direction and issuing of “orders” that are neither coherent nor consistent, manifests as interactions that are “interfering” rather than collaborative:

*And what we have seen happening in Malta, and what we see par excellence happening right now in Malta, is a super politicisation of the technical aspects of our work. The Ministry of Education interferes in what the University has to do, the Minister for Health interferes in what is happening at the micro level in the health centre, in a hospital, in some division* (Key Informant).

In seeking explanation for poor leadership participants perceived to be a feature of Maltese culture, a key informant turned to its historical legacy:

*When one thinks about the whole history of Malta and where we’re coming from, one actually notices, or at least tracks a trend, that the Maltese people have been led for many centuries as opposed to they lead [them leading] others. So one has to look at this factor when one starts to plan and design leadership projects within Malta, whether it’s at the University which is shaping other people and preparing them for the future, or the departments within the Faculty of Health Science, these people rarely, if ever, receive good, proper, training and development in leadership and management, and*
if the leader does not know about these things, things just continue to roll and evolve as we know, and very often it is in an ignorant and destructive way, rather than constructive (Key Informant).

This key informant offered an interesting perspective on historical reasons that may account for poor leadership traits in Maltese culture identified by the study participants; and in talking of inexperienced leadership that may even operate “in an ignorant and destructive way” this participant clearly underscores a need for intensive training in leadership and management skills as a prerequisite to any possible IPE initiative in Malta. This is not to suggest that all post holders in leadership positions in Malta are lacking in leadership qualities or competencies, rather, it is to take heed of the study participants’ comments on leadership brought up when expressing their views on IPE.

In summary, comments coded to this subtheme encompassed participants’ perspectives on macro level factors and the implications of such factors for any potential IPE initiative, with many participants suggesting that IPE would demand profound cultural change, a huge departure from “our way of doing things”, and some participants expressing doubt about the compatibility of IPE with certain cultural traits, characteristics and behaviours.

### 6.6 Conclusion

This chapter presented the findings generated from the process of data analysis by which two master themes were identified: ‘The Idea of IPE’ and ‘The Reality of IPE’, consisting of eleven subthemes encapsulating key issues and concerns raised by the study participants.

In their discussions of IPE as an idea, and as a possible reality, participants engaged with this complex topic at the interrelated micro (individual), meso (organisational/institutional) and macro (national culture) levels, offering a rich array of perspectives and insights. It was my task to tease out possible meanings, interpretations and implications of participants’ discourses and thus discussion of each subtheme offered extracts from such discourses accompanied by my analysis of their possible significance. This process resonates with Blaikie’s (2007) meaning of
abduction as “discovering why people do what they do by uncovering the largely
tacit, mutual knowledge, the symbolic meanings, intentions and rules which provide
the orientations for their actions” (p. 90); a process that is in keeping with a social
constructionist and insider perspective which this work espouses. Following from
this process, the chapter now closes with a summary of key themes and issues
identified across all subthemes as encapsulating the principal perspectives,
viewpoints and concerns of the study participants.

It was noted that, for some participants, the focus group sessions and interviews were
the first occasion in which they had heard of IPE so they were attempting to
understand its intricacies and consider its implications as the discussions were
unfolding. In their discourses on IPE as an idea, participants eagerly pointed to its
potential as a good mechanism for understanding the professional roles of others and
improving day-to-day working relationships, for enhancing the quality of patient
care and for making good use of limited resources. Some participants suggested that
the diversity of professions housed within one building and experiencing a new-
found sense of identity as a faculty (as opposed to an institute), constituted ready-to-
hand raw material for developing intra faculty IPE, although, they suggested, the
building’s distance from the main campus might not be so convenient for developing
inter faculty IPE.

It was predominantly in their discourses on IPE as a potential reality that participants
pointed to a wide range of factors, in the symbolic and practical realms, they
perceived as posing challenges and barriers to IPE.

In the practical domain, participants suggested that IPE would, mostly likely, add to
logistical and resource problems they were already facing on a daily basis, such as:
lecture scheduling problems, overburdened workloads of academics and students,
large numbers of students in courses and lack of adequate physical space to
accommodate delivery of IPE. A number of academics pointed to potential
complications in terms of accrediting IPE courses.

While agreeing that good teamwork cohered by strong leadership would be a
fundamental prerequisite to the development and success of any IPE initiative,
participants, drawing on their everyday experiences and observations, concluded that teamwork is generally poor in Malta, with some key informants suggesting that sometimes good leadership and management skills can be lacking, and one key informant offered an interesting perspective in that Malta’s history as a nation that has been ‘led for many centuries’ may explain this lack.

In the less tangible or symbolic domain, the question of professional identity emerged as a recurring issue of significance in analysis of participants’ discourses across several of the subthemes discussed in this chapter. It may be noted that notwithstanding the extended number of years working in academia (as seen in Appendix 16), academics who took part in this study first and foremost identified themselves as professionals rather than teachers *per se*, most likely because they had not trained nor started out on their careers as teachers but as health care practitioners and had later entered academia. In relation to the issue of professional identity, and indeed professional status, participants expressed concerns about medical hegemony over other health professions, about rivalries and battles for hegemony in between these health professions, about the question of identifying and maintaining conceptual territories and boundaries, and about the possibility that IPE could manifest in the dilution of health care professions.

It was interesting to note that participants sometimes shifted from talking about ‘we’ as professionals to ‘we’ as Maltese people, discussing features of Maltese culture that might account for some of the barriers they identified to IPE. In such discussions, participants talked about characteristics, traits and behaviours they perceived as inherent in the culture that would run counter to the principles of IPE, suggesting unconscious and/or taken for granted beliefs and values encapsulating “the general spirit of a nation” (Montesquieu, 2004, p. 216). They discussed such traits and behaviours, both at the level of the individual and of the established systems and structures, concluding, as summarised by Academic 36: “*there would [needs to] be a big culture change needed in order for IPE to work.*”

Having abstracted from across all the subthemes, the key issues and concerns of particular significance to the participants and relevance to the research questions, the
chapter to follow places these themes and issues in dialogue with relevant theoretical perspectives drawn from the literature.

6.7 The Inward Eye

The entire process of writing this findings chapter was fraught with struggles; struggles in ensuring that I was being faithful and respectful to participants’ accounts, struggles to be fair to the multiple voices, as well as to the single voice and struggles to represent and to capture the multilayered and multivoiced discourses of participants. At the end of this chapter I am quite confident that I achieved this.

The process was arduous; I tore the themes apart once, twice ... innumerable times and then put them together in different ways. I created temporary themes and left them there stuck on a chart in front of my desk. This helped me make sense of them and see if after a few days ... weeks, I felt that they still captured the essence of the participants’ discussions and interactions. Some themes worked and some did not. I started seeing the many points of convergences, as well as the inconsistencies and sometimes paradoxical findings in my data. This immersion in the data was intense and permeated my whole being. Slowly, I was getting closer to my participants’ worlds and truths and that made me see the world differently.

Stake’s (1995) words echoing that case study research should not only be what the ‘case is but also what the case is not’ encouraged me to go on ... what started as an exploration into potential IPE at the Faculty of Health Sciences as it was first anticipated ended up unearthing why developing and delivering IPE would be greatly influenced by determinants both inside and outside the organisation.

This construction was obviously supported by my understanding of the research context itself, its historical and cultural backgrounds and my role in it. I was not just a researcher; I was an integral member of this community. I started to hear my participants’ voices in other situations. Suddenly, everyday scenarios started to resonate with some of the paradoxes emerging from the findings. This transcended spaces other than academic contexts and I found myself questioning my normal daily activities, my routines, my relationships ... things that I used to take for granted: social constructions of professions, university structures, professional and human
relationships. What was considered ‘normal’ suddenly seemed different. I learnt to become the observer and the observed. And allowing this new perspective to infiltrate my thoughts seemed to enrich my knowing and being.
Chapter 7  Discussion

Interprofessional education ... is an opportunity to not only change the way we think about educating future health workers, but is an opportunity to step back and reconsider the traditional means of health care delivery. I think that what we’re talking about is not just a change in educational practices, but a change in the culture of medicine and health care (Student Leader, WHO, 2010, p. 6).

7.1 Introduction

As shown in the findings chapter, participants engaged with the topic of IPE at micro (individual), meso (organisational) and macro (national culture) levels, discussing it as an idea and as a possible reality. It was noted that participants were predominantly optimistic when exploring IPE as an idea, eagerly highlighting a wide range of potential positive outcomes for the student, for the professional environment, and ultimately for the patient. Yet, when debating IPE as a possible reality, participants were predominantly pessimistic, suggesting a multiplicity of factors, in the symbolic and practical realms, they perceived as posing immense challenges and barriers to IPE; immense almost to the point of rendering IPE an impossibility for the Faculty and the University. This gap or dissonance created incongruity between the two themes: between the ideal and the real, as typified in the following comment:

*I would say [that] in theory IPE [is] an excellent concept, however the difficulty comes in implementing it* (Academic 23).

And this dissonance was most apparent in academics’ discourses, perhaps reflecting their experience and knowledge of day-to-day realities of faculty and university life and the complexities required when implementing new approaches within these contexts. Some participants equated IPE with a ‘quantum leap’ that would demand ‘a leap of faith,’ ‘a paradigm shift’ and ‘an evolution in the culture’ that would lead
to ‘a different social world.’ These attitudes bring to mind Colyer’s (2008) evidence of a “cultural lag” (p. 126) in the UK, whereby despite the political and professional climate supporting IPE, faculty academics could not commit wholeheartedly to the philosophy of IPE. Similar to my findings, there seemed to be a dissonance between how Colyer’s respondents rated IPE and the way they actually expressed themselves.

Before placing the study findings in dialogue with the literature it is necessary to recap on the key findings and explain my search for an appropriate conceptual framework within which I might organise and explore their significance.

### 7.2 Summary of Key Findings

Although commending IPE as an idea, the participants in this study brought up a wide range of challenges that were diverse in their significance and complexity; some might be described as symbolic, while others were rooted in the practical domain of the systems and structures that govern university life.

In the practical domain, the participants recognised that IPE would add to the logistical and resource challenges they were already facing as a faculty. IPE seemed to be unachievable within the current University structures and curricula; moreover the urgency for change was not there.

While agreeing that good teamwork and strong leadership would be a fundamental prerequisite to the development and success of any IPE initiative, participants concluded that teamwork is generally poor in Malta, both in academia and in health service delivery. Some key informants considered that leadership and management skills can sometimes be lacking in Malta with one key informant suggesting that this could possibly be due to the country being “led for many centuries.”

In the less tangible or symbolic domain, participants were concerned that IPE could threaten their professional boundaries and might lead to the dilution of their professional identity. They expressed concerns about strong professional hegemonies, rivalries and territorialities between medical doctors and other health professionals, as well as between the health professionals themselves. Participants talked about characteristics, traits and behaviours they perceived as inherent in the
culture of Maltese people that would run counter to the principles of IPE. They discussed these traits both at the level of the individual and at a wider level of the local cultural milieu.

Having identified the key themes and issues of concern to the participants, rooted in the practical and symbolic realms, I decided to exclude discussion of the practical institutional and organisational issues from this chapter and concentrate on seeking a conceptual framework that might help illuminate the less tangible aspects of my findings. I made this decision on the basis that practical issues such as level of resources, time tabling issues, workload levels, student numbers and physical space, constitute operational challenges requiring tangible solutions at the level of the organisation; and that organisational practices and operational constraints are particular to individual organisations and would need to be addressed differently in every case. Furthermore, operational practices and constraints generally represent factual barriers and to discuss them would be to move away from the constructionist and interpretative philosophy guiding this work. Instead, this chapter focuses on the major issues and concerns raised by participants in relation to the interrelated complex questions of professional socialisation and the acquisition of professional identity, professional territoriality, rivalries and struggles for hegemony. In addition, and mirroring the participants’ discourses, the chapter explores, considers and interprets the role national culture may play in relation to IPE. My next task then lay in identifying an appropriate conceptual framework within which I might organise and explore the significance of my findings.

7.3 In Search of a Conceptual Framework for the Findings

At this stage, I engaged in what Simons refers to as “dancing with the data” (Simons, 2009, p.140) which is one way that data analysis and interpretation would culminate into the case study story. This was a creative process and entailed not only reading and re-reading the data and placing it in context but seeing it from different angles adding on another sense of ‘knowing’ of what is embedded in the data. Simons (2009) sees this process as an “interpretative form of thematic analysis that gains depth, insight, and holistic understanding” (p. 140) and this resoundingly encapsulated my process. I wanted to unearth, understand and theorise possible
reasons for the dissonance between the ‘ideal’ and the ‘real’ and the extent to which this may reflect participants’ ideas and beliefs; this was congruent with my interpretative theoretical perspective in providing deep insights into “the complex world of lived experience from the point of view of those who live it” (Schwandt, 1994, p. 118). Schwandt’s thinking supported my analysis by raising my awareness to the various contexts from which participants’ discourses emerged and the need to untangle them and look at different layers of meanings and nuances. The process of generating theoretical abstractions so as to anchor and provide a wider conceptual framework for my findings was akin to “the analytic equivalent of putting mortar in between the building blocks” (Dey, 2003, p. 48). It was also the process of making connections, looking beyond and transcending the tangible facts emanating from the findings so as to engage in higher order reconceptualisation.

From the outset, I realised that utilising one theoretical perspective or one system of thought to understand the social constructions of my participants’ worlds was impossible and so I drew on a wider pool of literature than the IPE literature. Theories with a social dimension seemed to resonate and offer insights into my findings, however, even within this field, I was still looking at diverse bodies of knowledge, namely Sociology, Social Psychology and Anthropological Literature.

Due to the myriad range of theoretical perspectives that might illuminate my findings, I decided to adopt an interdisciplinary approach. In other words, I would draw from a conceptual ‘tool-box’ a variety of theoretical perspectives, based on their suitability to articulate or improve my emerging insights and understandings (Hean, Craddock & Hammick, 2012). These various analytical ‘tools’ provided me with diverse insights into my findings and encouraged me to engage in “second order reflection” (p. 466), during which common and familiar practices were viewed from unfamiliar perspectives and eventually reexamined (Wackerhausen, 2009). And through this process, I developed the following conceptual framework made up of a tapestry of findings (through my themes and subthemes) interpreted through various theoretical perspectives/lenses I deemed most suitable for critically exploring, examining and perhaps finding explanations for these findings (Figure 7.1).
Figure 7.1 Conceptual framework to explore and interpret the Findings

Whilst developing this conceptual framework, the various theoretical perspectives helped me recognise how the “bigger picture” (Richards, 2009, p.173) issues emanating from this case study (that is the major issues and concerns raised by the study participants as presented in Chapter 6, Findings) resonate with the wider literature, that is, what is universal or common to all (or almost all) IPE contexts, and what is contextual (particular) to the Maltese context.

The left hand side of Figure 7.1 represents socio-historical perspectives influencing IPE and these are universal. The right hand side focuses on contextual socio-cultural concerns which, although particular to Malta, may also resonate with other countries that share similar contextual features. Although these universal and contextual lenses will be discussed separately, there is interdependency and overlapping between them, supporting Burr’s (1995) thinking on social constructionism that the
ways in which we commonly understand the world are historically and culturally situated. The sections to follow discuss how each of these theoretical lenses provide further insights and interpretations of my findings, particularly the dissonance between the ideal and the real. These debates should not be perceived as being negative but as prominent, overarching and intertwining theoretical constructs which could challenge the status quo and the predominant orthodoxy at the Faculty and the University. Figure 7.1, representing my conceptual framework for this study, will be broken down into its relevant components to accompany discussion of the various theoretical lenses as the chapter progresses.

7.4 The Inward Eye

My findings reflected the IPE literature...but they also departed from it. I enjoyed the sense of exploration ... looking beyond more than one discipline for new understandings and interpretations of my findings. I did not want to just consider participants’ words but also what was between those words; I wanted to transcend the realities of participant’ discourses and capture them into a succinct form. Considering all possible theoretical abstractions seemed but an impossible endeavour. I had to come to terms that certain threads would remain unexplored for now. But would that be doing justice to participants’ voices? Would the picture be different if other theories and theorists were employed? And what would happen if I used one major theoretical perspective? At these points, I remembered reading that in developing a conceptual framework, the researcher needs to be selective so as to decide on the key features of the study. With this in mind, I can thus only claim tentative interpretations of my findings; interpretations which have been influenced by my assumptions, knowledge, experiences and values.

7.5 Sociological Lenses [Universal Perspectives]

7.5.1 Socio-historical Analysis of the Discourse of Professionalism

The findings chapter discussed participants’ strongly held sense of dissatisfaction with medical dominance in the health and academic sectors (in subtheme ‘Medical model reigns supreme’), as well as in wider society; and, apart from medical hegemony over all health professions, participants were also concerned about
conflicts and rivalries at play between health professions at the Faculty (in subtheme ‘Hegemonies and territoriality at the faculty’). These interprofessional tensions, they suggested, would render IPE unworkable.

It was therefore imperative that I make sense of these findings by exploring the origins of conflict and theoretical perspectives on power structures and boundary conflicts between health professions. Socio-historical lenses analysing the discourse of professionalism, discussed briefly within the presage context in the Literature Review, proved to be a relevant analytic tool for this exploration as shown in Figure 7.2. Such perspectives provide a “critical framing of interprofessional activities to understand how micro interactions between professions are enacted within larger political, social and economic structures” in society (Reeves 2010, p. 218); these perspectives however have been largely underrepresented in the IPE literature (Reeves, 2011).

Figure 7.2  Socio-historical analysis of the discourse of professionalism
It is important to distinguish again between the concepts of professionalism and professionalisation. Professionalism may be defined as an occupational value that provides stability at the macro level of a society, while professionalisation may be considered as the processes that occupations engage in, so as to ensure market closure for that particular occupation (Evetts, 2005).

From its earliest roots, the discipline of sociology, that is, the academic study of a society’s systems and structures incorporated two competing schools of thought on how society may be analysed: the functionalist and conflict perspectives. The functionalist approach examines society as a unit that operates on the basis of consensus, that is, agreed and shared values, norms and beliefs. Society is explained in terms of its institutions or ‘organs,’ such as school, family, industry, which, through the way they interact, achieve social cohesion or the proper functioning of the ‘body’ of society. In this view, the function of each institution is to reproduce society in a way that will allow it to continue from one generation to the next. For education, this involves teaching in a way that transmits a selected set of traditions and values to the next generation and socialising students so they can fit into their future roles in society (Mooney, Knox & Schacht, 2007; Parsons, 1964; Slatterly, 2003).

Writing in the 1960’s, Talcott Parsons examined society as a complex system which achieves integration and functional stability through consensus around broad moral principles. He developed a model of society in which culture, social structure and personality are linked together in a logical and coherent way. The cultural system is made up of the values shared by all members of society; the social system is made up of social roles; and the personality system or individual personality is composed of motives and needs, and while some needs or motives may be innate, they are primarily social in nature and are acquired during the socialisation process. In Parsons’ view, the relationship between these systems is hierarchical: the cultural system controls the social system which, in turn, controls the personality system.

For Parsons, the broad values of society define the nature of the role persons are expected to play. Individual choices then, are understood by Parsons, as being resolved by reference to the moral standards of the cultural system. Society
therefore, coheres individuals into their appropriate roles, since the individual, through socialisation, has internalised its moral values and thus feels obliged to fulfil his expected role (Parsons, 1964; Parsons, Shils & Smelser, 1965). For Parsons, the existence of common culture, or a commonly shared system of symbols, whose meanings are understood, is crucial to the stability of the social system. Culture is transmitted and learnt through the social process, which itself determines the system of social interaction. Thus:

A social system is a function of common culture, which not only forms the basis of intercommunication of its members, but which defines, and so in one sense determines, the relative statuses of its members (Parsons, 1964, p. 22).

To summarise, key assumptions about society and education underpinning the functionalist perspective include the premises that society operates on the basis of consensus among its members, all members share the same norms and values; the maintenance and conservation of society takes precedence over any ideas of social change; education is an integrating and stabilising force responsible for the selection and allocation of human capital and its role is the transmission of knowledge to ensure that individuals have appropriate skills and learning for their respective roles in society; inequality is socially acceptable, it represents different abilities which respond to the different needs of society and unequal distribution of power reflects natural differences in abilities and efforts (Parsons, 1964; Parsons et al., 1965; Slatterly, 2003).

Conflict theorists, by contrast, reject the notion of consensus outright. This approach draws upon, develops and expands on the works of Karl Marx and Max Weber, whereby society is examined as a hierarchical and antagonistic set of social relations characterised by the oppression of subordinate groups by dominant ones. This approach variously focuses on the workings of social, political, economic and cultural systems and structures. The concept of ideology is central to this theoretical framework which holds that all communication and all meanings have a socio-political dimension: the groups with power dominate not only the production and distribution of goods, but also ideas and meanings; the economic system is organised in their interest and the ideological system derives from it. The ideological system
could be described as the set of cultural beliefs and practices operative in a society – it is the way things are. Theorists from this school of thought are concerned with the way ideologies function to maintain inequalities in the social order. They look at how the ideologies of dominant groups are constructed, perpetuated and reproduced through the various systems and structures of a society (Mooney et al., 2007; Slatterly, 2003). In this endeavour, such theorists draw on Gramsci's (1971) concept of hegemony or ideology as struggle, in which hegemony is attained through winning the consent of the oppressed to the constructed social order. However, this victory is never complete nor stable; resistances arise because of the contradictory experiences of everyday life. The struggle is constant and any ground won by the dominant ideology has to be constantly defended and actively held on to. The hegemonic process is therefore a dynamic of control, resistance and counter resistance. Counter resistance involves incorporating resistances into the dominant ideology by granting certain concessions to avert substantial change and maintain the established order (Hoffman, 1988; Slatterly, 2003).

Sociological theorists already discussed in the Literature Review, such as Freidson (1973; 1988a; 1988b; 1994), Larkin (1983) and Larson (1977) may be considered conflict theorists as they are critical of the functionalist perspective and focus on the complex processes and practices by which various occupational groups attain and retain their status and power in society. Indeed, it was interesting to note in the findings chapter that Academic 38 focused on process when proposing the concept of “professional indeterminacy” as a way of explaining how doctors attain dominance over other professions.

Turner (1995) adds to the work of conflict theorists in identifying a three-stranded process whereby, the medical profession in particular, sustains and reproduces its dominance over other health professions. In Turner’s model, these processes or practices are termed “subordination,” “limitation” and “exclusion” (p. 138) and examples of such practices may be evidenced in this study’s findings, both by the medical profession and between the other health professions. Turner holds that ‘subordination’ of activities to other groups limits that particular profession’s scope for autonomy and self-regulation and this is echoed in the discourse of Academic 23:
But our major role is having normal birth. Now the barriers are that our approach to care is medicalised, so sometimes we are faced with the problem that, for example, we prepare the midwife how to take care of a mother independently, and to do her antenatal care, but unfortunately this does not happen. So the midwife is prepared, but she has to work in conjunction with the doctor. Doctors are very much on guard on what this midwife is doing, and he prefers that the midwife does what he says, not what she was trained to do (Academic 23).

Turner’s concept of ‘limitation’, involving various forms of containment to a specific body part (such as dentistry) or therapeutic process (such as pharmacy) thus restricting the scope of practice, may also be evidenced in this study:

Right now we are bruised because of the way we have been treated vis-à-vis extending the qualification. I mean, what we have been told shows that there are classes of professionality – let me put it that way – and that these classes are not treated the same by the organisations (Academic 41).

Finally, in Turner’s model, ‘exclusion’ refers to the process whereby alternative and competing medical practices are denied legitimization through registration, which follows from the reality that physicians play a crucial role in registration boards of such occupations, and Academic 1 anticipated experiencing such exclusion:

I would have loved to include prescription medicines for example, for prescribing, medical prescribing, but I’m sure really at the pharmacology and the medical, that lot, you’re going to find a lot of resistance about that (Academic 1).

The Literature Review discussed how medical dominance is reproduced through the ‘professional project’ which is more far reaching than the simple acquisition of expertise translating into upper social mobility and higher status. This project is a strategic and ongoing process in which professionals persuade others of their claim to professional status and its rewards, through displays of expert knowledge and
skills (Larson, 1977; MacDonald, 1995). Academic 23 offered one such example of a novice medic enacting the ‘professional project’ through the ‘display’ of expertise:

The newly qualified doctor has never touched a needle and they suture, but the X that has, she’s not allowed because she’s called an X, and this doctor, brand new, poor him, he is still shivering with his needle (Academic 23).

Reeves et al. (2010a) suggest that health care professions are not only subordinated and limited by medicine but they themselves engage in processes and practices aimed at establishing relative rank and status thereby perpetuating a hierarchical order and “compounding the problem” (p. 262). And indeed, the study participants spoke at length about conflicts and rivalries at play between health professions at the Faculty suggesting that such interprofessional tensions would render IPE unworkable. This tension may be illustrated in the stroke symposium previously discussed in Chapter 2: Setting the Scene, Part 1 and Chapter 6: Findings. According to the participants, this event not only exemplified medical dominance but also the lack of cooperation and the escalation of rivalries between health care professionals who viewed it as an opportunity to show and assert dominance over certain areas of knowledge and/or therapeutic methods. The extent of this tension is best described by Academic 1:

And I remember there was someone saying ‘who does the hand belong to - physiotherapists or occupational therapists?’ – And we said the hand belongs to the patient (Academic 1)!

Such tensions reflect Hugman’s (1991) concept of “lateral closure” which refers to conflict and competition over a contended area of expertise between occupations of similar status and power (p. 101).

Many theorists in the sociological literature offer explanations of how professional groups who were subordinated and excluded by medicine, established their own relative power and status over other professions. For example, Larkin’s (1983) concept of ‘occupational imperialism’ refers to struggles between the medical and paramedical professions which, although practiced most successfully by the medical
profession, also took place between the paramedical professions themselves. In his study of four paramedical groups from the 1900s to the 1960s, Larkin (1983) describes how these groups historically all sought a form of monopoly so as to control the division of labour; they thus engaged in complex struggles between each other so as to dominate over their occupational space and to ensure that it will not be encroached upon from potential rivals or other competitor groups. On a similar note, Halpern (1992) observes that another way in which professions attempt to avoid competition is to transfer certain specialised aspects of their profession to a subdivision of that profession, thus discouraging neighbouring occupations from encroaching on that territory and this is illustrated by Academic 37.

_We have become very protective of our profession and don’t want to share, or we take it to the other extreme and we become a specialist_ (Academic 37).

