Institutionalising interprofessional education in small states: perspectives from faculty and key stakeholders in Malta

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Abstract

The benefits of a collaborative practice ready workforce for patient-centred care are internationally gaining momentum and the Interprofessional education (IPE) movement is contributing to this. In the small island state of Malta, the importance of a collaborative health care workforce is being promoted and endorsed in policy documents. However, IPE has not yet been formally integrated into professional health education curricula. This qualitative case study aimed to explore stakeholders' perspectives and perceptions of a possible IPE initiative at the Faculty of Health Sciences, University of Malta. A purposive sampling method with fifty-nine participants including academics and senior policy makers was used. Data was gathered through focus groups, one-to-one interviews and documentary searches and analysed using 'Framework' (Ritchie & Spencer,1994) supported by NVivo 10. Four major themes were identified encompassing enablers and barriers for IPE: a) IPE could be beneficial, b) institutional and organisational barriers, c) professional barriers, and d) cultural barriers. This study highlights a range of interdependent challenges in the implementation of IPE from the perspective of the small state of Malta that can nonetheless contribute insights for other smaller sized nations for the development and formalisation of collaborative innovations in the educational curricula of health professionals. In particular, it highlights that national cultural dimensions or traits may represent a relatively unexplored barrier to date for the successful implementation of IPE in specific countries.

Key words: interprofessional education, perceptions, small states, barriers, national dimensions

Introduction

Global overviews of IPE highlight the diversity of why, where and how IPE has been implemented in different settings (Barr, 2015; Bonello, 2016, Vyt, 2009). Factors crucial for successful IPE are multifactorial and include political drivers, national coherent policies, institutional and organisational support and earmarked central funding (Freeth, Hammick, Reeves, Koppel & Barr, 2005; Oandasan & Reeves, 2005). Successful implementation of IPE is also dependent to some degree as Barr (2015) indicates to "the readiness of interprofessional exponents to set aside professional protectionism and academic rivalry as they support each other across borders and boundaries" (p.2). Another factor that has been given relatively little attention is the influence of cultural dimensions on the implementation of IPE. Few researchers have looked at how wider cultural factors or cultural values can constrain or enable IPE development. Such an 'anthropological gaze" is vital to consider when developing pedagogic interventions and curricula changes (Ventres & Crowder, 2017, p.1).

This study was conducted in the small state of Malta located in the middle of the Mediterranean Sea. Although there is no general acceptance as to what constitutes a small state (Maass, 2009), the Commonwealth defines small states as sovereign

countries with a population of 1.5 million people or fewer (Commonwealth Secretariat, 2012). Malta is the smallest country in the European Union with a population of 431,747. Small states face special constraints in health care due to logistical, economic and structural barriers (Azzopardi-Muscat & Camilleri, 2017); and there is a dearth of literature on the relationship between country size and health systems. This paper presents perspectives from faculty academics and senior policy makers on the challenges and enablers associated with developing, implementing and sustaining IPE at the University of Malta, specifically within the Faculty of Health Sciences.

The context of this study

The study was carried out at the Faculty of Health Sciences which caters for the education (pre and post-registration) of health care professionals namely Applied Biomedical Science, Food Studies and Environmental Health, Midwifery, Nursing, Mental Health Nursing, Occupational Therapy, Physiotherapy, Podiatry, Radiography and Speech Language Pathology. Professional programmes for medicine, dentistry, pharmacy and social work are undertaken by other faculties University wide. Whilst over the years the concept of introducing opportunities for students from the various health care professions to learn together has been discussed at Faculty Board level, to date there are no interprofessional learning initiatives. Professional health education is carried out in the traditional mono professional manner interspersed with a few core modules of multiprofessional learning consisting of students from different professions sitting side by side listening to the same lecturer. Nonetheless, similar to other European countries, the importance of preparing a healthcare workforce that would work collaboratively so as so improve

the quality of care is recognised (O'Halloran et al, 2006). For example, the National Health System Strategy for Malta, 2013–2020, (Ministry for Health, 2014) makes numerous references to promoting collaboration across disciplines. However, it does not specify how this will be fostered. The assumption and expectation may be that health graduates will automatically learn to work together. The aim of this study was to explore understandings of IPE including the potential barriers and enablers to its implementation within the Faculty of Health Sciences, University of Malta.

