THE SOCIAL ORGANIZATION OF AN INTERPROFESSIONAL EDUCATION PROGRAM

by

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DEDICATION

This thesis is dedicated to my daughters, my family, fellow health professionals and health educators. To Nadya my daughter, best friend, role model, and continual support for my personal wellbeing and professional development. To my daughter Yasmina who is the source of my joy, happiness, and intriguing thinking. To my sister Nisreen and my nephews Majd and Firas for believing in me. To my brother, Nadeem for his encouragement and support.

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ABSTRACT

Background: Interprofessional Collaboration (IPC) among health care professionals has been identified as essential to enhance patient care. Interprofessional education (IPE) is a key strategy towards promoting IPC. Stereotypes held by students have been recognized as a challenge for IPE and IPC.

Purpose: To describe the norms and limits that shape facilitator's work in IPE interactions problematized by students' stereotypes.

Methodology and Methods: The methodology employed was institutional ethnography. Data was collected through observations, interviews, focus groups, and texts. Participants included facilitators, nursing students, and IPE committee members.

Results: Facilitation of IPE is impacted by several factors including: the composition/balance of the students within small groups, interpersonal relations between students across health professions; inconsistent focus on core IPC competencies and formal facilitator training.

Conclusion: Study results include the identification of several strategies to address student stereotypes and enhance collaboration, including directions for future curriculum decisions and the pedagogical organization of IPE.

LIST OF ABBREVIATIONS USED

WHO	World Health Organization
CIHC	Canadian Interprofessional Health Collaborative
IPE	Interprofessional Education
IPC	Interprofessional Collaboration
US	The United States
UK	The United Kingdom
IECPCP	Interprofessional Education for Collaborative Patient-Centered Practice
IHI	Institute of Health Improvement
CAB	Collaborating Across Borders
AIHC	American Interprofessional Health Collaborative
CHEB	The Collaborative Health Education Building
HTSS	Health Team Stereotype Scale
AHPQ	Attitudes to Health Professions Questionnaire
SSRQ	Student Stereotypes Rating Questionnaire
CST	Critical Social Theory
IE	Institutional Ethnography
IPECC	Interprofessional Education Coordinating Committee
FHP	Faculty of Health Professions
FH	Faculty of Health

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Chapter 1: Introduction

The healthcare system, both nationally and globally, is facing numerous challenges that impact healthcare delivery and expected outcomes. These challenges include shortage in health human resources (World Health Organization [WHO], 2006, 2010), changes in health care delivery models (Olson & Bialocerkowski, 2014; Thistlethwaite, 2012), patient safety and medical errors (Hood, Cant, Leech, Baulch, & Gilbee, 2014; Institute of Medicine, 2001; Kohn, Corrigan, Donaldson, & Institute of Medicine (US) Committee on Quality of Health Care, 2000; Thistlethwaite, 2012), the fast pace of technological advancements (Institute of Medicine, 2001), financial and budgetary constraints (Robert Wood Johnson Foundation, 2015), and aging populations (Thistlethwaite, 2012). National and international efforts to address these challenges emphasize effective collaboration among health care professionals as one promising solution (Canadian Interprofessional Health Collaborative [CIHC], 2008; Gilbert, 2010; Institute of Medicine, 2001; WHO, 1988, 2010; Olson & Bialocerkawoski, 2014; Robert Wood Johnson Foundation, 2015; Thistlethwaite, 2012). Interprofessional collaboration occurs when healthcare workers representing different health professions work together with patients, families, carers and communities to deliver best care and health outcomes (WHO, 2010).

> "The World Health Organization (WHO) and its partners recognized interprofessional collaboration in education and practice as an innovative strategy that will play an important role in mitigating the global health workforce crisis." (WHO, 2010, p. 7)
>
> "…many long-standing assumptions that have shaped the organization, delivery, and financing of health care are shifting beneath our feet. Interprofessional collaboration holds the potential to significantly contribute to the emerging model of care" (Robert Wood Johnson Foundation, 2015, p. 7).

The WHO 1988 report emphasized the necessity for having educational programs to teach health care professionals how to work efficiently together. Rudd, Estis, Pruitt, and Wright (2016) argued that healthcare professionals are not naturally prepared to work collaboratively, and concluded that collaboration must be learned. The education that provides the knowledge and skills for health care professionals to work collaboratively is called interprofessional education (IPE). The WHO (2010) reinforced that IPE at the pre-licensure educational stage is integral to ensure "collaborative practice-ready" (p.7) healthcare workforce. As defined by WHO, IPE "occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p.13).

Many national and international policy papers have reinforced the need to introduce IPE during undergraduate education. International reports include *Learning Together to Work together for Health* (WHO, 1988), *The World Health Report 2006: Working Together for Health* (WHO, 2006), and *Framework for Action on Interprofessional Education & Collaborative Practice* (WHO, 2010). Canadian national reports include *Building on values: The future of health care in Canada* (Romanow, 2002) with its subsequent reinforcement and support by Health Canada (Gilbert, 2010), *Situational Analysis: Current State of Interprofessional Education (IPE) in Canada* (CHIC, 2008) and *A National Interprofessional Competency Framework* (CIHC, 2010). National reports also include *To Err is Human* (Kohen et al., 2000) *in* the United States and *Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* in the UK (Great Britain Department of Health, 2001). Accordingly, and since the early 1970s, IPE has been introduced in different approaches in Canada, the US, the UK, and Europe. The first undergraduate university IPE course in Canada was offered in 1992 at the University of Alberta (Gilbert, 2010).

In spite of the fact that international and national legislative bodies have recognized and supported IPE, and despite more than four decades since introducing IPE programs, evidence regarding the evaluation and effectiveness of IPE is still lacking. Although, the WHO *Framework for Action on Interprofessional Education & Collaborative Practice* (WHO, 2010) provided a summary of the evidence supporting IPE, it is not a systematic review (Thistlethwaite, 2012). The WHO framework has been criticized for failing to address the "weighting and evaluating of the evidence" (Thistlethwaite, 2012, p.61). Nevertheless, several systematic reviews on IPE have been published (Oandansan & Reeves, 2005a, 2005b; Olson & Bialocerkowski, 2014; Reeves, Boet, Zierler, & Kitto, 2015; Sunguya, Hinthong, Jimba, & Yasouka, 2014; Thistlethwaite, 2012) and revealed that most published studies focused on development and delivery of IPE rather than its evaluation. The available literature on evaluation of the effectiveness of IPE is insufficient and lacks empirical data needed by decision-makers to support the IPE programs (Thistlethwaite, 2012, Reeves et al., 2015). Most of the existing literature evaluating IPE addresses mainly participants' satisfaction and reactions, and less evidence describes changes in knowledge, attitudes or behaviour (Reeves et al., 2015). Reeves et al. (2015) argued that this evidence does not meet the needs of policy makers and legislative bodies. Evidence needed by decision makers includes changes in behaviour on the long term, organizational changes, and benefits to patient/clients (Reeves et al., 2015; Thislethawaite, 2012).

Parallel to this lack of evidence on IPE programs evaluation, the literature presents numerous challenges and barriers in the development and delivery of IPE programs. Oandansan & Reeves (2005b) categorized these challenges into three levels: The micro level related to learners and their socialization process, the meso level related to the teaching environment and

administrative challenges, and the macro level related to availability of support from senior management and government. The micro level challenges relate to the stereotypes held by learners. Stereotypes are defined as "social categorical judgment (s)…… of people in terms of their group membership" (Turner in Hean, Clark, Adams, & Humphris, 2006). Stereotyping is neither positive nor negative, but rather a way to organize information about the group an individual belongs to or about other groups, thus shaping interactions between individuals belonging to different groups (Cook & Stoecker, 2014). Accordingly, when stereotypes involve negative or false perceptions of attitudes and behaviors of one's own or another group, then interactions between individuals holding these negative stereotypes will be associated with negative outcomes. In the interprofessional and collaboration context, when members of a healthcare team (professionals or students) hold inaccurate stereotypes about their own profession and about other health professions, then interactions and communication among them become challenging and ineffective, jeopardizing the effectiveness of IPE and collaboration (Cook & Stoecker, 2014; Rudd et al., 2016).

In a systematic review describing the stereotypes held by healthcare students, Cook & Stoecker (2014) identified similarities in the stereotypes held by practicing healthcare professionals and healthcare students. Cook & Stoecker's (2014) argued that healthcare students develop stereotypes before or during their healthcare education, and then carry these stereotypes with them into practice. The authors emphasized the importance of examining stereotypes healthcare students hold throughout their professional education.

Students entering a particular health profession hold a series of attitudes, beliefs and understandings of what that profession means to them, and how they see themselves in a professional role in the future. During their years of education, these students are further

socialized to learn their own profession roles. Professional socialization is a process through which healthcare students acquire profession-specific attitudes, values, knowledge, and behaviors, which continue into post-licensure working years (Dinmohammadi, Peyrovi, & Mehrdad, 2013; Oandansan & Reeves, 2005b). Oandansan & Reeves (2005b) argued that the professional socialization students experience can impact their experience of IPE. Oandansan & Reeves (2005b) identified that the training healthcare students undergo is usually done in their corresponding departments and involves minimal (if any) interaction with trainees of other healthcare profession students. Moreover, the professional socialization within each department has an important impact on how students approach IPE. For example, medical students are often socialized within their profession to be authoritative in professional and interprofessional settings (Oandansen & Reeve, 2005b). Additionally, diverse health professions place different emphasis on the scientific versus social values and knowledge, thus eliciting different cultures within each profession. Oandansen & Reeves (2005b) argued that as a result of these socializations, students form perceptions and stereotypes about their own professional identify and those of other professions. The stereotypes held then isolate professionals from each other, hinder communication, and can impede IPE and collaboration.

It is currently not known how stereotypes and IPE programs influence and shape each other. The existing evidence on the influence of IPE programs on the stereotypes students hold is not conclusive. The literature identified that healthcare students enter their IPE programs with stereotypes about their own profession and other health professions (Hind et al., 2003; Michalec, Giordano, Arenson, Antony, & Rose, 2013). Whereas some studies have shown a positive impact of IPE programs on students' held stereotypes (Ateah et al., 2011; Foster & Macleod Clark, 2015), other studies have shown that IPE programs were not successful in changing the

stereotypes students hold (Hansson, Foldevi, & Mattsson, 2010; Nisbet, Hendry, Rolls, & Field, 2008). For example, research by Tunstal-Pedoe, Rink, & Hilton (2003) and another study by Leaviss (2000) described an exaggeration of student stereotypes during IPE programs.

In conclusion, interprofessional collaboration and interprofessional education are well recognized as essential in the delivery of healthcare and optimization of patient and system outcomes. Despite recognition for the importance of IPE and IPC, there remains a need to further understand the impact of IPE on collaborative practice outcomes, including an understanding for how stereotypes held by health professional students can influence interprofessional socialization. Even though the above introduction identifies numerous gaps in our current understanding, this study does not start with an identified gap in the literature. Guided by institutional ethnography, this project started by identifying a problematic/area of concern, which is the existence of stereotypes within IPE context. This area of concern was first identified by my supervisor during her work on IPE activity. In keeping with the institutional ethnography methodology, the next step in developing the research ideas included an exploration of the relevant concepts of IPE, collaboration, and stereotypes.

This introduction serves as a background for the area of concern this study aims to investigate. As the literature identifies, stereotypes are a complex construct, shaped by numerous factors, to justify the choice of institutional ethnography as a method of investigation. Institutional ethnography aims to explicate all the social relations that govern a certain behavior or experience in a specific setting (Campbell & Gregor, 2002). Accordingly, investigating and explicating what context of IPE experiences are associated with students expressing their held stereotypes, what shapes the way these stereotypes are expressed, and what dictates the way these stereotypes are addressed by the student him/herself, by other students, and by facilitators

would provide an ethnographic analysis of the relations that dictate the pedagogical practices within IPE context.

Purpose

The purpose of this study is to:

1. Investigate the social relations and institutional discourse that organize facilitators' work in IPE activities at Dalhousie University.
2. Describe the IPE textual norms and limits that organize IPE interactions in contexts problematized by nursing students' stereotypes.

Research Questions

The research questions are:

1. What are the work processes executed by facilitators in IPE settings?
2. What social relations and institutional discourses of the IPE program organize the work conducted by facilitators in a local IPE setting?
3. How does the social organization dictating facilitators' work in an IPE setting shape students' stereotypes?
4. What textual norms and limits organize the interactions is settings where stereotypes are reflected?

Chapter 2: Literature Review

Institutional ethnography carries specific considerations for researchers' review of the literature. Intuitional ethnographers do not start their study by identifying a gap in the literature, but rather refer to the literature at later stages, after the problematic is identified and the social organization around that problematic is explicated (Campbell & Gregor, 2002; Smith & Turner, 2016). Institutional ethnography starts in everyday experience of people, identifies an area of concern/problematic for these people, and explicates the relations around this problematic as experienced and explained by people to make the problematic understandable for them (Campbell & Gregor, 2002). Institutional ethnographers believe that people experiencing the problematic are the best knowers of it, and that adopting the stand of these knowers determines what can be seen and explored (Campbell & Gregor, 2002). Institutional ethnography's concern about review of the literature in the first stages of the study, is that the literature may present a standpoint of the problematic different from what the people experiencing it have. Thus, the danger is in importing, from the literature, dominant perspectives and standpoints into the researcher's thinking and miss the people's standpoint (Campbell & Gregor, 2002).

Nevertheless, Campbell and Gregor (2002) acknowledged that reviewing the literature early in a study is an academic requirement for thesis students. The authors presented a specific institutional ethnography approach for literature review. Campbell and Gregor proposed that researchers conduct literature review to discover the scope of research knowledge about the topic and to focus on constituents and processes that determine the interactions and relations around the topic, thus identifying what is known and what still needs to be discovered to explicate the relations around the topic. Campbell and Gregor also emphasized that the researcher through reviewing the literature explores and justifies options for adopting a standpoint. In the following

section, I will present a review of the literature on IPE focusing on the constituents and processes that determine IPE interactions and experiences and commenting on explicating these interactions and on my adopted standpoint.

Search Strategy

A search of the literature included the following databases: CINAHL, Pubmed, Psychinfo, Sociological abstracts and Google scholar. The search terms used were socialization, professional socialization, collaboration, collaborative practices, interprofessional education, pedagogy, teaching strategies, learning strategies, online education, simulation, evaluation, and stereotypes. The search was limited to years 2000 till 2016 as I was focusing on undergraduate university IPE education mainly within the Canadian context, which had its earliest inception around 1994. Another reason for focusing on recent evidence is the fact that IPE has been evolving and changing in recent years, so I wanted to present the evidence of the current IPE programs. Studies were first screened and selected by title, then by abstract. Articles were eliminated if they did not meet the inclusion criteria: Undergraduate University IPE education for healthcare professions.

Hand searching the reference list of the relevant studies was another strategy used. The search strategy evolved and remained ongoing throughout the process of synthesizing the literature to provide more evidence in support of emerging themes.

Searching journals that specifically addressed interprofessional education or care was another strategy employed including *Journal of Interprofessional Care* and *Journal of Research in Interprofessional Practice and Education*. Moreover, relevant IPE websites including the CIHC, and Dalhousie University websites were searched for interprofessional education content along with suggested links to documents, publications and other Universities' IPE websites. In

total the following synthesis yielded 40 articles, inclusive of 10 reviews (systematic and scoping), four mixed methods, 21 quantitative studies, five qualitative studies, and 13 international and national reports.

The following section includes a review and synthesis of relevant literature and empirical evidence on IPE with a specific focus on the impact of stereotypes. This section includes a review of the relevant evidence including quantitative, qualitative, and mixed method research. This empirical review is presented under five themes: 1) IPE and IPC: definitions, drivers, and history of IPE in Canada and the US, 2) theoretical frameworks of IPE, 3) IPE curriculum and role of faculty members, 4) teaching and learning strategies, and 5) stereotypes as barrier for implementing IPE. The selection of these themes was guided by institutional ethnography to present the knowledge, the constituents and main processes of IPE.

IPE and IPC: Definitions, Drivers, and History

Definitions. Interprofessional collaboration (IPC) in health-care has been identified, both nationally and globally, as integral to promote safe patient care and effective health human resources planning (CIHC, 2010; WHO, 2008, 2010). Interprofessional collaboration is "the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients, clients, families, and communities to enable optimal health outcomes" (Thislethwaite, 2012. P. 60). Collaborative practices occur when multiple health workers from different professions provide comprehensive services through their work with patients, their families, and communities. Collaborative practices are not restricted to clinical work, but also include non-clinical work such as "surveillance, health communications, management and sanitation engineering" (Godden-Webester & Murphy, 2014). Research evidence has shown that collaborative practice can improve coordination of health-services

(Razk et al., 2007), appropriate use of specialist clinical resources (Barcelo et al., 2010), health outcomes for people with chronic diseases (Barcelo et al., 2010; Strasser et al., 2008), and patient care and safety (Barcelo et al., 2010; Janson et al., 2009; Morey et al., 2002). Research has also shown that collaborative practices have been associated with improvement in care efficiency (Capella et al., 2010; Wolf, Way, & Stewart, 2010) and cost reductions (Banki at al., 2013), and a decrease in patient complications (Janson et al., 2009), clinical error rates (Morrey et al., 2002), and mortality rates (Bliss et al., 2012; Knight et al., 2012). Moreover, evidence has also shown that interprofessional collaboration was associated with a decrease in tension and conflict among health professionals and a decrease in staff turnover (Barr et al., 2000). Thus, ensuring competency of health care professionals in performing collaborative practices is crucial (Godden-Webester & Murphy, 2014).

Interprofessional education (IPE) aims to prepare and train health care professionals to become a "collaborative practice-ready workforce" (WHO, 2010, p. 7). Interprofessional education occurs "when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p.7). Interprofessional education has been introduced into health care professions educational programs since the early 1970s (Gilbert, 2010). Accordingly, these students learn and acquire the skills of working interprofessionally, then enter the health care workforce as members of "collaborative practice teams" (WHO, 2010, p.7).

The evidence of the impact of pre-licensure IPE on interprofessional collaboration and on patient outcomes is inconclusive (Reeves et al., 2009, 2010, 2015; Thistlethwaite, 2012). However, evidence shows that IPE had a positive impact on understanding of the roles and responsibilities of other professional groups and on learners' attitudes towards one another's

professions among nursing, pharmacy, and medical students (Crutcher, Then, Edwards, Taylor, & Norton, 2004) and among nursing, medicine (family practice), physical therapy, dentistry, social work, hospital administration, pastoral care, audiology and speech pathology, dietetics and pharmacy students (Barber, Borders, Holland, & Roberts, 1997); knowledge of the nature of interprofessional collaboration among medicine, nursing, occupational therapy and physiotherapy students (Reeves, 2008), actual collaborative behavior among physicians, physician assistants and nurse practitioners (Helitzer et al., 2011), among physicians , nurses and technicians in an emergency department (Morey et al, 2002), and among surgeons, surgical technician, nurses, nurse anesthetists, anesthesiologists, an physician assistants in an operating room (Weaver, 2010) , organizational practices (referral practices, documentation) (Rask et al., 2007), delivery of care (patient satisfaction, length of stay) (Morey et al, 2002; Reeves & Freeth, 2006; Solberg, Kottke, & Brekke, 1998), and clinical outcomes (clinical error rates, infection rates) (Barcelo et al., 2010; Janson et al., 2009; Morey et al, 2002; Strasser et al., 2008).

Drivers for IPE. The need for building and sustaining interprofessional education programs has been emphasized both internationally and nationally. This need has been driven by the publication of reports that reflected the fragmentation and compartmentalization of the health services, and that emphasized the importance of having collaborative practice-ready workforce through interprofessional education. These reports include *Learning Together to Work Together for Health* (WHO, 1988) and *Framework for Action on Interprofessional Education and Collaborative Practice* (WHO, 2010) *by* the WHO, *Canadian Adverse Events Study* (Baker et al., 2004) in Canada, *To Err is Human* (Kohn et al., 2000) and *Health Professions Education- a Bridge to Quality* (Greiner et al., 2003) in the US, and the *Bristol Inquiry* (Great Britain Department of Health, 2001) in the UK. These reports played an important role in health

providers', health educators' and governments' reinforcement of collaborative practices and interprofessional education

In 1988, the World Health Organization published a report entitled *Learning Together to Work Together for Health*. The report acknowledged the fragmentation and inefficiency of the health services, and emphasized the importance of team work and proper team composition representing proper disciplines. The WHO report (WHO, 1988) emphasized that health care professionals should be taught and trained to work efficiently together as teams. The report stated that team members should be taught the responsibilities of the whole team as a group, the role of each member in carrying these responsibilities, the overlap of team members' roles, how to work together, and the role of the team in the overall delivery system (WHO, 1988, p.8).