These strategies could all be perceived as ways of creating certainty (fencing off an area) in a climate of uncertainty (boundaries being encroached by other professions) and this sits well with the social exclusivity that professions aim for. As discussed in the Literature Review, Larson (1977) proposed that the creation of occupational groups was, in effect, the result of critical engineering on the part of professions in translating their special knowledge and skills into social mobility and economic rewards, a process akin to market closure securing economic and status rewards. These professions then negotiated a relationship with the state and society to ensure that their specialised knowledge and skills remained solely within their control. The successful outcome of this negotiation was state registration or licence to practice; it was also a means of controlling the profession by the professions’ own self-governing agencies and by their membership.

In the nineteenth century, the medical profession was the first health occupation to successfully engage in professionalisation, becoming powerful enough to be able to dominate other professions engaged in health care activities (Larkin, 1983; MacDonald, 1995); and, it may be said, despite resistances and the growth of a multiplicity of specialities, this dominance still exists to the present day. Indeed, as Larkin (1983) notes, while a renegotiation of boundaries could alleviate this power hierarchy, it could never be sufficient to equalise medical dominance. So, how have
other health professions addressed the professionalisation of their occupations? The next section outlines the evolution and development of some of the other health professions and discusses how all this relates to the findings most evident in sub-theme ‘Hegemonies and territoriality at the faculty.’

7.5.1.1 Interprofessional Hegemonies and Hierarchies between Nursing, Midwifery and Allied Health Professions

The professions of nursing, remedial therapies and social work have variously been referred to as: emerging or marginal professions (Barber, 1963); semi-professions (Etzioni, 1969); paramedical or paraprofessional (Freidson, 1988a; Larkin, 1983); professions ancillary to medicine (Watkins, 1987); and the caring professions (Hugman, 1991). Generally, while these professions possessed some attributes that might define them as a full profession, they were lacking in others (Hugman, 1991). For example, by comparison with the field of medicine, they lacked scientific foundations and a robust knowledge base, they lacked self-government (Etzioni, 1969) and were engaged in healing activities which were ultimately controlled by physicians (Freidson, 1988a). Thus excluded from the central role of diagnosis, smaller health occupations began to organise their tasks around the central role of the physician who acted as supervisor to these subordinate groups.

Over the years, contrary to the medical professions who were encouraged to regulate themselves, professions supplementary to medicine such as, nursing and midwifery, were subject to the state’s imposed regulatory reforms (Larkin, 1983). It is noteworthy that the growth of nursing, remedial therapies and social work professions unfolded within a developing welfare state in which the state exerted control over the professions through legal, political and financial structures. Hierarchy, in its various forms, was prevalent in every aspect of public life and was one of the most fundamental features of social relations, and, it could be argued, still is (Hugman, 1991). Hence, the state mediated between the professions and their clients, as well as between the professions themselves. The power entrusted to a profession was dependent upon the negotiations achieved with the state and since medicine had a greater influence on the state, it enshrined its control over nursing and other remedial therapies. In the United Kingdom, it would not be until 1902 that registration for midwives would be granted, forty four years after state registration
for the medical profession which had been granted in 1858. Nursing obtained state registration in 1919 and allied health professions in 1960: sixty one and a hundred and two years respectively later than the medical profession (Larkin, 1983).

Medicine in Malta has been regulated since the time of the Order of the Knights of St. John, as early as 1724. Regulation for the other health care professions occurred centuries later with the regulation for midwives in 1901 (R. Borg-Xuereb, personal communication, December 11th, 2013), for nurses in 1936 (Bonavia, 2007), and for allied health professions in 1984 (G. Mifsud, personal communication, December 4th, 2013). Similar to the medical profession and what happened in Anglo-American contexts, over the years Maltese nursing, midwifery and allied health care professions have organised themselves so as to increase their autonomy, both as perceived by the general public and by the professions themselves. Albeit on different journeys, these professions have developed university-based programmes, secured state registration and established their status with the public. Professionals working in academia have also been encouraged to read for doctorate degrees so as to improve scholarship for the various professions.

Some scholars suggest that medical dominance is less pervasive today than decades ago (Coburn, 2006). For example, major restructuring in health care services has shifted control and power from the professions to the state (or corporate sector) and this has contributed to a blurring of roles between management and professions. The influx of economists and state bureaucrats influencing health policy has contributed to diluting medicine’s dominance (Engel & Gursky, 2004; Coburn, 2006; Cruess, Johnston & Cruess, 2002). Complementary and alternative medicine slowly became more credible when “health care became more than medicine and health became more than health care” (Coburn, 2006, p. 437). Nursing and a number of allied health professions have challenged traditional disciplinary boundaries by carrying out tasks which conventionally belonged to the medical profession, for example, when non-physician health professionals were given prescribing powers (Nacarrow & Borthwick, 2005). Moreover the high status of medicine has been further dented by the much-publicised medical errors during which the medical profession was perceived to have failed in regulating its own competencies by putting its own
interest above that of public safety (Cruess et al. 2002); such errors were identified in the Literature Review as contributing to a push towards IPE and IPC.

The Maltese context has mirrored these developments in health care practices and management. For example, financial controllers, economists and managers have, in recent years, been heavily involved in health policy restructuring and management, in contrast to earlier practices where decisions were the sole remit of physicians. Changing demographics and increased specialisation in certain areas have necessitated an increased demand for nursing, midwifery and allied health care professionals, as opposed to just medical doctors. The Ministry of Health has acknowledged the significance of these professions by recruiting specific directors for these areas\(^{72}\) and endorsing collective agreements outlining career pathways. Complementary and alternative medicines have become more mainstream.

Of note here is Freidson (1973, 1988a) and his contemporaries, who decades ago, argued that although paramedical occupations had been successful in legitimising their professions,\(^{73}\) their autonomy continues to be relative in comparison to the absolute autonomy enjoyed by the medical profession; and as recently as five years ago, Nugus et al. (2010) suggested that despite considerable global and socio-political changes, the medical profession still seems to be the most powerful profession, both internationally and locally. And indeed, based on the findings of this study, the medical profession’s continued dominance over the various allied health professions cannot realistically be disputed.

Chapter 6 showed that the question of professional identity emerged as a strong and recurring theme in the analysis of participant’s discourses and that they were concerned about this issue both at micro and macro levels; that is, according to Wackerhausen’s (2009) concepts of micro level as constituting the individual practitioner’s sense of professional identity, and macro level identity as the ‘public face’ of a profession. In other words, participants were concerned with the professional socialisation process and acquisition of professional identity at the level

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\(^{72}\) In the past, medical, dentistry, nursing, midwifery and allied health professions fell under the responsibility of one generic Director of Health Services.

\(^{73}\) This included moving into the higher education arena, developing formal curricula, creating theory to underpin their knowledge, developing codes of ethics and obtaining licences to practice.
of the student and/or practitioner as well as being concerned about how their respective professions were perceived by other professions and the public.

At the micro level of professional identity, participants spoke about curriculum cram as a barrier to IPE, in the sense that it would lessen the time that educators would otherwise devote to imparting essential theoretical knowledge and practical skills of the profession. Dall’Alba (2009) emphasises that learning to become a professional goes well beyond what one knows, or what one is able to do, and whilst a skills-based education is necessary, it would be insufficient for skilful practice and for the transformation of the self (skills necessary for proper engagement in IPE); professional education should involve ambiguous ways of enculturing professionals to become professionals themselves, as well as with others involved in that process. Dall’Alba suggests that being with others both within and outside the profession, could extend the “possibilities for being, potentially enriching the process of becoming” and that “an individual does not become a professional in isolation; conversely, a profession cannot exist without individual professionals” (p. 42). These insights into how to place emphasis on professional ways of being could open up possibilities for enriching professional educational programmes (Dall’Alba, 1994; 2005; 2009; Dall’Alba & Barnacle, 2007) way beyond the inculcation of monoprofessional identities evident in the findings. Such an approach which opens up the idea of learning to include collaborative and relational possibilities might also help lessen hegemonies and professional territorialities and, in the process, narrows the gap between the education and health service contexts.

The literature also suggests that a strong professional identity leads to individuals who view their professions as different, or indeed better, than similar professions (Baker et al., 2011). Indeed, the participants involved in this study questioned how students with less developed professional identities would fare in IPE activities, not just with dominant professions such as medicine, but also with those professions who were perceived implicitly to hold higher status than them at the Faculty of Health Sciences.

Arndt et al. (2009) suggest that professional identity is the outcome of the professional socialisation process taking place within uni-professional contexts.
Within this case study, participants’ territorial, stereotypical and “tribal” (Beattie, 1995, p. 1) behaviours resonated with the literature and appeared to be the overt manifestations of deep-rooted socio-historical origins of health care professions taking place through processes already discussed which include, inter alia, the ‘professional project’, ‘closure’ strategies, and ‘occupational imperialism’ (Freidson, 1988a; 1988b; Larkin, 1983; Larson, 1977; Weber, 1978); and reinforced by years of uni-professional socialisation. One of the consequences of these uni-professional socialisation processes was that participants remained largely unfamiliar with the functions of other professions or had limited/misconstrued knowledge; a definite barrier to IPE because, as D’Amour and Oandasan (2005) assert, familiarity with the roles and expertise of others is crucial for effective and meaningful interprofessional experiences.

Theorists have identified other factors at play in stereotypical behaviours and hegemonies between professions, such as gender, social class, body of knowledge underpinning the profession, level of medical supervision necessary, ‘scientific’ or ‘therapeutic’ work and hospital versus community-based work (Bainbridge & Purkis, 2011; Larkin, 1983); however exploring these issues is beyond the scope of this particular discussion as the latter was based on this study’s analysis of the findings.

Bourdieu (1930-2002), a renowned French sociologist of the twentieth century provides another theoretical lens which I deemed particularly suited to interpreting my findings. While Bourdieu’s theory of the educational system and its relevance to IPE was briefly discussed in the Literature Review, here the discussion considers his theories of society and social practices providing insights into the underlying structures of professionalism; insights which could provide further understandings and theoretical abstractions to subthemes ‘Medical model reigns supreme’, ‘Hegemonies and territoriality at the faculty’ and ‘Realities of teamwork’ thus further illuminating why participants seemed to be ambivalent and/or resistant to
‘The Reality of IPE.’ Figure 7.3 adds on Bourdieu’s perspective to the sociological lenses in my conceptual framework.

### 7.5.2 Bourdieu’s Perspectives on Professionalism

![Diagram](Image)

#### Sociological lenses [Universal Perspectives]

- Socio-historical analysis of the discourse of professionalism
- Inter professional hegemonies and hierarchies
- Medical dominance
- Field, habitus, capital, doxa

**Figure 7.3 Bourdieu’s perspectives on professionalism**

In *Invitation to a Reflexive Sociology* (Bourdieu & Wacquant, 1992), Bourdieu suggests that symbolic structures are inextricably linked to the cognitive and emotional structures of the individual, as well as to the social structures of society. Bourdieu demystifies power structures and power struggles by claiming that power is culturally and symbolically created and constantly reenacted through the interplay of agency and structure (Bourdieu & Wacquant, 1992).

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*Note: Bourdieu’s work is highly complex and is not amenable to synoptic analysis and hence this short account should only be viewed as a mere introduction to his work within this context; the reader is invited to his more profound writings for further insights.*
Bourdieu is fiercely critical of the concept of professionalism arguing that it implies the possibility of neutrality whereas in fact the word ‘profession’ has largely positive and value-laden implications. This view is supported by Evetts (2005), whose interpretation of professionalism discourse includes the idea of occupational change and managerial control as mechanisms for encouraging appropriate work ethics and practices. Bourdieu’s work is particularly inspired by Marxist ideas about social reproduction, and his (Bourdieu’s) theories are underpinned by the idea that class conflicts and material interests are primary pillars of social inequality (Navarro, 2006). Bourdieu engaged in debates on professionalism with sociologists, such as Abbot (1988), Collins (1979), Freidson (1988a) and Larson (1977) but argued that the analysis of professionalism should be expanded through using the concept of ‘field’ rather than the notion of a profession (Bourdieu & Wacquant, 1992).

Bourdieu claims that all actions and practices in any sphere of human interaction within social arrangements are interest motivated, be it by material or symbolic gains. The social field becomes one in which people struggle for positions so as to augment their gains and accumulate resources (Navarro, 2006); in other words playing to win. Bourdieu’s pivotal concepts centre on the interrelated ideas of field, habitus, capital and doxa and he uses these concepts to analyse social relations and the forces that shape them.

For Bourdieu, the metaphor of the field always signifies a field of force, power and competition. A field is described as a configuration of positions comprising agents (individuals, groups of actors or institutions) contesting to maximise their position, usually with regard to resources, stakes and access (Bourdieu & Wacquant, 1992). A field of practice represents an “arena of struggle around production, accumulation, circulation and possession of goods, services, knowledge, or status and the competition amongst agents to monopolise distinct capital” (Navarro, 2006, p. 18). A profession, from Bourdieu’s perspective, constitutes a group of individuals placed within circumscribed areas of knowledge, each within their own historical contexts, different positions, dispositions and likely courses of action so as to assume positions of the dominant and dominated. These positions within the field are, in turn, determined by multiple sources of influences, such as habitus and capital (Bourdieu & Wacquant, 1992).
Bourdieu’s (1990) concept of *habitus* refers to the “way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinate ways” (p. 316) (Wacquant, 2005). *Habitus* is also the individual features, viewpoints and dispositions with which an individual navigates the social world (Lynam, Browne, Reimer Kirkham & Anderson, 2007), these being the basis of practices that develop through socialisation (which is highly influenced by schooling and education) and determine a wide range of dispositions, shaping and guiding the individual in society (Navarro, 2006). This concept suggests that individuals develop and become themselves, so to speak, as a result of conscious and unconscious practices in the family context (product of history); and these dispositions are then transformed into secondary, tertiary or even further *habitus* as the individual journeys through different experiences and social institutions. The influence of context and environment imply that *habitus* is more of a social process (rather than personal), always changing according to new experiences (Navarro, 2006). It can appear in various ways and can be said to be an internalised cultural code (Nash, 1990).

Hence, *habitus* is not a rigid concept but a permeable one that can be moulded to form human behaviour (Navarro, 2006). It is also a combination of a person’s ingrained identity and a more transient (but likewise deep-seated) identity, representing skills and dispositions that are acquired from life experiences, for example being a student, a parent or a health professional (Meisenhelder, 1997). It seems reasonable to suggest that this transient or formative component of *habitus* which particularly develops through processes of socialisation (Navarro, 2006), can be compared with professional identity which, as already discussed, is the result of professional socialisation. This comparison could have a number of implications for IPE. For example, the idea that *habitus* (including dispositions, such as knowledge and attitudes, values and/or ways of behaving) is capable of change, suggests that identifying those periods when *habitus* is possibly more susceptible to external influences could be significant for the timing of an IPE initiative. The concept of *habitus* also reinforces the idea that IPE must be built on the consolidation of one’s own professional identity, plus the development of an interprofessional (or dual) identity (D’Amour & Oandasan, 2005; Gray, 2009; Khalili et al., 2013).
Bourdieu contends that individuals use and mobilise their resources so as to establish and sustain their position in the social order. These resources constitute Bourdieu’s third concept, capital, which refers to resources that are useful for power and which can be used to control objects, persons and institutions. Bourdieu uses symbolic capital as an overarching concept and then differentiates between social, cultural and economic capital. Symbolic capital refers to the social value given to certain things and is a form of capital that a group or a profession perceives as valuable (e.g. prestige, titles and reputation); it is not really recognised in itself but depends on other people’s perceptions that someone possesses those properties. Social capital refers to the socially advantageous position brought about by acquaintances and connections in networks of influence and memberships of social groups. Cultural capital, through which the influence of Karl Marx on Bourdieu is most evident, refers to the knowledge, skills, education and advantages that a person has and, in its institutionalised form, refers to credentials and qualifications that symbolise cultural competence and authority. Economic capital is the command over economic resources and other material values (Bourdieu, 1986). Within Bourdieusian terms, Schinkel and Noordegraaf (2011) explain professionalism as “a form of symbolic capital characteristic of a historically constructed field of power” (p. 85) which recognises the dynamic nature and vulnerability of professional fields. This construction of professionalism is consistent with previous sections of this chapter highlighting the crucial historical dimensions of the professions originating from decades of domination by the medical profession.

The ultimate stake in the social field is doxa, yet another structuring principle in Bourdieu’s field theory. Doxa is the taken-for-granted rules in the field or a shared common sense world and could be a set of core values and discourses which would tend to be viewed as inherently true and necessary. However, even within this doxa, agents can occupy positions aimed at either conserving or transforming the structure or relations of forces in a field (Bourdieu, 1990). Here, Bourdieu’s perspective mirrors that of conflict theorists who draw on Gramsci’s concept of ideology as a struggle suggesting that gaining hegemony involves winning the consent of society to the established order but that victory is never permanent. Resistances will arise, and ground won by the dominant ideology has to be constantly defended and
actively held on to, sometimes by granting concessions and thereby incorporating resistances into the established order (Slatterly, 2003).

7.5.2.1 Relevance of Bourdieu’s Perspectives

Bourdieu’s theoretical perspective serves well as part of the explanatory framework for this study’s findings particularly in trying to make sense of the contradiction in discourses between IPE as an idea and IPE as a possible reality. It could be said that each agent’s (participant’s) relative attributes depended on his or her position in this field (the position of that particular profession within the hierarchy of the other professions). The participants possessed different qualifications and competencies which meant they had different capital simultaneously operating at various levels and at different times. This capital was drawn upon or contributed to the professions entering the field and operating within the field. For example, the capital and habitus of nurses, midwives and allied health professionals differed from the capital and habitus of the medical doctor, specialist or surgeon. Furthermore, the capital and habitus of nurses, midwives and allied health professionals differed from each other. Capital of value denotes influential forces, whilst capital of no or lesser value implies restricted access to the field. It could be suggested that the excess of capital perceived by professions was reflected in those same professions’ eagerness to assert their dominance over other professions whom they recognised as potential subordinate rivals; akin to an implicit hierarchical pecking order where some professions were (or felt) more equal than others.

Bourdieu’s concept of power as symbolically created and constantly re-enacted helps to unpack and illuminate some of the reasons for the existence of hegemonies and territorialities identified in the findings. His views offer some insight into the various ways in which health care professions work and interact, and how this all makes sense within a wider societal context. For example, the field of power within the Faculty of Health Sciences, the wider university and the health sector could be seen as a contested one between academics, health professionals and administrators who are competing for personal and collective influence and dominance. Medical discourse is also one of the ways in which power relationships are played out during multiprofessional exchanges, such as ward rounds or meetings between different professions and faculties. Symbolic capital, such as dress codes and visible
stethoscopes used by the medical profession and some other health professions are also symbols of prestige and power. Likewise, sharing similar forms of institutionalised cultural capital, such as having the same health professional degree and qualifications, creates a sense of collective identity. Habitus, apart from family and early schooling experiences, is also influenced by the socialisation process a trainee professional undergoes, giving rise to the particular cultural code and professional identity of a profession. This acquired disposition (conscious and/or unconscious) would influence and partly determine the behaviour of a professional. An example would be the way a professional perceives himself and interacts with another professional, resonating with Wackerhausen’s (2009) idea of micro level professional identity requiring the professional to attune himself so as to embody the rules, beliefs and habits of that particular profession.

The idea of capital (symbolic, social, economic and cultural) as forms of valued resources in the hegemonic process also has relevance for this study. The various players (health professions) possessed and brought in different forms of capital that afforded them greater or lesser status, knowledge, skills and expertise. In addition, the various professions were deeply rooted in different traditions, each with its own level and form of capital, and professions mobilise additional capital (resources) so as to assert their position in the social order. For example, in the process of professionalisation, the professions (each with its own habitus) would have strived hard to acquire, develop and improve their access to institutionalised cultural capital through improvements in their body of ‘scientific’ knowledge, technological developments, visibility to the public and introducing new areas of expertise. Therefore, it is hardly surprising that professionals in this study should be suspicious and fearful that IPE might mean dilution and/or jeopardy of this capital. Another example would be private practice, by which professions would convert their institutionalised cultural capital (recognition, academic credentials and qualifications) to economic capital. The struggle to establish and maintain this economic capital was evident in the findings when participants suggested that private practice would challenge the notion of collaborative practices because
professions would be reluctant to refer patients to another profession fearing not only loss of economic but also symbolic and social capital.\textsuperscript{75}

*Doxa* too is a useful concept in reminding that, although all participants had a common health care background, their daily practices might be informed by differing core value systems. For example, the *doxa* of all medical, nursing and allied health professionals might indeed be the well-being of the patient, however the medical model of disability views disability as the ‘problem’ that belongs to that individual, while other professions might espouse the social model of disability which is more inclusive in its approach and draws on the idea that society plays a part in ‘disabling’ people through designing everything to meet the needs of the majority who have no disability. Different professions then could pursue strategies and make use of their power or capital to employ and/or impose rules that favour them the most.

In summary, the combination of Bourdieu’s concepts of *field, habitus, capital* and *doxa* helped disentangle possible hidden motives, mechanisms and struggles which professions might engage in so as to accumulate resources and entrench hierarchies. These ideas were useful in demystifying some of the findings enabling me to consider the different perspectives and positions that constitute the professional social world under study. They also provided me with a deeper understanding of Beattie’s (1995) anthropological metaphor of ‘tribalism’ for health professions in which he acknowledges that:

> Health is and will remain a vigorously ‘contested concept’, there will continue to be a plurality of competing views and values related to health, and that complexity and contradiction will be a constant challenge to all efforts at organisational development and social planning for health (Beattie, 1995, p. 6).

Having engaged with Bourdieu’s analytical framework as a means of examining participants’ concerns in relation to professional identity, rank and status, the section

\textsuperscript{75} Prestige, titles, reputations and knowing and being known to the right people could be real concerns for inhabitants living in a small geographical island, such as Malta. This is discussed in the next section.
to follow considers their concerns in relation to national cultural identity and its possible implications for IPE.

### 7.6 Cultural Perspectives & Determinants on IPE

Institutions cannot be understood without considering culture, and understanding culture presumes insight into institutions (Hofstede et al., 2010, p. 24).

The third and fourth theoretical lenses I found useful for interpreting and explaining the findings, draw on anthropological and microstate sociological perspectives, as shown in Figure 7.4. This reflects my social constructionist epistemology which as has been emphasised in Chapter 4, underscores the importance of understanding culture and cultural influences; hence situating my discussion within the culture of this case study becomes unequivocal.

**Figure 7.4** Anthropological and sociological lenses [Contextual perspectives]
Hofstede’s theory of cultural dimensions combined with microstate sociological constructs help illuminate why and how cultural values and the distinct ‘ecology’ of small states could provide further explanations and interpretations for the findings and thereby highlight factors that might influence the development and delivery of IPE in Malta.

The global context of IPE outlined in Chapter 2: Part 2, shows that different countries are at diverse points in their IPE journeys: in some countries, IPE is well-established and developed, whereas in other countries it is still in its initial stages or is essentially absent. Some countries seem to be better (or are better equipped) at overcoming challenges to IPE. For example, a WHO global environmental scan of IPE conducted in 2008, showed that only a few southern European countries were represented in the respondent list of countries (Rodger & Hoffman, 2010). And although Greece, Malta and Portugal were represented in the study sample, there was no guarantee that IPE was established in these countries. Indeed, completed survey returns from Malta confirmed that IPE was not part of the local general curriculum for health professionals (S. Roger, personal communication, March 7th, 2013); and nonrepresentation of countries, such as Italy or Spain could mean that either IPE was absent or that it existed but was not recorded in the global scan, although anecdotal and empirical evidence points towards the former scenario. In countries such as Greece and Spain, IPE initiatives are very sparse and it seems to be more difficult to develop and sustain permanent IPE (Liaskos et al., 2009; Mendez et al., 2008). This geographical imbalance suggests that, in addition to barriers identified in the literature, there could be other constructs lying deep within societies which could influence the disposition of a faculty, university and country to initiate and adopt IPE based curricula.

As noted in the Literature Review, there is a dearth of scholarship on the potential influence of national cultural determinants on IPE; of note is Irajpour (2009) who suggested that certain Iranian cultural traits could be incompatible with shared learning. The idea that cultural differences and other sociological constructs could be potential barriers or enhancers to curriculum change in health care education is worthy of examination, and the sections to follow unpack this idea.
7.6.1 Relevance of Hofstede’s Theory of Cultural Dimensions

The concept of culture and how cultural determinants could influence IPE was briefly discussed in the Literature Review. Culture could be described as a catch-all phrase for behavioural characteristics implying collective similarities or collective differences. Sekaran (1983) argues that culture is distinct, yet closely interlinked with macro environmental factors, such as politics, religion, education and the economy of a country; hence it becomes very difficult, if not impossible, to isolate culture from these influences. Indeed, Vygotsky (1978) posited that an individual’s thoughts and intellect are a consequence of internalised meanings constructed by the culture from which that individual originates.

Researchers from a range of academic fields, such as management, business, marketing, visual arts, health and social studies, employ various approaches to explore universal dimensions of culture. A twenty year review of cross-cultural consumer research conducted by Sojka and Tansuhaj (1995) concludes that researchers in this field conceptualise culture through three approaches: language, material goods/artefacts and beliefs/value systems. The latter approach, focusing on the beliefs or values of a social system, seemed particularly useful as an analytical tool for exploring participants’ discourses on Maltese culture.

Gert Hofstede is renowned for his pioneering research into cross-cultural differences between countries and organisations. His concept concerning people’s “mental programmes” (Hofstede et al., 2010, p. 5) which affects the way they think, behave and perceive the world, and his cultural dimensions theory showing the influence of national and regional cultural groups on behaviours of societies and organisations are relevant here as they are specifically developed to provide insights into the influence of national culture on certain phenomena. Hofstede speaks of national cultures as values that in adult life are well-defined and difficult to change as they are located at the most profound level of our ‘mental programmes’. As seen in the Literature Review, he proposes that organisational cultures, as opposed to national cultures, are acquired later on and reflect more a superficial phenomenon on a practice, rather than on a value level (Hofstede, 1989; Hofstede et al., 2010).
Hofstede’s reasoning suggests that the organisational factors identified in the findings, such as hegemonies, territorialities and ambivalence towards innovation, could be relatively superficial and reflective of something deeper and more complex. He argues that if we want to understand organisations, we need to understand the national societies in which these organisations are embedded in (Hofstede et al., 2010).

Indeed, participants’ discourses coded to the subtheme ‘our way of doing things’ included accounts which implied that there was an element of deep-rooted values intertwined with other beliefs and characteristics particular to the Maltese culture which could influence IPE; and it is to these particular characteristics (national cultures) that the discussion now turns.