Methods

Research Design

A qualitative research approach was employed to capture the complexity of potential IPE as well as to understand the impact of contextual variables. The underpinning epistemological position was one of social constructionism located within an interpretive paradigm (Crotty, 1998: Lincoln & Guba, 1985). Choosing such an approach hinged on the fact that qualitative research follows the naturalistic paradigm based on multiple experiences constructed by the research participants (Vishnevsky & Beanlands, 2004). It also looks for answers to how a social experience is created and given meaning (Denzin & Lincoln, 2008). These aims addressed the purpose of this research, that is of understanding participants' multiple meanings, interpretations and constructions of IPE. Within this methodology, a case study research approach was selected as it allowed in-depth, and multi-faceted understandings of a complex issue or phenomena of interest in a natural real-life setting (Merriam, 1998; Simons, 2009; Stake, 1995). In this study, this meant looking at the multi-faceted explorations of IPE from the point of view of participants set within the culture of the faculty and beyond.

The unit of analysis was 'the possibility of IPE at the faculty' rendering an in-depth exploration and understanding of a bounded system within its natural context

Data Collection

Data was gathered from 10 focus groups with faculty academics cross the 10 Faculty of Health Sciences departments (see Table 1), 5 one-to-one interviews with senior policy makers (key informants) and document searches. Data collection was carried out in successive phases so that each phase could build and seek clarification on the other phases. All focus groups and key informant interviews were facilitated by the first author.

The aim of the of 10 focus groups with Faculty of Health Sciences academics from each department across the ten departments was to explore and gain insights into participants' perceptions of IPE. Each focus group consisted of faculty academics representing just one profession as it was considered within the specific cultural context that participants would feel more at ease to discuss certain sensitive issues with only their own departmental colleagues present. Purposive sampling was used. This refers to the selection of cases whose study will illuminate the research questions (Patton, 2002), that is, the sample is chosen with a purpose (Ritchie, Lewis & Elam, 2003). Invitation letters plus an information letter outlining basic information about IPE and details of the study were sent to all full-time and part-time academics employed the Faculty of Health Sciences. The total number of participants agreeing to participate within these focus groups was 54 participants (46 with full time and 8 with part-time appointments) across the various health professions (Table 1). An open-ended, non-leading discussion route based on the research questions and pertinent literature guided each focus group (Appendix 1).

Insert Table 1 here

Table 1: Academic focus group participants and their professional background

Professional department	No. of participants	No. of total number of staff
Applied Biomedical Science	3	5
Food Studies & Environmental Health	4	6
Midwifery	6	8
Mental Health Nursing	4	5
Nursing	8[1]	18
Occupational Therapy	5	6
Physiotherapy,	4	6
Podiatry	4	5
Radiography	8	10
Speech Language Pathology	8	10
Total	54	79

The second phase of data collection consisted of one-to-one interviews with 5 key informants. These were 5 senior leaders and/or policy makers from the health and education sectors, who were thought could provide invaluable insights into the organisation, its activities, policies and future directions (Luborsky & Lysack, 2006). As with previous participants, an invitation letter with relevant information was sent. The development of the interview guide was based on pertinent literature, a core set

[1] Maximum number of participants accepted in focus groups.

of questions (similar to the other phase), themes emanating from these phases and topics 'exploiting' each key informant's unique position.

Document searches were also used to provide the historical and contemporary contexts of this study. This was carried out consistently during the two phases as well as after the completion of the second phase. Documents accessed included official and unofficial records from administrative offices at the Faculty of Health Sciences and the Department of Health. Scott's (1990) four control criteria for handling and assessing the quality of evidence emanating from these documents were employed.