In 2010, the WHO released the World Health Organization's *Framework for Action on Interprofessional Education and Collaborative Practice*. The framework reemphasized the fragmentation of health care systems across the globe, and that these systems are not able to meet the health needs of the population. Moreover, the framework identifies another challenge for the current and future health care workforce, who are frequently assigned new tasks to meet the increased complexity of the health system. The framework identified interprofessional collaboration as crucial to meet these challenges. However, the framework acknowledged that for a new health care professional to acquire the skills needed for collaborative practices, this professional should experience first the health care system. Thus, the framework advocated for preparing and training heath care professionals prior to joining the healthcare workforce through introduction of IPE to the health care professions educational programs.

History of IPE in Canada and the US. The history of IPE in Canada dates back to year 1969 with the publication of a paper entitled *Interprofessional Education in Health Sciences: A*

Project Conducted at the University of British Columbia (Szasz, 1969). Szasz acknowledged the fragmentation, compartmentalization, and poor communication within the health care system, and between scientific investigation and "approaches to human problems" (Gilbert, 2010, p.216). Moreover**,** Szasz identified a process to structure and develop interprofessional education:

> "Accordingly, a Committee on Interprofessional Education in the Health Sciences has been established to promote interprofessional education and to experiment with educational programs to arrive at recommendations concerning what the students should learn together with how they learn it" (Gilbert, 2010, p.216).

Since 1969, many attempts to introduce interprofessional concepts in educational programs across Canada have been made. The first IPE course was offered in 1992 in the University of Alberta. However, developing and sustaining "even the modest program have proven to be difficult" (Gilbert, 2010, p.216). Decisions regarding best practices and implementation strategies were usually made inhouse within each organization. Thus, organizations across Canada implementing IPE program differed in what each identified as best practice and what constitutes a successful IPE program (Gilbert, 2010), rendering it rather difficult to agree on a standard program.

Since 2002, IPE in Canada has gained federal attention and support. Publication of the report entitled *Building on Values: The future of Health Care in Canada* (Romanow, 2002), in 2002, was crucial in directing Health Canada's programs. The Romanow report presented a profile for Interprofessional education. Pursuant to that report, the subsequent First Minister's Accord on Health Care Renewal in February 2003 was associated with budgetary commitment to health human resource planning, recruitment and retention, and interprofessional education (Gilbert, 2010). This was followed by the establishment of the National Expert Committee for

Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP). The IECPCP initiative was a major milestone in IPE in Canada, associated with funding of 20 learning projects including a literature review and environmental scan which resulted in *Interprofessional Education for Collaborative Patient-Centred Practice: An Evolving Framework* (Gilbert, 2010). The initiative aimed to promote and demonstrate the benefits of IPE, increase the number of IPE educators and professionals trained for collaborative practices (before and after entry to practice), and encourage networking and sharing of best educational approaches. The IECPCP emphasized changing the way health providers are educated in order to ensure that health care workers gain the necessary knowledge and training to work effectively within interprofessional collaborative (Gilbert, 2010).

In 2006, and in an attempt to facilitate evaluation and implementation of IPE at a national level, Health Canada launched the Canadian Interprofessional Health Collaborative (CIHC). The CIHC aims to promote collaboration in health and serves as a national center for resources and networking around interprofessional education and collaboration (CIHC, 2016a). Moreover, the CIHC plays an important role in integration of interprofessional collaboration in policymaking and curriculum development. The CIHC exerts this role through sharing knowledge, education, and evidence, about interprofessional collaboration and education, with health systems planners, health providers and educators (CIHC, 2016b). In 2010, the CIHC published *A National Interprofessional Competency Framework* (CIHC, 2010) which is currently the guiding framework for IPE education and collaborative programs across Canada.

In the United States, introduction of IPE at university hospitals started as early as 1970's, but these programs lacked structure and were generally informal (Fairman, 2016). Conferences and congresses were the primary arena where scholars across the US would meet and discuss

their IPE initiatives; for example, the Annual Interdisciplinary Health Care Team Conference (started in mid-1970s and run through to 2003), and the Annual Congress of Health Professions Education and Group on Multi-Professional Education (started in the 1990s) (Blue, Brandt, & Schmitt, 2010). The main focus of IPE in the United States until the early 2000s was primary care. The starting point of a new approach in re-thinking IPE and team-based care was elicited by the publications of the Institute of Medicine: *To Err is Human* (Kohn et al., 2000), and *Crossing the Quality Chasm: A New Heath System for the 21st Century (*Institute of Medicine, 2001), and *Health Profession Education: A Bridge to Quality* (Greiner et al., 2003). These reports discussed the medical errors in the United States then, identified the fragmentation and lack of collaboration among healthcare professionals as a major cause of these errors, and emphasized the role of collaborative practice. The restructuring of health professional education and practice was supported by the Institute of Healthcare Improvement (IHI) by creating a nationally- focused collaborative. This resulted in shifting from a focus of IPE in communities to hospitals and universities (Blue et al., 2010).

In November 2006, an initiative for the US to collaborate with Canadian scholars around IPE was launched. *Collaborating Across Borders: An American- Canadian Dialogue on Interprofessional Health Education* (CAB 1) was held in 2006 in Toronto, and CAB 2 was held in 2009 in Halifax. Until 2007, a national organizational umbrella that coordinated the emerging IPE efforts in the United States did not exist, hence the American Interprofessional Health Collaborative (AIHC) as an affiliate agency to the CIHC was initiated (Blue et al., 2010).

In summary, within Canada and the United States there have been many efforts associated with an evolution of our understanding of the key concepts of IPE since 1969. IPE in

Canada has gained the federal and provincial attention and support, and Canada has been recognized, since the early 2000s, as an international leader in this field (Gilbert, 2010).

Theoretical Frameworks in IPE

IPE Educators have been encouraged to use theoretical frameworks to develop IPE programs and to inform the IPE pedagogical strategies (Oandansan & Reeves, 2005a). Utilizing theoretical frameworks is pivotal for evaluation and research purposes (Oandansan & Reeves, 2005a; Reeves et al., 2015). However, review studies have identified that theoretical frameworks are missing from most IPE educational programs and research (Abu-Rish et al., 2012; Olson & Bialocerkwoski, 2014). Abu-Rish et al. (2012) conducted a review of qualitative, quantitative and mixed studies evidence on the trends in interprofessional education of health sciences students. Out of the 83 studies reviewed, only half (39 studies) employed theories or conceptual frameworks to guide and inform study design and analysis. Even the IPE programs employing theories and frameworks did not describe clearly how these frameworks guided the development of the IPE models. Another systematic review of qualitative and quantitative studies of IPE in allied health by Olsen and Bialocerkowski (2014), revealed that only five of the 17 studies reviewed described development of IPE programs using a theoretical framework.

The rationalizing, structuring, and delivery of interprofessional education draws on educational, psychological, and sociological theories (Oandansan & Reeves, 2005a; Barr, 2013). Barr (2013) argued that having one theoretical orientation is not enough for the complexity of interprofessional education for different groups of learners, at different stages of their professional development. Oandansan and Reeves (2005a) in a systematic review submitted for Health Canada suggested the following theories to guide teaching strategies: adult education theory (Knowles, 1980), reflection on practice (Schon & Scheon, 1983), problem-based learning

(Barrows & Tamblin, 1980), and experiential learning (Kolb, 1984). Barr (2013) reviewed three IPE initiatives in the UK to describe the theoretical frameworks employed. Barr categorized relevant theories into two themes: learning process and learning context theories. Under learning process, Barr (2013) suggested the following theories: adult learning (Knowles, 1980), psychodynamic (Bion, 1961), contact (Allport, 1954), practice (Bourdieu, 1977), situated learning (Lave, 1991), and identity theories including social identity (Jenkins, 2004, 2014, Tajfel & turner, 1986), self- categorization (Turner, 1999), and realistic conflict (Brown, Condor, Mathews, Wade, & Williams, 1986). The learning context addressed the general systems theories including organizational theory (Senge, 1990), activity theory (Vygotskii, 1978), and complexity theory (Byrne, 1998; Plsek & Greenhalgh, 2001).

The above findings hold implications for the selection of appropriate theories when developing and evaluating IPE activities, and for employing theoretical frameworks to ensure appropriate and effective design of pedagogical practices. This also holds research implications given the need to evaluate the most appropriate theories for IPE programs. In terms of institutional ethnography, the utilizing of theoretical frameworks in IPE holds implications for investigating how facilitators employ theories in the IPE activities they lead. Another implication for this institutional ethnography is the identification of my standpoint as a researcher on behalf of the facilitators; as I investigated how theories dictated the facilitators' actions. The following section presents the empirical understanding on IPE curriculum and the role of faculty in IPE experience, including the implications each carry for this ethnographic study.

IPE Curriculum and the Role of Faculty Members

The CIHC (2010) published the *CIHC Interprofessional Competency Framework* which outlined the necessary competencies for each student or practicing professional to meet the

requirements of IPE. IPE course preparations and activities across Canada are guided by the CIHC framework. This framework provides six competencies required for effective interprofessional collaboration: 1) role clarification of students' own roles and roles of other professions; 2) patient/client/family/community-centered care by incorporating the input of the patient/client/family/community into healthcare services decision-making process; 3) team functioning through gaining and utilizing knowledge of team dynamics; 4) collaborative leadership by sharing decision-making and leadership; 5) interprofessional communication through collaborative, responsive and responsible manners of communication with all members of the health care IPE team; and 6) interprofessional conflict resolution active engagement and participation in any arising positive and constructive disagreement (CIHC, 2010). The CIHC *Interprofessional Competency Framework* has been adopted at Dalhousie University IPE program. This study aims to explicate how this framework dictate the IPE courses' material, syllabus, objectives of course, selection of teaching strategies, and interactions and reflections of facilitators. My standpoint remains that of facilitators who operationalize the material in syllabus and shape the IPE interactive experience.

Faculty members play a key role in IPE as they are perceived as role models by the students (Buring et al., 2009; Oandansan & Reeves, 2005a). Oandansan & Reeves (2005a) argued that when faculty members' behavior, talk, and discourse reflect their collaboration with, respect for, and knowledge of other professions, students may assimilate and imitate that behavior. This also applies to faculty's behavior in informal learning settings, such as students overhearing the faculty members' negative opinions of other health professions in a cafeteria or hallways (Oandansan & Reeves, 2005a), which may result in students assimilating negative opinions of other groups.

Buring et al. (2009) presented guidelines for implementation of IPE and identified the role of the interprofessional educator as a facilitator who works with learners. The authors recognized that interprofessional educators from diverse health professions should be competent in active learning methods, skilled in facilitating group dynamics, and knowledgeable about the roles of the various professions. According to the authors these competencies are acquired in an evolving process that can be reinforced and supported by IPE faculty development programs.

Buring et al. (2009) and Watkins (2016) argued that faculty development in IPE is essential for the success of IPE programs by improving the faculty members' knowledge, skills and attitudes about development, implementation and facilitation of IPE activities. According to Buring et al. (2009), IPE faculty development programs involving faculty members from different disciplines should start before engaging in an IPE activity. These early interactions among different professions faculty members constitute team work, thus helping in identifying the IPE activities they might be able to construct and work upon together. Buring et al. (2009) also addressed the issue of faculty members employing in IPE setting same uni-professional teaching methods they are used to employ in their own discipline. Through these programs, faculty members acquire the knowledge, skills and values needed to teach along other health professions faculty members, and to teach students of other health professions. In their guidelines, Buring et al. (2009) proposed some topics for IPE faculty members' development including interactive teaching and learning, facilitated learning, group dynamics, conflict resolution, technology, working with enthusiastic learners, and assessment strategies for IPE.

The availability of published evidence evaluating and supporting IPE faculty development is limited (Eegan et al., 2011; Simmons et al., 2011; Watkins, 2016). In a qualitative study, utilizing a grounded approach, Simmons et al. (2011) sought to understand the

impact of an interprofessional faculty development course on a sample of 34 faculty members and clinicians working in academic and community. Analysis revealed the effectiveness of the course in meeting its objectives, the ability of the participants to utilize the knowledge gained in their own institutions, and willingness to contribute into IPE faculty development programs at their own institutions. In a multi-case study approach, Eegan et al. (2011) evaluated the IPE faculty development program of 21 inexperienced IPE facilitators from different health professions. Semi-structured interviews were conducted before and after the IPE faculty development program which involved lectures, and small group discussions, role play, and direct face to face counseling sessions. Analysis revealed that after the training many facilitators were still unprepared and lacked understanding of the important IPE and interprofessional collaboration concepts. They confirmed that this lack of understanding resulted in "missed teaching moments" within the programs they implemented.

The above studies reflect inconsistent findings about evaluation of the IPE faculty development programs, and hold implications for future evaluative research. In the context of this institutional ethnography, the main investigation is what dictates and shapes the IPE interactions. Facilitators utilize their knowledge and skills in facilitating IPE activities thus shaping the IPE interactions of students. Therefore, investigating how the faculty developed these skills, such as through a faculty development programs, is an essential component to understand how and why IPE interactions occur the way they do. For the purpose of this study, I did not evaluate the competencies of facilitators. However, I uncovered the sources of these skills and knowledge which in turn facilitate the IPE interactions.

Learning and Teaching Strategies

IPE encompasses three aspects of interactive learning where students learn with, from, and about each other (Paige, Garbee, Brown, & Rojas, 2015). The authors (2015) argued that bringing different health professions students together and using didactic lecturing does not comprise an effective IPE activity, rather they suggested small group discussions, and simulation based teaching. Nevertheless, the literature describes a plethora of teaching strategies (Abu-Rish et al., 2012; Buring et al., 2009; Olsen & Bialocerkowski, 2014; Sunguya et al.; 2014). In a literature review of 83 quantitative, qualitative and mixed method studies, Abu-Rish et al. (2012) described a variety of teaching strategies utilized in IPE programs. The predominant strategies were small group discussion, problem-based learning, large group lectures, reflective exercises, clinical teaching or direct interaction with patients, simulation, and community –based projects. Less commonly reported educational strategies included use of e-learning for IPE delivery, or shadowing of clinical provider or students from other professions. In a systematic review of 17 quantitative and qualitative studies, Olsen and Bialocerkowski (2014) identified a number of IPE teaching/learning strategies including primarily patient simulation and practice-based learning. A smaller subset involved lectures or small-group focused on team-work. At Dalhousie University, the learning approaches across different IPE activities for the year 2016-2017 included simulation, small group work through face to face discussions, group work through online discussion, group work through blended discussions and clinical IPE experience.

Organizing clinical IPE experience has been identified as a challenge because of variations in the diverse professions' clinical placement requirements as well as training costs, patient availability, and clinical placement environments (Jones & Sheppard, 2011; Watson et al., 2012). Simulation has been suggested and employed as an IPE learning approach in IPE to

address some of these challenges (Gough, Hellaby, Jones & Mackinnon, 2012). Interprofessional simulation occurs "when two or more (health or social care) professions engage autonomously in highly realistic scenarios to learn with, from and about each other, in a safe and controlled manner" (Alinier et al. quoted in Gough et al., 2012). During simulation a real event, task, or experience is recreated, thus establishing a safe learning environment where skills, knowledge, attitude and behaviors are acquired (MacKinnon, 2011).

The literature provides evidence supporting the effectiveness of simulation in meeting IPE requirements (Gough et al., 2012; Liaw, Zhou, Lau, Siau, & Chan, 2014; Paige et al., 2015; Stewart, Kennedy, & Cuene-grandidier, 2010). In a literature review of 18 qualitative, quantitative, and mixed methods research studies of an interprofessional simulation-based education, Gough et al. (2012) detected favorable outcomes including increased confidence, knowledge, and leadership, teamwork, and communication skills among students. Using a mixed method design, Stewart et al. (2010) evaluated a pediatric simulation IPE activity comprised of 95 medical and nursing students. The scenarios involved six common pediatrics clinical conditions (e.g. bronchiolitis and acute gastroenteritis) where students practiced care and collaboration on a manikin. The findings revealed effectiveness of the simulation activity in acquiring clinical and practice-based skills for both groups, and in improving communication and team working skills among them. In another mixed method, prospective, quasi-experimental design study, involving 127 medical and nursing students, Liaw et al. (2014) evaluated a simulation based IPE program focused on the deteriorating health of a patient. The scenarios involved a 3-hour small group exercise and focused on communication about deteriorating patients. Findings revealed improvement in communication between medical and nursing

students while provide safe care for deteriorating patients. They also found that the student's perception toward IPE was improved.

At Dalhousie University, the Collaborative Health Education Building (CHEB) was opened in December 2016 to provide a collaborative setting for all health care professions students and faculty members. The CHEB houses the IPE simulation facilities for Dalhousie University including a simulation centre for health sciences professions specialized clinical skills training, simulated patient care labs including clinic rooms and seminar rooms, and specifically designed homecare, rehabilitation and hospital settings to enable realistic, simulation-based learning (Dalhousie University Interprofessional Education, 2016). As of this writing, no research has been conducted specific to this initiative but the timing presents a great opportunity for this study and other IPE research initiatives.

Online IPE activities have been introduced to manage some of the challenges of face to face IPE activities such as scheduling difficulties, availability of physical facility, and distribution of health programs across different geographical locations for the same university (Solomon et al., 2010; McKannae et al, 2014). However, evidence supporting the effectiveness of IPE online education strategy is inconclusive (Solomon et al., 2010; Waterston, 2011). Using a qualitative thematic data analysis, Solomon et al. (2010) evaluated the effectiveness of an online IPE module. Online discussions and reflections, focus groups, semi-structured interviews with a total of 77 volunteering students enrolled in an online IPE module were analyzed. Findings revealed that the online IPE activity was successful in students achieving collaborative problem solving among students, clarifying of their professional roles across disciplines, and recognizing the importance of collaboration during clinical work. Findings also revealed a gap in the organization of the IPE online activity related to clarity about group assignments and

deadlines. However, evidence is not consistently supportive of online IPE activity. Waterston (2011) in a mixed design study by Waterston (2011) evaluated the online interaction of a blended IPE activity (including both face to face and online interactions) among 323 health profession students. Mixed method analysis showed that students favored the face to face interactions (96 per cent) to online interaction (45 per cent). Analysis also revealed that online communication was influenced by facilitators' involvement, professions' representation in the group, relevance of the learning content, clarity of tasks and assignments, student's personal inclination towards online and group learning, and the effectiveness of technical factors. Analysis also showed that highly interactive groups employed own organizational techniques including planning their online collaboration, assigning topic leaders and having these leaders post introductory and summary messages.

The above findings have implications for future evaluative research of online IPE activities. Identifying and understanding the teaching strategies utilized in IPE is fundamental to institutional ethnographic context of this investigation. The IPE interactions which are the starting point of this study are informed by the selected teaching strategies, and this study will explicate how the facilitator's actions are shaped by these teaching strategies, which, in turn, are dictated by the guiding theories and facilitators' skills. This institutional ethnography aims to explicate how each of these IPE constituents (teaching strategies, facilitator's skills and theories) relate to shape the IPE interactions. These literature findings also support my research standpoint on behalf of the facilitators as they lead the IPE experience interactions.

Stereotypes as a Barrier for Implementing IPE

The literature identifies several barriers to implementing IPE including: curriculum, stereotypes and attitudes, diversity of students, IPE concept, teaching strategies, and group

dynamics (Sunguya et al., 2014; Oandansan & Reeves, 2005b; Buring et al., 2009). In this section I will be elaborating on stereotypes since stereotypes is the problematic that this study aims to investigate.

Stereotypes are defined as "social categorical judgment(s)….. of people in terms of their group membership" (Turner, 1999, p. 26). Foster & Macleod Clark (2015) defined stereotypes as beliefs that are generally shared about an individual. These beliefs are based on whatever is known about the social group the individual belongs to (Foster & Macleod Clark, 2015). Thus, stereotyping is neither positive nor negative, rather a way to organize information about the group an individual belongs to or about a different group, thus shaping interactions between members of different groups (Cook & Stoecker, 2014). Stereotypes may have negative outcomes when they involve inaccurate perceptions of the attitudes or behaviors of one's own group or another group, regardless whether these perceptions hold positive or negative adjectives (Cook & Stoecker, 2014; Hean et al., 2006). For example, a perception that physicians are arrogant influences the interactions between healthcare professionals and physicians. In this case, healthcare professionals will interpret any benign behavior of physicians as arrogance, and physicians themselves end up acting arrogantly (Hean et al, 2006). On the other hand, Siy and Cheryan (2013) described the impact of the commonly held positive stereotype of nurses described as caring, and nurses reported that they felt categorized and depersonalized.

Mandy et al. (2004) recognized that stereotypes within IPE context are commonly explained through Contact Theory (Allport, 1954) which states that when members of different groups contact each other, they discover similarities the share, and this helps to change the stereotypes towards each other; Realistic Conflict Theory (Brown et al., 1986) which states that opposing attitudes lead to discrimination and hostility among group members; and Social

Identity Theory (Turner, 1999) which states the discriminations among group members occur because some members favor those who represent their own professions over members of other professions.