7.6.1.1 Measuring Cultures: The Hofstede Model in Context

Hofstede’s model measures cultural factors and makes them visible beyond the level of assumptions. It shows how world cultures vary along consistent dimensions of culture. This model was developed after a decade of data collection (116,000 questionnaires) distributed to thousands of employees of one organisation, International Business Machines (IBM), between 1967 and 1973. The data covered over seventy countries, from which Hofstede selected the forty countries with the largest groups of respondents, later extending the analysis to fifty countries. Initially, Hofstede identified four distinct cultural dimensions that could distinguish one culture from another, in 1991 he added a fifth dimension based on Confucian thinking, and in 2010, a sixth dimension based on Minkov's analysis was added.

These six dimensions or values that distinguish country cultures from one another are defined as power distance, individualism/collectivism, masculinity/femininity, uncertainty avoidance, long term orientation and indulgence versus restraint. Hofstede scored the countries using a scale of 0 to 100 for each dimension; the higher the score, the more that dimension was exhibited in societies. In the last edition of Hofstede’s book, scores of the dimensions are listed for seventy six countries and these are partly based on replications and extensions of the IBM study

Michal Minkov is an Eastern European colleague of Hofstede who, together with the latter and Gert Jan Hofstede, coauthored the third edition of Cultures and Organizations: Software of the Mind (2010).
on different international populations and by different scholars (Hofstede et al., 2010). Table 7.1 presents Hofstede’s six dimensions of national culture:

1. **Power-distance (PDI)** is defined as the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally. It refers to human inequalities (such as prestige, wealth and power) and reflects how people handle the fact that people are unequal. It also highlights dependence relationships in a country.

2. **Individualism (IND)** pertains to societies in which the ties between the individuals are loose: everyone is expected to look after himself or herself and his or her immediate family. **Collectivism**, as its opposite, pertains to societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people’s lifetimes continue to protect them in exchange for unquestioning loyalty.

3. **Masculinity versus Femininity (MAS)** alludes to those societies in which social gender roles are clearly defined or those in which the gender roles overlap. A society is called masculine when emotional gender roles are clearly distinct: men are supposed to be assertive, tough and focused on material success; whereas women are supposed to be more modest, tender, and concerned with the quality of life. A society is called feminine when emotional gender roles overlap: both men and women are supposed to be modest, tender, and concerned with the quality of life.

4. **Uncertainty Avoidance Index (UAI)** is the extent to which the members of a culture feel threatened by ambiguous or unknown situations; ranging from relatively flexible to extremely rigid.

5. **Long Term Orientation (LTO)** is mainly derived from the teaching of Confucius and stands for the fostering of virtues oriented towards future rewards – in particular, perseverance and thrift. Its opposite pole, **Short Term Orientation** (STO), stands for the fostering of virtues related to the past and present – in particular, respect for tradition, preserving ‘face’ and fulfilling social obligations.

6. **Indulgence Versus Restraint (IVR)** indulgence stands for a society that allows relatively free gratification of basic and natural human drives related to enjoying life and having fun. Restraint stands for a society that suppresses gratification of desires and regulates it by means of strict social norms.

| Table 7.1 | Hofstede’s six dimensions of national culture |
| Source: | Hofstede et al. (2010) |
These dimensions are based on correlations and thus the country scores on these dimensions are relative scores, they are not absolute and do not constitute an individual’s personality or a combination of characteristics of a singular citizen; societies are compared to other societies as culture can be only used meaningfully by comparison. The scores do, nonetheless, imply that characteristics highlighted in particular dimensions are more often present in citizens with a common mental programme, and the collective behaviour of a particular society might include those characteristics and reactions which at times may seem perplexing to other groups. These characteristics have proven to be resilient over decades as the forces that cause cultures to shift tend to be global or continent-wide (Hofstede et al., 2010).

Hofstede’s model of cultural dimensions as an approach to analysing cross-national differences has been extensively praised for its depth and breadth and has been widely used across a spectrum of disciplines. However, it has also been criticised with the main arguments levelled at its failure to fully capture all the salient aspects of culture (Briley, Morris & Simonson, 2000), and the assumption that the domestic population of a nation is a homogenous whole (Redpath & Nielson, 1997). Nonetheless, it still remains one of the leading approaches to analysing cultural differences between nations, with more than 9,000 citations in peer-reviewed journals (Borg, 2011; Sivakumar & Nakata, 2001). It is also the most comprehensive framework vis-a-vis the number of national cultural samples (Smith, Dugan & Trompenaars, 1996).

Of particular relevance to my findings is Jippes and Majoor’s (2008) study which explored whether national culture is related to the relative number of medical schools in countries which adopted integrated or problem-based (PBL) curricula. Their study involved examination of the medical curricula of 134 of the 263 schools in 17 European countries using Hofstede’s scores for the particular countries. The researchers supposed a correlation between one or more of Hofstede’s dimensions of

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77 The areas of research employing Hofstede’s values encompass a vast range of topics, such as transnational education (Eldridge & Cranston, 2009), antibiotic consumption (Borg, 2011), marketing studies (Soares, Farhangmehr & Shoham, 2007) and medical communication (Meeuwesen, van den Brink-Muinen & Hofstede, 2009) amongst many others.

78 For example, in some countries there would be strong subcultures whose culture would be based on ethnicity of origin.
national culture and the relative number of schools with integrated and PBL curricula. Significant negative correlations were found between the percentage of integrated and PBL curricula and scores on the power distance index and the uncertainty avoidance index, which implied that in countries where both these dimensions were strong, medical schools were less likely to adopt integrated or problem-based curricula. Examples of this negative correlation were the European Mediterranean\textsuperscript{79} countries which had a very low percentage of integrated and PBL curricula and scored high values on these two dimensions. According to the authors, a high score on power distance suggested that inter alia heads of departments were unwilling to cooperate with other departments to develop integrated programmes, as the latter would require a shift from departmental control to multidisciplinary committees. With a high uncertainty avoidance index, a faculty might have also been reluctant to change any curricula due to national laws and university rules, as well as due to “fear of the unknown” (Jippes & Majoor, 2008; 2011, p. 11).

Although discussing PBL, Jippes and Majoor’s (2008; 2011) results and conclusions based on Hofstede’s scores resonate with my earlier suggestions that particular cultural traits could be relevant to IPE. PBL curricula and IPE are different pedagogical concepts, however they share many similar underpinnings, as well as challenges. For example, PBL, similar to IPE, is based on small-group collaborative principles, involves shared ownership of the learning tasks, is associated with an interactive learning environment and necessitates a great deal of planning, expertise and resources (Dahlgren, 2009). And although introduced more than fifty years ago, it is still considered as an alternative way of teaching and learning in some countries (Jippes & Majoor, 2011). This suggests that universities reluctant to adopt PBL curricula might share similar views and attitudes to IPE and thus it seems reasonable to look at Hofstede’s scores for Malta and the southern European area so as to explore the findings from his perspective.

Hofstede et al. (2010) emphasise that the two dimensions of uncertainty avoidance index and power distance index are critical to the way individuals think about organisations, that is, group beliefs and cultures. Indeed, in my data analysis, these dimensions were the most relevant and I employed them to understand how they

\textsuperscript{79} These countries included southern European countries, such as Spain, Italy, Greece and Portugal.
could have influenced participants’ discourses. Table 7.2 overleaf shows Hofstede’s scores for the six dimensions of culture for most European states and other nations who have developed IPE programmes, are in the process of developing IPE, or have no IPE. Together, these dimensions of culture represent independent preferences for one state of affairs over another that distinguish countries (rather than individuals) from each other; each country is characterised by a score on each of these six dimensions (Hofstede et al., 2010).

The dimensions of uncertainty avoidance and power distance in southern European countries are highlighted in blue and in the case of Malta they are highlighted in grey. Southern European countries have relatively high scores of power distance and uncertainty avoidance indices. For example, with a score of 96, Malta ranks as the sixth highest country globally in uncertainty avoidance and fourth highest European-wide, implying that people in Malta, together with other southern European countries, may tend to feel more threatened by uncertain or unknown situations. Hofstede et al. (2010) suggest that this is true of all Latin countries who, in one way or another, have inherited a part of their civilisation from the Roman Empire, an empire which was characterised by strong central authority and a system of law applicable to all subjects and which might have established in its citizens’ minds the value of centralisation (large power distance) and of laws (strong uncertainty avoidance). Hofstede et al. (2010) hold that such countries are inclined to maintain rigid codes of beliefs and behaviours, and are intolerant of unorthodox behaviours and ideas; and religion is important as it helps followers accept uncertainties which are an inevitable part of life. In these cultures, there seems to be an emotional need for rules (even if the rules never seem to work), time is money, people have an inner urge to be busy and work hard, innovation could be resisted, and security is an important element in individual motivation.

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80 My interpretative arguments are not implying that I conducted a cross-cultural study of IPE; they are based on my reflections using Hofstede’s dimensions to illuminate particular trends in the findings.

81 Malta became part of the Roman Empire during the 2nd Punic War (c.218 B.C) and remained part of it till the Vandals raided the Islands in AD 395 (Blouet, 1993). In contemporary times, the social fabric of Malta is said to consist of an interplay between Anglo and Roman Catholic traditions (Sultana & Baldacchino, 1994).
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<tr>
<th>COUNTRY</th>
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Table 7.2 Dimensions of national culture: Selected countries and their scores
Source: Hofstede et al. (2010)

Notes:
PDI Power Distance Index
IDV Individualism versus collectivism
MAS Masculinity versus Femininity
UAI Uncertainty Avoidance Index
LTO Long Term Orientation versus Short Term Orientation
IND Indulgence versus Restraint
As Table 7.2 shows, southern European counties, including Malta, also scored moderately high on power distance index. In these societies, people accept and expect a hierarchical order in which everybody has a place and which needs no further justification (inherent inequalities). The ideal boss of such hierarchical organisations would be a benevolent autocrat and subordinates working there, would expect to be told what to do (Hofstede et al., 2010).

The way particular dimensions of culture come together is of great significance here. For example, the combination of high uncertainty avoidance and a relatively high power distance is particular to Malta relative to other world cultures. Although these preferences may sound like conventional stereotypes, they are employed here to potentially expose and make tangible, the intangible cultural factors embedded in the findings, as well as to explain some of the contextual and occasionally paradoxical issues identified. Being aware of the potential impact of culture could also illuminate some reasons for the differences and similarities in IPE development, geographically.

Malta’s high score on the uncertainty avoidance dimension is perceptible and evident in the findings. For example, in discussing IPE in tangible terms as a possible reality, the participants evoked seemingly insurmountable challenges, such as its introduction would require an “evolution in the culture” and an “Arab Spring.” Some participants suggested that IPE would cause ‘an upheaval’ and bring with it a high degree of uncomfortable uncertainty, as may be witnessed in the following quotes:

> So we like it, and we like talking about it, and might use it, bits and pieces, but we like to have control of it at the same time; and if IPE is put in as being a necessity it would cause an upheaval (Academic 46).

> Okay, I will talk about IPE. A year ago there was the Arab Spring that started and a year later all these Arab states have changed, these North

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82 There are other countries, such as Belgium, France, Poland and Slovenia which have concurrently high scores in both these dimensions; it would be interesting to explore how those countries with established IPE (such as Belgium) overcame adverse cultural conditions and whether other dimensions were relevant to the development of IPE.
African states, and yet no-one knows what’s going to happen – no-one knows whether democracy will be there, no-one knows whether there’ll be an easier life for them, no-one knows exactly what’s what and where’s where – and I think with IPE, at this point in time, we need a sort of Arab Spring, but we’ll have to be very careful how we’re going to look forward to the future as well (Academic 50).

IPE is an unorthodox way how to educate health professionals (Academic 39).

It is significant to highlight that the latter quote reflects Hofstede’s observations noted earlier in that countries with a high uncertainty avoidance index seem to be intolerant of unorthodox behaviours and ideas; in this case Academic 39 who perceived IPE as an unorthodox idea.

Whilst participants viewed IPE as an admirable teaching and learning approach which could transform the professional educational system into a better one, they were generally wary of it as a potential reality. IPE was an interesting concept to talk about, but the possibility of such pedagogical change was fraught with trepidation and demanding of caution, as suggested by Academic 40:

*We need to be careful because in the ideal world IPE is the great thing and it’s the way forward; but in everyday life what is going to happen with the programme (Academic 40)?*

Interestingly, Piderit (2000) uses Ajzen’s (1984) tripartite framework of ‘attitudes, cognitive, emotional and intentional’ to explore how individuals may react to change proposals: the cognitive dimension refers to an individual’s beliefs about the attitude object, the emotional refers to an individual’s feelings in response to the attitude object and the intentional dimension, being more complex, is more likely to reflect past behaviours. Using this framework, Piderit (2000) suggests that the possibility of ambivalence towards a particular change proposal could be one in which one’s cognitive response may be in conflict with one’s emotional or intentional response to the proposal – akin to a clash between these dimensions and echoing a state of
Within this study, this phenomenon could imply that although participants endorsed ‘The Idea of IPE’ cognitively (in principle), they were also ambivalent and/or resistant to it, due to their emotional and/or intentional attitudes indicating that the real-life challenges to it were too immense. This interpretation is similar to Hofstede’s idea of tension between “the desirable” and “the desired”, that is, between “how people think the world ought to be versus what people want for themselves” (Hofstede et al., 2010, p. 28). The notion of clashes between the cognitive and emotional, between an ideology and practical contexts, between ‘the desirable’ and ‘the desired’ could go some way towards accounting for dissonance between the ideal and the real, for participants’ lauding of IPE yet simultaneous reluctance to embrace such change.

As already noted, the study participants first and foremost talked about themselves as professionals rather than teachers per se, and thus issues relating to IPE pedagogies and curriculum change were not emphasised by the participants, who focused predominantly on issues relating to professional identity, rank and status. However, some perspectives in the literature on the topic of teaching IPE and teachers’ responses to change are worth noting.

Gray (2009) suggests that IPE teachers would often be “experienced professionals and experienced mono-professional teachers” (p. 152); the differences between mono-professional and interprofessional teaching identities can produce tension, uncertainty and negativity and this was evident in some of the participants’ discourses. Teachers’ identities seem to be inextricably linked to the communities in which they would have worked (McGregor et al., 2010) and this view is relevant because academics in the study had originally been health professionals educated and socialised in silo-based programmes and would have mostly worked in the non-collaborative context of the national health services.

It is also well documented in pedagogical literature that teachers’ approaches to teaching are influenced by their own learning and teaching experiences (Postareff, Lindblom-Ylänne & Nevgi, 2007) and that teacher educators themselves rarely...
initiate educational changes and development (Smith, 2003). The literature cites numerous reasons for teachers’ resistance to innovations, including a willingness (or unwillingness) to learn, lack of consciousness of own teaching behaviour and dominant conceptions of teaching and learning (Könings, Brand-Gruwel & van Merriënboer, 2007), and lack of time or knowledge on teachers’ part to study their own practices, systematically (Lunenberg & Willemse, 2006).

Some participants suggested whether IPE might just be a passing ‘fashion-trend’ echoing Stevens’ categorisations of teachers when faced with innovative approaches: there would be the “innovators,” the “immovable” (who refuse to change) and a large middle group who tend to take a more “wait and see” attitude (Stevens, 2004, p. 391). This study’s participants largely consisted of the latter two categories: they perceived IPE as posing profound threats to established ways of teaching and learning, and, in any case, it may well be a case of ‘much ado about nothing’ so best wait and see if the idea will fizzle out.

Such ambiguous and ambivalent attitudes echo Mitchell’s (2002) findings on Malta in which he identifies profoundly ambivalent attitudes towards Europe and also more broadly to the key processes of modernisation, tendencies which Mitchell traces throughout a number of key areas of social life, such as family, community and politics. They also may be said to resonate with Irajpour’s (2009) suggestion that contradictory features of Iranian culture pose challenges to IPE, in the case of Iran, its religious emphasis on togetherness is counteracted by innate cultural inabilities to work in teams.

Another characteristic of strong uncertainty avoidance cultures is that senior managers⁸³ are usually more concerned with daily operations, as opposed to weak uncertainty avoidance societies in which managers are more concerned with strategy (Hofstede et al., 2010). As the findings chapter suggested the absence of a strategic plan for IPE from the Faculty’s mission statement could be deemed indicative of a lack of interest and commitment to strategic planning; and indeed, some of the key informants, albeit offering a historical explanation, suggested that leadership

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⁸³ Hofstede et al., (2010) uses the term ‘managers’ as opposed to leaders since he discusses this issue within an organisational context.
qualities are not the strongest feature of Maltese culture. Yet, as shown in Chapter 6, participants stressed the need for strong leadership for IPE “the Dean has to be convinced because it has to come from the very top (Academic 9)” and this looking to ‘the top’ supports Hofstede et al.’s (2010) proposition that identifying and implementing major changes are regarded as the sole responsibility of the highest levels of authority in countries with a relatively high power distance index scores. While strong leadership is crucial for IPE, given the lack of strategic leaders, high uncertainty avoidance and high medical dominance within the Maltese context, finding the right leaders to mobilise the Faculty for IPE and to oversee its implementation and development could prove challenging.

The relatively high power distance index shown by Hofstede’s scores for Malta (56) is significant because it suggests that there is a hierarchical order in which everybody has a place and which needs no further justification. Although power and inequality are fundamental to all societies, Hofstede (2011) argues that “all societies are unequal but some are more unequal than others” (p. 9). In high power distance societies, the system is based on existential inequalities, subordinates expect to be told what to do (from, for instance, leaders, politicians and religious leaders) and organisations tend to be centralised with power in the hands of the few. The major threat in such societies is the competition of other groups for the same territory and resources; hence the need for one central authority to keep order and balance (Hofstede et al, 2010). Such a structural configuration was identified in this study’s findings which, inter alia, highlighted the domineering influence of the medical profession, both in academia and the health services, as well as explicit and implicit interprofessional rivalries. However, despite these complaints, there seemed to be a tacit acceptance of the situation, it was the way things happened in Malta; and this reflects the definition of power distance, in which power is expected and accepted to be distributed unequally (Hofstede et al., 2010). These issues have already been examined from socio-historical and Bourdieusian perspectives and, in view of Malta’s relatively high power distance scores, it could be suggested that these hierarchies and existential inequalities could be more prevalent in Malta.

It could also be suggested that medicine’s social and political control might be even more accentuated in Malta than in other countries due to the strong historical roots it
enjoys. As mentioned earlier, the *Sacra Infermeria*, in Valletta, the foremost hospital of Europe in its day was established by the Knights of St. John in 1574. The Faculty of Medicine and Surgery in Malta instituted as *Collegio Medicum* also dates back to the time of the Knights of St. John (1771) and is the one of the longest established faculties in Europe (Savona-Ventura, 2004). At that time, the licence to practise the medical profession would only be given after serving six years at the *Sacra Infermeria*. Regulations for medicine were incorporated in the Legal Code of the Grandmaster Antonio Manoel de Vilhena in 1724 (Cassar, 1965; Savona-Ventura, 2005).

It is interesting to note that Nordic countries, such as Denmark, Finland, Norway and Sweden, well known for being egalitarian societies, and all of which have relatively well-established IPE within their professional health curricula, have low power distance scores. These countries have formed their own interprofessional network so as to foster interprofessional collaboration in education, practice and research (NIPNET). This is not to suggest that a country with a low power distance index necessarily equates with successful IPE initiatives, as indexes are relative and not absolute scores. However, having a low power distance index inherently in one’s culture seems to be a positive attribute in contributing towards equity between professions. For example, in such countries, strong egalitarian attitudes in the workplace seem to help in “levelling out the playing field” between professions, and this levelling is crucial for IPE (Clark, 2011, p. 323). Other attributes reflected in low power distance countries which might implicitly or explicitly be facilitative of IPE include student-centred educational processes, decentralised organisations, flexibility in roles, consideration of superiors and subordinates as existentially equal, and expectation from subordinates to be consulted before a decision is made that affects their work (Hofstede *et al.*, 2010).

The study participants voiced concern at the poor track record for teamwork and collaboration both in academia and in health service delivery in Malta. In addition to the wide range of human dynamics that are necessary to be developed within teams (D’Amour, Ferrada-Videla, San Martin-Rodriguez & Beaulieu, 2005), the lack of

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84 Power Distance Index scores for these countries are 18 for Denmark, 33 for Finland, 31 for Norway and for 31 Sweden.
good teamwork might be partly explained by the high *uncertainty avoidance index* and relatively high *power distance* index scores. Teams *per se* rely on the collective effort of team members and within a high *uncertainty avoidance* culture, this could be experienced as stressful and ambiguous as people with a high *uncertainty avoidance* index tend to feel more comfortable in structured environments (Hofstede *et al.*, 2010). One way of avoiding possible uncertainty arising from teamwork would be to rely on oneself, thereby avoiding the uncertainty of having to deal with others in pursuit of common outcomes and goals; this would translate as either being a poor team player or engaging in non-collaborative practices. Moreover, with a relatively high *power distance* index, there is a high preference in Malta to complacently accept and expect a hierarchical order, which contrasts with low *power distance* countries in which team members expect to be consulted in decision-making processes, and subordinates are more likely to question and challenge leaders or authority figures (Hofstede *et al.*, 2010).

The combination of high scores on both *uncertainty avoidance* and *power distance* may also help explain why participants described their students as being poor self-directed learners, resistant of new learning situations, such as group work with other professions, and expecting teachers to have all the answers. Living in an *uncertainty avoidance* country, students in Malta may tend to feel more comfortable in environments in which they are used to, such as teacher-centred and uni-professional silo-based health educational system. It is also customary for students in high *power distance* societies to consider teachers as the experts (Hofstede *et al.*, 2010) and so, the notion of both teamwork and learning in less traditional ways could create anxiety, and this is consistent with the study findings.

Hofstede’s dimensions also include the *individual* and the *collective* in a society. With a score of 59, Malta veers towards *individualism*, suggesting a high preference for a loosely-knit social framework in which individuals are expected to take care of themselves and their immediate families. This again could explain participants’ difficulty with working in teams as, in such societies the interests of the individual always seem to prevail over the interests of the group (Hofstede *et al.*, 2010). Moreover, these individualistic traits combined with the socio-historical factors discussed earlier could have other implications for IPE. For example, when
professions, due to their desire to be autonomous, fail to appreciate how their professional efficiency is dependent on others (Lingard et al., 2006), they could possibly be resistant to sharing their knowledge, expertise or skills. This suggests that the inherent nature of professions is individualistic rather than collectivist and competitive rather than cooperative. Perhaps then, participants’ inherent individualistic values (as per Hofstede’s scores) combined with individualistic professional characteristics contribute to making collaborative practices difficult, which again implies that in Malta, IPE would face universal (such as inherent nature of the professions) and additional contextual barriers (high values of individualism). This is significant because, as cited frequently in the literature, IPE necessitates an understanding of the different value systems and realities of other professions so that eventually, students would be able to reflect on how their own professional value system fits in within a larger and more integrative approach.

7.6.2 Relevance of Microstate Themes
Sultana and Baldacchino (1994), in their sociological analysis of Maltese society, suggested three themes, intimacy, totality and monopoly, which, individually and/or collectively, capture the essence of a “microstate syndrome” (p. 14) characterised by small size and small scale. The last two themes totality and monopoly have direct relevance to this work as they provide further insights into the findings, particularly in relation to participant discourses coded to the overarching theme: ‘The Reality of IPE’.

Totality, implies that the smaller the country, the larger the state features in its economy and society. Sultana and Baldacchino (1994) suggest that a small state government is characteristically present in the day-to-day lives of the people and one of the many consequences could be the screening and withholding of information for oneself. This implies that a professional who would have acquired professional expertise in a particular field would be very careful not to share this special information or to do so only within the ‘in-group.’ Hence, totality could render sharing of information more difficult; and indeed study participants, although espoused to collaborative practices, were paradoxically concerned that IPE would necessitate them imparting their knowledge to other professionals. Totality also implies a rigid adherence to role specificity (Sultana & Baldacchino, 1994), which
again goes against the notion of flexible working across professional and organisational boundaries.

*Monopoly* implies that if there is a desire to withhold information to oneself (*totality*), there is also a desire to secure and retain *monopoly* power, usually in the form of knowledge or expertise (Sultana & Baldacchino, 1994). These researchers suggest that in a microstate setting, if a person develops even a modest amount of expertise, most especially in a new domain of knowledge, there is an almost spontaneous and unavoidable inclination to proclaim oneself as the expert in the field. It thus becomes “relatively easy to become a big fish when one operates in a small pond” (p. 18) and, particularly in the social sciences community, this self-proclaimed authority “induces individuals to indulge in centrifugal adventures, locked within their own staunchly defended research pursuits, often in splendid isolation” (p. 18). This mentality seems to be perpetuated unless one takes his or her expertise abroad.

Indeed a good number of medical specialists within the local health service, as well as academia at the University of Malta further their education in mostly British and sometimes American universities spending a considerable number of years studying and working abroad. However, despite the fact that their practices might have changed whilst they would have been away from Malta (so as to conform with different cultural environments), the general pattern is that they would tend to appoint themselves as the ‘expert’ in the particular field once they return to Malta (M. Borg, personal communication, February 8, 2013). This tendency suggests that self-proclaimed exclusivity could be even more pronounced in Malta than elsewhere because universal monopoly of the professions, as illustrated by the discourse of professionalism, would be further amplified by the microstate *monopoly*.

Another issue of note is the small geographical context of Malta, coupled with the high density of people. Boissevain (1994), a Dutch social anthropologist who, for over half a decade, studied Malta’s social life, argued that Malta’s small size and intensely interrelated population contribute to high degrees of competition in all spheres, giving rise to factionalism. He suggested that factionalism (such as in sports, village feasts and national politics) is one of the dominant cultural themes of
Maltese society and is undeterred neither by rising prosperity nor by education. The findings chapter identified factionalism (in the form of competition and rivalry) both in academia and within the health sector as strong underlying discourses. Manifestations of this factionalism include both implicit and explicit hegemonies and territorial rivalries with the medical profession, and between professions represented at the Faculty.

One might therefore question to what extent these professional tensions in Malta might compare with international contexts. The literature consistently shows that unequal power relations, competition, elitism and territoriality are all realities in health and social care contexts (Baldwin, 2007a; Baker et al., 2011; Clark, 2011; Pecukonis, Doyle & Bliss, 2008). However, some participants recounted that in other countries where they had worked it was somewhat easier to work across professional boundaries, as territoriality was not as pronounced as it is in Malta.