Data Analysis

All focus group interviews (approximately 90-120 minutes) and one-to-one interviews (approximately 60-90 minutes) were audio-recorded and transcribed. The data was analysed by the first author using the 'Framework' approach (Ritchie and Spencer, 1994) supported by QSR NVivo 10. 'Framework' was developed during the 1980's by the UK's largest, independent non-profit research institute, the National Centre for Social Research and is a systematic qualitative analytical process which involves the sifting, charting and sorting of data (Ritchie & Lewis, 2013). It is particularly useful in case studies as in addition to being systematic and disciplined, it relies on the analysist's sense of creativity and conceptual analysis so as to gain a sense of uniqueness of the data and to understand complex narratives; whilst still allowing the analyst to rework early ideas due to the integrated documentation process (Mason, 2002; Spencer, Ritchie, Ormston, O'Connor & Barnard, 2014). In this study, 'Framework' was used as a hierarchical conceptual scaffolding which allowed the first author 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.[2] Throughout this study, the first author who was a lecturer at the Faculty of Health Sciences, and hence an insider researcher, was aware of how her multiple roles, views, subjectivities and experiences might influence the entire research process. Reflexivity, a tool to evaluate how "intersubjective elements influence data collection and analysis" (Finlay, 2002, p.531) became central to her work and this was documented in a 5-year reflexive diary. An independent reviewer who was an NVivo consultant, oversaw the entire process of higher order theme development.

Ethical Considerations

Ethical approval for this study was granted from the Faculty Research Ethics and Governance Committee at the University of Brighton and from the University of Malta's Research Ethics Committee. All participants signed an informed consent document.

Findings

Four key themes emerged in relation to participants' perceptions of IPE; a) IPE could be beneficial, b) institutional and organisational barriers, c) professional barriers and d) cultural barriers.

a) IPE could be beneficial

This theme encapsulated participants' perceptions that there is an opportunity for IPE.

[2] This process requires three kinds of activity: data management, descriptive accounts and explanatory accounts (Ritchie, Spencer & O'Connor, 2003).

They spoke about possible benefits and potential positive outcomes they associated with IPE namely, it being a good mechanism for building professional alliances, making use of limited resources, improving patient care and preparing professionals to work in real life contexts:

> *"From a philosophical perspective, the idea is very good". (Academic 40)*

> *"Yes, I completely believe in that, obviously, and bringing people together could help them work together in the long run."* (Key informant[3])

Participants seemed to be open to the concept of IPE and spoke about the likely benefits of collaborative initiatives during students' programmes. They saw such opportunities as imaginable enablers to improved collaborative patient-centred practices:

> "*Learning together will make them more prone to work together …because at the end of the day they are going to be working together*." (Key informant)

> "*Because at the end of the day, it's all about how the person is going to benefit from our care ."* (Academic 43)

There was also the perception of improved collegiality at the faculty which at the time of data collection had been granted faculty status (as opposed to an institute) and had

[3] Although key informants were enumerated during transcription and data analysis this practice was not pursued when using their direct quotations in publications because of the increased possibility that a local reader might identify a particular key informant's discourse throughout the text.

relocated to new premises. This new outlook and the physical proximity of the different departments was perceived to facilitate collaborative efforts:

> *"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)

They recognised that the heterogeneity of the faculty with its diversity of professions would be beneficial for IPE:

> *"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 Therapists."* (Academic, 7)

> *"We already have the resources here 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 togeth*er." (Academic 12)

IPE was also perceived as being advantageous for a small island with limited resources:

> *"if we are to acknowledge the limitations of the island and the size of the island…. I think we would make much more effective use of resources."* (Academic 34)

A key informant added that introducing such collaborative practices such as IPE could equip health professionals with the necessary competencies to work in contemporary health systems:

> *"Whereas in the past, people could possibly have worked in silos or isolated from each other, that today is not only not acceptable anymore but it is not sustainable*." (Key informant)

However, notwithstanding these positive perceptions towards possible IPE, participants seemed to be acutely aware that the reality of developing and implementing IPE was replete with challenges and these are discussed in the next themes.

b) Institutional and organisational barriers

This theme encapsulated many institutional and organisational barriers at both faculty and university level that participants perceived would challenge the development of sustainable IPE. The nature of these barriers were diverse both 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. An example of a symbolic barrier to IPE relates to the Faculty's mission statement, which does not include the concept of IPE:

> *"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 opposed – it was actually opposed by certain members of staff ."*(Academic 6)

Indeed, academics 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, because one, it is not compulsory, and two, because it will introduce scheduling problems, logistical problems… it would take a leap of faith."* (Academic 39)

> "*the policy isn't one that our Faculty encourages IPE ... the Head of Departments in this case, cannot promote it to their staff because the idea of having students from different professions working together isn't there."* (Academic 7)