Research examining stereotypes held by students has been predominantly quantitative in nature (Ateah et al., 2011; Cook & Stoecker, 2014; Foster & Macleod Clark, 2015; Hawks, Nunney, and Lindqvist, 2013; Hind et al., 2003; Michalec et al., 2013). In a systematic review of 13 quantitative and qualitative studies investigating stereotypes held by students, Cook and Stoecker's (2014) identified 11 quantitative studies utilizing four scales: Health Team Stereotype Scale (HTSS) which consists of 54 bipolar adjectives (as innovative/conservative, independent/subordinate) where each adjective is rated on a scale from 1 to 7; Attitudes to Health Professions Questionnaire (AHPQ) which consists of 20 items that measure two dimensions: caring and subservient, Health Care Stereotypes Scale which consists of four positive adjectives (as caring), three negative adjectives (as arrogant), and one control adjective (do-gooder) and each adjective is scored on a scale from 1 to 7; and Student Stereotypes Rating Questionnaire (SSRQ) which consist of nine characteristics (as leadership, independence), each scored on a scale from 0 to 5. Findings revealed that healthcare profession students rated their own profession higher than the rating they provided about any other profession. In addition, findings revealed that physicians were perceived as decision makers, and nurses were perceived as subservient to physicians. Cook and Stoecker (2014) provided a discussion on how these stereotypes were reinforced. For example, stereotypes about physicians as confident leaders and decision makers were reinforced when other health care team members deferred all decision-making to physicians and tend to be less confident or participative in discussions regarding patient cases. Nurses are perceived as subservient to physicians, but even when nurses

themselves do not hold this stereotype and refrain from delegating all decision making to physicians, the physicians themselves may not allow that. Another stereotype about physicians is that they are less caring than other professions. This stereotype can be reinforced when other professions take more responsibility for caring and less responsibility for decision-making. These examples of operationalizing and reinforcement of stereotypes can impede communication and collaboration.

The literature provides evidence that healthcare students enter their IPE programs with perceptions and stereotypes about their own profession and other health professions (Michalec et al., 2013; Hean et al., 2006). Utilizing a quantitative survey study, Michalec et al. (2013) investigated the pre-entry attitudes and perceptions of 638 health professions students about their chosen profession and that of other health professions. Data analysis revealed that each profession was perceived differently by students of other professions, and that students from each discipline rated their own discipline highest on every attribute (except for medicine). Nurses were perceived as being team players, having practical skills, but having less leadership skills. Medicine was rated highest in most attributes but lowest for team player and interpersonal skills. Michalec et al. (2013) attributed the high rating of medicine to the dominance of the medicine's professional model in the healthcare field. Another quantitative survey study by Hean et al. (2006) also explored pre-entry perceptions about other healthcare professions of 1200 new health and social care students. Analysis showed that students join their schools with established set of stereotypes about other health and social care professional groups. Stereotypes about midwives, social workers, and nurses included having interpersonal skills and being team players; and about doctors included their high academic ability. Doctors, midwives and social workers were perceived as having the strongest leadership role, and doctors were rated highest on decision-

making. Hean et al. (2006) acknowledged that the pre-existing stereotypes student hold are determined by different factors including the public image of professions transmitted through media, a perception of a profession the student acquired through previous healthcare encounter as patients. Another factor that determine these stereotypes is the historical influence of gender domination of a certain profession, such as nurses being females. Hean et al. (2003) also presented legislative rules as causes of development of stereotypes, for example, in the United states, the pharmacists were prevented from discussing treatment with patients, and this may have contributed to the development of the perception that pharmacists lack interpersonal or communication skills.

The existing research evaluating the ability of IPE programs to ameliorate the stereotypes students hold is inconclusive. Whereas some studies have shown a positive impact of IPE programs on students' held stereotypes (Ateah et al., 2011; Foster & Macleod Clark, 2015; Lidskog, Lfmark, & Ahlstrm, 2008), other studies have shown that IPE programs were not successful in changing the stereotypes students hold (Hawkes et al., 2013; Nisbet et al., 2008). Yet other studies described an exaggeration of student stereotypes after IPE programs (Leaviss, 2000; Mandy, Milton, & Mandy, 2004; Tunstal-Pedoe et al., 2003).

The literature also provides evidence supporting the positive impact of IPE on the held stereotypes (Ateah et al., 2011; Foster & Macleod Clark, 2015; Lidskog et al., 2008). Using a phenomenographical approach, Lidskog et al. (2008) evaluated the impact of IPE on stereotypes of 16 health profession students (nursing, occupational therapy and social workers) about their own professions and the other two professions. Data collected through interviews showed that the stereotypes students held changed after IPE training and that students exhibited better understanding of other professions. In a quantitative, pre-test, post-test, and quasi experimental

design study of 580 health and social care profession students, Foster and Macleod Clark (2015) studied the impact of IPE on the stereotypes held by these students about each other. Data was collected through survey at two points of time before IPE and after IPE experience, for two cohorts: intervention group of 580 students and control group of 672 students. The pre-test assessment showed that the health and social care professions were rated differently which suggested the existence of pre-conceived perceptions about each profession. The intervention group (group who had IPE experience) exhibited an amelioration of their stereotypes in comparison to the control group.

Utilizing quantitative experimental pre-test, post-test design study of 51 students, Ateah et al. (2011) also evaluated the impact of IPE on health profession students' held stereotypes. Students were randomly assigned to three groups: control group, education only intervention group, and interprofessional immersion experience group (experienced shadowing health professional in addition to education). Findings revealed that both IPE experiences were associated with ameliorating the stereotypes held by students: the rating of all professions increased after IPE experience; initially the physicians received the highest rate for independence and nurses achieved lowest rating, but after IPE experience all professions achieved equal rating on this attribute; physicians and dentists achieved lowest rating for team player, but after IPE experience all professions achieved equally high rating.

The literature also provides evidence that some IPE programs were not successful in changing the stereotypes held by students (Hawkes et al., 2013; Nisbet et al., 2008). Utilizing a quantitative survey study, Hawkes et al. (2013) evaluated the impact of IPE on 76 health professions students' attitudes about other professions. Data was collected at two points of time: before and after the 7-week IPE experience, and focused on the caring attribute. The findings

reflect that the IPE experience did not result in ameliorating the stereotypes and attitudes the students hold. Medicine was viewed as least caring both before and after the IPE experience, medical students viewed pharmacists as least caring, and all students perceived their own profession as more caring than others did both before and after the experience.

In a multi-method evaluation study of 16 health profession students, Nisbet et al. (2008) evaluated the impact of clinical IPE experience on these students' perceptions of each other. Findings revealed that students perceived physicians as leaders of the healthcare teams, highest in hierarchy. Some students expressed feeling intimidated by some doctors and thus refrained from discussing patient care with them, especially if they anticipated that discussion might lead to conflicting opinions. The findings showed that these attitudes towards doctors were maintained and reinforced for some students throughout their program. The literature also includes studies that describe exaggeration of stereotypes after IPE experience (Leaviss, 2000; Mandy et al., 2004; Tunstal-Pedoe et al., 2003). Utilizing a qualitative thematic analysis study, Leaviss (2000) examined the effect of the undergraduate IPE on work practices of the 15 newly qualified healthcare professionals who participated in IPE during their final undergraduate year. Through phone interviews participants reported that they have developed negative attitudes towards other professions during their undergraduate IPE experience. Most professions reported developing negative attitudes towards medical students; occupational therapists and physiotherapists reported developing negative attitudes towards each other; and no profession reported developing positive attitude towards any other profession. They participants reported that development of negative attitudes was reinforced by the tutors they had. In another quantitative survey study, Tunstal-Pedoe et al. (2003) evaluated the impact of an IPE program on attitudes of 175 health professions students about the course and towards each other. Data was

collected at the beginning and at the end of the first term for two consecutive years (1998 and 1999). The findings showed that students joined the university with stereotypes about each other, and that these stereotypes became reinforced and exaggerated after their IPE experience. Medical students initially held less positive attitudes towards other health professions students and this rating became worse after the IPE course. Other students initially identified doctors as less caring and dedicated, arrogant, and not good team players or communicators which also became exaggerated by the end of the IPE program. Medical students initially identified nurses to be "do-gooder", less practical and less assertive than other students, and at the end of the IPE course, almost all students described nurses as less dedicated, more detached, less hard-working, not good communicators and not such "do-gooders".

In a longitudinal, before-after quantitative study, Mandy et al. (2004) investigated stereotypes held by a total of 130 first year physiotherapy and podiatry students (of each other's profession) before and after an IPE experience. Findings reflected that both professional groups held stereotypes about each other prior to any education, and that these stereotypes were reinforced after IPE experience. Before the first semester, 7% of podiatrist student ratings of physiotherapists were negative and 17% of physiotherapy students' ratings of podiatrist were negative. After the semester, none of the podiatrists rated the physiotherapists negatively, but 24% of physiotherapists rated podiatrists as negative.

These studies provide contradictory evidence of the impact of IPE on the stereotypes held by healthcare professional students. This holds implications for future research, employing multi-method studies, to understand stereotypes along with the content and nature of IPE programming. This study employs institutional ethnography as a method to understand the IPE programming at Dalhousie University and specifically, investigates what shapes facilitators'

pedagogical practices upon facilitating IPE interactions, jeopardized by students' held stereotypes. This reinforces the need to explicate these pedagogical practices as described by facilitators, thus facilitators will be the reference point in this institutional ethnography.

In summary, a review and analysis of the literature revealed a number of themes in relation to IPE. The literature review revealed that more research on IPE is needed, that research on effectiveness of IPE is still needed, that research on stereotypes is inconsistent, that research on effectiveness of some teaching strategies (mainly online education) is also inconsistent; that theory is needed to guide IPE programs and research, and that facilitators play an important role which is still not fully investigated. This institutional ethnography investigated different constructs of the IPE program at Dalhousie University, including IPE course content, facilitators' training programs, and facilitators' work in order to reveal the relation between these constructs the stereotypes students hold.

Chapter Three: Design, Methodology, Methods

In this study, I used both Critical Social Theory (CST) and Institutional Ethnography (IE). My interest in CST stems from my personal experiences. CST typically addresses power relations; ideologies that are enforced by those in power and accepted by people in society without questioning. I have been subjected to such power relations and ideologies for many years of my life, a feature of society in my home country. Questioning these ideologies was the initiation of my emancipation, and hence the pursuit of my education in Canada. CST resonates well with my thinking and understanding of society as I experienced it. My interest in both IPE and IE is related to my previous work experience which includes 17 years of work in hospitals in Lebanon, the last 10 years of which I spent in leadership roles. During these years, I had to deal with different healthcare system challenges, mainly patient safety and health human resources shortage. My interest in IPE is influenced by the evidence that supports IPE leading to collaborative practices as a promising solution to these challenges. As for my interest in IE, I have learnt, during my work experience, that the key to managing challenges in the healthcare system was to understand, analyze, and improve the institutional processes associated with these challenges. I found that IE resonates well with this institutional system approach, and that it presents philosophical, logical investigational approach to understanding and analyzing the institutional process. The following sections describes the philosophical underpinnings I adopted, the critical social theory and the theoretical concepts of institutional ethnography.

Philosophical Underpinnings

In my research, and congruent with the above theoretical frameworks, I adopted the philosophical underpinnings of the critical paradigm. The following section presents the

ontological assumptions, the epistemological assumptions, and the axiology of the critical paradigm.

The ontological assumption of a critical paradigm is historical realism indicating that social reality of an individual is determined by social, political, cultural, economic, ethnic, and gender values (Scotland, 2012). Thus, social behavior is identified as the outcome of "particular illegitimate, dominatory and repressive factors, illegitimate in the sense that they do not operate in general interest- one person's or group's freedom and power is brought at the price of another's freedom and power" (Cohen, Manion, & Morrison, 2000, p.26). Language plays a very crucial role in shaping realities since the critical paradigm considers that language includes power relations, and thus it is used either to empower or weaken.

The epistemological assumptions of the critical paradigm describe subjectivism. Knowledge is socially constructed and influenced by power relations within society (Scotland, 2012). According to Cohen et al. (2000) "What counts as knowledge is determined by the social and positional power of the advocates of that knowledge" (p. 27). Knowledge is produced by power and is an expression of power rather than truth. The critical paradigm addresses issues of social justice and marginalization in forming this knowledge, and calls for the emancipatory function of knowledge.

The axiology of the critical paradigm questions what is useful for people. Thus, this paradigm is normative, considers how things should be, and judges reality accordingly. The CST calls for emancipation and freedom of knowledge.

The critical methodology of the CST challenges the existing social structure as well as the positionality of the individual in social relations. It questions the values and assumptions to expose hegemony and injustice (Crotty, 1998). The aim is to emancipate those who are

disempowered. This methodology dictates that people in a study are informed of their situation and then are called to achieve change through action.

With critical paradigm the researcher and participants are subjects in a dialectical endeavor of clarifying realities, critically analyzing them, and recreating their knowledge. Researchers do not lead the change for participants but participate in the change with them (Freirie, 1970). Here the participants are involved in setting the questions, collecting data, assigning more participants, analyzing information, and benefiting from research.

Critical Social Theory

Critical Theory originated with Marx in Germany in the late nineteenth century, and addressed the oppression of individuals based on economics. Critical Social Theory (CST) was developed in 1924, by a group of scholars from the Frankfurt school in Germany, influenced by Marx's critical theory, and it focused on social oppression based on gender, race, and class. In the 1960s, the Frankfurt tradition was revived by Habermas in Germany (Wilson- Thomas, 1995) which resulted in offering a social critique (as described below), thus building on the previous underpinnings of CST. I have chosen Habermas' CST as an approach because it is specific to the socialization process aligned with this inquiry and is well cited within nursing literature (Brown, 2000; Sumner & Danielson, 2007).

Habermas (1990) described socialization as a factor for developing identity. This socialization is actualized by communication, dialogue and language. Habermas (1990) believed that values and norms, hence ideologies, are communicated through dialogue. Accordingly, he called for equal dialogue, and refuted coercive dialogue, when the individual uses power to impose his or her ideas. Habermas (1990) addressed the innate vulnerability of all humans, and its impact in coercive dialogues. During coercive dialogues the individual will respond fearfully,

and adopt the ideologies imposed by the party with perceived/actual power. These adopted ideologies serve those in power rather than supporting the individual in the development of his/her identity (Sumner & Danielson, 2007).

Habermas (1971) addressed knowledge development and described three orientations of knowledge: technical, objective practical, and intersubjective emancipatory. Habermas (1971) advocated for the emancipatory knowledge. Habermas recognized all three orientations for development of knowledge, but claimed that the first two were not sufficient to develop a science of human beings (Duchscher, 2000).

The first orientation, *technical knowledge*, is usually associated with labour. With this type of knowledge, the individual acquires and masters the technical skills in a specific field. Habermas (1971) argued that this type of knowledge informs how one learns to dominate and control the environment (Habermas, 1971; Sumner, 2004; Wislon-Thomas, 1995). This type of knowledge orientation is not typically the focus of IPE; however, technical skills may become the focus of simulation activity when it should not.

The second orientation, *objective practical knowledge*, utilizes language and communication to transmit knowledge without questioning. It takes the form of didactic lecturing, where the ideologies are transmitted through language and subsequently internalized. With such knowledge transmission, power relationships are maintained and questioning of ideologies does not exist (Habermas, 1971; Sumner, 2004; Wislon-Thomas, 1995). An example would be employing lectures in small or large groups as teaching methods in IPE context. Another example would apply even with small group or online discussions when the facilitator or one profession dominate the discussion, and the other professions do not contribute to the discussion.

The third knowledge orientation is the *intersubjective emancipatory knowledge*, which allows for reality to be disclosed. This knowledge orientation calls for dialogue and communication to expose power relations and domination embedded within transmitted ideologies. Through this knowledge orientation, individuals develop their own self -knowledge and claim power over the forces that control their lives. Through emancipatory knowledge, the individual gains freedom from the constraints of ideologies (Habermas, 1971; Sumner, 2004; Wislon-Thomas, 1995). An example would be partnering with students early upon preparation of the IPE course, identifying the educational needs of students in the IPE context, and designing the teaching activities to build on students' knowledge and to meet their needs.

In this study, I employed CST as a theoretical framework to guide the data collection, data analysis, and discussion. My interest in critical social theory is related to my personal life as I found CST resonates well with my thinking and understanding of power struggles in society as I personally experienced it in my home country. I utilized IE as a method of investigation and in the following section I will provide a description of the foundations of institutional ethnography, along with the associated theoretical concepts.

Institutional Ethnography

Institutional ethnography is a critical form of social inquiry. It is a social theory and a method of inquiry (Prodingor, 2015) that has been developed by the Canadian sociologist Dorothy Smith (2005). Smith believed that ontology is grounded in the social and thus presented an approach to explicate the social and make it visible. Smith's institutional ethnography calls researchers to learn and start their research from people's daily lived experiences. Institutional ethnographers treat people as the subjects of knowledge rather than the objects of the study (Smith, 2005, 2007). Institutional ethnography

> "Explores the social world as it is known experientially, and it explores it as people's activities or doings in the actual local situations and conditions of our lives. The idea is to discover and map the world so that now it is being put together and can be made observable from the point of view of those caught up in it." (Smith, 2007, p.411)

Foundations of institutional ethnography. Smith was influenced by Marx and designed her institutional ethnography based on Marx and Engles' work on materialism (Smith, 1990b). Smith (2007) articulated that "They wrote of making a social science grounded not in theory, concepts, speculation, or imagination, but in actual people's activities and conditions of those activities" (p.411). Marx and Engel's work focused on the activities of individuals and the "material conditions of those activities" (Smith, 1990b, p.6). However, Smith extended these concepts to developing a sociology that begins with people's lived experiences rather than beginning with theoretical foundations. She emphasized the role of texts as mediators of institutional values and goals in current society, an aspect that Marx did not address (Campbell & Gregor, 2002; Prodinger, 2013).

Smith was also influenced by and involved in the feminist movement of the 1970s. As a female sociologist, Smith was interested in the forms of knowledge that claimed to be speaking about women and recognized that these forms did not represent women. Feminist scholars at that time (such as Harding and Beauvoir), including Smith, came to the conclusion that research conducted about and by women, failed women. Smith was frustrated by the ongoing research that attempted to fit people's experiences into theoretical frameworks instead of attending to the actualities of people's lives (Campbell & Gregor, 2002). In response, Smith (2007) explained, "I began to examine sociology from a standpoint as a woman, in my body, with my children, at work in my home, in the local particularities of my life" (p.410). Accordingly, Smith and other

female scholars presented new ways of looking into the accepted and authoritative methods of knowing that start from the standpoint of women in their everyday lives. Smith presented a sociology for women in her book *Everyday World is Problematic: A Feminist Sociology* published in 1987. Later, Smith changed her terminology from “sociology for women" to "sociology for people" (2005), in reference to her belief that to understand the world we need to adopt the standpoint of people in their everyday lives (Smith 2005, 2007).

Smith articulated that institutional ethnography is not concerned with epistemology (Smith, 2005), that is, “the process of thinking. The relationship between what we know and what we see” (Lincolin, Lynham, & Guba, 2011, p.103). Rather, institutional ethnography is concerned with ontology, the theory of reality, that provides “a guide to the aspects of dimensions of actual ongoing social processes, in time and in place (..) a conceptual framework for selective attention to actualities such that the project of inquiry can proceed as discovery of and earning from actualities” (Smith, 2005, p.52). Accordingly, Smith based her institutional ethnography on some key concepts and assumptions that will be presented in the following section under the heading theoretical concepts of institutional ethnography.

Theoretical concepts of institutional ethnography. The following section describes the key concepts, which “express the social ontology that institutional ethnography has been developed to explore” (Campbell & Gregor, 2002, p. 27), including: social organization, social relations, texts, text activation, text mediation, ruling relations, and discourse.

Social organization and social relations. Smith (2006) argued that people exist as social beings living in a world she identified as social. The social develops through the activities people perform in their daily life, and through the fact that these activities are ongoing and purposefully concerted and coordinated. Social relations are the relations that organize the activities going on

in daily life and are coordinated with events occurring at another location. Social organization corresponds to the interplay of people's activities with the social relations that coordinate these activities (Campbell & Gregor, 2002). For example, in an IPE course setting, students engage in some tasks which are planned to meet the course objectives. The tasks and the objectives of an IPE course are prepared as part of course syllabus earlier in a different setting. The tasks and objectives identify how activities should take place at an IPE course setting. Thus, the social relations in this example correspond to the process of developing the course syllabus which in turn dictates the activities taking place at the IPE course setting. The social organization of the IPE course corresponds to the interactions around the process of implementing the tasks specified the syllabus by the students and facilitators at the IPE course setting.

Institutional ethnography's interest lies in the forms of social organization that occur routinely in people's daily lives. These are the social organizations which seem to occur independently, people participate in without conscious thought, and are taken for granted. Social relations are usually invisible to people. Institutional ethnography is interested in exploring the puzzles and the invisible social relations of social organizations that occur in everyday life. Institutional ethnography answers questions about "how things are socially organized, or put together so that they happen as they do" (Campbell & Gregor, 2002, p.29). To elaborate, what may be the institutional factors that inform the content of the syllabus within an IPE course which student and facilitators are not aware of. For example, students may not be aware of the IPE competency framework adopted by Dalhousie university that dictate the objectives of the course, yet students work to meet the objective of the course.