Hence, whilst it is recognised across the literature that ambivalence and resistance to change is universal, multifactorial, is a ‘fact of life’ and could reflect a clash between the cognitive and emotional responses and/or between the ‘desirable’ and the ‘desired’ (Ellsworth, 2000; Fullan, 1993; 2007; Hofstede et al., 2010; Marris, 1986; Piderit, 2000), my analysis, supported by Hofstede’s scores and microstate themes, suggests that particular cultural factors in Malta tend to make collaborative working more difficult. This reflects the literature which posits that, even though national culture may not be a power in itself, it permeates the behaviours and conduct of individuals, contributing to differences in behaviours between countries (Geertz, 1973; Jippe 1 et al., 2013). It may be inferred that the particular cultural factors discussed here would count over and above the universal professional factors discussed earlier in the chapter which, taken together, would pose profound challenges to the implementation of IPE (as per CAIPE’s definition) in Malta, at least for the present.
7.7 Conclusion

Building on the findings identified in Chapter 6, this chapter placed key themes, issues and concerns raised by the study participants in dialogue with relevant discourses in the literature on IPE and beyond. Such key concerns, it could be said, pivoted on the complex issues of professional identity and strong professional hegemonies and hierarchies both with the medical profession and between the health professions themselves.

Participants expressed concerns about the challenge of identifying and maintaining professional territories and boundaries, and about the possibility that IPE could manifest in the dilution of some health care professions. In addition, they talked about characteristics, traits and behaviours they perceived as inherent and embedded in Maltese culture that would run counter to the principles and practices of IPE.

These themes and issues were examined and interpreted within an interdisciplinary framework that drew on the socio-historical discourse of professionalism and Bourdieu’s sociological concepts of field, habitus, capital and doxa, as a means of illuminating the social exclusivity that professionals aim for and the dynamics of interprofessional relationships. The framework also drew on concepts rooted in anthropological and sociological discourses, focusing in particular on Hofstede’s theory of cultural dimensions and local microstate themes as a means of teasing out and understanding the role of culture in shaping perceptions and behaviours.

Figure 7.5 is a synthesis of the core conceptual underpinnings employed in this qualitative case study; a synthesis which placed the core arguments in context, paving the way for deeper understandings and new insights. As seen in Sections 6.6 and Section 7.2, ‘territoriality,’ ‘loss of roles,’ ‘power,’ ‘our culture’ and ‘challenges to habitual way of thinking’ were the major areas of concern (the big ideas) emerging from the findings and which were subsumed in subthemes: ‘We’re suspicious,’ ‘Hegemonies and Territoriality at the Faculty,’ ‘Medical model reigns supreme’ and ‘Our way of doing things.’
Figure 7.5  Synthesis of the core conceptual underpinnings in this study

It may be concluded that the implementation of IPE in Malta would have to take account, not only of universal professional factors but also of particular cultural factors, such as a high uncertainty avoidance index, a relatively high power distance index and individualism, the presence of totality and monopoly power and a high degree of factionalism.

In short, the study participants had lauded IPE as an idea but were, in general, resistive of it as a possible reality. Piderit (2000) suggests that ambivalent and/or resistive perceptions must be primarily acknowledged and then used to create “widespread conversations” (p. 791); and it is to be hoped that this work has initiated such conversions by bringing to the fore discussions about IPE. Chapter 8 brings this study to a close by looking back at the context from which it originated and looking ahead to the context in which its insights and learnings may be useful and beneficial.
7.8 The Inward Eye

This was the time when I stood back and reflected on the story; a story featuring positive images of IPE contrasted with unspoken issues of power, uncertainties, reluctances and taken for granted ways of doing things. Simons (1996) used an artistic metaphor to illustrate the uniqueness and universality of case study research. Using the writings of Rollo May, she compared case study research with an impressionist painting which whilst standing back and seeing the impression of the painting we might not be aware of the individual brush strokes; however it is those individual brush strokes which make up the case study. The brush strokes in this case study were all the preceding chapters setting the scene for deeper understandings about possible IPE in Malta.

Capturing such complexity and multilayered nuances through words seemed an impossible endeavour. The maxim that the more you learn the more you realise how much you don’t know was not simply a cliché. So much time was spent in thinking through the many disparate issues emerging from the study participants’ words. Could these individual brush strokes eventually make up the painting? What is their relevance? ... Their currency to my work? I again immersed myself in the findings, listening to the audio recordings and rereading the transcripts innumerable times. I wanted to ensure that the picture that I was painting was grounded in participants’ voices and this placed me in a humble stance of interpreting participants’ discourses in relation to more macro narratives, between the universal on one hand and the contextual on the other.

I then took the liberty to slowly stand back from the individual brush strokes so as to be able to see the bigger picture. The bigger picture of my case study, the bigger picture of local health professional education in general, the bigger picture of potential IPE in Malta and how this could relate to the bigger picture of IPE internationally. The process again resonated with Simons’ (1996) views that a case study necessitates us to “think holistically, to perceive directly, to engage our passions and emotions as well as our intellect in coming to understand” (p. 236). In trying to understand and interpret the local culture, I was acutely aware that this was an inherent part of me as the interpreter as much as the data that I was trying to interpret. Reflexivity became profound; I was a product of my history and culture.
and this research prompted me to question what I hold true. It was the case of again looking at the familiar strange and the unfamiliar familiar. The selected theoretical underpinnings helped me reframe and synthesise my thinking, as well as developing new insights ... insights which eventually guided me in developing new understandings into why participants in this study experienced the possibility of IPE in the way that they did.
The only true voyage of discovery, the only fountain of Eternal Youth, would be not to visit strange lands but to possess other eyes, to behold the universe through the eyes of another, of a hundred others, to behold the hundred universes that each of them beholds, that each of them is (Proust, 1923/2006, p. 657).

8.1 Introduction
This final chapter opens by looking back to the original context that gave rise to my rationale for conducting this research, it then summarises and concludes the case study, next it looks ahead to the context in which the findings may be positioned and considers how learnings and insights gained from the study may be useful in a changed and changing context. The chapter also considers the originality and contribution that this study has made to knowledge; the implications for education, practice and further research; and the study limitations. The thesis concludes with a strategy for dissemination and an epilogue summing up my final autobiographical reflections.

8.2 Original Pre-Study Context (2010)
As explained in the introduction, my interest in the concept of IPE and rationale for undertaking this study was fuelled by a combination of events and factors arising from my professional experiences, the upgrading of the Institute of Health Care to faculty status, policy developments in the international arena, as well as national policy and practice in the education of health care professionals.

In summary, on a professional level, my experiences as Health Policy Coordinator within the Ministry of Health, as a member of the Committee for the Development of a National Dementia Strategy for Malta, and as lecturer at the Institute of Health Care were key in that through these roles I gained first-hand experience of the low levels of collaboration existing, not just within the field of health care education but
also between the education and health sectors, as well as between stakeholders within the health sector itself. These experiences were catalysts for my growing interest in IPE, as a key mechanism for developing good collaborative practices in the education of health care professionals which could, in turn, lead to more collaborative practice in the work environment. It was timely then that the upgrading of the Institute to faculty status in 2010 should herald a new era and possibly one of reform and change while, at the same time, the World Health Organisation’s *Framework for Action on Interprofessional Education and Collaborative Practice* outlined a strategic vision for a “collaborative practice-ready workforce” with IPE forming the cornerstone of this strategy, and emphasising the importance of health and educational systems as being the supporting pillars of IPE and collaborative practices (WHO, 2010, p. 7). While the concept of interprofessional education had previously been addressed in local educational policy documents, no IPE initiative has, to date, ever been designed or implemented. My case study, which assumed an insider’s perspective account underpinned by a social constructionist and interpretative stance, aimed to create knowledge about understandings and perceptions of IPE from relevant stakeholders and to encourage debate about such an approach within the newly formed Faculty of Health Sciences at the University of Malta.

8.3 Summarising and Concluding the Case

The study has endeavoured to address all of its research aims (page 91, Section 3.4) and has in the process addressed a knowledge gap in presenting perceptions and experiences of academic and health stakeholders regarding the possibility of IPE in Malta; a knowledge gap set against a backdrop of international IPE and contextual factors. The analysis of eleven focus groups and five key informant interviews (total of sixty-four participants) gave rise to two master themes and eleven subthemes unearthing the complexity of potential IPE within the socio-cultural context of the Faculty of Health Sciences at the University of Malta and beyond. Participants seemed to laud IPE as an idea but were, in general, resistive of it as a possible reality; a metaphorical chasm between the ideal and the reality. The findings were interpreted through an interdisciplinary conceptual framework during which theoretical abstractions were generated so as to provide a wider significance to these findings. This conceptual framework incorporated sociological, Bourdieusian and
anthropological lenses unpacking and unpicking potential influences on IPE, many of which go well beyond the level of the individual and involve the whole distribution of power in the professions and society at large. The highly territorial professional contexts and national cultural factors were key issues raised by the participants and these were closely examined making them visible beyond the level of assumptions and which in case study research (indeed any qualitative research) meant making “the implicit ... explicit, the intuitive ... self-evident and the abstract ... concrete” (Walker, 1983, p. 163).

On a practical or operational level, this case was about barriers that arise from individual, organisational and structural challenges. On a symbolic level, it was about professional hegemonies, territorialities, professional identities and socialisation processes deep rooted in socio-historical origins; it was also about the cultural determinants of Malta which encompass the distinct ‘make-up’ and national values of this society and which could possibly challenge change and innovations, such as IPE, to a greater degree than other countries.

It may be concluded that the absence of political or institutional drivers for IPE, combined with participants’ discourses that IPE was only perceived to stand a chance if it was made a priority within the University, suggest that the development and delivery of an integrated undergraduate IPE programme in Malta is currently neither opportune nor timely. Rather, taking a more long-term view, this study has initiated debate on the concept of IPE, and issues and concerns raised in this debate provide insight into challenges that any future attempt at IPE would face and, if the adage ‘forewarned is forearmed’ be true, provide deeper understandings into factors at micro, meso and macro levels that must be taken into consideration before any such innovation could be attempted.

As seen in the local context and from the global literature, drivers for IPE may arise either directly as a result of demographical changes, changing health care needs, or local governmental policies, or indirectly such as resource problems, fragmented practices or medical errors due to lack of collaborative practices. And, indeed, as will be discussed in the subsequent section, profound changes have already been occurring over the lifetime of this study.
8.4 Contemporary Post-Study Context (2015)

The result of national elections held in March 2013 heralded change for the health and education sectors as a new government, eager to implement reforms across these two sectors, was inaugurated. Of note is a major reform anticipated for the University of Malta in which government is considering reconstituting the University as a public-equivalent body and in so doing granting it administrative, as well as academic autonomy; a White Paper in this regard is currently being drafted (Schembri Orland, The Malta Independent, 2015). This policy development signals profound uncertainty and complex changes which eventually could have direct and/or indirect consequences for the potential development of IPE from organisational, administrative, financial and academic perspectives.

The form and shape that IPE could or might take would certainly depend on the motives and movements promoting it and educationalists’ key concerns should be with how best to adapt to the change and plan for its integration as part of a continuum of learning. The time required to develop such innovation needs to be acknowledged, as IPE cannot be a hurried or a half-hearted attempt and it must be meticulously planned to fit with the climate of the organisation, as has been shown by this study and by other studies before it (for instance Barr, 2015; Barr et al., 2014; Miller et al., 2006). In the interim, existing and interesting initiatives at the Faculty, (as discussed in Chapter 2) could be used as platforms to initiate interprofessional collaborations, albeit at more basic and modest levels. Notwithstanding the extent of these initiatives, they must be developed through ways which will consider and address the complex micro, meso and macro factors identified in this study.

8.5 Originality and Contribution to Knowledge

To date, most of the IPE research has been concerned with new or established IPE initiatives. This case study appears to be the first empirical study to explore perceptions of IPE from higher education and health stakeholders when this philosophy had not yet been considered within professional health education. It thus addresses curriculum innovation concerns *a priori* to a change being implemented which is an uncommon approach, but is one which underscores the value of evidence-based approaches towards higher education innovation; this could empower rather than impose change. This study is pertinent in that it is the first
study of IPE to be conducted in Malta and this could inform and support potential IPE development. The research could also be significant for local policy makers considering change and innovation in higher education and health service delivery contexts, as it provides deeper understandings about contextual determinants operating within these fields.

The case study methodology adopted in this instance was novel in that it explored the possibility of IPE at the Faculty of Health Sciences and then interpreted these findings in relation to wider determinants both inside and outside the organisation. Although a case study approach has previously been employed in IPE research (Gray, 2009; Irajpour, 2009), this study was amongst the first to focus on a particular socio-cultural political institution (the Faculty of Health Sciences), interpreted to discover possible insights about wider macro structural determinants. This was done by presenting a complete picture of the Faculty, as much as was possible including a chronology of events to help the reader understand and contextualise the story of health professional education in Malta and the connectedness of events.85 The combination of focus groups and interviews with faculty academics, newly qualified health professionals, and key informants from the higher education and health systems also constituted a new way of exploring the complex and multiple realities of the various stakeholders, an approach which has deepened understandings of IPE and its various implications. In addition, my continuous in-depth reflexive analysis exploring and acknowledging the central role I played in this case study could contribute to the wider academic methodological debates concerning qualitative insider research.

This study adopted an interdisciplinary conceptual framework comprising of two social science disciplines to transcend the tangible findings and to engage in higher order reconceptualisation: Sociology for looking at universal organisational and occupational values and practices, and Anthropology for looking at contextual and national values so as to understand the socio-cultural environment from which participants’ discourses emerged. Although interprofessional relations have always

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85 This included detailed information about the Maltese context, the faculty context including the process leading to its upgrading from an Institute of Health Care, the stroke symposium and current multiprofessional initiatives; all collected from documentary sources.
been a topic of debate within the IPE literature, it has only been in recent years that scholars have engaged with critical socio-historical theories providing a different perspective on how the discourse of professionalism could influence IPE. Theorists recommend the use of empirical research framed by sociological perspectives within the interprofessional field (Reeves, 2010; MacMillan & Reeves, 2014) and this study responds to that recommendation. My socio-historical analysis of the health care professions, combined with Bourdieu’s perspectives on professionalisation adds depth to understandings of imbalances in power and status between the local medical profession and other health professions and between the health professions themselves; imbalances which contribute to maintaining traditional hierarchies and which would undoubtedly challenge the notion of IPE in Malta.

The use of anthropology addresses a gap in the literature in that there is currently a dearth of knowledge on how specific cultural values could influence IPE. This study’s use of Hofstede’s (Hofstede et al., 2010) theory of cultural dimensions together with microstate sociological constructs, provides valuable insights into how cultural values could challenge or facilitate the development and delivery of IPE. Although the analysis and conclusions are particular to Malta, the implications of culture as an operational concept can make a wider and a significant contribution to scholarship on IPE and innovations in higher education. For example, understandings of national cultural factors could offer some reasons for variations in IPE uptake and development worldwide. My conclusion, suggesting that national culture might be a potential barrier to IPE in Malta, could also highlight new insights for European mini-states and other nations that share similar contextual features.

Arguably then, faculties worldwide considering the adoption of IPE would benefit from identifying ways their national culture might influence the development and delivery of IPE and developing a priori strategies to reduce its challenging effects and to take advantage of its facilitative nature. Consideration of cultural-specific factors together with universal factors could eventually translate into improved development and delivery of IPE programmes. The examination of unique cultural dimensions found in different societies is also relevant to higher educational contexts in general, and stakeholders could benefit from examining the potential impact of national culture, prior to introducing major innovations and/or changes; doing so
may well help mitigate negativity which is one of the biggest obstacles to curricular reforms.

Completion of this thesis has generated new understandings of potential opportunities and pitfalls in relation to the possible implementation of IPE in Malta. It has identified factors at micro, meso and macro levels which could potentially influence any IPE initiative and again emphasised the centrality of understanding the context at the planning phase. It has highlighted how political, professional and cultural contexts are all critical factors in the development and delivery of IPE. Although widespread, undergraduate IPE in Malta might not be achievable in the near future, these insights provide much needed knowledge which could inform modest IPE initiatives should the will be there.

8.6 Implications of the Findings

This section presents a number of implications arising from the study findings. These implications are discussed from a complexity perspective which necessitates novel insights and novel approaches and recognises that uncertainty and unpredictability are necessary for the functioning of a system respecting influences at the individual, organisational and systemic levels identified in the findings (Price, 2005).

8.6.1 Implications for Education and Practice

It has already been concluded, that at the time of writing, the absence of political or institutional drivers for IPE in Malta renders the development of IPE unfeasible, as strong leadership is a prerequisite to its successful implementation and sustainability. While a lack of top-down enthusiasm for IPE was identified in the case study, so too an absence of bottom-up enthusiasm was noted, most notably reflected in the dissonance between participants’ lauding of IPE as an idea but baulking at the notion of putting this idea into practice. This combination of top-down and bottom-up indifference, resistance even, to IPE resonates with Clark’s (2004) “law of academic inertia” (p. 254) and “law of permanency of academic change” (p. 257) suggesting that tension between these ‘laws’ looks set to continue and the educational setting

86 Political in this context refers to both the political climate at the Faculty, as well as central government politics.
may remain static and resistive to change, at least for the time being, and so how the University will respond to future government-imposed changes remains to be seen.

Notwithstanding, this study has shown the importance of understanding the complexities of innovation from a number of perspectives and of contemplating change based on evidence emanating from research, as opposed to simply imposing change.

Although developing fully integrated undergraduate IPE might not be timely, the findings provide understandings of innovation and potential challenges within the local context and knowing them helps support positive change at deeper levels, possibly leading to small scale research-informed IPE initiatives. For example, the idea that Malta could be considered an individualistic society (Hofstede et al., 2010), suggests that individuals’ professional and cultural values cannot be sidelined in any move towards change that will impact the collective; rather, change must be thought through and managed in such a way as to respect and accommodate individuals’ needs and negotiation of collective goals. Seeing that Malta is also high on uncertainty avoidance, pragmatic ways need to be found so as to allay fears and engender trust. Fisher and Shapiro (2005) suggest that when team members feel safe, they are more ready to take risks and to understand and address the emotional experiences that arise in any negotiating process. In this study, where participants openly discussed a lack of trust both on professional and personal levels, an explicit approach addressing these core concerns could provide the necessary groundwork for further interprofessional work. This approach could utilise theoretical perspectives from social psychology discussed in the Literature Review, for example, the ideas of Allport (1979) and Festinger (1962) so as to focus on the development of the individual preparing for collaborative practice. Another way could be to develop firm foundations of socio-cultural collaborations between academics and between students prior to developing more formal training programmes on which interprofessional working could be initiated. Furthermore, the idea of communities of practice (Wenger, 1998) discussed in the Literature Review

It is being assumed here that implications for the development of IPE within educational settings could be precursors to improved collaborative practices within health practice contexts; this is supported by amongst others, the WHO (2010) Framework for Action on Interprofessional Education and collaborative practice and the IOM (2015) report, both discussed in Chapter 3: Literature Review.
offers another possible theoretical framework for engaging faculty staff and driving transformation in health curricula.

The finding that cultural determinants in Malta could work against the notion of teamwork implies changing a culture to one in which professionals become more comfortable with working together. Various ways for developing the competencies of cultural change have been discussed in the Literature Review, notably in the works of Clark (2009) and Stinson et al., (2006). Another approach, as suggested by Academic 28, could be to introduce interprofessional activities within some modules at the Faculty during which the emphasis would be on educators identifying critical factors that make interprofessional teams work well and trying to engender the necessary competencies in the undergraduate students. Developing teamwork skills at an early age could be yet another consideration, however this would require getting educational partners on board so that the foundations for teamwork learning and working could be addressed in primary, secondary and post secondary schools.

It is also necessary to acknowledge what is realistically possible to achieve within the present climate of the Faculty of Health Sciences. Currently, it might be opportune to develop small-scale interprofessional activities based on existing multiprofessional initiatives; and should these be successful, broader initiatives could be developed, for example capitalising on national health concerns such as dementia and diabetes and using these to develop an undergraduate IPE programme across a number of curricula. Also, perhaps mandates in higher education reforms could be used as catalysts for creating new opportunities in IPE; an example would be the Bologna Process which, since 1999 has influenced the way higher education has evolved and will continue to evolve in Malta.

There is a further point worth considering. While the question of timing, that is when IPE might best be introduced to students, was discussed in this study, the timing of IPE also has implications for the professions that make up the Faculty of Health Sciences and indeed for the Faculty itself. Turner (2011) suggests that professions go through “developmental life stages” (p. 317) from infancy, through childhood, adolescence, young adulthood to maturity. Turner’s analogy suggests that the various professions at the Faculty might be at different ‘developmental’
stages, implying varying levels of readiness for IPE. And indeed, while the Institute of Health Care was established in 1987, the Faculty of Health Sciences per se is one of the youngest at the University and, perhaps, at this neophyte stage, it needs to address other priorities that would assert and strengthen its position within the University at large, before it would be ready to engage in either intra or inter faculty IPE.

8.6.2 Implications for Research

Whilst a central concern of the thesis focused on the potential influence of national culture on the development and delivery of IPE, the results were limited to participants’ perceptions of potential IPE rather than established IPE. Further exploratory research is required in order to provide more comprehensive understandings in which contextual variables impact on the design and delivery of established IPE in various countries.

It would be interesting if future research were to explore why some countries, identified within Hofstede’s model as having cultural values which might challenge IPE (such as high uncertainty avoidance, high power distance and high individualism) have succeeded in integrating IPE in their professional health curricula. Such studies might reveal other determinants and factors which can overcome these cultural characteristics.

The conceptual framework for this thesis employed sociological and anthropological analytical tools to examine and frame understandings of interprofessional relations and cultural determinants. Future research might employ further sociological perspectives which could deepen understandings of what is necessary in order for collaboration to take place. For example, Foucault’s (1982) theories, in particular his concept of power as a ‘regime of truth’ could frame future research adopting a post structuralist perspective. A Goffmanesque (Goffman, 1959) analysis of individuals’ situated performances and interactions forming the basis of teams could also generate further knowledge and build upon the findings of this research.

This study has identified a few opportunities within the Faculty of Health Sciences where undergraduate IPE could be introduced as small scale initiatives. One of these
initiatives could be developed as longitudinal action research which would build on existing modules and hence, would not necessitate major curriculum changes. Such research could be used as a pilot project to generate knowledge about an actual IPE initiative rather than a proposed one, and perspectives from social and dynamic psychology could underpin such an interprofessional initiative.

Future studies on IPE in Malta could consider widening the scope of IPE to include professions outside the Faculty of Health Sciences, such as medical practitioners, psychologists and social workers.

8.7 Limitations of the Study

Whilst this research has generated valuable knowledge for the planning and development of IPE, a number of limitations need to be highlighted.

8.7.1 Critique of Case Study Research

Case study research has been critiqued by the research community and I have attempted to recognise and address these critiques, both conceptually as well as within the context of this study. My position *vis a vis* the debate about the generalisability and transferability of the findings from this case study has been addressed in Chapter 4: The Research Process, Section 4.3.

It could be said that learning is by doing and, having utilised a case study approach, I can look back and affirm that this was an appropriate methodology to address my research questions and to gain understandings of stakeholders’ perspectives and perceptions of IPE in Malta. In telling the story of the case, I have come to value how the case could be looked at in-depth and from many angles. The bounded case, the possibility of IPE at the Faculty of Health Sciences in Malta, existed within an organisational and national context which could be understood and interpreted within the complexity of this context. This is not to suggest that another methodology would have not yielded significant knowledge; it would have elicited different kinds of knowledge because another methodology would have addressed different research questions. Nevertheless, I had a number of concerns which need to be highlighted. At the outset, I was apprehensive that my account might offer a distorted picture of the world under study. That is, that I might depict the participants’ world as I see it,
more so than as they perceive and experience it. Although I realised early on that my interpretation was partial and limited, demanding that I engage in continual self-reflection, I was still concerned that this thesis might report my representation and construction of reality. Therefore, to safeguard against possible misrepresentation, I employed strict methodological integrity to ensure rigour of the study (Lincoln & Guba, 1985); and the measures I took have been explained in-depth in Chapter 4, Section 4.6.

I was also concerned that I might underrepresent the perspectives of certain participant groups. For example, although the study sample included academics, key informants and newly qualified health professionals, the major representation consisted of faculty academics (fifty three participants in ten focus groups as opposed to five key informants and six newly qualified health professionals); this could have shifted my analysis in favour of the academics, risking over-reading or making claims about specific issues. Hence, I tried to be more sensitive towards newly qualified health professionals’ and key informants’ discourses during the entire research process particularly during analysis and discussion. I found this approach challenging in the case of the newly qualified health professionals because, as explained in Chapter 4, Section 4.5.1.5.2, they did not engage in discussion to the same extent or depth as did the academics and key informants; nonetheless, I was satisfied that I had gathered sufficient data and did not need to go back to the field. However, in hindsight, this study might have benefited from conducting focus groups with other health professionals who had been working in the service sector for a number of years as this would have given me another perspective to contrast and compare with the newly qualified professionals’ accounts.

Although acknowledging that one view will always emphasise a particular set of views over another, Walker (1983) suggests that the only way to give a balanced account would be to document the entire system and underscore the fact that a case study portrays a truth but not the truth. This, I have endeavoured to do by meeting with most of the academics at the Faculty of Health Sciences, a number of influential stakeholders (Key Informants) in the sector and engaging in a documentary search. The latitude of documents reviewed throughout this study (detailed in Chapter 4, Section 4.5.3) was particularly beneficial in that it enabled me to review a broad
spectrum of sources relevant to the research questions, the unit of analysis as well as furnishing me with background information to participants’ discourses both from an academic as well as from a health policy/service perspective. Documentary data also provided details and rich descriptions not only of the Faculty of Health Sciences but also of where the Faculty is positioned in relation to the University of Malta, the Health Sector and the wider ambit of Maltese culture, all pertinent to address the research questions. Nonetheless, the possibility of authors’ bias in these documents was constantly regarded and taken in consideration.

I was also cognisant of the temporal dimension inherent in a case study approach echoing Walker’s concern that a case study is ‘conservative’ in that it “captures an instant in time and space which can then be held against a moving changing reality” and that some case studies might “live only in the literature and in the minds of their readers” (Walker, 1983, p. 163). In this case study, although my research objectives were considered to be well-timed so as to capture the upgrading process from an institute to a faculty, the element of people moving on, as Walker (1983) suggests, was not relevant. The significance of this case study came from the fact that the realities described by participants were seen to reflect wider contexts and realities; an example of “studying the uniqueness of the case ... we come to understand the universal” (Simons, 1996, p. 167).