Participants realised that although IPE in principle seemed beneficial, there was not the impetus from the leaders to push it forward both at university level as well at a faculty level; without such a vision and a strategic plan, it was perceived that any attempts at IPE, would fail:

> "*You can't implement something unless the policy holders accept and push the idea."* (Academic 27)

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

There was also the question of tangible evidence underpinning IPE:

> "*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?"* (Academic 16)

> *"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)

Within the practical domain, participants brought up systemic and logistical barriers which centred on the lack of adequate and appropriate physical spaces, scheduling and accrediting challenges, curriculum rigidity and already overwhelming workloads. Participants were apprehensive that the possibility of developing, 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 a faculty:

"All sorts of resources. There's also the logistics and also a lot of co-ordination between the administration because you need to shift, fix timetables; so logistically it's quite a nightmare." (Academic 44)

"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)

Participants also identified the need for further training in teaching methodologies necessary for IPE and the challenges to do so:

"We need to learn about it ourselves first … one major challenge is that we already have so much on our plates. I mean, we have said that this involves a major shift. It needs so much planning." (Academic,14)

"the staff haven't been prepared for IPE, so if you want to get this going then you must start off, you know, introducing this to the staff, and hopefully getting them on board, but it's not an easy thing to do. Everyone gets into their own turf." (Academic 27)

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).

c) Professional barriers

This theme reflected participants sense of dissatisfaction with medical dominance, territoriality and rivalries existing between health professions; dynamics they perceived as incompatible with IPE. Participants reported that, although nursing, midwifery and other health professions had come a long way in the professionalisation process, medical dominance was still acutely perceived both in academia as well as in clinical practice. Moreover, it seemed that wider society in Malta largely reveres medicine and its specialities which meant that frequently participants perceived that their expertise was unrecognised and was generally undervalued:

"Medicine has all the power and is reluctant to give some of their territory." (Academic 2)

"It will be very difficult to get the medics on board this one." (Key informant)

In addition to perceived medical dominance, participants also brought up long standing interprofessional rivalries and conflict in between the health professions themselves challenging the idea of introducing IPE:

> *"The professions here…beneath the seemingly collegiate surface, they are at loggerheads."* (Academic 8)

> *"This sense of competition has been happening from the first year I was here ...and that is many years. Personally, it is disappointing."* (Academic 19)

> *"Territoriality, turf wars…it will be extremely difficult to attempt any kind of IPE."* (Key informant)

Many participants perceived that IPE could be a threat to their own professions' identity. For example, an academic referred to the dilemma in reconciling sharing of knowledge during IPE, with maintaining the boundaries that define and delineate individual professional territories:

> *"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)

Other participants spoke about the dangers of producing generic health professionals and of diluting the core identity of their own profession:

> *"Because at the end of the day we do not want our students to become rehab therapists* ."(Academic 9)

> *"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)

> *"We need to be careful so that the professions are not lost in building this inter professional concept or alliances*."(Academic 13)

Participants alluded to professional territories and boundaries in terms of both physical and conceptual 'spaces'. For example, one academic focused on physical resources of maintaining "*strict*" boundaries:

> *"We have our clinical practice 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 other."* (Academic 46)

Another academic focused on conceptual 'spaces' where blurring of boundaries could result:

> *"I mean if I am an Inter-Professional lecturer can I trust my student audience to know their limits if I'm going to address issues for everybody? I mean you get people who, because they have learnt something, they think that they can practise it, so one has to be careful*."(Academic 41)

There was also discussion about IPE being influenced by the more powerful or established professions:

"some professions might be so strong with their identity, that it might dishearten the professions who are younger maybe, less established." (Academic 16)

d) Cultural barriers

This theme encompassed participants' perspectives on macro level factors and the implications of such factors for any potential IPE initiative. They reported that IPE would demand a profound cultural change casting a high degree of uncertainty about the compatibility of IPE with certain cultural traits, characteristics and behaviours prevalent in a small state such as Malta.