This extrapolation of social organizations involves two sites of interest: the local and the trans-local setting (Smith, 2005). The local setting refers to the current setting where people

indulge in their daily life experiences and activities; the translocal refers to a setting "outside the boundaries of one's everyday experience" (Campbell & Gregor, 2002, p.29). Smith believed that the translocal plays a very important role in determining the social relations and their coordination (hence social organization) that shape the daily life experiences of people locally (Smith, 2006). Smith declared that these social relations, identified translocally and dictating the local activities, are usually invisible and that people, at the local settings are usually not aware of their existence. IE aims to explore and explicate these social relations, and how activities in local settings are related to activities of people translocally. Texts, according to Smith, are pivotal instruments that coordinate the social relations. The following section provides definition of texts in institutional ethnography, texts of interest to institutional ethnography, text activation, role of texts, and the power of texts and their ruling effects.

Texts in institutional ethnography. Texts, in institutional ethnography, are defined as "words, images, sounds that are set into a material form of some kind from which they are read, seen, heard, watched, and so on" (Smith, 2006, p.66). Texts are fixed and replicable, they have a material form that can be stored, copied, transferred, and disseminated to people active at different times and different places.

The texts of interest in institutional ethnography are the replicable texts. Replicable texts are the texts that can be "reproduced many times, so that different people can read the same text in different places or at different times" (Smith & Turner, 2014, p.5). These texts have a mediating role in coordinating the social relations between the local and translocal sites. The recognizable identity of texts from one site to another is also integral for the text's role in coordinating social relations, where the ethnographer is able to explore the social relations that extend across, coordinate and regulate multiple sites.

IE aims to explicate how texts coordinate the activities of people across different work setting (Smith, 2006). For individuals active in the local setting, the coordination of their work with translocal relations is not necessarily visible. Institutional ethnography starts from these individuals and traces which texts coordinate their work to translocal relations (Smith, 2005, p.108). An example would be the schedule of the "Dalmazing Interprofessional Challenge" at Dalhousie, which is an IPE event that involves all first-year health-related students including medicine, health profession, and dentistry. Students are grouped in teams and assigned one facilitator who oversees various tasks the students are supposed to accomplish as a team. The facilitators at the local setting are handed a schedule, specifying the time period of each activity, which they follow even if students at the local site requires more or less time. The facilitators do not know who prepared this schedule or what criteria it was based on. Institutional ethnography traces this schedule that dictates what occurs at the local site, and investigates who prepared these schedules and why they were set in that manner. This requires that the institutional ethnographer goes to the translocal setting where the coordinators of the event prepared the material.

Activating texts and their ruling effect. Texts carry the determinants of many of people's actions, so when people utilize and process the same texts, then their actions are coordinated by the requirements of working with these texts. In social relations, texts function as an invisible working connection between individuals who do not know each other. Moreover, people who know and relate to each other, may not recognize how, their actions are being shaped by the texts. Accordingly, Smith (2005) described texts as having the power to coordinate and concert and people's activities across time and space. Smith used the term "Ruling" to name the socially organized exercise of power, mediated by texts, that shapes people's actions and their lives. The

capacity of the texts to rule depends on the capacity of the text to carry messages across sites, and to coordinate someone's actions here with someone else's there. However, the ruling social relations exerted by texts are only in effect when the texts are activated. An example of a text, regulating the work of facilitators in the IPE program at Dalhousie University, is the facilitator's guide by Godden-Webster & Murphy (2014). This guide identifies the teaching strategies to be utilized by all facilitators in the IPE program across courses and settings. The guide was prepared in another setting, translocally, 2 years ago, and has been dictating (in IE terms) the strategies of the all IPE facilitators in different IPE courses since then. All facilitators have been following the instructions in that guide even though they might not know each other and most probably do not know what takes place in another course offered in a different time or at a different place.

Texts are activated by the people who handle and use them (Smith, 1999). Activation of texts encompasses the human involvement in the capacity of texts to get things done in a specific way and to coordinate actions across settings. Smith (2001) elaborated on the text-reader conversation, that occurs at a local setting, resulting in activation of texts. According to Smith, the text speaks to the reader once the reader takes it up and reads it. The words, ideas, and concepts contained in texts are not isolated but rather invite the reader to a conversation that becomes enacted once the text is read (Bell & Campbell, 2003). The distinction between reading and interpreting a text is crucial. As Smith says, in text-reader conversation:

> "One side of the text is obstinately fixed and unresponsive to the reader's interpretations. The reader activates the text (…) she takes up its words. They become in a sense hers as she activates their meaning (…) Interpretation lies in the other part of the text-reader conversation, her response to what she reads" (Smith, 2003, p.155).

The institutional ethnographer's interest is not in how people interpret texts but rather on the activation of these texts and how this activation coordinate activities of people across local and translocal settings (Smith, 2006). In addition to the texts that are read, filled in, and forwarded by people active in particular local work settings, Smith also described other texts she called the regulatory texts, ruling texts, or boss texts. Regulatory texts function as a frame of reference for active texts, and are not usually visible in the local work setting.

Texts and the ruling ideologies. Smith argued that texts, through their capacity to coordinate people's actions across space and time, have a ruling capacity. Texts are prepared translocally and carry specific concepts consistent with the ideologies and interests of people at the translocal setting. Once texts are activated by people at local sites, then these concepts become common sense and people locally identify themselves with them (Walker, 1995). Moreover, by activating these texts, identifying with them, and processing the embedded concepts, the activities of individuals in everyday life become confined into a "technological and technical specialization, elaboration, differentiation, and objectification" (Smith, 1999, p.77). People's actual activities are confined by specific concepts identified translocally and embedded in texts. These concepts become a reality lived by actual people in actual time and place. As Smith articulated, "ideology can be viewed as a procedure for sorting out and arranging conceptually the living actual world of people so that it can be seen as we already know it ideologically" (Smith, 1990a, pp.42-43). Upon exploring and investigating the social relations, institutional ethnography provides an opportunity to inquire into the ideologies of the people in the translocal setting (Turner, 2003). Campbell and Gregor (2004) considered that texts reinforce the ideological relations of ruling because their effect is practiced locally to serve the intentions and will of those who designed the texts translocally. Thus, the ruling effect occurs when their

interests dominate actions of people applying the texts. An example of ideologies in IPE are stereotypes such as 'physicians are the sole decisions makers'. With the dominance of the medical model, physicians are trained and socialized in their profession to be authoritative and the decision-makers. This stereotype might have been dictated by an unwritten, visual and heard text. Over the years, medical students, have adopted and operationalized this belief. This stereotype serves to reinforce the medical model as the dominant model within the healthcare at a cost to the healthcare team and collaborative practice. It also does little to support physicians who believe in collaborative practice.

Discourse and social relations. Institutional ethnography aims to explore the everyday life of subjects, and how it is organized and ruled. Moreover, institutional ethnographers work is guided by a theory that aims to explicate ruling practices and their associated text-based discourses (Campbell & Gregor, 2002). For institutional ethnographers, discourse happens in the subjects' bodily experience, even if not visible, focusing on discourse as an organizer of this experience, and maintains the subject as the center of analysis. Whereas both Smith and Foucault's work involve exploring discourse, their reference to discourse is distinct:

> "In Foucault's work and in work taking up his approach, for example, the notion of discourse designates a kind of large-scale conversation in and through texts….. For Smith, discourse refers to a field of relations that includes not only texts and their inter-textual conversation, but the activities of people in actual sites who produce them and use them and take up the conceptual frames they circulate. This notion of discourse never loses the presence of the subject who activates the text in any local moments of its use" (Smith, 2006, p.44).

An example of explicating social relations and their associated text-based discourse would be the way tasks of a specific IPE course are met. Discourse in this sense refers to the interactions and the bodily experiences of people in the local setting as their activities are guided by the texts. In a face to face discussion specified in the syllabus of an IPE course (text), a nursing student might choose not to discuss the social or psychological aspect of a patient with the physician (bodily experience) because this nursing student holds a stereotype that physicians do not care for the patients. Nursing students might avoid eye contact with physicians and avoid bringing up the roles of healthcare members in attending to social and psychological aspects of the case (bodily experience).

The selection of institutional ethnography is directly related to my research question that aims to uncover the institutional limitations of facilitator's work that shape the problematic of this study. My selection of a critical approach is driven by my interest in change and improvement in the IPE program to promote interprofessional education and practice. In comparison to other qualitative approaches, which may also provide insight into the problematic, my interest in institutional ethnography is specific to the maps that are generated to show how work process at the local and translocal settings contribute to the identified problem-student stereotypes. Attending to the maps of the social organization in a critical approach is integral for change and improvement and institutional ethnography provides concrete tools for future direction in addressing the problematic-which aligns with the focus and aim of my study.

While institutional ethnography intends to explicate, expose, and make a visual presentation of the relations and organizations in an institution, CST exposes the ideologies supporting these relations and whose benefit do these ideologies serve. Moreover, this study addresses an educational context, IPE program. Habermas as a critical social theorist addressed

dialogues (face to face discussions) and teaching strategies, two interactions I investigated within the IPE context of my study. Thus, the theoretical framework, the method of investigation and the topic of study (IPE) form a complementary fit that will result in informing the pedagogical practice for the IPE program at Dalhousie University.

Methods

Unlike traditional research designs, institutional ethnography starts with a general idea, and then the process of inquiry develops (Campbell & Gregor, 2002). The institutional ethnographer does not plan interviews, or questions, or select interviewees or texts in advance.

> "The process of inquiry is rather like grabbing a ball of string, finding a thread, and then pulling it out. Institutional ethnographers know what they want to explain, but they can discover only step by step whom they need to interview or what texts and discourses they need to examine" (DeVault & McCoy, 2006, p.383)

With institutional ethnography, the study starts with the first stage of data collection to identify a problematic, then the second stage of data collection, and the last step is data analysis. The second stage of data collection is based on the findings of the first stage (Campbell &Gregor 2002).

First stage of data collection: the problematic. The target of the first stage of data collection was to investigate an experience, in every day practice of participants, to identify an area of concern- the problematic. The problematic of concern, which is the starting point of this study, is the stereotypes nursing students hold (about their own and other professions) which problematize the IP interactions. These held stereotypes jeopardize the ability of the nursing students to achieve the competencies of their IPE experience, including understanding the roles of other professionals, and the ability to achieve equitable coordination and collaboration. This

problematic was identified by my supervisor during her role as course professor for an IP course. An example of this problematic, nursing students hold common stereotype that physicians are leaders and decision makers. As a consequence, nursing students defer decisions regarding patient care to physicians and avoid providing input about a specific case, especially if they anticipate different opinions (Cook & Stoecker, 2014).

Identifying positionality. As the problematic is identified, the researcher needs to identify his/her positionality and point of entry. This is an integral step since the researcher needs to recognize his/her own power and influence on the research setting (Smith, 2006; Campbell & Gregor, 2002). At this level, the researcher identifies whose standpoint he/she adopts; for the purpose of this study I adopted the standpoint of the facilitators. My positionality with the facilitators is related to their ability to identify the texts that regulate IPE activities. As mentioned earlier, the texts organizing the social relations in an institution are prepared translocally and are activated locally (Campbell & Gregor, 2002). The facilitators observe the IPE interactions and communications through which students learn about each other and reflect the stereotypes they hold. I worked with the facilitators as a team to uncover the norms and limits applied to them (through texts) while facing interactions problematized by stereotypes.

Participants. The setting for this study is the School of Nursing, Dalhousie University which is located in Atlantic Canada. Considering the time-line barriers associated with this master research, I decided to track the ruling relations up till the transloal level of the IPE Coordinating Committee. Thus, the facilitator and student participants represent the local IPE setting, and course organizers, IPE coordinators, and members of the IPE coordinating committee represent the translocal settings. Institutional ethnography does not identify the

typical sample size; the sample size corresponds to the number of participants needed to investigate the work done.

IPE facilitators were selected because it is the work that they execute in local IPE setting that was investigated. IPE Facilitators are faculty members of either the Faculty of Health, Dentistry or Medicine who have participated in development and/or implementation of one or more current IPE experiences at Dalhousie University. Facilitator participants may hold the position solely of a facilitator or a dual position of facilitator and course organizer, or even multiple positions of facilitator, course organizer, coordinator, and committee member. The number of facilitators recruited was three. The sample size for facilitators was determined by the data collection methods utilized: observations, interviews, and focus groups which are described below. Facilitators had the choice of participating in either the observations, interviews or focus groups, or any combination of those. There are four different teaching methods at Dalhousie: face to face small group discussions, online or blended, simulation, and an embedded IPE activity as part of a major course. However, due to study logistics and associated program timeframes, I focused on observing and interviewing faculty in relation to the methods of face-to face instructions and simulation. I also conducted one focus group involving a third facilitator and two nursing students.

Nursing students were selected because they embody the problematic that this study investigated. Students hold stereotypes about their own profession and other professions. They provide input into IPE interactions based on these stereotypes. Nursing Students were selected to understand how their held stereotypes shape IPE interactions, and what determines these stereotypes. I focused on nursing students given my positionality as a nurse and to meet the timeframe requirements of the Master of thesis program. I initially aimed to recruit six to ten

nursing students in their fourth year, which is recognized as an appropriate sample size for a focus group interview (Eliot & Associates, 2005). I selected nursing students in their fourth year because they would have had different IPE experiences exposures, and the possibility of having had an experience involving any or all of the teaching methods is high. However, I was not able to recruit more than one student after more than three months of recruitment. As a result, I submitted an ethics amendment for nursing students' recruitment to include any nursing student who had at least four IPE activities, and offered a compensation of $10 gift card at the end of the first group interview, and $15 gift card at the end of the second group interview. Following the ethics amendment, I recruited two nursing students who both participated in the two types of focus groups conducted.

Representatives of the IPE Committee were selected because they are a source of information about institutional policies and practices that organize IPE activities. I interviewed two representatives from the IPE Coordinating Committee (IPECC) who also hold membership in the following subcommittees: IPECC executive, faculty development, curriculum mapping, research and evaluation, and Large-scale events. These representatives also hold the position of IPE coordinator in their own faculty/school. These participants verified the texts identified by facilitators and identified other texts prepared translocally.

Recruitment. I recruited my participants through email communication. Emails to nursing students (Appendix A) were sent by the undergraduate nursing program office following ethics approval. Emails for facilitators (Appendix B), and committee representatives (Appendix C) were sent by the IPE program main office.

Methods of data collection. The methods of data collection included observations, interviews, focus groups, and texts (Campbell & Gregor, 2002).

In terms of conducting observations, as a graduate student in health care profession, I had the opportunity to enroll as a student in IPE mini-courses. Starting the current academic year, I enrolled as a student in more than eight IPE mini-courses, each employing different teaching methods including: face to face, online, blended and simulations. I attended all the sessions of each course and took the role of a student. Because of this experience, I could observe and identify the work processes conducted by facilitators in an IPE setting (Appendix D- Observations Guide). I was also enrolled as student in the three IPE mini-courses that were led by the facilitator participants in my study.

In terms of interviews, I conducted one-on-one interviews with two facilitators, who employed the teaching methods of face to face discussions and simulations. The interviews focused on identifying the work processes that took place in the local observed IPE setting, and understanding how coordination of activities occur across multiple sites, identifying the texts that shape these coordinated activities, and tracing these texts (Appendix E- facilitator's interview guide). Interviews took place in closed private setting, one was the facilitator's office and the other was a CHEB study room. Interviews were recorded and lasted 90-120 minutes. I also interviewed two representatives from the IPE coordinating committee. The focus of the interview was the documents that organize the development and implementation of IPE experience which are prepared at the level of the committees and circulate back to the facilitators (Appendix F- Committee Members Interview Guide). Interviews took place in closed private locations, one was conducted in on of CHEB's study rooms, and the other took place in the coordinator's office. Interviews were recorded and each took 90 minutes.

In terms of focus groups, I conducted two types of focus groups. During this first focus group, the students discussed the stereotypes they developed and held during their IPE, and how their IPE experience shaped the development and sustainability of their stereotypes (Appendix G- Interview Guide- Focus Group 1). The second focus group involved one IPE facilitator participant and the same two nursing students (from the first focus group). The same students were selected because the second focus group was structured so that the nursing students reflect on the first focus group discussions. Then the students and facilitator discussed some possibilities and recommendations for change (Appendix H- Interview Guide: focus Group 2). Focus group sessions were recorded and took 90 minutes.

Texts are essential in institutional ethnography. Texts include "words, images, or sounds that are set into a material form of some kind from which they can be read, seen, heard, watched, and so on" (Smith, 2006, p.66). Texts include various forms as emails, course syllabi, the cases prepared, frameworks and models, and the facilitators' guide. Unwritten texts include facilitator's experiential knowledge and skills in facilitating group work. Another example of unwritten texts include stereotypes commonly held by a students of a specific profession, it is a spoken text when students discuss it among themselves, or a visualized text when students observe professionals operationalizing these stereotypes. Examining these texts is important because they describe the social organization that regulate IPE experience, speech, interaction, and outcomes. In this study, I tracked the ruling relations up till the transloal level of the IPE Coordinating Committee.

Data analysis. Devault and McCoy (2006) considered institutional ethnography an "analytic project" (p.38) where data analysis is a continuous process that starts with data collection (Devault & McCoy, 2006). The data analysis was guided by CST as a theoretical

framework. The CST was used as analytical framework. The tenets of CST shall function as a lens through which the social and ruling relations that mediated the facilitation and limitation of the facilitator were examined. The goal of analysis was to uncover the ruling relations and texts that shape and coordinate the lived experience of participants (Smith, 2006). Data analysis involved identifying work processes, interfaces of work processes, institutional discourse analysis, and text-work mapping.

The first step upon analyzing the data collected was to identify and explore the work practices occurring at local setting. Work in IE refers to "what people do that require some effort, that they mean to do, and that involves some acquired competence" (Smith, 1987, p. 165). Based on observations and reading all through the interview, I answered the following questions:

- "What is the work that these informants are describing or alluding to?
- What does if involve for them?
- How is their work connected with the work of other people?
- What particular skills or knowledge seems to be required?
- What does it feel like to do this work?
- What evokes the work?
- How is the work articulated to institutional work processes and the institutional order?" (McCoy, 2006, p. 111)

The second step was to focus on the interface between the individuals in their embodied experience, and other people, social and physical world (McCoy, 2006) to identify the translocal settings. This was analyzed by trying to answer "Why the work takes this form" (McCoy, 2006, p.112). In the context of this study, the analysis of interviews focused on identifying the work processes executed by facilitators and analyzing the interface between facilitators executing

these work process in their bodily experience with 1) the institutional discourse that regulate the work and teaching methods and teaching content, 2) facilitator's prior expertise in leading a learning experience, 3) students' contribution and input into IPE.

The third step was followed by identifying and analyzing the texts that regulate these processes through institutional discourse analysis. Analysis of institutional discourse was conducted by attending to the how: "how it is that people can talk about their experience? How does it come to be available to them to know and tell their experience in that way?" (McCoy, 2006, P.118). Analysis in IE should attend to all forms of institutional discourse that explain the work processes taking place in local setting. According to IE, institutional discourse is not exclusive to inside discourse, but it moves into wider circulation through the media and literature. For example, one institutional discourse that shapes the stereotypes students hold may include messages transmitted through media reflecting health professions in a specific role and image. Other institutional discourses are transmitted through formal education or applied as a result of other similar encounters with institutional work processes. As an example, facilitators leading an IPE work process have had previous education and experience in leading uni-professional teaching experience, and they might be employing that experience and knowledge in an IPE setting. Thus, analysis in IE aims to identify and uncover all the inside and external discourses that shape the institutional work processes.

Analysis of institutional discourse also addresses the extent that people in an institution participate in inside institutional discourse. Some individuals in an institution follow the internal institutional discourse strictly, they move with greater ease through its process. This is a kind of individual-institution interface which can be seen in interviews, and participants can readily identify the institutional texts they follow. On the other hand, IE calls for considering the

accounts of participants who don't comply with inside institutional discourse because of 1) "Extra-institutional talk" which is structured by other agencies. An example of other agency would be a hospital setting where physicians and health professionals interactions reinforce the role of physicians as the ultimate decision makers. With "extra-institutional talk" students in an IPE setting interact with other student professions based on their observations of this hospital setting. 2) "Oppositions critical talk" which highlights the differences between the common institutional discourse (commonly done by facilitators across IPE courses) and what one facilitator might do differently. The "Oppositions critical talk" is informed by the facilitator's perceptions about and lived experience with a common discourse. An example would be a facilitator who may introduce a different teaching method than the ones commonly employed by the IPE program. This facilitator's work is determined by their lived experience, with the common teaching methods, which involves a lack of satisfaction with students' ability to learn from, with, and about each other. These facilitators then introduce a different teaching method. The analytical interest here is not in describing the facilitators in opposition with institutional discourse but to discover how and which discourse operates in their IPE experience and what difference it makes for students and facilitators. Thus, through analysis all aspects of discourse should be attended to and identified, so that the texts (written and unwritten) are identified for further mapping exercise.