### 8.7.2 Lack of Knowledge and/or Misconceptions about IPE

As discussed in the findings chapter, some participants were unclear or confused as to the exact meaning of IPE and such misconceptions could have influenced the way certain discourses unfolded. For example, there were a number of instances when participants thought they were discussing IPE, whereas in fact they were referring to multiprofessional education and/or shared learning. Further, most participants’ discourses were based on a hypothetical knowledge of IPE, as only a few of them had actually experienced IPE as per CAIPE’s (2002) definition; and when they did, this was mostly postqualification.

Participants’ potential lack of knowledge and clarity surrounding IPE was an issue which I considered at great length at the beginning of the research process and which I attempted to partially address by providing basic information about IPE both in the
participant information sheet and at the start of each focus group. However, in retrospect, I could have attempted to increase and clarify their understandings of IPE by sending them participants prefocus group/interview reading material.

8.7.3 Focus on the Faculty of Health Sciences
This study primarily focused on IPE at the Faculty of Health Sciences, as opposed to including other health and social care professionals outside the Faculty. Although it was acknowledged that this was an artificial boundary for IPE per se, to have explored perceptions other than from the Faculty of Health Sciences might have compromised the depth of the study, as well as bringing to the fore a number of variables between faculties which would have been difficult to reconcile during data analysis. For example, different undergraduate programmes would have different programme organisation and durations, different ways of organising practice placements, different ways of granting licensure to practice and different departmental compositions. The Faculty of Health Sciences was unique in the sense that there was a certain amount of commonality amongst its departments; nevertheless, widening the scope of my research would likely have generated more complete conclusions. The use of a single case research context also limits the wider relevance of this work.

8.7.4 Confidentiality and Anonymity
As explained in Chapter 4 (Sections 4.7.3 & 4.7.4) I took all necessary measures to ensure confidentiality and the anonymity of participants and professions represented at the Faculty of Health Sciences; and this necessitated omission of certain issues and discourses from the final write up which limited my findings and discussion; inclusion of this data would have provided a more comprehensive picture.
8.8 Dissemination Strategy

I will undertake dissemination of this study, both locally and internationally and be continually cognisant to present information in a sensitive and anonymised manner, particularly when presenting the findings to local audiences.

Locally, dissemination will be at the University of Malta and this will encompass presentations at research seminars, workshops and other symposia. I will also endeavour to present my findings at local health and social care events, conferences, professional associations’ conferences/meetings, and focused initiatives, such as the recently constituted multiprofessional Health Research Group for Islands and Small states in Europe.\(^88\) I will look to the Malta Journal of Health Sciences (MJHS) the Malta Medical Journal (MMJ) for publication, and to other publications issued by the Faculty of Education, the Faculty of Social Wellbeing, Department of Sociology, Social Work and Institute for Small Islands and Small States.

Internationally, over the last five years, I have presented my work-in-progress at every annual University of Brighton PhD/ Professional Doctorate conference. I have also presented my preliminary findings at the European Interprofessional Practice and Education Network (EIPEN) conference (Bonello, 2013). Following completion of this work, I will endeavour to present my findings at IPE specific and collaborative practice conferences (such as those organised by EIPEN, CAIPE, NIPNET, ATBH), as well as at allied health and other higher education conferences. I will also pursue various scientific publication channels in peer-reviewed journals on interprofessional education and practice, allied health and higher education, and I will explore open access internet scientific publications.

Apart from disseminating through the media of publication, there are other fora where I can share and perhaps apply knowledge and learnings arising from this study. For example, I have been requested by various departments at the University of Malta to participate in interprofessional activities; such activities have included participating in an online debate about IPE, delivering a lecture on IPE to Masters

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\(^{88}\) This follows a WHO meeting in July 2014 at which representatives from eight small countries in Europe adopted a manifesto entitled *Implementing the Health 2020 vision in countries with small populations* which draws upon an intersectorial approach to health policy (WHO, 2014).
students (mental health nursing), and participating in the planning of a multiprofessional MSc in Rehabilitation. I have been invited to participate on a multiprofessional Health Research Group as part of a World Health Organisation programme to support research and capacity-building on health systems in small states in Europe. I have also been appointed as a board member for the selection of a number of health professionals to work as a community dementia intervention team; this initiative is a first for Malta, both in the selection process of the multiprofessional team and in the proposed working collaborative practices.

8.9 The Inward Eye … Epilogue

In sum, nothing has been said. We have not stopped at any word; the chain rest on nothing; none of the concept satisfies the demand, all are determined by each other and, at the same time, destroy or neutralise each other. But the rule of the game or, rather, the game as rule has been affirmed (Derrida, 1978, p. 347).

And this brings me to the end of my thesis; the end which in reality is no end at all. The end signifies some form of closure but, in this story, many questions are left unanswered. This journey has brought to the fore another aspect of this research; letting go of the need to answer all questions. My initial months of searching for certainty quickly ebbed away when I realised that the core of this experience would be a process of uncertainty and impermanence characterised with exploring alternate ways of seeing. I have questioned my taken-for-granted beliefs; beliefs in myself as an occupational therapist, as a researcher and as an academic all juxtaposed within one cultural milieu. Initially, I resisted this process as it was personally challenging, uncomfortable and rather self-indulgent, however as the process unfolded, I slowly learnt to strike a balance and be open to other realities; realities of participants’ worlds and realities of my world and how the closeness of these two realities gave rise to this story.

During this journey, I have worked against silencing my own personal and professional biases. There was no claim for personal objectivity as my world was interwoven with that of the participants. I tried to expose my biases so as to let readers be privy to my conflicts, dilemmas and inconsistencies. These were many,
and some of them are exposed in the reflexive excerpts woven throughout the thesis. At this final stage, two particular issues stand out. The first was my position as an insider researcher at the Faculty and the second, was my inexperience as an interpretive researcher most especially in interpreting my own culture.

And, as the study progressed, I slowly gained more confidence and learnt how to celebrate my subjectivity, as well as to trust my intuition. This was the only way I could make sense of this world in which I was both living, as well as researching. This process was guided by a strong element of tacit knowledge stemming from my understanding and appreciation of the context; both the organisational context, as well as the bigger cultural context. It seemed natural to me to understand how the parts and the ‘wholes’ were interrelated; in a way, a deeper way of seeing resonating with Simons’ view of case study research. Assuming such an epistemology, I was acknowledging the importance of the context both of the personal, as well as the collective and this again underscored some benefits of being an insider researcher. I also opened up to Habermas’ idea, that by understanding the structural forces which shape and embody us, the more we can change the course of history.\(^89\)

There were many challenging moments during which I felt frustrated and overwhelmed. There were other moments in which nothing seemed to be happening and I felt stuck. At those moments, Confucius’s words inspired me to go on “It does not matter how slowly you go, as long as you do not stop.” In retrospect, I understood that some of those moments were periods of incubation in that although nothing was happening ‘on top,’ ideas seemed to be developing in my subconscious. And occasionally those challenging moments gave rise to creative outbursts. It only took the right moment, the right excerpt, the right dialogue to unleash those ideas into new possibilities - possibilities which sometimes took me on a wild goose chase, however at other times opened doors to new insights and opportunities. A particularly Eureka moment to this work was the realisation that the largely tacit cultural traits alluded by the participants could be made visible beyond a pragmatic level.

\(^{89}\) Habermas as cited in Giddens (1985).
It goes without saying that engaging in such research over a period of five years blurs into all other professional and personal boundaries. Indeed, many times it felt like this research had taken over my life. There were many moments where my life as a researcher/student was at odds with my life as a mother and as a lecturer. Juggling commitments, piecemeal working and multitasking became the fabric of my everyday life; and at times my efforts and best intentions seemed futile. During those moments, I tried to negotiate some sort of compromise between order in my academic thoughts and ideas, as opposed to the chaos of everyday real life; and slowly I learnt to live with that.

The creation of this thesis also felt like an emotional roller coaster at times; beautiful moments of clarity and delight in grasping and playing around with difficult concepts, juxtaposed with moments of darkness and conceptual lack of clarity. There was only one way to jump off this roller coaster and clarify the cacophony of these thoughts. Solitude. It was only when I was alone and secure in my cocooned silence that I could engage in the difficult business of thinking, looking for connections and hoping that new insights and inspirations would develop. And they did. Looking back, inhabiting this cocoon challenged me and pushed me towards my ultimate goal in writing this thesis. It also transformed me. I might have not become a butterfly but I have developed new perspectives about defining the world and being in the world. This, I believe, has moulded me into a better person, both professionally and personally; a person with increased presence and more confidence to grasp the complexities of what I had set out to do. An excerpt from T. S. Eliot’s Four Quartets\(^{90}\) aptly encapsulates the end of my PhD journey ... and possibly new IPE beginnings for IPE in Malta.

We shall not cease from exploration  
And the end of all our exploring  
Will be to arrive where we started  
And know the place for the first time (T.S. Eliot, 1944/1979).

\(^{90}\) This excerpt is from The Little Gidding which is the last poem in T.S. Eliot’s Four Quartets.


Finlay L. (2006a). 'Going exploring': The nature of qualitative research. In L. Finlay, & C. Ballinger (Eds.), Qualitative research for allied health professionals (pp. 3-8). Chichester: Whurr Publishers Limited.


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Appendix 1
Letter from IHC Chairman to Rector, UoM

Letter from Chairman, Institute of Health Care, to Rector, University of Malta, highlighting the importance of interdisciplinary cooperation within a faculty context.

During the year 2009 discussions started at IHC Board level regarding the possibility of the Institute moving towards Faculty status. The discussions focused mainly on the strategic analysis of each Division within the Institute of Health care, as well as the formulation of a future strategy that would define each Department within a Faculty of Health Sciences. Throughout the year several meetings were also held with the Rector, while the Director had meetings with the Secretary of the University and the Director, Human Resources Management and Development to explore the impact that a Faculty status would have on the current human and financial resources. On 26th March 2010 the Rector encountered all the academic members of the IHC. During this meeting the Rector remarked on the great academic progress that had been made by the Institute over the last twenty years and that in his opinion the Institute was ready to become a faculty and that he would be setting in motion the necessary procedures for this purpose with Senate and Council of the university. He also suggested that the academic members should suggest the name of the new faculty bearing in mind the mission statement of the Institute of Health Care.

Practically all the academic members of the Institute contributed towards choosing an appropriate Name for the new Faculty. The vast majority suggested that the new faculty should be Faculty of Health Sciences for various reasons including the fact that most of the European and U.K. universities had chosen this name for a similar faculty with the same objectives. A much smaller number had preferred Faculty of Heath Care Sciences.

The Care aspect of this Faculty of Health Sciences is highly important and would be emphasized by keeping the original mission statement of the Institute: “To achieve excellence in the education and training of reflective, caring, accountable health
professionals, in response to the health and health service needs of the population” that was formulated in 1992 and reflected the needs and the social climate of the Maltese Islands at that time but is still very relevant today. This will remain the basic mission of the new Faculty. However, Research on the effectiveness of our Health Services at the point of delivery, and the health of the population will also remain a highly important goal of our faculty together with active and continuous efforts towards more and more interdisciplinary cooperation, similar to the Zammit Clapp Hospital Concept approach towards patient care with ‘team working’ among the various departments for a greater and more effective approach towards patient care and the health of the population in general. Refer to my Introduction to the Interdisciplinary Seminar held on 3rd February 2008.

The IHC has grown in stature and beyond recognition during the last twenty years. Over the last ten years the Institute began to put a greater emphasis on research as part of the formation of our academics and has been assisting them in attaining postgraduate qualifications at Masters and Doctoral levels. This has proved a good investment and at present nine out of ten divisions have members of staff with PhD’s. Altogether there are

When one takes into consideration that twenty years ago there were no Maltese members of staff who were in possession of post-graduate degrees, and we were heavily dependent on foreign staff to teach in our various courses, one must congratulate all our teaching staff for their dedication and commitment to the advancement of their various disciplines. We can today state that the vast majority of our teachers have attained post-graduate qualifications at Master’s level without neglecting their teaching commitments.

We can also state that we are no longer dependent on foreign teachers for the running of our various courses. This fact must be recorded as the greatest achievement of the Institute of Health Care and the most important and urgent of its targets as stated in its mission statement at its birth twenty years ago.
We have to remember the difficulties and handicaps we had at that moment in time. Twenty years ago recruitment into the Health Care professions was a great problem and we used to have very few recruits with ‘Advanced Level’ degrees applying to join our courses. We must also note that historically ‘Nursing’ in particular had suffered, for various reasons, from a very poor image among the general public right up to the nineteen eighties. It is very satisfying to note that, over the last ten years, there has been a steady increase in the number of students entering our various courses; so much so, that today we have a problem of numbers and had to introduce a ‘numerus clausus’ for some of our courses on account of our limited facilities. As a matter of fact last summer (2009) we had the problem of selecting the admissions out of the several hundreds that had applied for the diploma and degree courses in Nursing Studies. At present we have altogether 888 students following courses in the ten divisions, while a total of 2,769 students graduated during the last ten years.

The ten departments that are expected to form part of the new faculty are the following:

**Departments of the new Faculty of Health Sciences:**

- Nursing Studies
- Midwifery
- Biomedical Sciences
- Communication Studies (Speech Therapy and Pathology)
- Physiotherapy
- Occupational Health Therapy
- Environmental Health
- Radiography and Radiotherapy – A new combined Courses of Radiography and Radiotherapy is being prepared.
- Health Services Management
- Podiatry
- Dental Technology – It is suggested that the small division of Dental Technology should be integrated with the Faculty of Dentistry.
University Strategic Development Plan 2002 – 2006
Address by Professor Rizzo Naudi, Chairman Institute of Healthcare – 18.09.02

I wish to welcome here the Pro Rectors, Professor Charles Farrugia, and Professor J. V. Bannister and congratulate Prof. Farrugia on the preparation of the Draft Development Plan document which should serve to indicate the way forward for all the Faculties, Institutes and other departments within the University for the next five years. The University needs to have and follow a plan if it is to survive and flourish and retain relevance in today’s world.

Today’s conference is a working conference designed to discuss the development plan or the University in relation to the strategy to be adopted by the Institute of Health Care for the next five years.

The Strategic Development Plan that we will be discussing today lists nine goals that we have to try and achieve:

Quality Education, Excellence in Research, Quality of life of the people, The World of Work, Student Numbers increase, Streamlining of Administration, Improvement of the Physical Environment, Funds Generation and Enhancing of Quality Assurance.

The Institute of Health Care (as we know it today embracing many disciplines of the caring professions) was founded in 1992 and is therefore ten years old this year. A good way to introduce this conference is to refer to the document prepared by Dr. Gauden Galea for the first strategic conference of the I.H.C. held on 6th June 1995 in which he outlined the general thrust of the proposed strategy for the last five years of the twentieth century and beyond.
1. The IHC was to adopt a structure that permitted each of its divisions to carry out their functions in a manner that was as autonomous as possible, in a subsidiary relationship with the centre and with an emphasis on multidisciplinary action.

2. The established courses needed continuous updating and maintenance. By the end of the 5 year period, the basic courses in most professional divisions of IHC were to be at degree level. Furthermore, most staff at IHC were to have achieved a postgraduate qualification and some would have acquired their doctorate by the end of these five years.

3. Forging of alliances. The IHC was to enter into discussions with the Medical, Dental and possibly, the Pharmacy Faculties to create a structure for an Allied Health Sciences grouping within the University that recognised the contribution and autonomy of each of the professions represented in the group. Furthermore, the IHC was to seek to strengthen links with partners in public or private organisations that could assist the Institute in fulfilling its mission.

4. Expansion and innovation. Its basic courses close to finalisation, the IHC was to develop increasingly the post basic element, seeking to further integrate theory and practice among established professionals. The IHC was to also seek and explore new areas of activity, such as consultancy and direct service provision.

5. International growth. The small number of international students and projects in the IHC was expected to grow as the Institute gathered momentum in research and publication, in the marketing of courses and in experience at grant applications and international project proposals.

Most of these targets were reached to a greater or less extent. The IHC is justifiably proud of its achievements during the first ten years of its existence.
When one takes into consideration that ten years ago, there were no Maltese members of staff who were in possession of post-graduate degrees, and we were heavily dependent on foreign staff to teach in our various courses, one must congratulate all our teaching staff for their dedication and commitment to the advancement of their various disciplines. We can today state that the vast majority of our teachers have attained Masters post-graduate qualifications without neglecting their teaching commitments. There are, in addition, six teachers, with a Ph.D. including three Ph.D. this year. There are also a number who are working towards a Ph.D. We can also state that, today, we are no longer dependent on foreign teachers for the running of our various courses. This fact must be recorded as the greatest achievement of the members of staff of the IHC and the most important and urgent of its targets as stated in its mission at its birth ten years ago. We have to remember the difficulties and handicaps we had at that moment in time.

Ten years ago, recruitment into the Health Care professions was a great problem and it is very satisfying to note that, over the last few years there has been a steady increase in the number of students entering our various courses: so much so, that today we have a problem of numbers. We have also seen a great improvement in the quality of the students, which has enabled us to discontinue the Certificate Course for Nurses. The Mission Statement of the IHC, “To achieve excellence in the education and training of reflective, caring, accountable health professionals, in response to health and health service needs of the population,” which was formulated ten years ago, takes into consideration a number of goals set by this strategic plan. It also reflected the needs and social climate of the country at that time. Perhaps the time has come to include a greater emphasis on research as part of our mission.

Over the last five years, courses have been continually updated, whilst an increase in the quality of the courses can also be recorded as attested by examiners and by feedback from clinical areas.

Certain courses, such as Communication (Speech Therapy), Physiotherapy, Occupational Therapy and Medical Laboratory Science and Environmental Health, are only offering a degree course, whilst others, such as Nursing and Midwifery
studies, and Radiography are offering Diploma and Degree Courses. Health Services Management on the other hand is only offering post graduate course at Diploma and Master’s Level. The Health Services Division has also run a good and useful programme in Management, in collaboration with Bocconi University. This programme was organised principally for the Departmental Heads in the Health Service. 1st and 2nd Line Management courses are being offered for all our nurses. These courses are all well attended.

A new post graduate course on Nutrition and Dietetics was started two years ago and will be offered again this year. A number of students are attending. We are also planning a new course in Dietetics.

The IHC is characterised by the number of very different disciplines and courses in the various divisions. After many meetings of the coordinators, a broadly coherent set of courses across and within these professions has been created although there are still some persistent differences inherent to the IHC.

An important first achievement by any faculty or institute to be recorded is the very positive Quality Assurance Exercise which was carried out this year by Professor Bannister, Dr. Sandra Buttigieg and Ms Jo Anne Stivala our very efficient ‘administrator.’ We can also make another more important statement, that is: although we value greatly the links that we have established over the years with other Universities, we are no longer dependent on foreign universities for the running of our present courses. This may sound triumphal, and indeed it is, but it is a good thing to recognise our strengths on a day when we have met to discuss and plan the strategy and general future direction of the Institute of Health Care. Having said this, I do not wish to convey the message that we have no problems at the IHC. All of us gathered here know our weaknesses and the many problems and tribulations that we have to face throughout the years.

Distance Learning. The IHC has over the last year been working on developing this new medium of learning. It is planned to start this Distance Learning Programme in January as an experiment with Gozo Hospital.
Any future strategy needs to be planned against existing real constraints.

The problem of limited space within the IHC is very real. The effective classroom space is fully utilised and the allocation of classrooms and other areas within the IHC is a real headache for the administration.

Funding of the various courses run by the IHC has always been a major problem. The resource base of the IHC is still uncertain. The staff at IHC have different employers and reporting relationships. Too much uncertainty is generated by the annual budgetary exercise where academic standards may be compromised by the provision of resources that fall below the essential level. We are still very heavily dependent on the Department of Health for the financing of our facilities and courses. At this point, I wish to thank the Department of Health for their continued support over the years. The situation has improved during the last year but a further exercise is necessary at political and administrative level where an appropriate level of funding is agreed upon and administered.

The future of the health service in our country will depend on the quality of the training and preparation of the persons working in that service.

There is still a lot of work and development that needs to be done at pre- and post-graduate level. The training of the personnel for The New Hospital that will be commissioned in a year’s time is only one of the major challenges facing the Institute of Health Care, other urgent tasks are specific programmes, such as strengthening the Primary Health Service.

Primary Health Care and Family Medicine have now become very urgent challenging problems. These will need to be tackled by joint efforts by the Medical School, the Institute of Health Care and the Government Health Service. The M.M.D.N.A. needs also to become involved in this exercise.

I wish to conclude by emphasising one important aspect of Health Care Education and that is Research.
Health Services Research is a tried and effective means of assisting the strengthening of health systems management. Such research conducted at all levels, will become increasingly important as the costs of health care mount and there are demands for greater efficiency, effectiveness and improved quality of care.

Need for a target directed Health Service Research strategy must be developed involving the Health Division, the University, the Medical School, the Institute of Health Care and the various health care professionals. Priority setting is essential. Training in Health Services Research and epidemiology should be promoted. It is being proposed that a special unit within the IHC should be set up which could serve other Departments in Health Care Education.

I wish to conclude by showing my appreciation and to express my sincere thanks to all the teaching, administrative and supporting staff at the I.H.C. for their dedication and work.
Chairman’s Address

Professor John Rizzo Naudi, M.D., B.Sc., F.R.C.P. (Edin.)

The years 2008 and 2009 have been quite eventful and rich in experience. During these two years the Institute of Health Care made the important move from the inadequate building that had originally housed the old School of Nurses at St. Luke’s Hospital and settled in the new purpose-built premises at Mater Dei Hospital near the Medical School and the Library. The Institute of Health Care now operates on a single floor with offices for the administrative and academic members of the staff that facilitates easier communication between the various departments. The new premises at Mater Dei also have fully functioning laboratories for the various divisions and are equipped with the latest technologies and facilities for the students’ practical sessions.

The original mission statement of the Institute – “To achieve excellence in the education and training of reflective, caring, accountable health professionals, in response to the health and health service needs of the population,” which was formulated in 1992, reflected the needs and the social climate of the Maltese Islands at that time but is very relevant today.

The IHC has grown in stature and beyond recognition during the last twenty years. Over the last ten years the Institute began to put a greater emphasis on research as part of the formation of our academics and has been assisting them in attaining postgraduate qualifications at Masters and Doctoral levels. This has proved a good investment and it is a great pleasure to report that six academic members of staff completed their doctoral studies during 2008/2009 and that at present nine out of ten divisions have members of staff with Ph.D.’s.

When one takes into consideration that twenty years ago there were no Maltese members of staff who were in possession of post-graduate degrees, and we were heavily dependent on foreign staff to teach in our various courses, one must congratulate all our teaching staff for their dedication and commitment to the advancement of their various disciplines. We can today state that the vast majority of our teachers have attained post-graduate qualifications at Masters level without neglecting their teaching commitments.
We can also state that we are no longer dependent on foreign teachers for the running of our various courses. This fact must be recorded as the greatest achievement of the Institute of Health Care and the most important and urgent of its targets as stated in its mission statement at its birth twenty years ago.

We have to remember the difficulties and handicaps we had at that moment in time. Twenty years ago recruitment into the Health Care professions was a great problem and we used to have very few recruits with ‘Advanced Level’ degrees applying to join our courses. We must also note that historically ‘Nursing’ in particular had suffered, for various reasons, from a very poor image among the general public right up to the nineteen eighties and our gratitude should go to the few nursing students of that period who must be considered as the true ‘pioneers’ of the modern nursing profession. It is very satisfying to note that, over the last ten years, there has been a steady increase in the number of students entering our various courses; so much so, that today we have a problem of numbers and had to introduce a ‘numerus clausus’ for some of our courses on account of our limited facilities. As a matter of fact last summer (2009) we had the problem of selecting the admissions out of the several hundreds that had applied for the diploma and degree courses in Nursing Studies. At present we have a total of 888 students following courses in the ten divisions, while a total of 2,769 students graduated during the last ten years.

During the year 2009 discussions started at IHC Board level regarding the possibility of the Institute moving towards faculty status. The discussions focused mainly on the strategic analysis of each Division within the Institute of Health Care, as well as the formulation of a future strategy that would define each Department within a Faculty of Health Sciences. Throughout the year several meetings were also held with the Rector, while the Director had meetings with the Secretary of the University and the Director, Human Resources Management and Development to explore the impact that a faculty status would have on the current human and financial resources. On 26th March 2010 the Rector encountered all the academic members of the IHC. During this meeting the Rector remarked on the great academic progress that had been made by the Institute over the last twenty years and that in his opinion the Institute was ready to become a faculty and that he would be setting in motion the necessary procedures for this purpose with Senate and Council of the University.

Another important event that has to be recorded for this year is the setting up of the Midwifery Division as a separate division from Nursing. Midwives in Malta have always been considered as a separate profession from nurses. As a matter of fact the University held three-year courses for midwives, at irregular periods from 1915 onwards until 1946 when they were taken over by the Department of Health. By 1958, midwives in Malta were “fully qualified to render the best service” but there were not enough of them, since there were no facilities in Malta for the training of midwives at that moment in time, and aspiring midwives had to go overseas (usually the UK) for training. In 1974, Miss Mary Vella Bondin took over the running of the Midwifery Training courses and of other educational programs related to Maternity Care and to in-service education of midwives until her retirement in 1993. With great sadness I have to report that this great pioneer and founder of Midwifery training in Malta died on 13th December 2009 mourned by all of us.
A shortage of trained midwives persisted and in the nineteen nineties the Institute of Health Care decided to hold four direct entry courses for midwives, which helped to relieve this problem.

An important initiative undertaken by the Institute of Health Care was the introduction in October 2009 of an E-learning B.Sc. (Honours) Degree with the aim of facilitating and providing more accessible education to qualified health care professionals by allowing flexibility and by decreasing the demands on the health service sector for the release of staff. This course was offered to health care professionals in possession of a 'Diploma' qualification and replaced previous diploma-to-degree programs that various divisions at the Institute were offering.

A major event that must be recorded was the successful organisation by the Nursing Division of the conference ‘Nursing and Midwifery – A celebration of Care’ that was held in May 2009 against the background of the global financial crisis.

The Institute of Health Care through its various Divisions has remained very active on the international front. Indeed, the Institute of Health Care has been quite heavily involved with staff and students’ exchanges, as shown in the Divisional reports. Furthermore, the Institute of Health Care has invited a number of visiting lecturers and professors from international academic institutions, to deliver lectures to our undergraduate and postgraduate students.