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

"We cannot stick our head in the ground…the reality is that it's just not the way we do things." (Key informant)

Participants discussed both their professional identity and national cultural identity as influencing factors:

"Us Maltese love our safety zones, we don't really want to change because we are comfortable and we are not sure we want to cope with change or new ideas." (Academic 4)

"I think in reality, our culture, how we work, live and generally get on with things, life…it will be difficult ."(Academic, 10)

Participants perceived that there seemed to be an ingrained cultural pattern of initiating

projects without thinking about the longer-term issues of continuity and sustainability. This was mostly perceived to be because of the locals' way how to do things as well as the radical change of policies when governments change:

> *"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)

Participants also noted that limited resources may inhibit the development of IPE. For instance, one academic suggested that in addition to the obvious tangible lack of resources, having only one university on the island limited 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."* (Academic, 19)

Another issue highlighted was leadership. Whilst participants identified strong leadership as a central ingredient for successful IPE, there was the general perception that currently there were no clear "change leaders' who could push IPE forward. Moreover, leadership often tended to become intertwined with political issues:

> *"And what we have seen happening in Malta… is a super politicisation of the*

technical aspects of our work." (Key informant)

Discussion

As seen from the international literature and results, developing, implementing and sustaining IPE is complex and truly necessitates a "paradigm shift" (D'Amour and Oandasan, 2005). Participants in this study were generally enthusiastic when exploring the idea of IPE, highlighting potentially positive outcomes for the student, for the professional environment, and ultimately for the patient. They also noted that the faculty possessed a number of enabling factors such as the diversity of professions, physical proximity and a sense of newly found collegiality. However similar to current findings in the literature, IPE enablers (Lawlis, Anson and Greenfield, 2014) were outweighed by existing barriers.

When debating IPE as a tangible possibility, participants were predominantly pessimistic, reporting a multiplicity of factors, in the symbolic and practical realms, as posing immense challenges and barriers to IPE in Malta. In the practical domain, participants recognised that IPE would need to overcome a myriad of "internal and external inhibitors," (Pirrie *et al.,* 1998, p. 413) which in practical terms would add to the logistical and resource challenges they were already facing as a faculty. IPE seemed to be unachievable within current university structures and curricula; moreover, the urgency for change was not there.

IPE signifies "changes" on many levels. Ginsburg and Tregunno (2005) argue mild incremental changes do not challenge deep structures of an organisation; and only transformational change can overcome the more substantial barriers which entrench resistance to change within a system. This study highlighted a lack of change leadership for IPE in Malta. Strong visionary leaders are a major force in curricular

change and innovation such as IPE as they can effectively influence key decision making on educational policies and faculty support (Goble, 1994; Oandasan & Reeves, 2005); moreover, they are crucial for the sustainability of such a pedagogy (Clark, 2004).

In the less tangible or symbolic domain, participants expressed concerns about medical dominance, rivalries and territorialities between the health professionals. This reflects the literature in that health care professions seem to be not only subordinated by medicine but they themselves engage in practices aimed at establishing relative rank thereby perpetuating a hierarchical order (Reeves, MacMillan & Van Soeren, 2010). Such insights highlight the centrality of interprofessional power and conflict which although a reality in a number of practice contexts (Baker, Egan-Lee, Martimianakis & Reeves, 2011; Cameron, 2011; Khalili, Orchard, Laschinger & Farah, 2013; Kitto, Chesters, Thistlethwaite & Reeves, 2011) continues to be largely absent from the IPE literature (Paradis & Whitehead, 2015; Reeves, 2011).

Another highlighted barrier was the relevance of national culture in relation to IPE as shown by participants' reflections on the influence of deep-rooted values, beliefs and characteristics particular to the Maltese culture. Scholarship on this potential influence is scarce but Irajpour (2009) suggested that certain cultural traits could be incompatible with collaborative learning. 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 IPE.

Malta's small size and interrelated population seem to contribute to high degrees of competition in all spheres, possibly giving rise to factionalism. Boissevain (1994), an anthropologist who spent many years in Malta, observes that factionalism is one of the dominant cultural themes of the Maltese society and similar small states. The findings did indeed show strong degrees of factionalism as encapsulated by the third theme concerning dominance, professional rivalries and territorialities. This suggests that in small states, such practices could be more pronounced than in other contexts.