The final step in the analysis was mapping actual sequences of work and texts. This analytical procedure resulted in an account of text-based work and institutional discourses practices that shape the work processes that take place in an IPE setting. After identifying the work, work interfaces, and institutional discourse, maps were drawn to show the relation between each work or work interface with a specific text in a translocal setting. The discourse

analysis also reflected the sequence of work and hence the sequence of text-based work can be tracked and mapped. Turner (2006) presented the following instructions for drawing maps:

- Circles indicate the work activity performed by facilitators who activate a text.
- Boxes indicate the texts that are prepared translocally and shape local work practices
- Solid lines indicate that the text is also available in local setting.
- Dotted lines indicate that the text in not available in local setting.

Ethics

I obtained ethical approval from Dalhousie University Research Ethics Board (Appendix I). I also obtained approval from the School of Nursing Research Committee to recruit nursing students.

Throughout the stages of this study, I complied with the policies of *Dalhousie University Policy on the Ethical Conduct of Research Involving Humans* (Dalhousie University, 2012). The core principles of ethical conduct include respect for person, concern for welfare, and justice (Dalhousie University, 2012).

Respect for person addresses the participant as autonomous being, thus ensuring the consent is informed and voluntary (Dalhousie University, 2012). Informed consent means the participants have all the information on the purpose and design of the study. This involved informing the participants on the nature of study, study design, how the data will be used, how the results be disseminated and used, and how their confidentiality will be ensured. Ensuring confidentiality is challenging with institutional ethnography considering the design of the method and the fact that investigation starts and explicates the information provided by the participants. This was clarified and discussed within the process of informed consent. Consent was also voluntary process, and thus participants were informed that it is their choice to decide to

join the study or not, and that they could withdraw from the study at any time (Appendices J, K, L) (Creswell, 2013). Please find Appendix J: Informed Consent- facilitators; Appendix K: Informed Consent- Students, and Appendix L: Informed Consent- Committee Members).

The second core principle is concern for welfare, which means to do well to the participant and minimize the harm done to them (Dalhousie University, 2012). In this principle, the confidentiality and anonymity are addressed. This was achieved when the participants were not disclosed to anyone, using pseudonyms in transcripts and any other text used (Speziale, 2011), and providing locked storage of the taped interviews, transcripts, and all texts gathered.

Finally, the principle of justice is achieved by spreading the benefits and burden of research equitably across all participants (Dalhousie University, 2012), this was achieved by similar duration of interviews and review of documents. This was also achieved by ensuring that the findings were shared with all stakeholders to inform decisions regarding enhancing IPE. Vulnerability is caused when participants have limited decision-making capacity (Dalhousie University, 2012). In this study, recruitment for students was not done directly by me as researcher nor their professors but through the undergraduate office. Given that the students may have felt vulnerable during focus groups, especially the one involving facilitators, students were assured that their participation was voluntary. To address issues of student vulnerability, approval for their participation was attained from the School of Nursing Research Committee. Students were also ensured that their participation would not influence their evaluation/grades in the school; that there was no right or wrong answer; that their participation is not an evaluation of their IPE work; that their input will help in the improvement of IPE curriculum; and that they would not be identified through the data they provided. The same assurance was provided to facilitators who were recruited through email sent by the IPE main office. The recruitment letter

and informed consent were provided to the participants with the choice to participate and withdraw from the study at any time. Given the facilitators may have felt vulnerable given they were being asked questions about their work, I provided reassurance that the focus was on understanding their standpoint to explore the institutional discourse in the context of a non-judgmental and blame free environment (Smith, 2016).

Trustworthiness and Rigor

In qualitative research, the accuracy and strength of findings indicate trustworthiness (Creswell, 2013). Trustworthiness and rigor specific to institutional ethnography include recursivity (Smith, 2006), reflexivity, triangulation, member check (Campbell & Gregor, 2002), and catalytic validity (Lenzo, 1995).

Recursivity indicates the recurring events, or recurring use of words, that shows things happen in a specific location in the same way they happen in another location. Recrursivity is achieved when the researcher shows patterns in the way the work is organized (Campbell & Gregor, 2002; Smith, 2006). During the data collection, different methods of data collection were employed to describe how work is organized and which texts and unwritten rules shape the actions of participants. All types of data were collected through different data collection methods, and this is done to support patterns across all forms of data. The methods of institutional ethnography inherently ensure trustworthiness since the maps of social relations serve to confirm and explain the data gathered from participant about their lived experience.

Triangulation "requires the researcher using a combination (minimum of two) methods to research the same phenomenon; that is to seek convergence and corroboration through the use of different data sources and methods" (Bowen, 2009, p. 28). I achieved this by utilizing three methods of data collection, and even interviewing more than one participant to identify the same

discourse. Moreover, I myself participated as a student in several IPE activities.

Member check involves the participants review of their interview transcripts to confirm content. performed as the participants can review the transcripts of their interview and confirm is content. I forwarded the transcripts to the participants to review and confirm its content. Participants were informed that in case they case they have any question or need clarification, then we would meet to discuss their points of concern.

Reflexivity is another way to ensure trustworthiness that is employed in institutional ethnography. Reflexivity is achieved through field notes, memos, peer debriefing sessions, and processing sessions with the participants. Guilleman and Gillam (2004) stated that goal of various reflexive practices is to reflect critically about the knowledge produced and generated because of the research. This was conducted through the last focus group that included a facilitator and two students where uncovering of discourses took place, and was debriefed with the participants (students and facilitators). Facilitators were also asked to reflect on data collection processes and analysis, mainly after all interviews were conducted.

Catalytic validity (Lenzo, 1995) is " concerned with the documentation of the degree to which research process re-orients, focuses, and energizes participants so that respondents gain self-understanding and ideally, self-determination through research participation" (P.18). This validity is guided by both institutional ethnography and critical social theory to achieve emancipation of participants. This was achieved through meetings with participants and focus groups where all participants were providing suggestions for change. It was also achieved upon sharing the findings with the facilitator participants where they identified the ruling relations that govern and limit their work.

Chapter Four: Findings

This chapter presents the findings from this institutional ethnography which focused on the social organization of the IPE program at Dalhousie University. The specific research questions of this study explore the translocal ruling relations that dictate the facilitators work in local IPE setting, and how these relations shape the problematic of this study: students' stereotypes. In keeping with the methodology, the social organization of the IPE work processes uncovered in this study will be described and presented in a series of maps.

Based on data collected through observations, interviews, and focus groups, I identified four main work processes conducted by facilitators in an IPE local setting and are related to the problematic identified. These work processes include: 1) forming teams, 2) facilitating student's introduction to group members, 3) facilitating team dynamics, and 4) providing course content and context. In the following section, I present each work process with a description of what it involves. Then, I provide an explication of the translocal work processes that shape each local work process. As per institutional ethnography, local work may be shaped translocal institutional discourse, extra-institutional discourse, and/or critical institutional discourse, and in occasions when these are identified, I will present them. I will also provide a map for each local work process that depict the text-work sequence between translocal and local settings. Finally, under each work process, I will present how students embody the social organization of each work process thus shaping the development and sustainability of the problematic of this study: students' stereotypes.

Work Process 1: Forming Teams

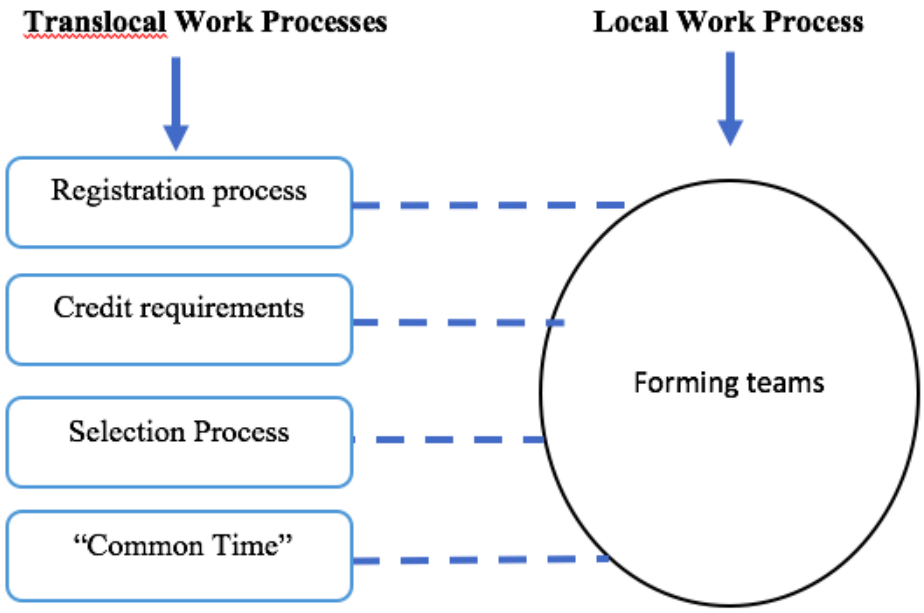
Description of the local work process. On the first session of an IPE course, a group of students from different health professions report to an IPE classroom (local setting) at a specific

time. The number of students varies and the number of students allocated to one facilitator ranges from four to eight. The facilitator then subdivides the students into smaller working groups (ranging from 2 to four eight students per group) while trying to maintain equal diversity of professions within each group. The final composition of each team is determined by the number of professions represented, and the number of students representing each profession. Thus, depending on composition of the group, there may be an under or over representation of some professions. In addition, within the various courses there is also diversity in relation to student experience/program year. In one specific course, the facilitator/organizer explained that a group with over representation of one profession but with diversity in student experience/program year is intentionally structured so that students in first year of one profession may "learn from" the students in the other professions from fourth year.

Description of translocal work processes. The formation of teams is a work process conducted by facilitators in local IPE settings. However, this work is shaped by work processes which can take place in other translocal settings. Specifically, the process of forming teams is informed translocally by: 1) the IPE program course registration process set by the Faculty of Health (FH), 2) IPE courses scheduling as set by the FH, and 3) the process through which organizers select students to join their courses. Students choose and register in IPE courses they are interested in, and they do so based on the credits they are expected to acquire as determined by the FH and the students' own program policy. Course selection is also determined by policy related to the scheduling of IPE programs. For example, students cannot choose IPE courses that conflict with departmental courses. At Dalhousie, there is a designated "common time"- which means IPE classes take place weekly on Tuesdays and Thursdays of each week between 3:30 pm and 5:00 pm. Thus, students can only register for an IPE course if their departments abide by the

"common-time" by not offering any required departmental courses during this period. The third translocal work process that shapes the way facilitators form teams in the local IPE setting is the way course organizers select students who have registered in their course, which is currently decided on a "first come first served" basis. For example, if a course holds a capacity for 30 students, the registration process stops when the number of students who have registered reach the number 30. This selection process can result in under and over representations of students from the various professional programs. For example, through my observations and participation, I have noted that some IPE classes have included three health professions with more than two third of the class representing one professional group and less than one third representing the other two professions. The following figure (Figure 1) provides a detailed visual mapping of the translocal work texts that shape the local work process in relation to the formation of IPE teams.

Figure 1: The Social Relations of "Forming Teams" Work Process



The above map (figure 1) depicts the ruling relations that translocal work texts hold to shape the local work of facilitators. The map reveals that facilitators' work involving forming

teams in local settings is determined by translocal work processes that occur at the FH, departments/schools and course organizers level. Facilitators do not have input into these translocal ruling work processes and oftentimes are not aware of them. As a matter of fact, unless the facilitator is also a course organizer, then he/she may not be aware of these ruling translocal processes.

Embodiment of the translocal processes in the local setting- shaping students' stereotypes. Upon analysis of how the team forming work process relates to the problematic, I identified that students and one of the facilitator participants described that a lack of team balance, especially in relation to having first-year and fourth-year students together, was noted to promote and perpetuate the development of stereotypes. For instance, first- year students interacting with students of fourth year, regardless of their profession, may view the more experienced cohort as more knowledgeable and expert. Students in fourth year also perceived themselves as leaders operationalized by dominating the class discussions. As one of the facilitators, Naya shared:

> The third year are more willing to communicate, to jump, to start, and to be the first one who ask a question to the patient. So this is maybe the level of experience, but not the profession. I did not see it as between the professions, but it's more about how much, or how long you been in this [program of education].

In situations where some fourth-year students assumed a dominant role, students in their first year tended to adopt a role of followers, operationalized by assuming a passive, listening role. Students also communicated that this lack of group balance created power dynamics inside the group in that the first-year group members feel overpowered and dominated. These students revealed that power differentials arising from the team imbalance created an IPE experience that was more "learning from", rather than "learning with, from and about" as per the formal

definition of interprofessional education (WHO, 2010). The following student quote illustrates the effect of having unbalanced teams in terms of experience, as Mark shared:

> There was one IPE that I did in my first year, we were teaming up with the [profession] students. I mean, the [profession] students were probably in third year, I can't recall, I know it's not first year [profession]. There wasn't really much of like interacting, learning about each other's roles. It was more like first year nursing students who don't know much receiving information from [profession] students about how to turn a patient to their wheel chair, bed, you name it. So, I guess at that point we probably all felt underpowered. There's really no equal interaction at all……before I entered the room I thought we were going to work together but …., we're just learning from them, we're just first years listening to a lecture by them.

As the above quotes demonstrate, student groups which lack balance across the professions and across program years can create a dynamic that impedes the ability for students to learn with, from and about. The above quotes also reveal power dynamics among students in the local IPE setting, which students in advanced years of their program hold power by virtue of their seniority. Guided by the epistemological assumptions of the critical paradigm, knowledge and perceptions are constructed through interactions and socializations and are influenced by power relations. As analysis of the interactions occurring in local IPE setting reveals a hegemony of senior students manifested by dominating and leading the group work. The hegemony of senior students results in development of perceptions and stereotypes among junior students about the dominance of certain professional roles. Habermas calls for equal dialogue to address power dynamics and hegemony of one group, a task that facilitators in local settings try to achieve and will be discussed in more depth in the below work process "Facilitating Team Dynamics".

The social organization of facilitator's work of forming teams in local IPE setting, including the teams that lack the proper balance, reveal that facilitators do not have a role in the selecting students for an IPE course. Moreover, analysis of this work process reveals that this work is dictated by translocal discourses and processes that facilitators do not necessarily

contribute to unless they also assume the role of organizer. Analysis of this work process also reveals that there are institutional limits imposed on facilitators that may impede facilitators' ability to promote students' learning with, from and about each other. As presented in the maps, the translocal discourse shaping this work process can be identified as area for improvement and change to ensure proper team balance, and hence address student stereotypes.

Work Process 2: Facilitating Student Introductions

Description of the local work process. This work process involves facilitators introducing their name, their title and department, and asking every student to introduce their name, their department, and their interest in the IPE course offered. This process is a general introduction structured at the beginning of the course that is done over a short time period (five to ten minutes depending on the size of the group). As revealed in participants' interviews, and particularly by students, this introduction process did not enable them to get to know one another in any depth. In fact, the participants mentioned that they at times could not even identify one another's names or professions following this exercise.

Description of translocal work processes. Facilitating students' introductions of one self to other group members process is shaped by three translocal discourses: 1) a common institutional practice employing the same introduction process across IPE courses; 2) a prescribed IPE course activity among other activities to be planned within a specific timeframe; and 3) an "oppositions critical talk" that emphasizes personal introductions.

IPE course organizers plan the IPE activities to be covered within each IPE class session including the first session where the introductions process occurs. Course organisers present these activities to facilitators through the course syllabus and emails specifying the activities to

be covered in each session of the IPE course with the timeframes for each activity- including the introductions process.

Through observations and interviews, I identified an "oppositions critical talk" by one participant who held a dual role of an IPE organizer and facilitator. This "oppositions critical talk" refers to the difference between the common work practice of facilitating introductions and what occurs in the local setting. In this case, this participant shared her lived experience as a facilitator for several years and expressed a lack of satisfaction with the group introduction process and a concern that the time for introductions is too short. Moreover, she shared that the format of group introduction is impersonal and prescriptive in nature which impedes students' ability to truly get to know one another and may hinder future collaboration. As Alya shared:

> Because what I've experienced, what I've noticed in all - I've done lots of IPE [courses], if the students don't all get to know each other and talk together, then they all just function in silos.

This facilitator believed that establishing human connection and being able to communicate and relate to one another as humans is central for collaboration and communication. Alya shared:

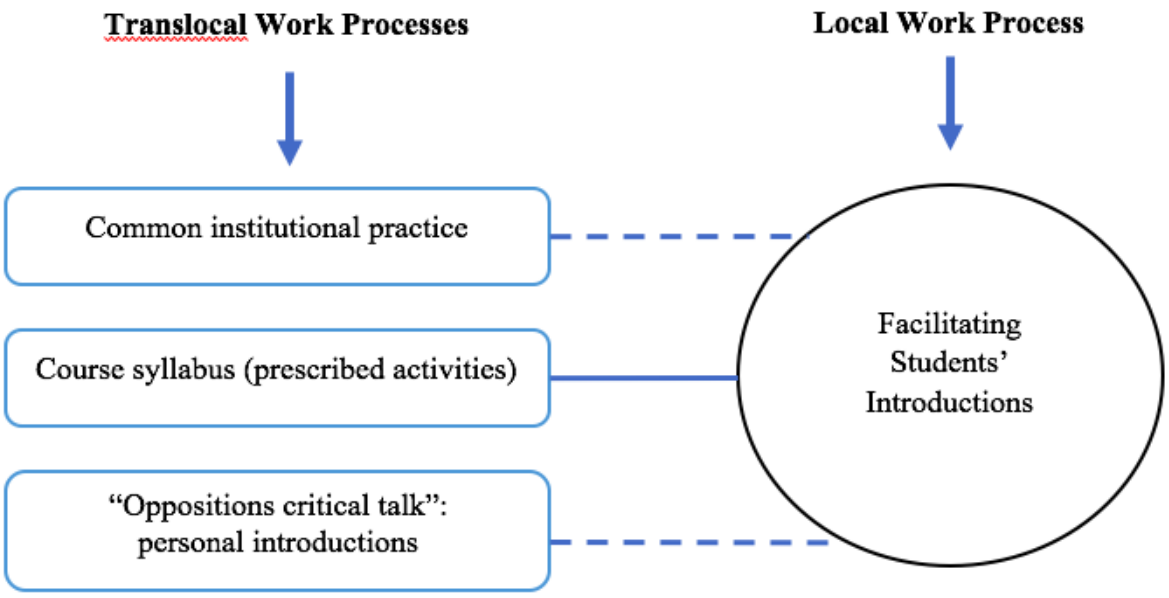
> If we really want to have good interprofessional collaboration, understanding who we are as humans first and then moving to our professions.

Thus, this facilitator, who also holds a position of IPE organizer, introduced a different introduction work process within the courses she facilitates. In her classes, more time was allocated to the introduction process, and every student was asked to share with the group a personal information or interest so that students start relating to one another as individuals beyond a name and profession. As Alya described her work:

> If we are all human beings. When we go around the room, one of the things I started asking not so much in this course but in the {course name}, is as you introduce yourself I want to know your name first, then I want to know your discipline, then I want to know something that is important to you, as a person, about anything. So what I have noticed is that people bring up different kinds of things.

The below figure provides a visual mapping of this local work process and the translcoal work processes.

Figure 2: The Social Relations of "Facilitating Student Introductions" Work Process



The above map shows that the work process of introductions, executed by facilitators in local class room, is determined by translocal processes. For most of the courses I observed, facilitators led the short introductions process. However, during data collection I identified one facilitator/ course organizer participant who drew from her lived experience and expertise to adjust the process to allow more time for more personal introductions. As depicted in this mapping of translocal processes, dissatisfaction with the common institutional discourse of short impersonal introductions, resulted in one facilitator introducing a new discourse. Within the delivery of the course, other planned IPE activities were revised to accommodate the new personal introductions process within the specific timeframes of the course-which reflects both translocal and local contexts. Because this facilitator also holds the position of course organizer, she is in a position to revise the IPE activities to accommodate the timeframes of the new

introduction process. Facilitators who do not hold a position of course organizers do not contribute into the organization of IPE activities and the corresponding timeframes, and thus remain limited by the timeframes set by course organizers. As such, it is crucial that feedback and input from all facilitators regarding the introductions process be shared with course organizers who hold the power and capacity to re-plan the IPE activities.

Embodiment of translocal work processes in the local setting- shaping students' stereotypes. Within the interviews, student participants reflected on how the introduction process could at times operationalize their stereotypes of other professions. Students explained that introducing themselves solely in the context of their profession could activate group members' pre-held stereotypes about the various professions which may influence the way they interacted with the other students. As Cameron shared:

> But participating in those IPHE courses, I guess, with all of the different stereotypes already, that we already have coming in, ….. Because now you see the person as their role and not who they are as an individual." "Where automatic stereotypes can make it really hard to really know the other people scope of practice.