In conclusion, I would like to thank the Director, Dr Sandra Buttigieg, the Coordinators of the various divisions and all the academic members of staff for their enthusiasm and dedication to the advancement of the Institute to its present academic level. In particular, I wish to thank all the administrative and technical members of staff for their hard work and continued support and assistance whenever it was required.

It is with great pleasure and satisfaction that I present this biennial report for 2008/2009.

[Signature]

Professor John Rizzo Naudi
Chairman
Institute of Health Care
Appendix 4  
IHC Strategic Plan & SWOT Analysis (2009 – 2014)  

Paradigms guiding the strategic planning process:  
a) The open-systems model which emphasizes that organizational development occurs within an external environment and often as a response to changes in that environment.  
b) The marketing paradigm which emphasizes that the services of an organization will only be requested (bought and paid for either directly or indirectly through taxpayer money) by client stakeholders because the services offered are seen as being of value to them.  

Core values guiding the strategic planning process:  
a) Search for Excellence: We consistently set, pursue and maintain the highest quality education and research,  
b) Respect: We respect the dignity, uniqueness and particular learning needs of every student and healthcare profession,  
c) Professionalism: We work with expertise, commitment, integrity, fairness, reliability and flexibility, hence providing role modeling opportunities to our students,  
d) Service: We maintain positive relationships when fulfilling our duties with respect to the expectations of those students and other clients who request our services,  
e) Teamwork: We recognize that quality healthcare and consequently healthcare professional education are both intrinsically inter-professional activities,  
f) Lifelong learning: We affirm that in a knowledge-based society, excellence, professionalism and service are based on a process of lifelong learning.  

The strategic planning process used in preparing the plan:  
A) Setting up of an inventory of SWOT themes for the IHC (based on those produced by the various individual divisions),  
B) A portfolio analysis for the IHC (identification of clients and core competences from the SWOT audit),  
C) Forecasting of key external environmental issues from the SWOT audit,
D) Formulation of an updated mission statement for the IHC,
E) Formulation of an updated vision statement for the IHC,
F) Carrying out of a gap-analysis between the vision and present state of the IHC (as determined by the SWOT position audit),
G) Formulating key strategies and specific actions for gap reduction by matching internal strengths and weaknesses with external opportunities and threats
H) Setting a timeline for fundamental actions.

A. SWOT theme inventory for the IHC
A comprehensive SWOT audit for the IHC is attached as Appendix A to this strategic plan. This inventory is based on the SWOT audits of the individual divisions. Fifteen strengths (S1 – S15) and eighteen weaknesses (W1 - W18) have been identified within the internal environment, whilst seven opportunities (O1 - O7) and eleven threats (T1 - T11) have been recognized in the external environment.

B. Portfolio analysis
Our clients are:
   a. Students (as a university entity),
   b. DoH staff (contractual obligation),
   c. Fee paying clients: professional associations, general public, private hospitals.
Core competences:
   a. healthcare professional education provision
   b. some areas of healthcare research

C. Key external environmental forces
1) European faculty ranking (T10)
2) Developments in healthcare professional education e.g., inter-professional education (O6)
3) Competition from other EU universities for students and staff (T1)
4) The escalating cost of higher education and research (T2, T3)
5) Competition for limited EU research funds from other European universities and for local funds from other UoM faculties (T5)
D. New mission statement

“To strive for excellence in creating a learning and research environment that helps students develop into reflective, caring, and accountable professionals providing an integrated, holistic, and evidence-based healthcare service to the local and international communities.”

E. Proposed vision statement (W1)

The IHC will:

(a) Consolidate its position as the leading educational facility for healthcare professionals in Malta.

(b) Earn a reputation among Faculties of Health Sciences in Europe as a center of healthcare learning and research.

F. Key strategies and associated specific actions

_Strategy 1: Focus preservation_

a. Concentrate human and other resources on the educational and research areas in Appendices B and C (W1, W10),

b. Take steps such that all members of staff are aware of the new mission and vision statements (which should guide their initiatives) (W1)

c. Set up an inter-divisional entity for developing the inter-professional dimension of our services (S7, W3, O6),

d. Collaborate in local and international research initiatives consonant with the mission and vision statements,

e. Develop stakeholder partnerships, in particular set up a formal, transparent agreement with DoH specifying rights and obligations of both parties (W13, W16)

_Strategy 2: Innovation_

a. Set up new inter-divisional programmes in healthcare (e.g., M. Sc. Inter-Professional Education in Healthcare) (O3, O6, S7)

b. Set up more fee paying clinical services (O3, S15),

c. Set up fee-paying CPD courses and courses for the general public (O2, O3, S1, S9),
d. Develop new programmes in line with emerging healthcare requirements (S1, O3),
e. Set up more shared and inter-professional modules at undergraduate level (S1, O6)
f. Set up blended learning programmes

Strategy 3: Develop organizational status
a. Move to faculty status to further enhance our image both locally and internationally (W4)
b. Establishment of Academic Chairs for distinguished visiting scholars

Strategy 4: Develop human and other resources
a. Ensure that resident-academics have the opportunity to do Ph. D.
b. Provide pedagogical training using e-learning methodologies
c. Access to relevant journals
d. Development of a research support unit

G. Timeline for fundamental actions
a. Appointment of one resident-academic as policy developer and coordinator for research: immediate
b. Appointment of one resident-academic as policy developer and coordinator for developing inter-professional education: immediate
c. Formulation of a strategy for regularization of the position of DoH employees: immediate
d. Move to faculty status: October 2009
e. Increase of number of staff at associate professor level: October 2010
f. Pedagogical courses using e-learning methodologies: February 2010
g. Higher representation on Senate / Council committees: October 2009
h. Increase the number of full-time resident-academic staff in each division to ensure survival of all divisions: immediate

Chairman Director IHC Board, 2009
### Appendix A

<table>
<thead>
<tr>
<th>Internal Strengths of the IHC</th>
<th>Internal Weaknesses of the IHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1) Highly qualified and motivated academic staff with strong educator values</td>
<td>W1) Our vision and mission statements have served us well up to now. We need to update them for the future.</td>
</tr>
<tr>
<td>S2) Most divisions are members of the respective European thematic networks</td>
<td>W2) Insufficiently high profile of certain professions in Maltese society and alternative student career options (leading to low intakes in certain programmes even though they are a national need)</td>
</tr>
<tr>
<td>S3) Strong links between the divisions and respective DoH clinical departments/ high level management</td>
<td>W3) Inter-profession collaboration and support has started but needs to be greatly improved</td>
</tr>
<tr>
<td>S4) Strong links between the divisions and the respective professional associations</td>
<td>W4) Institute status perceived as inferior to that of faculty both locally and internationally by both academic peers and students</td>
</tr>
<tr>
<td>S5) Employability oriented curricula with a good balance between theory and practice</td>
<td>W5) Institute staff cut off from mainstream university structures, institutes on margins of UoM planning</td>
</tr>
<tr>
<td>S6) High level of research output in some divisions</td>
<td>W6) Insufficient awareness among some members of staff of academic ethos and opportunities available through university channels (owing to the fact that many staff members came from the DoH)</td>
</tr>
<tr>
<td>S7) All non-medical healthcare professions under one roof - excellent base for inter-professional education</td>
<td>W7) Hardly any representation on Senate / Council committees</td>
</tr>
<tr>
<td>S8) High individual attention to students notwithstanding the low resident-academic : student ratio</td>
<td>W8) A governance system which does not tap sufficiently the available expertise: no rotation of the higher echelons of governance and less than desired level of involvement of non-coordinators – both direct consequences of institute status</td>
</tr>
<tr>
<td>S9) Wide range of programs on offer - from undergraduate to doctorate plus many CPD courses</td>
<td>W9) Insufficient technical support staff for the skills labs</td>
</tr>
<tr>
<td>S10) High level of innovative curriculum development</td>
<td>W10) Low staff-student ratio and low level of administrative support in some divisions</td>
</tr>
<tr>
<td>S11) Good skills labs</td>
<td></td>
</tr>
<tr>
<td>S12) High level of response to the human resources needs of the</td>
<td></td>
</tr>
<tr>
<td>National Health Service</td>
<td>Leading to loss of focus and little time for post-doctoral work and attention to career progression - crucial as time spent on teaching and administration is not sufficiently recognized by the UoM for promotion to the higher academic grades.</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>S13) Most programs have (or are seeking) international accreditation</td>
<td>W11) The role of the division coordinators is anomalous - doing the work of heads of departments without the necessary administrative support (no equivalent of Departmental Secretary) or associated level of remuneration.</td>
</tr>
<tr>
<td>S14) Capability of servicing to other faculties is on the increase</td>
<td>W12) Insufficient resources to support the desired level of publication.</td>
</tr>
<tr>
<td>S15) Capability of fund generation is on the increase (e.g., community service provision, fee paying students, use of skills labs by other faculties)</td>
<td>W13) Striking the right balance between the interests of the university and those of the DoH is sometimes problematic. The contractual obligations of the IHC with respect to the DoH need to be clarified and made transparent.</td>
</tr>
<tr>
<td></td>
<td>W14) Financial planning at divisional level is difficult. Divisions have insufficient authority over divisional funds including those generated by the division itself.</td>
</tr>
<tr>
<td></td>
<td>W15) Ambiguous and uncertain situation of DoH employees seconded to the university on a full-time basis. These individuals have been giving service to the institute over many years yet have no resident-academic appointment with UoM. The position of these academics needs to be regularized so that they may focus their energies on institutional and personal academic development.</td>
</tr>
<tr>
<td></td>
<td>W16) Insufficient recognition by the DoH of the status of the IHC as a major stakeholder in policy formation.</td>
</tr>
<tr>
<td></td>
<td>W17) Insufficient access to clinical areas for student practice placements and for research.</td>
</tr>
<tr>
<td></td>
<td>W18) As a consequence of our institute status, representation on senate is not guaranteed.</td>
</tr>
<tr>
<td><strong>External Opportunities for the IHC</strong></td>
<td><strong>External Threats to the IHC</strong></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>O1) Increased participation in EU funded thematic / research opportunities</td>
<td>T1) Competition from other EU universities for students and staff</td>
</tr>
<tr>
<td>O2) Increased societal awareness of the need for higher quality and safety standards in healthcare</td>
<td>T2) The escalating cost of higher education</td>
</tr>
<tr>
<td>O3) Increasing demand for new educational programmes and CPD activities</td>
<td>T3) The escalating cost of research</td>
</tr>
<tr>
<td>O4) Fund generation through entrepreneurial activities (community service provision, fee paying students, consultancy etc)</td>
<td>T4) Low incentives for healthcare professionals to join academia on a full-time basis</td>
</tr>
<tr>
<td>O5) Strategic alliances with potential market competitors</td>
<td>T5) Competition for limited EU research funds from other European universities and for local funds from other UoM faculties</td>
</tr>
<tr>
<td>O6) Developments in international healthcare professional education e.g., inter-professional education</td>
<td>T6) Low number of resident-academics in some divisions could lead to amalgamation of divisions with attendant loss of identity of the various professions</td>
</tr>
<tr>
<td>O7) New opportunities in the industrial sector for students from some programs.</td>
<td>T7) Potential market competitors (e.g., MCAST, private commercial Educational institutions)</td>
</tr>
<tr>
<td></td>
<td>T8) Market saturation for some programmes</td>
</tr>
<tr>
<td></td>
<td>T9) Some aspects of university policies e.g., excessively harmonized regulations sometimes create difficulties</td>
</tr>
<tr>
<td></td>
<td>T10) European faculty ranking - would become a threat if not addressed</td>
</tr>
<tr>
<td></td>
<td>T11) Absence of professional indemnity insurance for students lowers the number of opportunities of foreign clinical placements for our students</td>
</tr>
</tbody>
</table>
Appendix B: Programmes Offered by the IHC by Division

<table>
<thead>
<tr>
<th>Division</th>
<th>Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Midwifery</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td>Applied Biomedical Sciences</td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
</tr>
<tr>
<td>Communication Therapy</td>
<td></td>
</tr>
<tr>
<td>Dental Technology</td>
<td></td>
</tr>
<tr>
<td>Environmental Health</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Existing / Developing Research Areas of the Divisions

<table>
<thead>
<tr>
<th>Division</th>
<th>Research Focus Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Dimensions of Chronicity, Aspects of Community Care, Learning and Education</td>
</tr>
<tr>
<td>Midwifery</td>
<td>Transition to Parenthood,</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td>Applied Biomedical Sciences</td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td>Diabetes, Podiatric biomechanics, Podiatric care for the elderly</td>
</tr>
<tr>
<td>Communication Therapy</td>
<td></td>
</tr>
<tr>
<td>Dental Technology</td>
<td></td>
</tr>
<tr>
<td>Environmental Health</td>
<td></td>
</tr>
</tbody>
</table>

Possible Performance Indicators

Performance indicator: Recognition by healthcare authorities and professional regulatory bodies and councils as the leading educational facility for healthcare professionals in Malta.

Performance indicators: Course accreditation by …
- Minimum annual number of incoming Erasmus students of … per division.
- Active participation in the corresponding European thematic network
- Active participation in at least one international research project.

Performance indicator: One article published in a peer reviewed journal and one conference paper per year in each research area.
Appendix 5
Excerpts from the IHC Strategic Plan

Instances where the term ‘interprofessional’ was mentioned in the main SWOT document in preparation for the final strategic plan document

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Relevant Sub-section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Core values guiding the strategic planning process</td>
<td>e) “Teamwork: We recognise that quality healthcare and consequently healthcare professional education are both intrinsically inter-professional activities.”</td>
</tr>
<tr>
<td>3</td>
<td>Key external environment factors</td>
<td>C2) “Developments in healthcare professional education e.g. inter-professional education.”</td>
</tr>
<tr>
<td>3</td>
<td>Key strategies and associated specific actions; Focus preservation</td>
<td>Fc) “Set up an inter-divisional entity for developing the inter-professional dimension of our services.”</td>
</tr>
<tr>
<td>4</td>
<td>Key strategies and associated specific actions; Innovation</td>
<td>F Strategy 2 a) “Set up new inter-divisional programmes in healthcare (e.g. MSc Inter-professional Education in Health Care.”</td>
</tr>
<tr>
<td>4</td>
<td>Key strategies and associated specific actions; Innovation</td>
<td>F Strategy 2 e) “Set up more shared and inter-professional modules at undergraduate level.”</td>
</tr>
<tr>
<td>6</td>
<td>Timeline for fundamental actions</td>
<td>Gb) “Appointment of one resident academic as policy developer and coordinator for an inter-professional education: immediate.”</td>
</tr>
</tbody>
</table>

1 In this local document, the term interprofessional was hyphenated.
## Appendix 6
### FHS List of Registered Students (2015-2016)

<table>
<thead>
<tr>
<th>COURSE NAME</th>
<th>No. of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applied Biomedical Science</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor of Philosophy Applied Biomedical Science</td>
<td>1</td>
</tr>
<tr>
<td>Master of Philosophy Applied Biomedical Science</td>
<td>1</td>
</tr>
<tr>
<td>Master of Science Applied Biomedical Science</td>
<td>13</td>
</tr>
<tr>
<td>Bachelor of Science (Honours) Applied Biomedical Science</td>
<td>72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87</strong></td>
</tr>
<tr>
<td><strong>Communication Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor of Philosophy Communication Therapy</td>
<td>1</td>
</tr>
<tr>
<td>Master of Philosophy Communication Therapy</td>
<td>1</td>
</tr>
<tr>
<td>Master of Science Communication Therapy</td>
<td>2</td>
</tr>
<tr>
<td>Master of Science Audiology</td>
<td>8</td>
</tr>
<tr>
<td>Bachelor of Science (Honours) Communication Therapy</td>
<td>62</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74</strong></td>
</tr>
<tr>
<td><strong>Food Studies and Environmental Health</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor of Philosophy Food Studies and Environmental Health</td>
<td>1</td>
</tr>
<tr>
<td>Master of Philosophy Food Studies and Environmental Health</td>
<td>4</td>
</tr>
<tr>
<td>Master of Science Food Studies and Environmental Health</td>
<td>5</td>
</tr>
<tr>
<td>Postgraduate Diploma in Dietetics</td>
<td>5</td>
</tr>
<tr>
<td>Bachelor of Science (Honours) Applied Food and Nutritional Sciences</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
<tr>
<td><strong>Health Services Management</strong></td>
<td></td>
</tr>
<tr>
<td>Master of Science Health Services Management (research)</td>
<td>1</td>
</tr>
<tr>
<td>Master of Science Health Services Management (taught)</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
<tr>
<td><strong>Medical Physics</strong></td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
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</tr>
<tr>
<td>Master of Science Nursing (Mental Health)</td>
<td>5</td>
</tr>
<tr>
<td>Bachelor of Science (Honours) Mental Health Nursing</td>
<td>25</td>
</tr>
<tr>
<td>Bachelor of Science (Honours) Mental Health Nursing</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
</tr>
<tr>
<td>Field</td>
<td>Program</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Midwifery</strong></td>
<td>Master of Science Midwifery</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Midwifery</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>Doctor of Philosophy Nursing</td>
</tr>
<tr>
<td></td>
<td>Master of Philosophy Nursing</td>
</tr>
<tr>
<td></td>
<td>Master of Science Nursing</td>
</tr>
<tr>
<td></td>
<td>Master of Science Nursing (taught)</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Community Nursing</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Health Science</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Nursing</td>
</tr>
<tr>
<td></td>
<td>Diploma in Health Science Nursing</td>
</tr>
<tr>
<td></td>
<td>Prep Course for Higher Diploma in Health Science</td>
</tr>
<tr>
<td></td>
<td>Preparatory Course for Diploma in Health Science</td>
</tr>
<tr>
<td></td>
<td>Certificate in Clinical Nursing Practice Adult Cancer Care</td>
</tr>
<tr>
<td></td>
<td>Certificate in Clinical Nursing Practice Emergency Nursing</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>Bachelor of Science (Honours) Occupational Therapy</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Doctor of Philosophy Physiotherapy</td>
</tr>
<tr>
<td></td>
<td>Master of Philosophy Physiotherapy</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Physiotherapy</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry</strong></td>
<td>Master of Philosophy Podiatry</td>
</tr>
<tr>
<td></td>
<td>Master of Science Podiatry</td>
</tr>
<tr>
<td></td>
<td>Master of Science Clinical Biomechanics</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Podiatry</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Radiography</strong></td>
<td>Doctor of Philosophy Radiography</td>
</tr>
<tr>
<td></td>
<td>Master of Philosophy Radiography</td>
</tr>
<tr>
<td></td>
<td>Master of Science Radiography (Vascular Ultrasound)</td>
</tr>
<tr>
<td></td>
<td>Bachelor of Science (Honours) Radiography</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total No. of Registered</strong></td>
<td>Students at the Faculty of Health Sciences</td>
</tr>
</tbody>
</table>

Source: Administrative Officer, Faculty of Health Sciences
### Appendix 7

<table>
<thead>
<tr>
<th>Publication Year</th>
<th>Policy Papers / Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>The <em>NHS Management Inquiry</em> commonly referred to as the <em>Griffiths Report</em>. Professions working in the community were urged to provide a seamless service to the patients.</td>
</tr>
<tr>
<td>1990</td>
<td><em>Caring for People: Community Care in the Next Decade and Beyond</em> (Department of Health): This emphasised the need for more permeable healthcare delivery in the context of transferring of services from institutional to community settings. This was also the policy document that proposed an organisation overhaul in the NHS and Social Services since 1948 (Pietroni, 1994).</td>
</tr>
<tr>
<td>1992</td>
<td><em>The Health of the Nation - A Strategy for England</em> (Department of Health): Based on WHO’s health for all, this was the first explicit attempt by the government to provide a national health strategy.</td>
</tr>
<tr>
<td>1993</td>
<td><em>Working Together for Better Health</em> (Department of Health): One of the key themes stressed the importance of working together in “healthy alliances” rather than by working separately.</td>
</tr>
<tr>
<td>1996</td>
<td><em>The Schofield Report</em>: Recommended a multi-skilled workforce in which IPE was seen as the means to reform this workforce.</td>
</tr>
<tr>
<td>Publication Year</td>
<td>Policy Papers / Reports</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>1997</td>
<td>The white paper, “The New NHS: Modern, Dependable” (Department of Health, 1997): This paper projected how the internal market was to be replaced by a system called 'integrated care' based on partnership and driven by performance. Moreover, this paper also encompassed the development of Continuing Professional Development (CPD).</td>
</tr>
<tr>
<td>1997</td>
<td><em>Sainsbury Report</em> (1997): The first report to address the different roles and training of mental health professionals. It also identified the core skills, knowledge and attitudes required by staff, so as to outline the future development of the mental health workforce.</td>
</tr>
<tr>
<td>1998</td>
<td>The white paper “Our Healthier Nation” (Department of Health, 1998a): This paper encouraged different professional groups to learn together.</td>
</tr>
<tr>
<td>1998</td>
<td><em>Partnership in Action</em> (New opportunities for joint working between health and social services) (Department of Health, 1998b): This policy emphasised how integration of services (partnerships) could improve patient outcomes.</td>
</tr>
<tr>
<td>1998</td>
<td><em>Working together: Securing a quality workforce for the NHS</em> (Department of Health, 1998c): This policy placed importance on a new service wide-approach in managing human resources in the NHS.</td>
</tr>
<tr>
<td>1999</td>
<td><em>A Review of Continuing Professional Development in General Practice</em> (Calman, 1999): This policy placed emphasis on “Practice Development Plans” which were seen to encourage team working and facilitate professional flexibility.</td>
</tr>
<tr>
<td>2000</td>
<td><em>A Health Service of all the Talents: Developing the NHS Workforce</em> (Department of Health, 2000a): This consultation document reviewed workforce planning and emphasised the need for teamwork and flexible working.</td>
</tr>
<tr>
<td>2000</td>
<td>The <em>National Service Framework for older people</em> (Department of Health, 2000b): This policy spoke about the necessity that pre-qualifying courses for health and social care professionals would include interprofessional learning.</td>
</tr>
<tr>
<td>2000</td>
<td><em>Meeting the challenge: A strategy for Allied Health Professions</em> (Department of Health, 2000c): This policy examined Government's commitment to expanding the roles of allied health professions ensuring that their skills are better utilised.</td>
</tr>
<tr>
<td>Year</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>2000</td>
<td><em>The National Health Service Plan: A Plan for Investment, a Plan for Reform</em> (Department of Health, 2000d): This influential report outlined ten principles to improve integrated working and provided an impetus for “common learning” initiatives.</td>
</tr>
<tr>
<td>2001</td>
<td><em>Working together, learning together: A Framework for Lifelong Learning for the NHS</em> (Department of Health, 2001): This framework underscored government’s commitment to ensure that common learning is implemented across United Kingdom universities by 2004. Part of this commitment was the funding of four leading-edge sites to implement common learning in health and social care pre-registration programmes.</td>
</tr>
</tbody>
</table>
Appendix 9
Systematic Search Strategy

- A diversity of electronic databases using different search engines were scanned. These included EBSCO, ERIC, Embase, CINAHL, Cochrane, Medline, Pub Med, PsychINFO, Science Direct and Web of Science.

- During these searches, the following phrasal terms were used so as to gain a generic understanding of the topic:
  - Interprofessional education OR interprofessional education
  - Interprofessional learning OR interprofessional learning
  - Interdisciplinary education OR interdisciplinary education
  - Multidisciplinary education OR multidisciplinary education
  - Multidisciplinary learning OR multidisciplinary learning
  - Multiprofessional teaching or multiprofessional teaching
  - Shared learning
  - Common learning
  - Collaborative teaching

- This resulted in the retrieval of an inordinate number of publications and duplicate publications. Subsequent searches were limited by: ‘Timeframe: 1980-2010/2012’ and ‘English Language.’ As the process was underway Advanced Search Faculties for potential subject headings such as ‘Health Professionals,’ ‘Perceptions,’ ‘Evidence,’ ‘Elements of,’ ‘Outcomes’ and ‘Historical’ were used. This was done so as narrow the search in line with my research focus.

  This involved reviewing hundreds of abstracts. This immersion phase was invaluable so as to obtain a generic picture of the field, as well as to help me identify key elements in the IPE world. Due to the large number of abstracts involved, a rating criteria was developed so as to appraise these abstracts. This rating was based on a three point scale of whether:
  - The article could directly inform my research context and questions.
  - The article could possibly inform my research context and questions.
  - The article was irrelevant for the scope of my work.

  Full text papers were obtained where relevance was seen. These included international overviews, historical perspectives, justification, development, delivery, evaluation and evidence of IPE (plus all its interchangeable terms).

- As recommended by Reeves, Koppel, Barr, Freeth and Hammick (2002), three types of information were abstracted from these articles, namely: contextual, methodological and outcome information.

- This process was repeated for all the search engines mentioned above. As new insights were gained and I became more experienced in scanning the
abstracts, this practice became more focused. I used Advanced Search Facilities adding and / or changing the key terms and other synonymous terms according to the database and according to the phase of the search strategy e.g. ‘Organisational theory of change’ AND ‘Interprofessional Education in PsychINFO’ and ‘Canada’ AND ‘Interprofessional Education in CINHAL.’ Identical articles and studies were excluded.

- The reviewed data from the various search engines were grouped and compared vis a vis content, research designs and methodologies.

- The key issues and themes emerging from the literature which were thought to be relevant to this research study were grouped and synthesised. The CASP (Critical Appraisal Skills Programme) was used so as to assess the trustworthiness, relevance and results of the research articles.

- Parallel to this process, a thorough and iterative search was conducted based on citations emanating from the reference lists of the full articles (snowball search). This resulted in the collection of over 700 papers and publications pertaining to IPE and its wider determinants.

- Hand searches of various other journals was also undertaken.

- Grey sources were also a major and valuable part of this review. These included:
  - Books and book chapters related to IPE in the broadest sense.
  - Seminal texts, policies, legislation and documents by national governments, websites of international universities, health associations and conference proceedings. These included WHO, CAIPE, Department of Health, U.K., Health Canada’s Interprofessional Education for Collaborative Patient-Centred Practice and Learning and Teaching for Interprofessional Practice L-TIPP, Australia.