Another cultural lens to the findings is offered by the Dutch social psychologist Geert Hofstede. He defines culture as the "mental software which affects the way we think, feel, perceive the world and behave" (Hofstede, 1989, p. 391). He argues that national cultures are developed first and represent our most profound values. His theory of cultural dimensions consists of six dimensions or values which distinguish country cultures from one another (Hofsede *et al.*, 2010). The Maltese culture is described as a culture with a high *uncertainly avoidance* and a high *power distance*. *Uncertainty avoidance* is the extent to which the members of a culture feel threatened by ambiguous or unknown situations whilst *power distance* refers to the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally. This implies that similar to Latin countries which, in one way or another, have inherited a part of their civilization from the Roman Empire, Maltese people are inclined to maintain rigid codes of beliefs and behaviours, and tend to be feel threatened by ambiguous or unknown situations (Hofstede et al., 2010). As the findings above have shown,

Malta's preference for avoiding uncertainty was perceptible and evident in the findings when discussing IPE in tangible terms as a possible reality.

High *power distance index* suggests that Malta is a hierarchical society. Hierarchy in an organisation reflects centralisation and inherent inequalities where subordinates expect to be told what to do from leaders, politicians and religious leaders. A major threat in high *power distance* societies is competition with other groups for the same territory and resources (Hofstede *et al,* 2010). Strong power distance traits also emerged from the findings for example the strict professional hierarchies in academia and the health services and explicit and implicit interprofessional competitiveness and rivalries. Hence, whilst it is recognised across the literature that ambivalence and resistance to change is universal, (Ellsworth, 2000; Fullan, 1993; 2007; Hofsede *et al.,* 2010, Piderit, 2000), this study suggests that particular cultural factors in Malta and possibly similar small states tend to make innovative practices such as IPE more difficult. The broader implication is that cultural differences could potentially be a neglected factor acting as a barrier to IPE and explaining the varied picture of IPE development worldwide.

Concluding comments

This study has looked at the possibility of developing and implementing IPE at the Faculty of Health Sciences in Malta through the lens of academics and senior policy makers. It raised concerns about a number of challenges faced within the local context. This study also suggested that particular realities such as the sense of competition and resistance to change faced by a small island state such as Malta are deepened due to specific cultural factors. However, if such issues are integrated into the planning and development of change management initiatives, these need not be binding constraints.

The form or shape that IPE might take would certainly depend on the motives and movements promoting it and need to be adapted for the specific cultural contexts. Existing and interesting initiatives at the Faculty, could be used as platforms to initiate interprofessional collaborations, albeit at more modest levels. Notwithstanding the extent and scope of these initiatives, they must be developed in ways which would consider and address the complex micro, meso and macro factors identified in this study and in the IPE literature.

Limitations

The findings and interpretations of this case study may not be generalisable to other settings however might be still of value due to transferability (Lincoln & Guba, 1985). Descriptions of the research context, approach, and processes were given so as to enable readers to judge whether the findings would be transferable to other settings (Bassey, 2003: Lincoln & Guba, 1985). Nevertheless, due to the position of the primary researcher being an insider researcher in one particular faculty, vigilance needed to be exercised so as to protect the identity of small qualitative samples; hence the paucity of information and the non-numeration of the 5 key informants.

This study focused on IPE at the Faculty of Health Sciences, as opposed to including other health and social care professionals across University such as physicians and social workers. Whilst exploring the whole organisation would possibly have produced more extensive findings, the primary objective was to explore IPE at the Faculty of Health Sciences as this exists in its own particular context and culture.

Moreover, Stake's (2005) notion that a case study should "not represent the world but to represent the case" (p. 460) was observed. This case study was also carried out from an insider researcher's perspective which although being advantageous for a number of factors (such as having an in-depth understanding of the politics and culture of the institution and easier access to data sources) posed a number challenges. These included potential power issues, promising anonymity and confidentiality (contentious is small communities) and the possibility to bias. These issues were all taken into consideration by the researcher by adopting a preventative, reflexive and self-critical approach throughout the entire research design, implementation and writing up processes (Coghlan, 2007; Unluer, 2012).

Declaration of interests

The authors report no conflict of interest. The authors alone are responsible for writing and content of this article.

References

Azzopardi Muscat, N. and Camilleri, C. (2017). Challenges and Opportunities for the Health Sector in Small States. In L. Briguglio (Ed.), *Handbook of Small States: Economic, Social and environmental issues (pp. 445-474).* United Kingdom, UK: Routledge.