As Cameron's quote demonstrates, introducing yourself by identifying your profession emphasizes the profession over the person. Students identified that they would have preferred to establish a level of human connection with other students in the team before they start discussing professions and professional roles. This finding aligns with the experience shared by the facilitator Alya who emphasized the need for human connection during the process of getting to know one another. Students participants suggested that ice breaker exercises and small group games at the start of the sessions may facilitate personal introductions before the professional choices of each student is discussed. As Cameron shared:

> I am talking about a human individual because everybody is a human first regardless of what role you have, whether you are a custodian, a physician, a fire fighter, police officer, we're all human beings first and I think to get to know them as a person – because we all

> have the same goal, we're all here to care for the patient. We all are caring individuals, and we all are compassionate. But if we put the stereotype in front of that, it's just like a barrier…

This quote demonstrates how students emphasized the importance of establishing human connections with their peers, and that this connection could be established by focusing on shared interprofessional values such as caring and compassion. Cameron presents caring and compassion as common values that can be a base of establishing human connections among students from different professions. However, her quote also reveals a pre-assumption that health profession students are caring and compassionate. These pre-assumptions are a typical example of stereotypes, where Cameron identified health care students as caring, because what is generally known and expected of health professions. As much as it is integral to identify common values and common interests to establish human/personal connections, it is crucial to ensure that these connections are not based on inaccurate stereotypes. Moreover, it is also important to establish a human/ personal connection on a platform from that is not based on stereotypes which can help to mitigate the negative effect of stereotypical beliefs. As Cameron shared:

> it's kind of like looking as a friend. Like if you see someone as a friend first you forget about what their role rather than putting the role onto the person. ……. Because I feel like the role limits…like when you have a negative perception about someone, what ever they say, it is really hard to take in…… But if …. you see them as a person first and then their role you start to….. Become more accepting them of what they say. And you don't like take everything they say as negative.

Cameron's quote is reflective of her lived experience interacting with students from other health professions who are also her friends. Students who have an established personal connection with each other can often address and interact as individuals not as representatives of a specific profession, which can be helpful in overcoming stereotypes as barriers to leaning with, from, and

about one another. This personal connection can enhance student collaboration even when stereotypes about other professions exist. As Cameron stated:

> For me because I have friends in different health care professionals, and …. I have that really strong bond with them. And, I don't see them as the role, even though I know what the scope of practice is, I know them as a person first. So, I am friends with pharmacy students, dentistry, medical students, but I don't really put the role….The role doesn't really serve as a barrier. So, I don't really have that stereotype with them. Because I see them as my friend….. So, if I were to work with them I've bonds so strong, that we could collaborate together despite the stereotype that we hold……. Yeah! It would be easier to collaborate. Easier to talk to. Like, there is no hierarchy because we're both individuals, we're both like the same – like we're friends.

As reflected in the above quotes, Cameron emphasizes the importance of establishing a human connection and reinforces the significance of establishing friendship with other members of the group. Students emphasized the need to establish a more personal connection with other students to be able to learn from, with and about them. Students also draw from other examples in their life and lived experience, where they have been successful in relating to other students they already have a personal connection or friendship with. As much as friendship among team members might help mitigate the stereotypes held about the professions these students represent, it is important to note that having friends within a group can also impact team dynamics. With friendships, strong communication may already exist, and this can shift the power differential where these students might dominate the discussions thus reinforcing marginalization and stereotypes of the other students in the group.

The social organization of this work process reveals that there is a need that facilitators/course organizers adopt a people/patient centered approach during development and delivery of the IPE courses. Facilitators and course organizers do not attend to students' perspective, or even to their own perspective even if they identify a need for a different discourse. They tend to follow the current common practices determined by the translocal

setting. However, this study shows that facilitators/course organizers hold a level of autonomy and they can and did activate an alternative discourse so that students a level of connection which enables them to learn from, with and about each other.

Work Process 3: Facilitating Team Dynamics

Describing the local work process: This work process involves introducing students to the course logistics and teaching methods which include face to face planning, simulated interview exercise, and face to face group debrief. The students in the IPE setting represent different professions and are expected to interview simulated patients (with a specific disease condition) and their family/caregivers. Students first meet for a short time to plan the simulated interview exercise as a team. During this planning exercise, and guided by a framework specific to the course topic, students agree on the interview questions to be asked and the questions that will be posed by each student profession. The students then conduct the interview with the simulated patient and caregivers within a specific timeframe that differs from one IPE course to another. The simulated interviews are designed so that every student gets a turn to ask a question. Facilitation of this exercise involves the following elements: attending to the students' and simulated patient's body language during the interview, ensuring student engagement, and assessing the ease of discussion. If the facilitator identifies an issue with body language, engagement or ease of discussion during the interview, they can either intervene on the spot, or wait until the group debrief. The face to face group debrief is comprised of the following elements:1) simulated patients reflect on their experience as patients' interaction with students, 2) students reflect on their own experience interacting with patients and with each other, and 3) each student reflects on the performance of other students in the group.

Description of translocal work processes: Facilitating team dynamics is shaped by 1) the criteria course organizers follow in selecting facilitators which focuses mainly on the facilitator's knowledge of and skills in relation to the subject matter, 2) the training facilitators receive in terms of facilitating team dynamics- which is offered by course organizers, 3) the facilitators' knowledge of and skills in facilitating group work and team dynamics. Through interviews with facilitators and one course organizer, it was identified that the main criteria that course organizers follow to select facilitators for a specific IPE course is the facilitator's knowledge of and skills in the content focus of the course topic. This is described in Naya's quote:

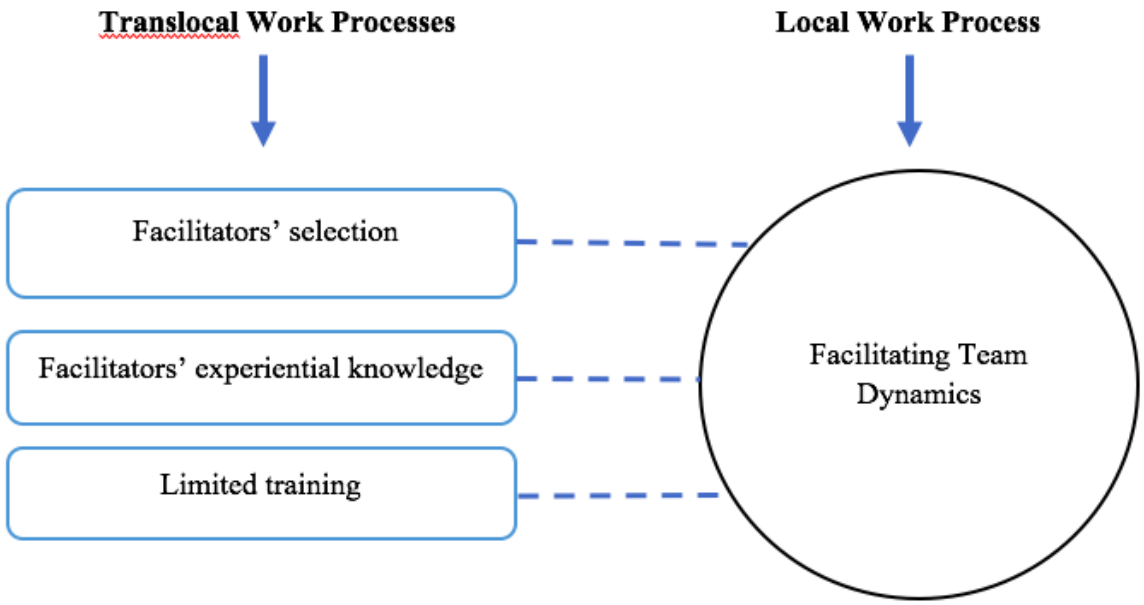
> I was selected based on recommendation of a faculty member…... So, my thesis focused on teaching and communication, and she suggested that this area is very critical in that course, so she recommended my name to the committee of that course. They contacted me and I agreed to work with them.

Through participant interviews with facilitators, one course organizer, and IPE coordinating committee representatives, it was discovered that Dalhousie does not provide any formal facilitator training programs. One facilitator participant mentioned that although there is no consistent training prior to each course, in some instances the facilitators meet with course organizers prior to the course start and may discuss the topic of the course and instructions on facilitating the team dynamics. Instructions about facilitating team dynamics are limited and include information on attending to students' body language and human cues, eliciting students' participation, intervening during long moments of silence, and addressing dominance of one student or one profession in the group. As described by Naya:

> There was - the faculty members who were facilitators, we didn't even have a training session….. so they had [course content- health condition focus] expertise, but you know they generally work and collaborate with different team members, but do they actually work collaboratively? I don't know. Everybody is different.

Naya's quote also reveals that what determines facilitators' work in team dynamics is often their own experiential knowledge of team work, and which is typically informed by their experience and knowledge related to their own discipline/profession. The below figure provides a detailed visual mapping of this work process and the translocal social relations that were considered in the analysis.

Figure 3: The Social Relations of "Facilitating Team Dynamics" Work Process



The above map depicts that the facilitators work of facilitating team dynamics is shaped by their own personal and professional knowledge and skills. The lack of formal and structured training reinforces for the facilitator to rely and employ own facilitation knowledge and skills acquired earlier through uni-professional experience. As such, the knowledge and skills facilitators have acquired throughout their uni-professional experience may not be appropriate for the interprofessional context. The lack of institutional IPE formal training renders the whole work of facilitating team dynamics totally based on facilitators' discretion and skills.

Embodiment of translocal processes in the local setting - Shaping students' stereotypes. Within interviews, student participants reflected how the manner in which facilitators addressed team dynamics, specifically in conflicts that arise when students' stereotypes are operationalized, could both reinforce existing stereotypes and introduce new ones. Cameron, one student participant, shared an example of conflict that occurred between her and another student in an IPE team. The conflict occurred while Cameron was trying to address the stereotypes in relevance to nurses' roles that another student from another profession was expressing. Cameron expressed a lack of satisfaction with the way the facilitator addressed a team conflict that she was a part of. The conflict occurred because of the reaction of one student to what and how the student participant explained the role of her profession. Cameron shared:

> I guess in one example a team member brought up something that I said [a conflict that aroused in response to discussion about roles]….. so I guess that dynamic was negative from the start. And then during our debrief he brought it up to everybody and then my facilitator tried to make light of that. So, she tried to make it more positive by- but she wasn't really addressing it. She was just like "oh, every—It happens to everybody." Like she just brushed it aside, and then moved on……

Cameron's quote reveals her lack of satisfaction with the way the facilitator addressed the conflict students had regarding their perceptions and stereotypes in relation to the roles of each other. Cameron was not satisfied with the way the conflict was handled because the operationalizing of stereotypes which was the cause of the conflict was not addressed or discussed. Cameron expressed lack of confidence in the facilitator's skills and knowledge in addressing such conflicts and team dynamics, Cameron shared:

> I still feel not respected…. I think they try to [facilitate dynamics] but they just don't know how.

Cameron's quote reveals a feeling of being not respected by another profession, a situation that reinforced the existing stereotypes which was the cause of the conflict.

The social organization of facilitators work in managing team dynamics emphasizes the crucial role that facilitators play in conflict resolution and addressing stereotypes. The lack of formal education program is a gap clearly identified in the social organization, and this gap reinforces the need for a standardized and formal facilitator's training program.

Work Process 4: Delivering Course Content

Description of the local work process. In this work process, facilitators in the first session of the IPE course share with the students the curse objectives, course syllabus, guiding framework (s) and tools. Later in each class session, the facilitators share new material with the students, which in the simulated courses include the case of the patient. Then facilitators organize the activities of students in IPE classes focusing on utilizing the tools, frameworks, course material, and simulated patient cases. The content of the courses, the objectives and the frameworks vary from course to another. Some course objectives and frameworks are relevant to and focus on the topic of the course. Other course objectives and frameworks focus on the collaborative competency framework where a number of collaborative competencies are the focus of the objectives of the course.

Description of translocal work processes. The content of the IPE course that the facilitator delivers in a local IPE setting is determined and prepared by organizers of the course in a trans-local setting. The course organizers' work of preparing the course objectives and content varies among organizers and is shaped by: 1) course organizers' knowledge and expertise in the course topic, 2) organizers personal interest and agendas in providing a course in a specific topic, 3) The CIHC collaborative competencies, 4) an " oppositions critical talk" that emphasize humanistic communication and communication theories, and 5) and "extra-institutional talk" which emphasizes the dominance of the medical model. Extra-institutional talk

refers to discourse that exists in another institution such as the medical model in practice setting, yet it shapes the work practices occurring in the institution studied (the IPE program) (Smith, 2005).

Some IPE courses focus on collaborative competencies, while others focus on a specific topic of interest for the organizers in relation to their own discipline. The IPE program at Dalhousie adopts the CIHC framework of collaborative competencies and course organizers are expected to focus the courses around these competencies, but this is not always the case. As one member of the IPE coordinating committee participant Jackie shared:

> I was involved with one mini-course when the development- I kept bringing this back to the IPE competencies and it was….. "you know I got my money now, this is the information, we really want to get this information shared, and weren't so big to focus in on the competencies". Others really do, I think, I think we're going to see that tighten up. That people won't get away with just pushing agendas through.

Jackie's quote reveals that even when she, as representative of IPE coordinating committee and an expert in IPE, contributes to the development of an IPE course, the course organizers are the ones who decide on the content focus based on their own interests and goals. Another participant of the coordinating committee considered facilitator's/organizer's lack of expertise and knowledge about collaborative competencies as a major factor for organizers' focusing on a specific topic rather than collaborative competencies. As Jeff shared:

> If I am a new facilitator to IPE, I've never done anything officially IPE before but I am really interested in this and I want to do an activity… maybe I am not even fully aware of the IPE competencies. You know, because I have never conducted an IPE activity before…..

Jeff's quote reflects a discourse that shapes the work of some course organizers as they prepare the course content and objectives, specifically that course organizers who lack prior experience in preparing IPE courses and knowledge in IPE competencies may focus course content on other topics.

Another translocal work that shapes the course content was identified through one facilitator/organizer's "opposition's critical talk". In this opposition critical talk, the organizer/facilitator guides the simulated interviews to focus on a potential shared topic of interest- something relatable to most individuals- such as hobbies or interests versus the collaborative competencies or the patient's clinical condition. This oppositions critical talk is shaped by this facilitator's experiential knowledge and belief that in order to achieve collaboration and patient centered care, students need to establish a level of human connection and communication with the patient. As Alya shared:

> When we go around the room, one of the things I started asking…., is as you introduce yourself I want to know your name first, then I want to know your discipline, then I want to know something that is important to you, as a person, about anything. …… and I said "now given that we are going to interview Ms. Jones….. what sort of things come to your mind about how you could link what you like with something that that person might like. So that, ……it might help that patient talk about their issue and maybe make it a little bit more human." So for instance the person who really likes cooking, we were half way through the interview when it was very clear that the person eating was an element……., so she started talking about "what do you like to eat? Oh do you cook yourself or does someone else? How do you like to cook" that kind of stuff. So she was using something that she understood quite well, that was outside her discipline, but it helped connect her with the patient. They were talking about, it could be anything silly, but it was the person felt connected. So, recognizing that we are humans first, then we have a discipline, and then we are working with you as a team.

In this quote, the participant chooses not to focus the content on collaborative competencies or the clinical condition but instead on a social topic that can serve as a context for establishing connection with patients. This "oppositions critical talk" is embodied in this organizer/facilitator's work in local IPE setting, where she and other facilitators in the same course direct students' interactions with simulated patients guided by "establishing therapeutic communication" guidelines adopted from Egan and Schroeder (2009) to establish a therapeutic

communication and rapport with the patient. The facilitator/course organizer elaborates her belief that this is the basis for establishing a patient centered care which is a collaborative competency.

The focus group interviews with students and one facilitator also revealed another translocal "extra institutional talk". This extra-institutional talk revealed that the inherent medical model of health care settings that functions as a text shaping of what takes place in IPE settings. As the facilitator participant Mina shared:

> Sometimes because of the curriculum that we are learning, that it's a medical curriculum and it is based on the diagnosis. So we start from the diagnosis, then we make all our plans as health professions. So we are not starting from something humane or something, we start from the disease, then we start to make the plans. So we see the limitation first, so this is like the health limitation, not the social limitation. But usually we start all the other plans when the patient reach the level of diagnoses. So, okay, what about nursing here, what about speech therapy, what about the social work. So it is all based on the diagnosis.

Mina's quote emphasizes that the inherent medical model dictates that all professions in educational and practice setting start planning their work after the physician makes the diagnosis and that this model reinforces the dominance of the medical model and absence of other professions prior to diagnosis.

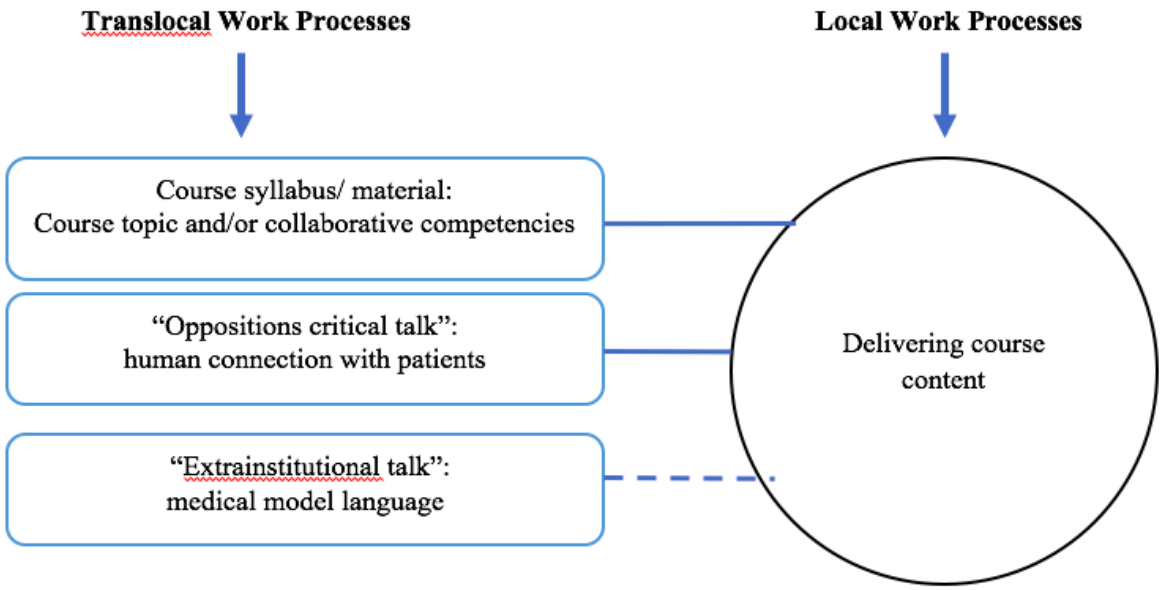
The student participants also described how the education and simulation exercises they experience in IPE activities reinforce the dominance of physicians. As Mark shared:

> We were in a scenario where the physician, the student physician wanted to do up an order for a drug to give our simulated patient but because I viewed him as the top guy making the decision, I heard him verbally say the order but I was sort of- I felt like a subordinate who wanted him to write his signature on the binder just to cover my self. "Just so he could have- just so he could demonstrate his responsibility for writing out that order ."

In this quote, the nurse participant describes a hierarchy in his interactions with a physician, where he felt a subordinate in an IPE activity structured to be collaborative in nature. The below figure provides a detailed visual mapping of this work process and the translocal social relations

that were considered in the analysis. The below figure provides a visual mapping of this local work process and the translcoal work processes.

Figure 4: The social relations of "Delivering course content" work process



The above map (figure 4) depicts various translocal discourses that shape the content of IPE courses delivered in local IPE settings. Texts such as syllabus exhibit different focus and this creates a variation in the focus of the course content delivered in local IPE settings. Even though Dalhousie adopts the CIHC collaborative competency framework (CIHC, 2010), the course objectives and content may not always focus on these competencies. Course organizers focus on either course topic, collaborative competencies (CIHC, 2010), or a combination of both. The above map also reveals an oppositions talk that adopts a people centered approach, a similar concept was identified in the above work process "Facilitating Team Introductions". This approach is adopted by one facilitator/course organizer and focuses on establishing connections between students and with simulated patients. This organization also presents the level of autonomy that facilitators/course organizers possess. Finally, the dominance of the medical

model in practice setting (extra-institutional talk) is depicted in the map and it is as a discourse that shape work processes at both the local and translocal settings.

Embodiment of Translocal Processes in the local setting- Shaping students' stereotypes. Within interviews, student participants reflected on how the inconsistencies in course content across IPE courses could reinforce existing or create new stereotypes. Students identified that they enter their undergraduate educational programs with pre-existing stereotypes about various professions. The students also identify that because the IPE courses lack objectives and content that directly address stereotypes, the course work does not necessarily help in ameliorating these stereotypes. Students expressed that when they gain clarity about their own roles and the roles of other professions, then they can form a more accurate perception of their own profession and other professions. Thus, when students join an IPE activity, they expect that through these courses they will be learning about their own roles and the roles of other health professions in a specific course context. It is not solely the role clarification that they expect to learn about, but all the other collaborative competencies. However, in courses shaped by the critical "oppositions critical talk" where the focus of the discussion was a topic of common interest (cooking), students were at times confused about the learning objectives. Students' expectations to learn about their roles was not met, and they did not understand the rationale about the focus on social communications and connections, and thus ended up describing the course as disorganized. Students, as such, discussed among themselves how they developed opinions and perceptions of the IPE program and IPE courses as being disorganized.