- Attendance to European IPE conferences (EIPEN) and UK, CAIPE events ensured that I was aware of the latest developments in the field.
Appendix 10

Biggs’ 3P Model of Classroom Teaching

Source: Biggs’ 3P Model of Learning to Collaborate (Biggs, 1993)
## Appendix 11
### Themes/Subthemes of Synthesised IPE Outcomes

<table>
<thead>
<tr>
<th>Outcome/Theme</th>
<th>Subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teamwork</strong></td>
<td>- Knowledge of and skills for (including recognition of importance of common goals).</td>
</tr>
<tr>
<td></td>
<td>- Knowledge of, skills for and positive attitudes to collaboration with other health professionals.</td>
</tr>
<tr>
<td></td>
<td>- Assume the roles and responsibilities of team leader and team member.</td>
</tr>
<tr>
<td></td>
<td>- Barriers to teamwork.</td>
</tr>
<tr>
<td></td>
<td>- \textit{Improve collaboration with other health professionals in the workplace.}</td>
</tr>
<tr>
<td></td>
<td>- Analysis of when and why professionals become key workers.</td>
</tr>
<tr>
<td></td>
<td>- \textit{Facilitate interprofessional care conferences, team meetings etc.}</td>
</tr>
<tr>
<td></td>
<td>- Team dynamics and power relationships.</td>
</tr>
<tr>
<td></td>
<td>- Cooperation and accountability.</td>
</tr>
<tr>
<td><strong>Roles/Responsibilities</strong></td>
<td>- Knowledge and understanding of the different roles, responsibilities and expertise of health professionals.</td>
</tr>
<tr>
<td></td>
<td>- Knowledge and development of one’s own professional role.</td>
</tr>
<tr>
<td></td>
<td>- Similarities and differences relating to roles, attitudes and skills.</td>
</tr>
<tr>
<td></td>
<td>- Understanding of role/professional boundaries.</td>
</tr>
<tr>
<td></td>
<td>- Being able to challenge misconceptions in relations to roles.</td>
</tr>
<tr>
<td></td>
<td>- \textit{Knowledge of the health system and organization of health care within it.}</td>
</tr>
<tr>
<td></td>
<td>- Philosophies of care.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>- Communicate effectively with other health professional students.</td>
</tr>
<tr>
<td></td>
<td>- \textit{With other professionals.}</td>
</tr>
<tr>
<td></td>
<td>- \textit{Negotiation and conflict resolution.}</td>
</tr>
<tr>
<td></td>
<td>- Express one’s opinions to others involved with care.</td>
</tr>
<tr>
<td></td>
<td>- Listens to others/team members.</td>
</tr>
<tr>
<td></td>
<td>- Shared decision making.</td>
</tr>
<tr>
<td></td>
<td>- Communication at beginning and end of shifts (handover, handoff).</td>
</tr>
<tr>
<td></td>
<td>- Awareness of difference in professionals’ language.</td>
</tr>
<tr>
<td></td>
<td>- Exchange of essential clinical information (health records, through electronic media).</td>
</tr>
</tbody>
</table>

\(^2\) Outcomes in italics are more likely to be achieved post qualification.
| Learning/Reflection                  | - Identification of learning needs in relation to future development in a team.  
|                                      | - Identification of common professional interests through reflection.  
|                                      | - Learning through peer support.  
|                                      | - Reflect critically on one’s own relationship within a team.  
|                                      | - Transfer interprofessional learning to clinical setting.  
|                                      | - Self-questioning of personal prejudice and stereotyped views.  
| The Patient                          | - The patient’s central role in interprofessional care (patient-focused or centred care).  
|                                      | - Understanding of the service user’s perspective (and family/carers).  
|                                      | - Working together and cooperatively in the best interests of the patient.  
|                                      | - Patient safety issues.  
|                                      | - Recognition of patient’s needs.  
|                                      | - Patient as partner within the team.  
| Ethics/Attitudes                     | - Acknowledge views and ideas of other professionals.  
|                                      | - Respect.  
|                                      | - Ethical issues relating to teamwork.  
|                                      | - Ability to cope with uncertainty.  
|                                      | - Understand one’s own and other’s stereotyping.  
|                                      | *Tolerate difference, misunderstandings and shortcomings in other professionals.*  
|                                      | - Whistle blowing.  

### Appendix 12

**Kirkpatrick’s Adapted Typology**

The JET (Interprofessional Education Joint Education team) classification of interprofessional education outcomes.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Reaction</th>
<th>Learners’ views on the learning experience and its interprofessional nature.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 2A</strong></td>
<td>Modification of attitudes / perceptions.</td>
<td>Changes in reciprocal attitudes or perceptions between participant groups. Changes in perception or attitude toward the value and/or use of team approaches to caring for a specific group.</td>
</tr>
<tr>
<td><strong>Level 2B</strong></td>
<td>Acquisition of knowledge / skills.</td>
<td>Including knowledge and skills linked to interprofessional collaboration.</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>Behavioural change.</td>
<td>Identifies individuals’ transfer of interprofessional learning to their practice setting and their changed professional practice.</td>
</tr>
<tr>
<td><strong>Level 4A</strong></td>
<td>Change in organisational practice.</td>
<td>Wider changes in the organisation and delivery of care.</td>
</tr>
<tr>
<td><strong>Level 4B</strong></td>
<td>Benefits to patients/clients.</td>
<td>Improvements in health or well-being of patients / clients.</td>
</tr>
</tbody>
</table>

**Source:** Barr et al., 2005 - Reproduced with permission.
Appendix 13
Request Letter to Dean of FHS

15th December, 2010

Professor Angela A. Xuereb
Dean, Faculty of Health Sciences

Dear Professor Xuereb,

Re: Interprofessional Education research at the Faculty of Health Sciences

I am currently reading for an MPhil/PhD at the University of Brighton. The overarching aim of this research is to explore Faculty of Health Sciences in Malta academics’ attitudes and perceptions towards interprofessional education (IPE). Primarily it will seek to uncover their understandings and views of IPE and secondly it will aim to highlight the perceived barriers and facilitators of IPE within the Maltese context. As a minimum it is envisaged that data obtained from this study may stimulate an IPE debate within the faculty (at least for the duration of the data collection phase) and as a maximum this study may inform future developments and initiatives for IPE within our allied health programmes. The research design will make use of various data collection methods and it is envisaged that data collection will take place from mid-2011 till the end of 2012. These data methods will include:

- Uni-professional focus groups with the various professions represented at the faculty.
- Multi-professional focus group with health professionals who would have recently graduated from the faculty and are now in employment.
- Semi-structured interviews with yourself, Head of Department Health Services Management and other key informants (the necessity of these, if any, will emerge from the interviews or focus groups).
- Secondary data review in the form of faculty and departmental documents and annual reports.
- Informal and unstructured observations of everyday events at the faculty which may inform and enrich my “case”.

POSTAL ADDRESS: MSIDA 8432 2000, MALTA
TEL: (356) 2133 3965-6  FAX: (356) 2144-6 Extension Number  E-MAIL: healthsciences@um.edu.mt
The data collected from these informal observations as well as the written documents could inform the research questions guiding the study. It could also serve as a starting point to my reflexive practice thus leading to a richer understanding of the emergent themes.

This study has been reviewed and accepted by the University of Brighton Faculty of Health and Social Science Research Ethics and Governance Committee and an application is currently being submitted to the University of Malta Research Ethics Committee. During the course of the entire research process, I will be supervised by two supervisors from the University of Brighton as well as by a local field supervisor, Dr. Stephen Lungaro-Mifsud who will ensure that all ethical procedures are in place.

As the Dean of the Faculty, I am requesting your permission to carry out the focus groups and interviews with the Faculty’s academic staff as well as allowing me access to secondary data as outlined above. I am willing to supplement any more information as is deemed necessary. Whilst thanking you beforehand for your support towards this research project, I await your reply.

Regards,

Marjorie Bonello
A/Lecturer Occupational Therapy Department
Faculty of Health Sciences
University of Malta
e-mail: marjorie.bonello@um.edu.mt
Telephone: 23401149, 79401301

Permission granted

[Signature]

(Prof. A. Xewda)

16th Dec. 2010
Appendix 14
Request Letter to FHS Department Heads

5th May, 2011

Dr. ___________
Head, Department of ______
Faculty of Health Sciences

Dear Head of Department,

Re: Interprofessional Education research at the Faculty of Health Sciences

I am currently reading for an MPhil/PhD at the University of Brighton. The purpose of this study is to explore Faculty of Health Sciences academics’ attitudes and perceptions towards interprofessional education.

The first stage of this project involves uni-professional semi-structured focus groups within the Faculty of Health Sciences. I would therefore be most grateful if you, as Head of Department for the _____________ were to accept participation in this focus group. Moreover, it would be appreciated if you were to grant me permission to contact a number of your staff so as to recruit them for this same focus group.

During this focus group we shall be discussing and debating understandings and perceptions of interprofessional education within our professional health education context. The group will take approximately 90 minutes and will be audio recorded. Participation in this focus is entirely voluntary and you are free to withdraw at any time without giving the reason for doing so. Information and opinions discussed during this group will be treated in strictest confidence. However, I will seek your consent so as to use the material emanating from this interview for analysis and illustration in the final doctoral thesis, future publishing and presentation purposes.

Further details about the project may be found on the attached information sheet.

Whilst thanking you beforehand for your support and co-operation towards this research project, I await your reply.

Regards,

[Signature]

Marjorie Bonello
A/Lecturer Occupational Therapy Department
Faculty of Health Sciences
University of Malta
e-mail: marjorie.bonello@um.edu.mt
Telephone: 23401149, 79401301
1. Study title
Interprofessional Education in Malta: Finding common ground.

2. Invitation paragraph
I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. If you feel that something is not clear or if you would like more information, please feel free to ask me. Take time to decide whether or not you wish to take part.

3. What is the purpose of the study?
Interprofessional education (IPE) is defined as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 2002, p. 1). The overarching aim of this research is to explore Faculty of Health Sciences (University of Malta) academics’ understandings, attitudes and perceptions towards IPE. Phase 1 will involve the conduction of focus groups and Phase 2 will consist of semi-structured interviews with selected participants.

4. Why have I been invited?
You have been invited because you are an academic member within the Department of Podiatry at the Faculty of Health Sciences. The other participants of this focus group will be fellow members of your department.

5. Do I have to take part?
Contribution to this focus group is entirely voluntary and it is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

6. What will happen to me if I take part?
If you decide to take part you will be asked to attend one focus group which will take no longer than 90 minutes. During this focus group we shall be discussing and debating understandings and perceptions of interprofessional education within our professional health education context. The focus group will be audio recorded after which I will be sending you a transcript. I will endeavour to retain anonymity throughout by changing names at the transcription phase and using specific measures (see point 11 below). Consequently, I will seek your consent to use this material in the final doctoral thesis, future publishing and presentation purposes.
7. What will I have to do?
As an academic member of the Faculty of Health Science you are requested to participate in a focus group and discuss your understandings and perceptions about Interprofessional Education.

8. What are the possible disadvantages and risks of taking part?
One possible discomfort that may arise whilst taking part in this focus group is that the discussion might be slightly awkward at first. However the researcher will try to create a safe and comfortable environment where everyone will be free to discuss and listen.

Another disadvantage that may possibly occur is that there might be instances that some unique quotes will be identifiable in the final dissertation report or any other reports, publications and presentations due to the nature or your role. I will seek your consent to this.

9. What are the possible benefits of taking part?
You will not benefit directly from taking part in this study but the information obtained from the data will help improve understandings of interprofessional education within the local context of our Faculty.

10. What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered can be addressed by contacting my supervisor in the UK or my local supervisor. For contact details see the bottom of the information sheet.

11. Will my taking part in the study be kept confidential?
Information and opinions discussed during these groups will be treated in strictest confidence. All names will be changed at the transcription phase. I will use specific measures such as using coding, pseudonyms/false identities, cross gendering and removal of all identifying information so as to ensure that individual participants will not be identifiable in the final dissertation report or any other reports, publications and presentations emanating from this work. All the information generated through data collection and analysis will be accessible only to me, the researcher and my two supervisors at the University of Brighton. I will also ensure that all electronically stored data will be password protected and stored on my personal hardware rather that the University's computer mainframe.

The data emanating from this study will be used to create understanding about possible IPE in Malta. It will be retained for the duration of the degree programme (until 2016) following which it will be disposed of appropriately.

12. What will happen if I don’t want to carry on with the study?
Contribution to this focus group is entirely voluntary and you are free to withdraw at any time without giving the reason for doing so. In such circumstances, it is normal practice to allow that the data collected up to that point may be used by the researcher for the purposes described in the information sheet. However, you as the participant retain the right to decide whether that data can be used.

13. What will happen to the results of the research study?
The main purpose of the results of this project is to assist me the researcher in obtaining a doctorate degree. In addition, some of the results are likely to be published in academic journals. This will only be on the condition that there will be no identification either directly or
indirectly of any individuals involved. In the event that certain sensitive information will be identifiable, I will seek your consent.

If you wish, you can obtain a copy of the published results through the researcher.

14. Who has reviewed the study?
This study has been reviewed and approved by the School Research Ethics and Governance Panel, School of Health Professions, University of Brighton, as well as the University Research Ethics Committee (University of Malta).

15. Contacts for further information:

Research Student: Marjorie Bonello  
A/Lecturer Occupational Therapy Department  
Faculty of Health Sciences  
University of Malta  
e-mail: marjorie.bonello@um.edu.mt  
Telephone: 23401149, 79401301

Research Supervisor, UK: Prof. Gaynor Sadlo  
School of Health Professions,  
Faculty of Health and Social Science  
e-mail: G.Sadlo@bton.ac.uk  
Telephone: 0044 (0) 127364365

Research Supervisor Malta: Dr. Stephen Lungaro-Mifsud  
Faculty of Health Sciences  
University of Malta  
e-mail: stephen.lungaro-mifsud@um.edu.mt  
Telephone: 23401161

You will be given a copy of the information sheet and a signed consent form to keep.

Thank you for considering taking part in this study.
Dear ____________,

**Re: Interprofessional Education research at the Faculty of Health Sciences**

I am currently reading for an MPhil/PhD at the University of Brighton. The purpose of this study is to explore the Faculty of Health Sciences academics’ attitudes and perceptions towards interprofessional education.

The first stage of this project involves uni-professional focus groups with all professions represented at the Faculty of Health Sciences. Your Head of Department has given me permission to invite you to participate in your department’s focus group.

During this focus group we shall be discussing and debating understandings and perceptions of interprofessional education within our professional health education context. The group will take approximately 90 minutes and will be audio recorded. Participation in this focus group is entirely voluntary and you are free to withdraw at any time without giving the reason for doing so. Information and opinions discussed during this group will be treated in strictest confidence. However I will seek your consent so as to use the material emanating from this focus group for analysis and illustration in the final doctoral thesis, future publishing and presentation purposes. Further details about the project may be found on the attached information sheet.

Whilst thanking you beforehand for your support and co-operation towards this research project, I await your reply.

(Dr. __________ has earmarked Thursday 26th May, Monday 30th May or Tuesday 31st May as possible dates for this focus group (approximately starting at 11.30am). If you decide to take part in this research project, I would appreciate if you could choose the date/s which is most convenient for you).

Regards,

Marjorie Bonello, MSc (Lond.) A/Lecturer
Department of Occupational Therapy
Faculty of Health Sciences
University of Malta, Msida, MSD 208
Tel: (00356) 2340 1149 mobile: (00357) 79401301
e-mail: marjorie.bonello@um.edu.mt

[The email to academic participants included the same information sheet as shown in Appendix 14.]
### Appendix 16
**Positions of Academic Participants at FHS**

<table>
<thead>
<tr>
<th>Participant Codes</th>
<th>Position at the Faculty of Health Sciences</th>
<th>Highest Qualification (at the time of data collection)</th>
<th>Years in Academia</th>
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<tr>
<td>A1</td>
<td>Full-time Assistant Lecturer</td>
<td>PhD in progress</td>
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<td>FT - 2 years</td>
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<td>FT - 20 years</td>
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<td>PhD</td>
<td>PT - 16 years</td>
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<td>FT - 2 years</td>
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<td>Highest Qualification (at the time of data collection)</td>
<td>Years in Academia</td>
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<td>A54</td>
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<td>MSc</td>
<td>FT - &lt; 1 yr</td>
</tr>
</tbody>
</table>

**Key:**

FT Full time  PT Part time

**Notes:**

**Note 1:** Ten of these participants also occupied Head of Department posts. However, for reasons of confidentiality and anonymity, this information was not included in this list.

**Note 2:** This participant withdrew from the study. Reasons given were outlined in Chapter 4 Section 4.7.4.
Appendix 17
Request Letter to Chairperson, FREC, UoM

[Re slight amendment to recruitment criteria]
Appendix 18  
Request Letter to Registrar, UoM, plus confirmation e-mails

21st December, 2011

Dear Ms Grech,

Re: Interprofessional Education Research at the Faculty of Health Sciences

I am an Assistant Lecturer within the Faculty of Health Sciences, University of Malta and am currently reading for an MPhil/PhD at the University of Brighton. The overarching aim of this research is to explore perceptions and understandings of Faculty of Health Sciences academic staff and health care professionals towards interprofessional education (IPE).

One of the data collection methods proposed is a focus group with recent graduates from the Faculty of Health Sciences. The scope for meeting these former students in a focus group context will be to explore and gain insights into their realities of collaborative healthcare practices. This focus group will take place at the Faculty of Health Sciences, itself.

I am planning to invite the first ten former faculty students from the university lists (or less where the group is of a small number) to participate in this focus group possibly to be held early 2012. These former students would be from the Departments of Medical Laboratory Science, Mental Health Nursing, Midwifery, Nursing, Occupational Therapy, Physiotherapy and Radiography as it was these departments that had graduate cohorts in the year 2011. The number 10 (or less in the case when the group is a smaller number) was decided upon as it is envisaged that I will not have a very high response rate for this focus group. If no replies will be received from the first 10 former Faculty students, the next 10 former students would be sent the invitation letter. Since I am aiming at having one or two representatives from each profession, I will select people in order that their acceptance is received. I will be clear in my invitation letter regarding this policy.
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and I will acknowledge all acceptances to my invitation. All ethical considerations as outlined in my proposal will be duly followed and respected.

This study has been reviewed and accepted by the University of Brighton, Faculty of Health and Social Science Research Ethics and Governance Committee, and by the University of Malta Research Ethics Committee (Reference No. 027/2011). However, since there was a slight change in the access arrangements for this particular focus group, the Faculty (Health Sciences) Research Ethics Committee requires your written approval prior to clearing this part of my study.

I am therefore requesting your written permission to grant me access to these participants’ addresses so that I will be able to invite them to take part in this focus group. I am willing to supplement any more information as is deemed necessary. Whilst thanking you beforehand for your support towards this research project, I await your reply.

Regards,

Marjorie Bonello
A/Lecturer Occupational Therapy Department
Faculty of Health Sciences
University of Malta
e-mail: marjorie.bonello@um.edu.mt
Telephone: 23401149, 79401301
Thread of e-mails confirming access to 2011 FHS graduates

From: Veronica Grech [veronica.grech@um.edu.mt]
To: ‘Elaine Xerri’
Cc: marjorie.bonello@um.edu.mt; ‘Maria Filletti’
Sent: 04 January 2012 10:41
Subject: RE: PhD focus group request permission

Dear Elaine

Can you please provide labels with graduates of 2011 addresses as requested below?

With best wishes for the New Year.

Regards
Veronica

Veronica Grech
Registrar
Room 207, Administration Building
University of Malta
Msida MSD 2080
Malta

From: Marjorie Bonello [mailto:marjorie.bonello@um.edu.mt]
Sent: 04 January 2012 10:36
To: veronica.grech@um.edu.mt
Subject: RE: PhD focus group request permission

Dear Ms. Grech,

Just sending a gentle reminder regarding the mail below. Dr. Wright has confirmed that the information requested is required as part of my PhD studies.

Regards,

Marjorie Bonello
Dear Ms Filletti,
I am one of Marjorie Bonello’s PhD supervisors from the University of Brighton in the UK. I am writing to confirm that the information that she has requested regarding the addresses of former students is required as part of her studies.

If you require any further information, please do not hesitate to ask myself or Professor Gaynor Sadlo (Marjorie’s other supervisor).

Kindest regards,

Jon

Dr Jon Wright
Dear Ms Bonello,

It would be appreciated if you could send me a statement by your supervisor that the information requested is required for your studies.

Regards,

Maria Filletti

On 20/12/2011 11:39, Marjorie Bonello wrote:

Dear Ms Grech,

I am enclosing a letter requesting your permission to grant me access to former Faculty of Health Sciences Students’ addresses (graduates of 2011). Whilst thanking you beforehand for your consideration, I await your reply.

Kind regards,

Marjorie

Marjorie Bonello, MSc (Lond.)
A/Lecturer
Department of Occupational Therapy
Faculty of Health Sciences
University of Malta, Msida
MSD 208
Tel: (00356) 2340 1149
mobile: (00357) 79401301
e-mail: marjorie.bonello@um.edu.mt
6th January 2012

Dear Health Professional,

Re: Interprofessional Education Research at the Faculty of Health Sciences

I am Marjorie Bonello, an assistant lecturer at the Faculty of Health Sciences within the Occupational Therapy Department. I am currently reading for an MPhil/PhD at the University of Brighton focusing on Interprofessional Education (IPE). Interprofessional Education (IPE) is defined as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 2002, p. 1). The overarching aim of this research is to explore local understandings, attitudes and perceptions towards IPE.

Part of my Phase 1 data collection involves a multiprofessional focus group whose participants will be 2011 graduates from various professions represented at the Faculty of Health Sciences. During this focus group we shall be exploring the group’s views on the realities of collaborative practices and what kinds of learning would have helped during your undergraduate years to help in this process. The discussion will take approximately 60-90 minutes and will be audio recorded.

Information and opinions discussed during these groups will be treated in strictest confidence. However, if you choose to participate, I will seek your consent to use the material emanating from these groups for analysis and illustration in the final doctoral thesis, future publishing and presentation purposes.

Contribution to this focus group is entirely voluntary and although there will be no personal benefit from taking part in this study, the information obtained from the data will help to improve understandings of interprofessional education within the local context.

I am therefore inviting you, as a recent Faculty of Health Sciences graduate, to participate in this focus group. This will be held on Wednesday 15th February at 1pm at the Faculty of Health Sciences (Committee Room). Since this will necessitate departure from your place of work, I will be able to verify that you attended this focus group.

My aim is to have a few representatives from each profession and therefore, I will select people in order that their acceptance will be received. All replies will be acknowledged. If you wish to participate in this focus group, you can contact me by e-mail, post or telephone (details below).
Whilst thanking you beforehand for your support and co-operation towards this research project, I await your reply.

Regards,

[Signature]

Marjorie Bonello
Ass. Lecturer /Doctoral Candidate
Occupational Therapy Department
Faculty of Health Sciences, University of Malta
e-mail: marjorie.bonello@um.edu.mt Tel: 23401149, 79401301

[The email to newly qualified health professionals included the same information sheet as shown in Appendix 14.]
Appendix 20  Research Instrument: Questioning Route for Academic Focus Groups

Introduction
Welcome. Thank you for taking the time to join our discussion. As you know, I am Marjorie and this focus group forms part of my doctoral studies. During Phase 1, I will be inviting all departments represented at the Faculty for a similar group. You were selected for this focus group because you represent the Department of ____________.

Today, we will be discussing your opinions and perceptions on Interprofessional Education. During the discussion there are no right or wrong answers, but rather differing points of view. I am just as interested in negative comments as positive comments.

Please share your point of view even if it differs from what others have said. If you would like to follow up something that someone has said, you want to agree, or disagree, or give an example feel free to do so. The important thing is to make sure each of you have a chance to share your ideas. There is no need to reach a consensus or to arrive at an agreeable plan.

Before we begin, let me share some ground rules.

a. You may be assured of confidentiality and all names will be changed and cross gendered during transcription. Please, I urge you not to discuss what was said in this group with other colleagues etc. as I will be having similar groups with the other divisions.

b. Please speak up - only one person should talk at a time. I am tape recording the session as I do not want to miss any of your comments. Please, I urge you to let each other finish their arguments. If several of you are talking at the same time, the tape will get garbled and I will be unable to pick up your comments. If you speak at the same time, I will put up this RED card.

c. I would appreciate if you could put your mobiles on silent.

d. Language to be used.

e. I would like to stress the nature of my role here: I am the moderator who will prompt you and ask for further clarification regarding certain issues. I would also like to stress that I have an open mind towards IPE … and in no way want to influence you either way.

Although I do know you all, I think it would be helpful if we were to go round and introduce ourselves and your present roles both at the Faculty and elsewhere.
Ice-breaking questions: Let us start generally first.

1.1 At present it seems we are all busy and fully committed with the running our individual professional courses. Which in your opinion are the main drivers influencing our courses in this Faculty?

1.2 As professionals / academics how would you ensure / encourage that the way you are educating / training your students would adequately prepare them to work in today’s health care contexts?

(PROMPTS contemporary practice with all its implications: lack of resources, drive towards person-centred care and evidence based practice, collaborative practice, value for money, aging population, etc.)

Transition question:

2.1 How do you perceive that your programme of studies would affect students' professional identities?

Key questions: Now let’s turn to the special topic of this focus group, IPE.

3.1 Do you have experiences of IPE … maybe even outside this Faculty, internationally? Can you tell us about that experience?

3.2 What in your opinion should be the main objective of IPE?

3.3 What are your perceptions about IPE? Do you think it is necessary in health professional education?

3.4 And what is your opinion about IPE locally ... at the University of Malta, more specifically in this Faculty?

3.4.1 Do you think it will be beneficial or detrimental? In what ways?

3.5 Do you think there would be particular facilitators or barriers for IPE at our Faculty?

3.5.1 Do you think these barriers could be overcome?

3.7 How do you think IPE could be developed? Who should take the lead?

3.8 When would you think would be the best time for IPE ... undergraduate or post-graduate?
Other possible peripheral key questions depending on the depth of the discussion:

3.9 What is your opinion about the learning styles and teaching methods that would be appropriate for IPE?

3.10 How do you feel about the sort of facilitation that IPE necessitates?

3.11 What could be the possible courses which would lend themselves to interprofessional learning in this faculty?

Ending questions

4.1 So, all things considered, what do you think is the most important issue when discussing IPE? Possibly do a round robin at this stage...

4.2 Summary (brief) of key points of our discussion ... Does this summary sound complete? Do you think it reflects your discussion today? Do you have any changes or additions? Do you think we have missed anything?