Baker, L., Egan-Lee, E., Martimianakis, M. A., & Reeves, S. (2011). Relationships of power: Implications for interprofessional education. *Journal of Interprofessional Care*, 25(2), 98-104.

Barr, H. (2015). Interprofessional education: The genesis of a global movement. Fareham, UK: CAIPE, *Centre for the Advancement of Interprofessional Education.*

Boissevain, J. (1994). Festa partiti: Parish competition and conflict. In R. Sultana & G. Baldacchino (Eds.), *Maltese society: A sociological inquiry* (pp.271-284). Malta: Mireva Publications.

Bonello, M. (2016). *Conceptualising the development and delivery of inter professional health care education in Malta.* (Unpublished Doctoral Dissertation, University of Brighton).

Cameron, A. (2011). Impermeable boundaries? Developments in professional and inter-professional practice. *Journal of Interprofessional Care*, 25(1), 53-58.

Clark, P. G. (2004). Institutionalizing interdisciplinary health professions programs in higher education: The implications of one story and two laws. *Journal of Interprofessional Care*, 18(3), 251-261.

Coghlan, D. (2007). Insider action research: Opportunities and challenges. *Management Research News, 30*(5), 335-343.

Commonwealth Secretariat. (2012). *Small States: Economic Review and Basic Statistics, Volume 16* (Vol. 16). Commonwealth Secretariat.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Australia: Sage Publications Ltd.

D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care*, 19(S1), 8-20.

Denzin, N. K., & Lincoln, Y. S. (2008). The discipline and practice of qualitative research. In N. K. Denzin & Y.S. Lincoln, (Eds.), *Strategies of qualitative inquiry* (pp.1-44). London: Sage.

Ellsworth, J. B. (2000). *Surviving Change: A Survey of Educational Change Models.* ERIC Clearinghouse on Information & Technology, Syracuse University, 621 Skytop Rd., Suite 160, Syracuse, NY 13244-5290.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12*(4), 531-545.

Freeth, D., Hammick, M., Reeves, S., Koppel, I., & Barr, H. (2005). *Effective interprofessional education: Development, delivery and evaluation*. Oxford, UK: Blackwell Publishing Ltd.

Fullan, M. (1993). *Change forces: Probing the depths of educational reform.* London: Falmer Press.

Fullan, M. (2007). (4th ed.) *The new meaning of educational change*. London: Routledge.

Ginsburg, L., & Tregunno, D. (2005). New approaches to interprofessional education and collaborative practice: Lessons from the organizational change literature. *Journal of Interprofessional Care*, 19, 177-187.

Goble, R. (1994). Multi-professional education in Europe: An overview. In A. Leathard (Ed.), *Going inter-professional: Working together for Health and Welfare* (pp.175-187*).* NY*:* Routledge.

Hofstede, G. (1989). Organising for cultural diversity. *European Management Journal*, *7*(4), 390-397.

Hofstede, G., Hofstede, G. J., & Minov, M. (2010). *Cultures and organizations: Software of the mind: Intercultural cooperation and its importance for survival*. New York: McGraw-Hill.

Irajpour, A. (2009). *Development of shared learning in medical sciences education in Islamic Republic of Iran.* (Unpublished doctoral dissertation, Isfahan University of Medical Sciences).

Khalili, H., Orchard, C., Laschinger, H. K. S., & Farah, R. (2013). An interprofessional socialization framework for developing an interprofessional

identity among health professions students. *Journal of Interprofessional Care*, 27(6), 448-453.

Kitto, S., Chesters, J., Thistlethwaite, J., & Reeves, S. (2011). *Sociology of interprofessional health care practice: Critical reflections and concrete solutions.* New York: Nova Science Publishers.

Lawlis, T. R., Anson, J., & Greenfield, D. (2014). Barriers and enablers that influence sustainable interprofessional education: a literature review. *Journal of Interprofessional Care*, 28(4), 305-310.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. CA: Sage Publications.

Luborsky, M., & Lysack, C. (2006). Overview of qualitative research. In G. Kielhofner (Ed.), *Research in Occupational therapy* (pp. 326-340). Philadelphia: F.A. Davis Company.

Maass, M. (2009). The elusive definition of the small state. *International politics*, 46(1), 65-83.