Students and one facilitator participant also described how the extra institutional talk and dominance of the medical model reinforce the stereotypes that students hold. The inherent

structure and roles of the current health care educational and delivery system reinforce the dominance of physicians, and as Mina the facilitator participant shared:

> …. As a health profession, if there is like a physician or a nurse, they will talk first. Because what- all the plans laid on the medical or the health issues. So that is the medical model you are describing and does collaborative practice suggest a different model? No, it is how this medical model affect even the collaborative programs.

Mina's quote describes the dominance of the medical model that dictates the roles of physicians and/or nurses to be the first health professions addressing the health complaints of a patient. The fact that physicians and/or nurses are the first profession to attend and initiate a patient diagnosis and case aligns with the traditional medical model which thus has a tendency to dominate any collaborative model. Students also reflected on the dominance of the medical model. Students considered that leadership roles are embedded within health professions scopes of practices and dictate that physicians will always be the leaders who write the orders and other health professions will follow their orders. As Cameron shared:

> I mean I guess that there will always be a stereotype, right? Like you will always, you will always have the misconception of the role….. Because we will always follow physician's orders in a way….But in a way, in a way that is their scope of practice. right? And that's our scope of practice ….

The above quotes emphasize the power of the medical model as a translocal talk that shapes students and facilitators' stereotypes, clinical practices, and even the education provided in the IPE program.

The social organization of this work process emphasizes the role of the translocal setting in determining the content of the course delivered. A level of autonomy is evident in facilitators' critical work, but facilitators who were able to introduce an "oppositions critical talk" held a dual position of both a facilitator and organizer. Nevertheless, the social organization identifies 1) lack of training and 2) lack of content standardization in the IPE program as areas of

improvement that can be addressed at the IPE program level not only organizers' level. Moreover, the extra local talk emphasizing the dominance of the medical model is a challenge that necessitates a clear definition of what collaborative practice is, and what it would comprise in a medical model.

Chapter Five: Discussion

This study is unique in the sense that it is the first institutional ethnography that explores the social organization of an IPE program. Starting with students' stereotypes as a problematic, this inquiry sought to explicate the social relations that shape the work facilitators perform in local IPE settings problematized by students' stereotypes. Analysis revealed four practices performed by facilitators in local IPE settings and uncovered the institutional translocal discourses that dictate these work processes. Institutional ethnography(IE) and Critical Social Theory (CST) provide an opportunity to not only reveal the translocal ruling discourses that shape the problematic, but also uncover opportunities for change and improvement. In accordance with the methodological and theoretical framework of this study, if identified changes and improvements are executed in a critical approach and supported by evidence, then the institution (IPE program at Dalhousie) will be able to ameliorate the problematic at hand, namely the stereotypes the students hold which impede IPE.

Guided by the philosophical underpinnings of the critical theory adopted in this study, any proposed changes and improvements in the work processes are identified, initiated, and led by the facilitator participants. In other words, part of the research process in IE is to reveal to the study participants how their work is shaped by the translocal ruling relations. Empowered by this knowledge, facilitators can then choose if, and how, they are going to call for action. In my role as researcher, I revealed the ruling relations to facilitators during the interviews, focus group and as part of a process to ensure rigour known as the catalytic validity meetings. During these meetings, the facilitators and the students presented ideas and suggestions for change and improvements which I will share in the following section.

Guided by IE, the following discussion centers on the social organization of each of the local work processes identified as contributing into the problematic of this study. The discussion will be presented under the following section headings which relate to identified work processes: Forming Teams; Facilitating Students' Introductions, Facilitating Team Dynamics, and Delivering Course Content. In accordance with my methodological framework, the discussion of each work process is organized to include: 1) A discussion of each process in relation to the available literature supporting this finding as a challenge to IPE and/or in relation to stereotypes; 2) Suggestions for change and improvements provided by the participants (facilitators and students); 3) Evidence and/or plausible theories to support the participants' suggestions and recommendations; and 4) Implications for future practice and research.

Forming Teams

The findings from this study demonstrate that forming a team of students from diverse professions alone is not enough to enable IPE. The composition of the team – specifically, the balancing of professions within the group is essential to enable not only diverse representation, but also equal voice and input. Having dominance of one group over the others in terms of balance can perpetuate stereotypes as they relate to dominance among the health professions.

The literature recognizes that team work is central to IPE as it enables the three aspects of interactive learning of IPE where students learn with one another, from one another, and about each other (Paige, Garbee, Brown, & Rojas, 2015). The literature acknowledges the importance of team composition and balance to achieve interactive learning, and recognizes that it is the context, focus of IPE, and the environment that contribute to the team composition (Billups, 2001). According to Billups (2001), students in interprofessional teams participate in "democracy of talent" and that the composition of the teams should be structured so that no

student's profession is dismissed or ignored. The process of forming teams requires a balance of polarities so that diverse contributions from the various professions are equally valued as the members of the team coordinate and collaborate to meet agreed upon course goals and objectives (Billups, 2001). The literature on IPE acknowledges the importance of team balance, but also acknowledges that it is context specific, and that balance is determined by the context, objectives to be met, and contributions the students of each profession are able to provide.

The IPE literature does not provide models or guidelines for how team balance can be achieved. Moreover, the literature does not directly address the role of team balance in relation to student's stereotypes. Several questions arise from the findings of this study including- what are the indicators of team balance? Is balance related to the number of professions represented, the level of students (in their program), or the number of students from a specific profession? For instance, if medical or physiotherapy students are by default advanced in their educational training because they are required to have a previous degree, should this be considered in decisions of achieving balance? In addition, some students may have participated in other IPE activities during their programs which may impact balance of perspective and knowledge. The formation of balanced team has been identified as an important work process, yet the concept of balance is complex and this is a current gap in the literature as it relates to IPE.

The findings of this study revealed that team composition in IPE settings at Dalhousie shapes the problematic of this study, and that facilitators and students were not always satisfied with the team configuration. Guided by the axiology of the critical paradigm, the translocal processes shaping the work of facilitators as they form teams in local settings were uncovered and discussed with participants (facilitators and course organizers) during interviews, focus groups, and catalytic validity meetings. By uncovering the translocal ruling relations, the

participants were empowered with the knowledge to understand what shapes their work, and hence come up with suggestions for improvements. Through the focus groups and interviews, facilitators, course organizers and IPE program coordinators proposed suggestions for translocal practices at the FH and individual departments/schools level and among course organizers. Suggestions for the FH and individual departments level included a commitment that the various departments and schools abide by the institutional "common time" discourse. Even though "common-time" allocated for IPE activities is a strategy adopted at the level of the FH, departments and schools still have a challenge in consistently abiding by this common-time, because of the competing demands and scheduling constraints within their programs.

Another practice implication that course organizers reinforced and is already implemented at Dalhousie within the College of Pharmacy and School of Nursing is the notion of embedded IPE activities. Embedded IPE refers to the inclusion of IPE activities within the offering of a departmental core/required course. Embedded courses are unique in the sense that students and faculty members focus on the specific discipline content within an interprofessional context. Dalhousie students have reported their satisfaction with the knowledge and skills they acquired through embedded IPE courses in relevance to both the core course content specific and the collaborative skills (Dalhousie University, 2017). The significance of embedded courses in team balance is that upon designing embedded courses, course organizers plan the composition of the team as to what professions should be represented based on the specific context, which considers both the level and number of students representing each profession. Although embedded IPE activities have been underway for several years at the College of Pharmacy, there has not been any formal evaluation of its general effectiveness in relation to IPE, nor has the relation to students' stereotypes been assessed. Future directions for this type of IPE activity

could include a formal evaluation of how this strategy enables collaborative practice and accurate shaping of students' perceptions of their own profession and other professions.

One participant who also holds the role of course organizer, facilitator, and IPE program coordinator suggested revisions to course organizers' translocal work process related to selecting the students who join the IPE courses. It was suggested that course organizers are currently best positioned to identify the level of students eligible to register in IPE courses which may facilitate ensuring balance across the teams in terms of year of study. The course organizer shared that she performs this selection process in some of the courses she currently organizes and develops. This is a process she executes in coordination with teaching assistants and can be done through an excel sheet. This participant explained that she is careful that the budget allocated to the course covers the rates of the teaching assistants. This recommendation was made in the belief that this strategy could enhance team balance more than the current registration process of first come, first served.

As per IE and CST, and as part of the knowledge translation plan for the project, I will be sharing the findings of this study with other IPE facilitators at Dalhousie through presentations and publication. The translocal relations will be shared with all facilitators and hence more suggestions for change may develop at the translocal levels of organizers, FH and departments/schools. As per the critical paradigm, any suggested or proposed changes require the engagement and consideration by all those involved in the facilitation of the IPE courses. Thus, it is imperative that all stakeholders are knowledgeable about the importance of team composition in IPE education. As such, this hold implications for education at all levels to ensure that all stakeholders including facilitators, course organizers and departments are aware of the necessity of team balance. As per Habermas (1977), changes to work processes calls for an equal dialogue

between all stakeholders at both the local and translocal levels to agree and achieve consensus on suggestions for improvement. Guided by IE, it is crucial to integrate suggested changes into institutional texts and policies, and then to activate the new texts and policies by disseminating to all facilitators and course organizers to enable implementation. It is crucial to educate all stakeholders on the content of these new texts and documents and to monitor the proper implementation of the changes during IPE coordinating committee meetings, and through facilitators' training program (which will be discussed below).

The above discussion poses numerous implications for future research. Several questions remain in regards to the definition and description of team balance. Further understanding the concept of team balance, and evaluating the outcomes, is essential towards ensuring balanced teams within an IPE context. It is also imperative that any research in the field of IPE be interprofessional in nature- drawing on expertise in areas such as the health professions, sociology, social relations, and education. In addition, although embedded IPE activities have been implemented at Dalhousie, there is a need for future evaluative research to assess the effectiveness of this approach on team balance, stereotypes and interprofessional competencies. Finally, the above discussion presents several suggestions for practice and policy conceived by facilitators and coordinators, and evaluative research, using both qualitative and quantitative methods to assess the impact of these changes, is essential.

Facilitating Students' Introductions

The second local work process is facilitating students' introduction of themselves to other group members, which was described by students as an activity which can promote or accentuate their stereotypes. The standard introductions process across most IPE activities involves short, non-personal, statements which emphasizes the profession of each student. This introduction

practice is largely adopted by facilitators across most IPE activities without questioning the impact on students, students' participants described these short introductions as promoting and accentuating their stereotypes. Facilitators and students indicated that they were dissatisfied with the impersonal nature of the introduction and one facilitator rejected the standard approach and adopted an activity that allowed the students to connect personally.

Searching the published IPE literature did not yield any evidence about the role of establishing personal connection within team introductions on IPE or collaboration. In addition, there were no published articles or studies specific to the how establishing personal connection in introductions between students might shape students' stereotypes. One theory related to this issue is Tajfel's (1982) theory entitled Social Psychology of Intergroup Relations. Tajfel (1982) described intergroup relations (relations between different professions) as an operationalization of ethnocentric beliefs. Ethnocentrism means that individuals of one group (one health profession) evaluate individuals of another group (another health profession) based on the preconceptions they hold about the second group (Tajfel, 1982). These preconceptions are formed when the first group (specific heath profession) apply their own professional standards to evaluate the second group (the other health profession). Tajfel (1982) believed that intergroup interactions are shaped by the ethnocentric beliefs commonly held by members of each group. It is this dynamic that the facilitator and student participants are trying to avoid when they call for early personal connection prior to introduction of professions. Tafjel's theory helps explain how stereotypes are operationalized when students interact with each other based on belonging to different professions, and the theory provides support for more personal introductions. Tajfel's theory supports the benefits of personal introduction to team building, with personal introductions that start at the stage of interaction where all students belong to one group. Holding

an identity of human social beings versus disparate professions, can limit the early operationalization of ethnocentric beliefs and stereotypes. Aligned with the needs and experiences of the study participants, adopting a more personal introduction process can facilitate an environment where members interact, communicate, and identify as social human beings. This introduction process will help initiate an effective process for communication among team members which is a core collaborative competency (CIHC, 2010).

Literature from sociology emphasizes the importance of first day introductions in setting the social norms of a classroom (Winston, 2007). Winston (2007) believed that the instructions that facilitators provide to guide the introductions process shape the type of information students provide about themselves and create a social norm that students follow and rarely stray from. For instance, when the first student is instructed to introduces oneself by name, discipline, and level in own program, this creates a pattern and norm that other students follow as they also introduce themselves only by name, discipline, and level in program. Thus, facilitators play a central role in setting the social parameters through which students socialize and interact. Even though the findings from this study highlight how important the introductions are, yet course organizers and facilitators give this part of the course very little time/attention. Facilitator participants in this study described that they do not focus on revising or extending the introductions procedure in large part due to the time constraints of completing all the course activities within the designated time frame- which is determined by course organizers. Through focus groups, students suggested incorporating short icebreakers in the form of games as part of the introduction process. Students participants also suggested that students add personal pictures to BrightSpace account for online courses. The introductions process poses practice implications including agreement on the best format and most convenient time frames for the introductions process. Establishing such an

agreement requires collaboration and dialogue between course organizers and facilitators to plan for the activities of the first IPE session (including introduction) along with the time frame for each activity.

The above discussion poses implications for future research including generating more qualitative and quantitative evidence on the impact of introductions on IPE and students' stereotypes. One area for future research is in regards to the introductions process and its relation to students' socialization and students' interactions. There is also a need to evaluate different approaches to group introductions and to explore and compare the impact of various approaches on IPE outcomes. Additional questions arising from these findings are: What constitutes an effective introduction process in an IPE setting? What might be the best format for the introduction process? When is it most effective to start the introductions process, in classroom face to face meeting or before classroom through online or social activity? What might the appropriate timeframes for the introductions process be? What type of information shall the students share to ensure that stereotypes and ethnocentric beliefs are not operationalized? Given how students and facilitators identified this introduction process as essential for building relationships and effective team work, understanding how to enhance this aspect of IPE is critical.

Facilitating Team Dynamics

The facilitator is responsible for facilitating team dynamics within an IPE setting yet, as the analysis revealed, this is dependent on the facilitator's knowledge and training. The literature identifies team dynamics as a challenge for IPE, and emphasizes the importance of faculty development programs to enhance the faculty members' ability to facilitate team dynamics among students (Buring et al., 2009). The analysis revealed that Dalhousie lacks a formal faculty

training for IPE facilitators. Therefore, it is crucial that Dalhousie initiates an IPE faculty development program. Even though Universities across Canada have implemented different IPE faculty development programs, there is limited evidence that supports the effectiveness of these initiatives (Eegan et al., 2011; Simmons et al., 2011; Watkins, 2016).

Buring et al. (2009) argues that IPE faculty development programs should enable facilitators, representing diverse health professions, to become competent in active learning methods, skilled in facilitating group dynamics, and knowledgeable about the roles of the various professions- preferably, prior to serving a facilitator role. Buring et al. (2009) also argued that it is important for training/faculty development programs to introduce facilitators to teaching methods appropriate for the IPE environment in contrast to the uni-professional approach. These programs are important towards ensuring that faculty members acquire the knowledge and skills needed to work and teach alongside other health profession course organizers, facilitators, and students within an IPE setting.

Facilitating team dynamics is a complex process that requires attention to interpersonal elements of the work groups. In a systematic review submitted for Health Canada, Oandnasen and Reeves (2005a) supported Barrows and Tomblin's (1980) Problem Based Learning theory to guide teaching strategies employed in IPE. In highlighting the importance of facilitators to the group work process, Barrows (1992) claimed that facilitators of small groups work should attend to students' metacognition and groups' interpersonal dynamics. Metacognition is a level of thinking where students learn about a problem and identify what they need to learn to deal with it. This requires that the facilitators deeply probe the students' knowledge and ensure that all students are involved in group discussions and work. Barrows (1992) suggested that facilitators use metacognitive approach in addressing problems related of interpersonal dynamics which

includes recognizing early cues of disrupted team dynamics including silence, sarcasm, a lack of participation in team discussions, arguments, taking sides on an issue, expressions of dissatisfaction with learning, or attempts by a student to dominate the group. Barrows (1992) also provides several detailed examples of approaches not only in assessing interpersonal dynamics but also toward engaging students to solve issues among themselves within the group. Barrows' (1992) approach has been implemented in group work in medicine and other health professions and may provide one theoretical approach to guide the role of facilitators and faculty development with IPE.

Study findings in relation to team dynamics also hold implications for future IPE research. Several questions arise in regards to these findings including: What should the content of IPE faculty development programs include? What frameworks should be employed to guide the development of these programs? What professions/disciplines are pivotal in structuring IPE faculty development programs? What might be appropriate teaching and learning methods to employ in these training programs? Future evaluative research of the effectiveness of the suggested program is integral to Dalhousie IPE program and to the Canadian literature on IPE faculty training. Given how students identified the skills of faculty members in facilitating team dynamics process as essential for effective team work, understanding how to enhance this aspect of IPE is critical.

Delivering Course Content

An analysis of the work process related to delivering course content at Dalhousie, revealed that course organizers prepare the course content and objectives based on their knowledge of the subject matter as well as collaborative competencies. However, findings also revealed that organizers might focus more on the course topic than on collaborative

competencies which creates a problem for the course content which does not align with the objectives of IPE. One question that arises from this study is: What should the objectives and content of the IPE program and IPE courses focus on?

A literature review conducted by Thistlethwaite (2012) revealed that most reviewed IPE activities lacked course objectives. The most common IPE objectives identified in the review included: teamwork, role differentiation, communication and awareness of differences in professionals' language, reflection on own relationship with the team, patient centred care, and perceptions and stereotypes of own profession and other professions. Accreditation bodies mandate that the objectives of IPE programs shall include a focus on team work and knowledge of professional roles (Thistlethwaite, 2012). However, the focus and objectives of IPE courses at Dalhousie lack consistency in regards to aim and objectives.

Findings of this study revealed that the stereotypes students hold can constitute a challenge for IPE. The analysis also showed the existence of several discourses at Dalhousie IPE program that contribute to the development and accentuation of students' stereotypes. The practice implications this holds is whether Dalhousie IPE program should adopt objectives and course content specific to addressing stereotypes. Even though, role clarification as a collaborative competency (CIHC, 2010) is an objective of some IPE courses at Dalhousie, attending to students' stereotypes encompasses more than role clarification. As such, several questions arise as how should stereotypes be addressed: How do students express stereotypes, and how can a facilitator identify when student stereotypes are operationalized? What would be the best teaching and/or learning methods to identify and address stereotypes? What course topics and activities might contribute to the operationalization of stereotypes? Who might the stakeholders and disciplines be to help answer these questions?

The analysis of this study also revealed that establishing human connection was identified as a pre-requisite to acquiring the collaborative competencies. This is a new finding that the published IPE literature does not specifically address. In addition, attending to human connection between students was not content considered with the IPE courses observed and analyzed in this study. It was proposed that this establishing of human connection can be incorporated within the objectives addressing the collaborative competencies: communication and patient centered care. Utilizing communication theories to guide this step of incorporation are integral to ensure that human connections are addressed. One communication theory proposed as guiding IPE framework was "Therapeutic Relationships" by Egan and Schroeder (2009). It was proposed that the first IPE activities that students, in their first year on their programs, engage in could focus on communication and patient centeredness to enable human connection with other team members and with patients. In these early stages in IPE courses and in students' own programs, students' knowledge about specific clinical conditions is limited and thus the topic of these early IPE activities can be any topic of human interest. As students progress in their programs and in IPE activities, other collaborative competencies (CIHC, 2010) or clinical issues can be added as course objectives, while maintaining communication and patient centered care as core competencies.

Historically IPE was introduced at the pre-licensure educational stage to ensure "collaborative practice-ready" (WHO, 2010, p.7) healthcare workforce. The definition of IPE reveals an inherent relation between IPE and practice where different professionals "learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010). In a systematic review by Reeves et al. (2016), the authors recognized that IPE contribute to interprofessional collaboration by improving students' attitudes and perceptions of one

another and increasing their knowledge and skills in collaborative competencies. However, Reeves et al. (2016) also acknowledged the limited evidence on whether IPE enabled collaborative practice in practice settings. The relationship between IPE and IPC is complex and not a straightforward one, and a gap still exists between the objectives of IPE programs in educational institutions and practice (Nynke, Albine, & Wiestske, 2017). Nyke et al. (2017) acknowledged the difficulty in aligning the educational programs to workplace reality and questioned how to optimally connect higher education and healthcare. The practice implications arising from an analysis of this work process include the importance of creating and sustaining a system that ensures the engagement between IPE programs and health care delivery systems. As such, IPE program decision makers at the FH, medicine, and dentistry need to uptake and integrate the idea of such a system into the vision and goals of the IPE program, Critical implications of this suggestion involve an equal dialogue between all stakeholders including IPE program decision makers, IPE coordinators, course organizers, facilitators, students, and representatives from practice settings.