4.3 What are your parting words on the subject?
Appendix 21 Research Instrument: Questioning Route for Newly Qualified Health Professionals

Draft Questioning Route for multiprofessional focus group
(2011 Graduates from the Faculty of Health Sciences)

- Introduction

On Readiness to practice

- Can you talk about your first few months as qualified health professionals? (Let’s just look at each own’s profession for the moment)
  
  - Probe: Did you feel that your undergraduate programme of studies prepared you to work to work in the real-world of practice? (not meant as a criticism to the programme in any way)

On Collaborative practices:

- Is working with other health professionals part of your daily practices?
  
  - If yes, can you speak about it?
  
  - Do you think this kind of working impacts on patient care? And how would this impact? (Do you think this kind of practice is important?)
  
- Did you feel prepared to work collaboratively when you qualified?
  
- If yes, what made you feel prepared?
  
- If no, what do you think would have helped in making you feel prepared?
• How well did you know about other professionals’ roles when you qualified? Do you think your knowledge was adequate? And how did you get to know this information? (specific course, clinical practice etc.)
  
  Probe: Do you think this was important?

• What were your experiences as students vis a vis learning with other students from other departments at the faculty?
  
  • On “common core learning” modules ... (Prompts: teaching employed, venues, interaction with other students etc.)
  
  • Do you think this could have been done differently? How?

On Specific IPE

• Do you have experiences of IPE? …maybe even internationally in your Erasmus exchanges, outside this Faculty, hospital etc.?

• Do you think there is scope for IPE at the Faculty of Health Sciences (and maybe even beyond it)?

Is there anything that you would like to add?

Summary of key points of our discussion … Does this summary sound complete? Do you have any changes or additions? Have we missed anything? What are your parting words on the subject?
Appendix 22
Outline of Salient Issues Pertaining to IPE

1. **Definition** of IPE: "Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE, 2002, p. 1).

   The goal of IPE is to prepare a “collaborative practice-ready” workforce driven by local health needs and local health systems designed to respond to those needs (WHO, 2010).

2. Some of the **policy drivers** for IPE:
   - Changing demographics,
   - new models of health care,
   - quality and safety agenda,
   - global health workforce shortages.
   (Nisbet, Lee, Kumar, Thistlethwaite & Dunston, 2011)

3. **Worldwide uptake** of IPE

   Worldwide uptake: Varied uptake across North America and Europe.

   Endorsed by WHO in 1988 and more recently with the Framework for action on IPE and Collaborative Practice.

4. **Current Evidence**

   “Quality of evidence is limited and variable, however it is improving

   It’s difficult to compare qualitative and quantitative methods –and decision makers require both” (Reeves, Goldman, Sawatzky-Girling, & Burton, 2008b).
Appendix 23
‘Reflections Just-out-of-the Field’ Template

Focus group/ Interview:
Date:

Subjective attitudes, values, knowledge, judgements prior to interview

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How did the interview go?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Did the interview/group result in any new thoughts?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What did I like about the group/interview?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What didn't I like about the group/interview?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What was surprising or unexpected?
________________________________________________________________________
________________________________________________________________________
What do you think were the major themes at this preliminary stage?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What were the most important points that you've learnt from this interview?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What quotes were particularly helpful?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How was this interview similar to or different from early groups/interview?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does anything needs to be changed before next group/interview?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix 24
Invitation Letter to Key Informants

Dear ,

Re: Exploring the concept of Interprofessional Education at the Faculty of Health Sciences, University of Malta

I am currently reading for an MPhil/PhD at the University of Brighton, United Kingdom. The overarching aim of this study is to explore the concept of Interprofessional Education (IPE) at our Faculty of Health Sciences.

Phase 2 of this project involves semi-structured interviews with key informants which can shed light on the systemic and organisational/institutional determinants affecting possible IPE initiatives. I would therefore appreciate if you as the ___________________________ were to accept my invitation for this interview. This will take no longer than one hour, will be audio-recorded and will be held at a place and a time convenient to you.

Participation in this interview is entirely voluntary and you are free to withdraw at any time without giving the reason for doing so. Information and opinions discussed during this interview will be treated in strictest confidence. However I will seek your consent so as to use the material emanating from this interview for analysis and illustration in the final doctoral thesis, future publishing and presentation purposes. Further details about the project may be found on the attached document.

Whilst thanking you beforehand for your support and co-operation towards this research project, I look forward to your reply.

Regards,

Marjorie Bonello
A/Lecturer Occupational Therapy Department
Faculty of Health Sciences
University of Malta
e-mail: marjorie.bonello@um.edu.mt
Telephone: 23401149, 79401301

[The email to key informants included the same information sheet as shown in Appendix 14.]
Appendix 25  Research Instrument: Questioning Route for Key Informants

Key informant:

Date:

Introduction
Welcome. Thank you for taking the time to join our discussion. You were selected for this interview due to your current position at this Ministry. During the discussion there are no right or wrong answers, but rather differing points of view. There is no need to reach a consensus between us or to arrive at an agreeable plan.

Introductory Questions

- As the _________________________, you are one of the main employers for our graduates from the Faculty of Health Sciences. Can you talk about the relationship / linkages between current government policy and this Faculty (which is responsible for the education of all nurses, midwives and allied health professionals in the Maltese healthcare service)?

- Do you think our graduates from this Faculty are well prepared to work in today’s health services? (with all its implications such as increasing demands for services, multiple pathologies, aging population, increasingly social issues, lack of resources, value for money, etc.)

Main Key Questions

- Do you think that there is scope for new ways of working in the health sector? For example, increasing collaborative working between different professions.
  
  o Would this affect service delivery? Why is that?

- Are there any policies from your Ministry’s side which stress the importance of creating a collaborative workforce?

- Do you think that being more collaborative could be a role that future health professionals need to be equipped (and hence trained) in?

- And in your opinion, how could we go about creating these collaborative competencies in our students?
  
  o What would need to be done at an educational level to be able to do this?

- Are you aware of Interprofessional Education?
Main Key Questions (cont.)

- Do you think this could be developed at the Faculty of Health Sciences? Would there be any enhancers? And possible barriers / challenges? Could these be overcome?

- Do you think our wider social, cultural and political dimensions would influence such collaborative developments?

Concluding Questions

- Do you think national policy has a place to promote IPE?

- What will it take for local policy makers to be convinced of the case for IPE and other developments in line with the latest WHO statements, etc.?

- Any parting words on the subject?
Appendix 26
Ethical Approval: FREGC, University of Brighton

From: onbehalfofJ.Scholes+brighton.ac.uk@manuscriptcentral.com on behalf of J.Scholes@brighton.ac.uk
Sent: 08 December 2010 17:41
To: marjorie.bonello@um.edu.mt; G.Sadio@bton.ac.uk
Subject: Faculty of Health and Social Science Research Ethics and Governance Committee - Decision on Manuscript ID FREGC-10-042.R1

08-Dec-2010

Dear Ms. Bonello:

It is a pleasure to accept your manuscript entitled "Interprofessional Health Education in Malta: Finding common ground" in its current form for publication in the Faculty of Health and Social Science Research Ethics and Governance Committee.

Please advise the Faculty of Health and Social Science Research Ethics and Governance Committee, of any changes to your project design and also of any adverse incidents.

Sincerely,
Prof. Julie Scholes
Chair, Faculty of Health and Social Science Research Ethics and Governance Committee
J.Scholes@brighton.ac.uk

Reviewer(s)’ Comments to Author:

I am pleased to take Chair’s action and approve this revised application. All the issues raised by the reviewers have been given due consideration and have been addressed.

One area where I disagree with the reviewer is on the transcription of the PG. You may have difficulty in transcribing focus group interviews - this is notoriously difficult and capturing the detail of conversation may be problematic. Being a pragmatist I feel it would be safer to inform the participants that notes will be taken of the meeting and these will be supplemented by taped recordings - but attempting to guarantee a transcript implies a level of accuracy that is sometimes impossible when recording a group meeting. The intention is to enable people to ensure you are fairly representing them and notes can do this, possibly in a more respectful way as transcriptions of speech are very cumbersome.

Good luck with this fascinating study.
Appendix 27

Ethical Approval: UREC, UoM

Marjorie Bonello

From: Bertha Darmanin <bertha.darmanin@um.edu.mt>
Sent: 28 January 2012 11:59
To: Bonello Marjorie
Subject: Proposal approved

Dear Marjorie,

This is to inform you that you have full approval of your research proposal. Documentation will be received from UREC next week and I will inform you when I will receive this.

Regards,
Bertha

Bertha Darmanin
Secretary
FREC
Faculty of Health Sciences
University of Malta
Msida MSD2080
MALTA

Tel: 00356 2340 1576
Appendix 28
Data Clearance: Data Protection Officer, Mater Dei Hospital

Marjorie Bonello

From: Data Protection at MDH [datapro.mdh@gov.mt]
Sent: 14 December 2010 16:46
To: Marjorie Bonello
Subject: Study: "Interprofessional Health Education in Malta: Finding common ground"

14th December 2010
Ms Marjorie Bonello

Dear Ms Bonello,

With reference to the above-named study, this is to confirm that, on the basis of the documentation you submitted, from the MDH data protection point of view you have been cleared to proceed with your study.

Good luck with your study.

Regards,

Hugo Agius Muscat

Dr H Agius Muscat MD MSc
Consultant (Public Health Medicine)
Data Protection Officer, Mater Dei Hospital
Tel: (00356) 2545 5334
Appendix 29
Participants’ Informed Consent Sheet

<table>
<thead>
<tr>
<th>Research Project Title: Interprofessional Education in Malta</th>
<th>Please initial box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marjorie Bonello</td>
<td></td>
</tr>
</tbody>
</table>

- I agree to take part in this research which is to explore attitudes and understandings about interprofessional education in Malta. 
- The researcher has explained to my satisfaction the purpose, procedures and possible risks involved. 
- I have had the opportunity of ask questions which have been answered to my satisfaction. 
- I am aware that I will be required to participate in a focus group. 
- I will respect the confidentiality of the group/interview by not divulging anything that was discussed during the session outside the focus group. 
- These focus groups will be audio-recorded and I have been assured that these confidential information will be seen only by the researcher and her two supervisors. This data will be anonymised before analysis. 
- I understand how the data collected will be used, and I have been assured that any confidential information will be seen only by the researcher and her two supervisors. This data will be anonymised before analysis. 
- All the data generated from the focus groups will be kept on a hard drive accessible only to the researcher. 
- I give permission to allow the researcher to anonymously quote what I have told her in written or spoken presentations or publications. However, there could always remain a remote possibility that some unique quotes might be identifiable and I agree to this. 
- I understand that I am free to withdraw from the study at any time without giving any reason. (Researcher can be reached on 2340-1149 or 79401301). 
- I agree that should I withdraw from the study, the data collected up to that point may be used by the researcher for the purposes described in the information sheet.

Name of Participant   Date   Signature

Researcher           Date   Signature

Supervisor           Prof. Gaynor Sadlo

Copies: One copy of this form is to be returned to researcher and the other is to be kept by research participant.
Appendix 30

Account of a Minor Ethical Incident

Fourteen days after I had conducted a focus group with a particular department, I sent back the transcript of that focus group as an attachment to an e-mail. This e-mail stated that I was attaching the transcript and to refer back to me if there was something which the participant felt did not reflect the actual discussions. This was a standard e-mail which I sent to all participants (see below).

Dear colleagues,

Following our focus group held on the 9th November 2011, I am forwarding the transcript of our discussion. All names have been deleted and instead one finds the common and gender-free term “Respondent”.

Please feel free to come back to me if something is not to your satisfaction.

Thank you once again for your most interesting contributions.

Regards,

Marjorie

After six days, I received an e-mail from a participant of this particular group.

Dear Marjorie,

With reference to the focus group held on the ___________2011, and the transcript of the discussion that was circulated, I would like to inform that I wish to withdraw from this study.

I request that all my contribution during the focus group discussion is removed from the transcript. The primary reason for my decision is due to the fact that a participant of the said focus group has breached the ethical and confidential conditions that we signed for prior to the start of the focus group, and this to my personal detriment.

Regards,
The participant did not divulge the nature of this breach of confidentiality and I did not feel it was in my jurisdiction to probe further into the nature of the matter. On receiving this e-mail, I immediately wrote back to him/her to inform him/her that his/her wishes would be respected and all his/her discourse relayed during the focus group will be deleted both from the audio tapes as well as from the transcripts.

In response to this email, I followed all ethical procedures as outlined in my information and consent form in that a participant was free to withdraw from the study at any time without giving reason (which in this case was given). In the consent form, the participants also consented to the fact that “the data collected up to that point may be used by the researcher for the purposes described in the information sheet.” However, in this case, since the participant asked me specifically to delete the data, I respected his/her request and deleted his/her contributions. This was an unfortunate incident primarily because it caused some distress to the participant and secondly because of the loss of participant’s valid contributions. Following this incident, I had a debriefing session with my local ethical supervisor.
Appendix 31
Example of the contents of a tree code (node)

Notes:

1. As mentioned in the Chapter 5, coding in NVivo is stored in nodes. Here
codes and nodes are used interchangeably due to this table being imported
from NVivo.

2. Primary, secondary and tertiary levels in the first column refer to the
emergence of a gradual hierarchical organising structure for the various
concepts identified during data analysis.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Code Definitions</th>
<th>Interviews Coded</th>
<th>Citations Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 2: Analysis</td>
<td>Re-ordering, re-labelling, distilling, merging and imposing a hierarchy (see memo).</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Theme 1: IPE as an idea</td>
<td>Participants’ discourses towards IPE as a philosophy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary level:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imagining IPE.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary level:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-qualification IPE.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Various factors which need to be considered when thinking about
planning IPE (which setting or context, when is the right time, what are the
factors that need to be in place before and how must it be ‘taught’). Includes
some ideas how to start off.

14/01/2012: This node incorporates free node "Courses and ideas."

When should IPE occur? Made up of "Timing" free node. 15/01/2011:
Although this free node is broken down into two distinct subcategories, the issue
is far from being clear. There were a moderate number of participants who
argued the case both for pre-qualification, as well as post-
qualification IPE.

Arguments for post-grad IPE and possibilities for the development of
appropriate courses. Perceived difficulties brought up.
<table>
<thead>
<tr>
<th>Codes</th>
<th>Code Definitions</th>
<th>Interviews Coded</th>
<th>Citations Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Tertiary</em> &lt;br&gt;Undergraduate IPE.</td>
<td>Arguments for undergrad IPE - variation regarding best times to introduce IPE. Seems like the stronger argument is in favour of starting it late in the undergraduate years.</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td><em>Secondary</em>: Where?</td>
<td>Learning settings and possible initiatives which are deemed to be appropriate for IPE to start off.</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td><em>Tertiary</em>: Lecture-based IPE.</td>
<td>Range of courses and possibilities which are believed to lend themselves to IPE within the didactic setting</td>
<td>12</td>
<td>52</td>
</tr>
<tr>
<td><em>Tertiary</em>: Practice-based IPE.</td>
<td>Possible ideas for IPE in the clinical or service setting.</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td><em>Secondary</em>: Appropriate teaching approaches.</td>
<td>Teaching approaches and methods which could be amenable to IPE. 14/01/2012: The perceived appropriate teaching approaches, models and strategies appropriate for IPE was not explored in-depth during the focus groups/interviews and so this node will not be further sub-categorized.</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td><em>Primary</em>: Teams are ideal.</td>
<td>Participants' perceptions, understandings &amp; experiences of teamwork &amp; multi-disciplinary work at a clinical, organisational or research level.</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td><em>Primary</em>: We like it.</td>
<td>Participants' perceived outcomes of IPE. This node, contains a lot of overlap with &quot;Motives for IPE&quot; (14/01/2011).</td>
<td>16</td>
<td>142</td>
</tr>
<tr>
<td><em>Secondary</em>: Could help in teamwork.</td>
<td>IPE could be a vehicle so as to promote interaction and communication at student levels, as well as future collaboration and good practices at the workplace (which could also include work satisfaction). Further it could contribute towards integrated care which can eventually lead to an improved health care system.</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td><em>Secondary</em>: Emerging challenges to health system.</td>
<td>Could contribute towards alleviating major challenges faced by the local health system.</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
<td>Interviews Coded</td>
<td>Citations Coded</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Secondary: Getting to know other professionals' perspectives.</td>
<td>IPE could facilitate a professional to look at a broader and possibly different point of view about the case.</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Secondary: Interprofessional familiarisation.</td>
<td>One of the goals would be to introduce students to the roles and functions of other professionals outside their own disciplines.</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Secondary: Helping the patient in the long run.</td>
<td>IPE could contribute towards improved outcomes for patients (client-centred), families &amp; communities (continuity in care and holistic care). Includes the free node &quot;Client centred care.&quot;</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td>Secondary: The concept is good.</td>
<td>Positive attitudes towards the concept of IPE.</td>
<td>15</td>
<td>101</td>
</tr>
<tr>
<td>Primary: We ourselves have become more collaborative.</td>
<td>Existing factors which could facilitate IPE at the Faculty. 14.01.2012: This tree node incorporates &quot;Facilitators&quot; free node.</td>
<td>16</td>
<td>72</td>
</tr>
<tr>
<td>Secondary: Collegiality at the Faculty.</td>
<td>Facilitators at FHS which were perceived to be right attributes towards IPE.</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Secondary: Nature of the faculty.</td>
<td>The supportive (and multidisciplinary) nature of the environment could lend itself to collaborative initiatives; these include research seminars, development of common research modules and cross faculty work. Node also includes views on how the existing structural elements can facilitate IPE.</td>
<td>14</td>
<td>31</td>
</tr>
<tr>
<td>Secondary: Social climate at the faculty.</td>
<td>Views on how the recent transition to Faculty status, plus current leadership could facilitate IPE. Includes views on how the current social aspects of the Faculty could also facilitate IPE.</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Secondary: Shared learning, CPD &amp; post-graduate opportunities.</td>
<td>CPD &amp; post-grad &amp; other opportunities which could be an impetus for the development of IPE. Key informants' contributions.</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
<td>Interviews Coded</td>
<td>Citations Coded</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Primary: We're suspicious.</strong></td>
<td>Critical and negative perceptions, attitudes &amp; assumptions towards the principle of IPE. Mostly made up of free node ‘Perceptions IPE’ and now subdivided in further child nodes.</td>
<td>15</td>
<td>324</td>
</tr>
<tr>
<td><strong>Secondary: Not really ... at undergraduate level.</strong></td>
<td>Ambivalent &amp; unfavourable attitudes towards undergrad IPE.</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td><strong>Secondary: We don't really know what IPE is.</strong></td>
<td>Lack of understanding and ambiguity surround IPE.</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td><strong>Secondary: We need our individual identities.</strong></td>
<td>Concerns that IPE will dilute the core of the professions.</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td><strong>Theme 2: IPE in the real world</strong></td>
<td>Contrary to the largely positive perceptions towards the idea of IPE outlined in the previous theme, this theme highlights the major challenges that participants brought up when it came to discussing the realities of developing and sustaining IPE.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary: Needs a paradigm shift.</strong></td>
<td>Perceived challenges towards IPE in principle and a real initiative ever being introduced at the Faculty. 14/01/2012: This tree node is mostly make up of free node &quot;Barriers.&quot; 21/01/2012 Plus from &quot;Perceptions&quot; free node.</td>
<td>16</td>
<td>447</td>
</tr>
<tr>
<td><strong>Secondary: Medical model reigns supreme.</strong></td>
<td>Predominance of the medical model and unequal power relationships between the professions. This was perceived to impede IPE as one party is seen to have the ability or means to influence or affect the state or disposition of the other profession. Very closely linked to Territoriality &amp; Stereotyping</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td><strong>Secondary: Our organisation cannot take it.</strong></td>
<td>The organisation isn't prepared for it (policy, admin, logistical, structural). Barriers to potential IPE pertaining to institutional, organisational and structural issues (including administrative, curriculum, teaching, resources, logistics and space etc.)</td>
<td>16</td>
<td>115</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
<td>Interviews Coded</td>
<td>Citations Coded</td>
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<td>------------------</td>
</tr>
<tr>
<td>Secondary: What needs to be in place? (Groundwork)</td>
<td>Perceived pre-requisites for an IPE initiative to take place at FHS. What can be done in preparation for IPE and who should take the lead? Made up of tree node &quot;Pre-requisites&quot; and &quot;Starting off&quot;.</td>
<td>16</td>
<td>355</td>
</tr>
<tr>
<td>Tertiary: Clarification of IPE as a concept.</td>
<td>The importance of clarifying what IPE really means (as opposed to the variety of terms that are used interchangeably).</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Tertiary: Commitment from higher up.</td>
<td>Support, leadership &amp; sets of ideas and principles (at a meso and macro level) that are necessary to introduce and move IPE forward. Includes what it would take to convince policy makers.</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>Tertiary: Demonstrates that it works.</td>
<td>This node captures the need to show evidence of the field.</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Tertiary: Extra resources and infrastructure to support it.</td>
<td>The necessity of having the appropriate infrastructure in place and securing sufficient resources so as to be able to address the logistical challenges involved.</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Tertiary: Thorough planning and considerations.</td>
<td>This node contains the perceived importance by participants for the thorough and exhaustive planning of any IPE initiative. Moreover it contains those aspects that need to be taken into consideration when planning, such as the possible factors which could influence IPE. It also suggests some initiatives as start-up developments.</td>
<td>12</td>
<td>39</td>
</tr>
<tr>
<td>Tertiary: Staff need to be prepared &amp; educated in the concept.</td>
<td>This node contains views about the education that staff need to undergo so as to acquire knowledge about IPE itself and secondly about the skills necessary (plus continuing support) for IPE facilitation.</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Tertiary: We have to believe in it ourselves.</td>
<td>The importance of being convinced that IPE would be beneficial. Linked to the need to show evidence for it.</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Tertiary: We need to work together ourselves.</td>
<td>This node captured participants' perceived need to improve collaborative practices prior to IPE happening at the Faculty. This need was seen to be present at a faculty level, between faculties as well as at a Health Service level.</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
<td>Interviews Coded</td>
<td>Citations Coded</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Tertiary: Health services need to work in this way.</td>
<td>Node captures the need for a shift in health services delivery towards more collaborative practices</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Tertiary: Need to collaborate between us at the Faculty.</td>
<td>Awareness of collaborative attitudes and commitment necessary from tutors so as to create the culture for IPE. Includes creating a social fora at the faculty.</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Tertiary: Need to collaborate with other faculties.</td>
<td>IPE, if ever contemplated by University, should not be isolated to the Faculty of Health Science so as to reflect realities of clinical practice.</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Secondary: Our way of doing things.</td>
<td>This node encapsulates those elements within the cultural context of Malta (and beyond) which were possibly perceived to be barriers for an eventual IPE initiative. These influences did not only straddle the geographical or physical location of Malta but also included emotional and ideological inferences ... our way of doing and perceiving things in Malta. (Our island mentality).</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Tertiary: Cultural change needed</td>
<td>Introducing IPE will necessitate incremental changes to the whole system (culture change) including changing attitudes at all levels. These small movements will hopefully allow change to infiltrate slowly.</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Secondary: Professions as a threat.</td>
<td>Professional issues/barriers to potential IPE pertaining to beliefs, territoriality, prejudices, turf-guarding, lack of knowledge about other roles, etc. Incorporated a lot of free node content of &quot;professional issues&quot;. Within this context &quot;Professionalism&quot; is defined as a socially constructed concept which connotes that within their own specialisation, professionals have a body of knowledge and skills which are unattainable to others (Pecukonis, Doyle &amp; Bliss, 2008) (21/01/2012).</td>
<td>16</td>
<td>246</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
<td>Interviews Coded</td>
<td>Citations Coded</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Tertiary: Development of professional identity.</td>
<td>Views of how faculty members perceive the development of PI in their own students, what contributes (or influences) its development, as well as concerns to how this level of PI may influence interactions between professional groups. The difference between professions is apparent.</td>
<td>10</td>
<td>95</td>
</tr>
<tr>
<td>Tertiary: Ingrained attitudes.</td>
<td>Deep seated beliefs which would challenge any notion of learning and working together. Protection of professional boundaries.</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Tertiary: Lack of knowledge &amp; misconception about other professions.</td>
<td>Lack of knowledge and misconceptions about the roles of other professionals, differing philosophies guiding the professions, about IPE and what would IPE necessitate in our courses. Also the lack of good role models.</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Tertiary: Some are more equal than others.</td>
<td>Tendency of many professions to work in silos (territoriality) and guard their patch (turf guarding). This is compounded by traditional and/or hierarchical perceptions of the different professions; profession specific stereotyping.</td>
<td>15</td>
<td>65</td>
</tr>
<tr>
<td>Secondary: Realities of teamwork.</td>
<td>The disparity that exists between how participants espoused teamwork as a concept and what actually happens in real life; at the Faculty and beyond. This includes service realities (and usually constraints) of the health service which seem opposite to collaborative health practices. (This node includes ‘espoused teamwork versus realities of practice’ earlier node).</td>
<td>15</td>
<td>151</td>
</tr>
<tr>
<td>Secondary: Our associations with IPE.</td>
<td>Participants' experiences of IPE both personally (academic and clinically), as well as within their courses. Many times it is more shared learning 14/01/2012. This node is made up of free node &quot;Personal experiences&quot; plus &quot;stroke symposium&quot; and &quot;shared learning&quot; to broaden it up. Aspects of free node &quot;teamwork&quot; added too. (was previously - Our experiences of IPE and shared learning).</td>
<td>15</td>
<td>123</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
<td>Interviews Coded</td>
<td>Citations Coded</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Tertiary: Our stories.</td>
<td>Participants' personal experiences of IPE, other collaborative educational experiences and possible IPE elements in their course.</td>
<td>11</td>
<td>40</td>
</tr>
<tr>
<td>Tertiary: That did not work!</td>
<td>Perceptions of the 2008 symposium.</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Tertiary: Times gone by.</td>
<td>Past practices which seemed to encourage collaboration, as well as past high level discussions for better collaboration between health professionals.</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Tertiary: Shared listening at the Faculty.</td>
<td>Perceptions on the multiprofessional (or shared learning) learning at FHS (under and post-grad). At undergraduate level this is usually learning alongside one another, without planned interaction. This node incorporates both experiences of and possibility of developing courses together. Made up mostly of free node &quot;shared learning.&quot;</td>
<td>10</td>
<td>64</td>
</tr>
</tbody>
</table>
Appendix 32
Examples of Early Models of Data Analysis

An early model for my data using the Transtheoretical Model of Change (Proschaska & DiClemente, 1982) as a basic framework for my thinking.
A further refined model for my data, again using the Transtheoretical Model of Change (Prochaska & DiClemente, 1982) as a basic framework.