Marris, P. (1986). *Loss and change.* (2nd edition). London; Routledge.

Mason, J. (2002). *Qualitative researching*. London: Sage.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education. Revised and Expanded from Case Study Research in Education*. CA: Jossey-Bass Publishers.

Ministry for Health, (2014). *A national health systems strategy for Malta (NHSS): 2014-2020 Securing our health system for future generations*. Malta: Ministry for Health. Retrieved from

https://deputyprimeminister.gov.mt/en/Documents/National-Health-Strategies/NHSS-EN.pdf

Oandasan, I., & Reeves, S. (2005). Key elements of interprofessional education. Part 2: Factors, processes and outcomes. *Journal of Interprofessional Care, 19*(S1), 39-48.

O'Halloran, C., Hean, S., Humphris, D., & Macleod-Clark, J. (2006). Developing common learning: the new generation project undergraduate curriculum model. *Journal of Interprofessional Care*, *20*(1), 12-28.

Paradis, E., & Whitehead, C. R. (2015). Louder than words: power and conflict in interprofessional education articles, 1954–2013. *Medical Education*, *49*(4), 399-407.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* Sage Publications, Inc.

Piderit, S. K. (2000). Rethinking resistance and recognizing ambivalence: A multidimensional view of attitudes toward an organizational change. *Academy of Management Review,* 25(4), 783-794.

Pirrie, A., Wilson, V., Harden R.M. & Elsegood J. (1998). AMEE Guide No.12: Multiprofessional education: Part 2-promoting cohesive practice in health care. *Medical Teacher*, 20(5), 409-416.

Reeves, S. (2011). Using the sociological imagination to explore the nature of interprofessional interactions and relations. In S. Kitto, J. Chesters, J. Thistlethwaite & S. Reeves (Eds.), *Sociology of interprofessional health care practice* (pp. 9-22). New York: Nova Science Publishers.

Reeves, S., MacMillan, K., & Van Soeren, M. (2010a). Leadership of interprofessional health and social care teams: A socio-historical analysis. *Journal of Nursing Management*, 18(3), 258-264.

Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman, & R. G. Burges, (Eds.), *Analysing qualitative data* (p. 173- 194). London: Routledge.

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers.* London: Sage.

Ritchie, J. & Lewis J. & Elam, G. (2013). Designing and section samples. In A. Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers* (p.77-108). London: Sage.

Ritchie, J., Spencer, L., & O'Connor, W. (2003). Carrying out qualitative analysis. In Ritchie, J., & and Lewis, J. (Eds.), *Qualitative research practice: A guide for social science students and researchers* (219-262). London: Sage.

Scott, J., 1990. *A matter of record: Documentary sources in social research*. Cambridge: Polity Press.

Simons, H. (2009). *Case study research in practice*. London: Sage Publications.

Spencer, L., Ritchie, J., Ormston, R., O'Connor W, and Barnard, M. (2014). Analysis: Principles and Processes. In J. Ritchie, J. Lewis, C. McNaughton Nicholls and R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers*, (pp.269-290). London: Sage.

Stake, R. E. (1995). *The art of case study research*. CA: Sage Publications.

Stake, R. E. (2005). Qualitative Case studies. In N. Denzin and Y. Lincoln (Eds.). *The Sage Handbook of Qualitative Research*, (3rd ed.), Thousand Oaks, CA: Sage (pp.443-466).

Unluer, S. (2012). Being an insider researcher while conducting case study research. *Qualitative Report, 17*, 58.

Ventres, W., & Crowder, J. (2017). When I say… anthropological gaze. *Medical education*.

Vishnevsky, T., & Beanlands, H. (2004). Qualitative research. *Nephrology Nursing Journal*, *31*(2), 234-239.

Vyt, A. (2009). *Exploring quality assurance for interprofessional education in health and social care*. Antwerp: Garant Publishers n.v.

Footnotes

1. Maximum number of participants accepted in focus groups.

2. This process requires three kinds of activity: data management, descriptive accounts and explanatory accounts (Ritchie, Spencer & O'Connor, 2003).

3. Although key informants were enumerated during transcription and data analysis this practice was not pursued when using their direct quotations in publications because of the increased possibility that a local reader might identify a particular key informant's discourse throughout the text.