Nyke et al. (2017) acknowledged that practice and workplace settings still do not always demonstrate best practice of IPC. Frenk et al. (2010) argued that when students are well-prepared and trained in collaboration, they could act as change agents once they join the practice setting and contribute to the development of the collaborative practice. Practice implications arising from this work process include the necessity of incorporating long term IPE goals that address students' contribution into collaborative practice once they join the workforce. IPE goals should also include outcomes that enhance knowledge of the subject matter and the CIHC collaborative competencies (CIHC, 2010). As such, it is crucial to utilize a theoretical framework to guide the development of the proposed goals. Currently, Dalhousie University adopts the CIHC (2010)

Collaborative Competency framework to guide the content of IPE courses, but does not adopt any theoretical framework(s) to guide the development of goals and content as well as the delivery of the IPE program. The literature describes limited utilization of theoretical frameworks in the Canadian IPE programs; and acknowledging the complexity of IPE education, proposes the utilization of educational, sociological, and psychological theories (Barr et al., 2012). Aligning teaching methods to meet the IPE program goals also necessitates considering the philosophy and theory behind selected teaching methods. One example of a theory which could be utilized is Fink's Adult Learning Theory. Fink's theory provides direction in relation to the development and delivery of IPE courses and this is a framework I have successfully used to design long term goals within the development of an IPE course at Dalhousie.

Findings also revealed that the dominance of the medical model language and practices shape the problematic of this study. The medical model of care is inherent in health professions' daily practices and languages and is embodied in students' perceptions and stereotypes. This discourse may be difficult to address, but there is a need to understand what collaborative practice looks like within the context of the medical model-specifically in promoting leadership and decision-making among all team members. The current language within the IPE course content reinforces the dominance and hegemony of the medical model, and the term "physician's order" is another discourse that is worthy of reconsidering to incorporate less hegemonic terms. Changing the language may not necessarily change the culture and practice. However, all of these hidden practices, texts and discourses that can reinforce negative stereotypes and impede IPC need to be examined and addressed.

The aim of IPE is to ensure "collaborative practice-ready" healthcare workforce, thus focusing IPE activities in practice settings may give students the chance to socialize, learn from,

with and about each other in practice setting. IPE in practice settings can provide an opportunity for students to explore and learn about the current practice of a medical model, discuss what would comprise an appropriate collaborative practice in these setting, and propose the most appropriate model of collaboration for the practice setting. IPE that takes place within the clinical setting may also narrow the education-practice gap and may provide a setting where students can start setting a personal vision that might meet future term goals of advocating and implementing a collaborative practice structure to replace the existing medical model.

The findings of this study hold several practice and research implications. Further understating what content IPE programs and courses should incorporate is crucial. In addition, there is a need to understand the effective balance between short term knowledge related goals and long term practice related goals. Several questions remain such as: Who are the stakeholders that need to contribute into the design of IPE programs vision and goals? What theoretical frameworks best guide this alignment? What is the best environment for IPE courses- practice or classroom settings? In addition, there needs to be commitment to measuring the contribution of IPE to collaborative practice outcomes-which is currently a significant gap in this field. Lastly, it is important that educational and practice institutions partner to both implement strategies to enhance pre and post licensure IPE and to research the critical questions that remain.

Strengths and Limitations

There are several strengths of the study design which contributed to the generation of a new understanding of the norms and the limits that shape facilitator's work in an IPE setting. These insights can be used to inform future changes and improvements in the IPE program. The methodology itself is designed to guide the examination and explication of ruling relations. Through interviews and catalytic validity meetings, facilitators dealt with questions about what

dictates the limitations of their work. As such, this study has engaged facilitators in a critical inquiry of their work process in relation to IPE which may be a means for future changes and improvements.

One of the strengths of the study was engaging myself as a researcher in as many possible IPE activities and in different capacities as facilitator and as student. Engaging in IPE activities gave me a deep appreciation of the similarities and differences of work processes across different IPE experiences. Through my engagement as a student, I could identify the situations and activities associated with development and accentuation of my stereotypes. These insights were pivotal in structuring my investigations. Another strength of my study was adopting the standpoint of facilitators in my investigation. This was reassuring for facilitators, and provided a level of comfort for them to share their work and ideas for improvement too.

Another strength was using a variety of data collection methods including living the experience of participants, observations, focus groups, and texts. Add to this, the methods employed to achieve rigor including reflexivity and catalytic validity all confirmed the findings, and started building in the findings by proposing changes and improvements. Even though there were challenges in recruiting students, the two students who participated were very cooperative and skilled in reflecting their own IPE experiences. They were willing and eager to discuss their concerns and suggestions with facilitators. The data that students provided was very well aligned with the data facilitators provided and this adds to the rigour of the study.

Although this institutional ethnography is well suited to guide this research inquiry there are several considerations to be recognized in relation to this methodology and methods. Institutional ethnography is not intended to show causation or be generalized to other populations. The findings from this study are not necessarily transferable to all IPE programs.

However, this research provides an in-depth, contextualized understanding of the limitations of an IPE program that does not currently exist in the published literature.

The limitations of this study were also dictated by the timeframes requirements associated with meeting master's degree. One limitation arising from the time constraints included the number of participants I interviewed and the types of IPE activities I investigated. For example, I did not investigate IPE activities employing online, high fidelity simulation, and embedded courses. Another limitation was associated with the translocal levels this study explicated which was identified to be the level of IPE coordinating committee. This was also determined to meet the expected timeframes of my degree requirements. Another limitation faced during the study was the difficulty in recruiting nursing student participants. I started with a target of six students and only succeeded to recruit two students despite of amendments to the recruitment process and providing compensations for their time.

Conclusion and Knowledge Translation

Several unique findings have arisen from this study including the importance of establishing human connection and a people centered approach within IPE. The study findings also identify a need for IPE facilitator training. As such, these findings have significance for the decision makers who set the vision and goals of IPE programs, IPE coordinators and committee members who plan the structure, processes, content and activities of the courses, the facilitators who facilitate students' learning, and the students engaged in IPE. The findings also have significance for stakeholders across related professions and representing academic and practice organizations who seek to ensure that IPE results in enhanced collaborative practice-optimizing patient and system outcomes. Future research must explore the best content and teaching methods to enhance IPE as well as evaluate outcomes on future collaborative practice.

In addition to the novelty of the findings, this study provided a unique approach to investigating a problematic associated with the Dalhousie IPE program experience- a problematic also identified as a challenge to IPE in the literature. This institutional ethnography provides a unique understanding of how institutional relations and discourses shape students stereotypes as a problematic for IPE. The different categories of participants provided an understanding of the work processes and discourses that take place at different levels of the institution (IPE program). Facilitator and student participants provided an understanding of how institutional relations are embodied into both facilitators' work and students' perceptions. This methodological approach helped to uncover some of the institutional determinants of the problematic of this study and facilitators were empowered by this knowledge to identify several strategies to address their dissatisfaction with the existing institutional work. This uncovering is a part of the knowledge translation of this research. When facilitators gained an understanding of the institutional translocal limitations of their work, they provided more suggestions for changes and improvements in the institutional processes and pedagogical practices.

Continuation of the knowledge translation of this study will include sharing the findings from this inquiry with other facilitators in the IPE program in a form of workshop. Guided by critical theory which calls for action by participants, the second stage of knowledge translation will include a workshop to be organized and coordinated by the research team and the facilitators and student participants of this study, along with representatives from practice settings and education departments. The audience of the workshop will include the facilitators of the IPE program and students from a variety of different professions. The workshop will aim to share the research findings and uncover the translocal work processes that limit the facilitator's work. The expected outcome is that the audience will provide ideas and suggestions for future IPE

improvement. As an anticipated deliverable, a list of suggestions, recommendations, and plans for future IPE curriculum development will be prepared and submitted to the Faculty of Health. This knowledge translation aims to advocate for and promote this critical approach to address the problematic identified. Other forms of knowledge translation will include peer reviewed publication and presentation of my findings at local and national conferences, including other universities with IPE programs. Dissemination of the findings using a critical approach may assist all stakeholders to engage in a multidisciplinary collaborative approach to develop and deliver IPE programs which can enhance not only collaborative practice, but also patient and organizational outcomes.

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Appendix A

Recruiting Script- Nursing Student

Hello, my name is Nadine Ezzeddine. I am a graduate student at the Dalhousie University School of Nursing. I am conducting a research on the organization of the interprofessional education (IPE) program at Dalhousie University. I am inviting you to participate in this study because you are currently enrolled in the nursing program and have participated in at least four IPE activities including face to face and simulation.

Participation in this research includes participation in two focus groups.

1. The first focus group includes you and 5 to 9 other nursing students, and this will take approximately 45 -60 minutes.
   During the first focus group, your perceptions of nursing as a profession and other health professions will be discussed briefly. Discussions will focus on the impact of the IPE you experience on the perceptions you hold.

2. The second focus group includes two to three nursing students (from the first focus group) and an IPE facilitator. This will take approximately 45-60 minutes.
   During this focus group, you will be asked to reflect on the first focus group discussions. You will be presenting, to the facilitator, how a specific IPE interaction impacted the perceptions you hold. Then you and the facilitator will discuss these specific IPE interactions and come up with recommendations for change if needed.

If you participate in both focus groups, your total time of commitment will be between 90-120 minutes.

As a compensation, you will receive a $10 gift card to Starbucks at the time of the first focus group, and a $15 gift card to Starbucks at the time of the second interview.

If you have any questions or would like to participate in the research, I can be reached at *902-412-2609* or *nadine.ezzeddine@dal.ca*

Appendix B

Recruiting Script- Facilitator

Hello, my name is Nadine Ezzeddine. I am a graduate student in the Dalhousie University School of Nursing, and my supervisor is Dr. Sheri Price. I am conducting a qualitative research study, investigating the social organization of the interprofessional education program at Dalhousie University. This involves exploring how the IPE interactions and teaching methods are organized, and what texts (policies, frameworks, etc…) dictate this organization.

I am inviting you to participate because you, as facilitator of a current IPE experience at Dalhousie, have participated in the development and implementation of either a face to face/blended or a simulation IPE experience at Dalhousie University. As a facilitator, you know how the IPE experience is organized, and what texts inform the planning and facilitation of the work you do, which my study will be investigating.

This study employs the following methods of data collection: observations, interviews, focus groups and texts. Your participation in this study involves participation in any one method or any combination of the data collection methods. For instance, you can choose to participate in only one method, or in any two methods, or in the three methods. I encourage you to participate in the three methods, since this is more efficient for me as researcher, but the decision is totally yours.

1) Observations include myself, as main researcher, observing an IPE experience where you are a facilitator. I will be asking few questions after the observation, which will take 30 minutes.
2) Interviews will focus on the work you do upon developing and facilitating an IPE experience, and the documents (like policies and frameworks) that guide your work. Interviews will take 90-120 minutes.
3) A focus group will involve one facilitator and two to three nursing students and will focus on how the work of the IPE facilitator intersects with contributions made by students – contributions shaped by the stereotypes students hold. Facilitator and students are expected to suggest recommendations for change if needed. Each focus group will take 60-90 minutes.
4) During observations, interviews, and focus groups, I will be asking about associated documents and texts such as policies, course syllabi, and requesting copies for further analysis.

If you approve to participate in both observation(s) and interview, the questions about the observations will be incorporated during the interview, and your time commitment (for interviews related to interviews and observation) will be 90-120 minutes.

If you approve to participate in the three methods of data collection: observations, interview, and focus group, your total time commitment will be between 2.5 –3.5 hrs.

If you have any questions or would like to participate in the research, I can be reached at 902-412-2609 or ezzeddine.nadine@dal.ca.

Appendix C

Recruiting Script – committee member

Hello, my name is Nadine Ezzeddine. I am a graduate student at Dalhousie University School of Nursing, my supervisor is Dr. Sheri Price. I am conducting a qualitative research study investigating the social organization of the interprofessional education program at Dalhousie University. This involves exploring how the IPE interactions and teaching methods are organized, and what texts (policies, frameworks, etc…) dictate this.

I am inviting you to participate because you are a member of a committee involved in setting the guiding rules and texts that organize the IPE activity at Dalhousie University.

Participation in this research includes participation in an interview. The interview focuses on the texts and documents that determine the development and implementation of IPE experiences at Dalhousie University. The texts may include policies, guidelines, frameworks, and memos. You will be asked to explain how texts circulate (from your committee) to other committees and to IPE facilitators. Questions will also address the criteria for designing these texts, and all the personnel involved in the circulation of these texts. Moreover, I will be asking to retain copies of the texts for further analysis.

This will take approximately 60-90 minutes.

If you have any questions or would like to participate in the research, I can be reached at 902-412-2609 or nadine.ezzeddine@dal.ca.

Appendix D

Observations Guide:

Observations in institutional ethnography are conducted for with two objectives, 1) to identify the work done and explore how the activities are sequenced and organized, and 2) to understand what determines this organization of activities.

I will be observing facilitators during their work facilitating an IPE experience. I will be observing over the whole session; observations may include more than one session, an issue that will be agreed upon with the facilitator.

I will be observing and taking note (without any intervention) of each activity the facilitator engages in and the sequence of the activities.

Questions post interview will include:

1. Try to describe the activities you facilitated in the IPE experience. Why did you choose these activates?
2. What work did you do in preparation of these activities? What guidelines, references, and polices did you utilize upon preparing these activities? Who was involved in the preparation? Which IPE committee did you report to?
3. Do you think any of the activities you facilitated address the stereotypes students hold (about their own profession or other professions)? If so, why did you chose an activity that addresses student stereotypes? How do you determine that the activity addresses stereotypes? What references, guiding rules and texts determine that? Who prepared these texts and where?
4. What happens after you finish the IPE session? IPE experience? Do you communicate with any one, and department or any committee? What means do you communicate through? Describe the process of reporting and the documents utilized.
   I will also ask for access to the policies, forms, guidelines and all documents identified.

Appendix E

Interview Guide- Facilitator

The facilitator (faculty member) is informed about the study and the study process. Informed consent in attained in a previous meeting where the study is introduced

I would like to ask you few questions about the processes of preparing and facilitating an IPE experience. Questions will also explore the link you make between facilitating students' IPE experience and the policies and rules that govern preparing and facilitating the IPE program at Dalhousie University.

I will be seeking detailed account of the work processes.

1. Selection of facilitator and topic:
    a. Policy of selection a facilitator: Who can become a facilitator for an IPE experience? What are the required credentials? Which texts specify that? Who provided these texts?
    b. Procedure you went through in being selected/approved as an IPE experience facilitator.
    Describe whom did you communicate with when you were selected/applied to prepare an IPE course? In what form was this communication conducted (emails, phone, meetings. application,..)? What were main questions you asked, and were asked?
    c. People involved in the selection/ approval process. Whom did you communicate / sought approval from in your department, in the IPE program, or from an IPE committee? Which IPE committee did you report to?
    d. Place: describe the meeting locations, and the level of the people involved in this process? (track texts to whatever translocal level)
    e. Texts: What texts guided you in all these steps? How did you get access to these texts? Who was responsible for each of the processes identified in the texts?
2. IPE Course Content:
    a. Policy: what are the objectives of the course? How did you determine these objectives? What text guided you in this? Who provided the text? Who clarified the text?
    b. People: Who was involved in preparation of the course and how? How did they get involved? Who in your department and in the IPE program was involved in preparation or approval? Who in the IPE program was involved in preparation and approval? Which IPE committee did you communicate with? Any texts involved in the communication?
    c. Procedure: how was the course material prepared? Whom did you consult with if any? Who approved the content? Whom did you communicate with as you were preparing the course? Who approved the course and how? What texts were employed?
    d. Place: at which level did each process take place? And at what levels were the texts originally prepared? What levels where they utilized?

3. Learning/teaching methods:
    a. Policy: what teaching methods did you employ? What determines what teaching methods you used? What text? Who was involved in selection of the teaching methods? Why were these teaching methods selected? When, during the preparation of the course, were the teaching methods selected? Did you need approval? From whom? How? What texts?
    b. People: who was involved in the selection of the teaching methods? Who was invovled in the preparation of the teaching methods? Who was involved in the approvals?
    c. Procedure: describe how where the teaching methods selected? How you decided at which stage of the course to employ them? What part of the content was covered by each teaching method? How did you determine that? What is the role of the student is the preparation of your teaching methods? How do you assess students' input? How do you evaluate students' knowledge acquired and How do you structure activities to ensure student's input?
    d. Texts: list of all texts involved? Where do these texts originate? What is the cycle of the texts?
    e. Place: at what level where the processes and communications taking place
4. Did you have any training? What were the objectives of the training? How did the training go? When was it conducted? Who led the training? What texts did you use?
5. Student stereotypes: have you ever been faced with a situation where interactions between students were impaired because of some stereotypes students hold? If not
    a. Policy: is there any existing policy or guidelines regarding the stereotypes students hold? How are these addressed in the IPE context?
    In case these do not exist, then how do you think that the stereotypes students hold should be addressed? How do you identify these situations? Do the objectives of your course address the stereotypes students hold (explicitly or hidden)?
    b. In case you were faced with such a situation, what was your response? Why? What determined your response? How did you evaluate students' change in perception later?

Common questions about texts:

1. How do the texts come to you and where it does go after you are done with it.
2. What do you need to know in order to use the text (create it, respond to it, fill it out, and so on)
3. What do you do with, for, and on account of the text?
4. How the text intersects with and depends on other texts and textual processes as sources of information, generators of conceptual frames, authorizing texts, and so on.
5. The conceptual framework that organizes the text and its competent reading

Appendix F

Interview Guide- Committee Member Representatives

Interview with committee members will focus on focus on the role of the committee and on the texts and documents which the committee issues and utilizes. Interview with committee representative will take place after observations, interviews and focus groups with facilitators and students done. Relevant documents identified through observations and interviews might be brought into the meeting and you will be asked about the role of the committee in these documents.

I will ask:

1. Can you please describe the role of your committee and the major process your committee engage in? Can you please identify any related documents?
2. What documents and texts does your committee issue and employ? How do texts and documents circulate between this committee and other committee, and between this committee and facilitators?
3. What is the relation between your committee and the work done by facilitators upon developing and implementing an IPE activity? What are the related documents?

   The following questions will be asked regarding the texts identified that are related to the work of facilitators:
4. How the texts comes to you and where it does go after you are done with it.
5. What do you need to know in order to use the text (create it, respond to it, fill it out, and so on)
6. What do you do with, for, and on account of the text?
7. How the text intersects with and depends on other texts and textual processes as sources of information, generators of conceptual frames, authorizing texts, and so on.
   The conceptual framework that organizes the text and its competent reading

Appendix G

Interview Guide- Focus group 1

The first focus group will include six to ten nursing students you are currently enrolled in the nursing program and have participated in at least four IPE activities including face to face and simulation."

I would like to ask you about the IPE experiences you have had, your perceptions of nursing as a profession and other health professions, and will focus on how the IPE experiences you have had impacted the perceptions you hold.

1. Can you describe what type of IPE experience you had? When? What teaching methods were utilized (face to face, online, simulation)? What were the topics? Which other health profession students where involved?

2. Would you please describe your perception of the nursing profession, nursing students, and practicing nurses? So choose one health profession, would you please describe your perceptions of this profession, the students, and professionals? Compare the traits you identified to your perception of nursing.
   Can you identify where, when and how you acquired these perception? What life or professional experience dictated that?
3. Identify an IPE experience that addressed students' perceptions of health professions' roles. Can we focus on the health profession you just identified, did the IPE experience address the roles of nursing and those of that specific profession? When? How and what learning methods were you engaged in? Describe the team composition? What happened in that IPE experience? How did you learn about the roles of other professions during that experience? What did you learn? Describe the documents used? Describe the dynamics and interactions with the facilitator and other group members? Any conflict arose, or difference in opinion? How was that resolved?
4. What do you think the activities that the facilitator employed to clarify the health professions' roles were? Why did she/he use that method? How effective was that in changing your own perceptions? Do these perceptions change when the environment change, like in the hospital setting?

Appendix H

Interview Guide- Focus group 2

Main points of focus group 1 will be presented by the students.

The students will elaborate on their experiences with IPE interactions where stereotypes are expressed.

They will identify how their thinking process and input into group discussions intersected with the planned activities of the IPE experience, the sequence of events determined by the facilitators, and the time frames specific for each activity.

The facilitators will be asked how their planned activities intended to achieve.

The both will debrief how the intersection of their input shaped the IPE interactions.

Both will come up with recommendations for improvement.

Appendix I

Health Sciences Research Ethics Board Letter of Approval

Health Sciences Research Ethics Board

Letter of Approval

January 24, 2017

Nadine Ezzeddine

Health Professions\Nursing

Dear Nadine,

REB #: Project Title:

Effective Date: Expiry Date:

2016-4069 The Social Organization of an Interprofessional Education Program

January 23, 2017 January 23, 2018

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans.* This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Tannis Jurgens, Chair

Appendix J

CONSENT FORM- Facilitator

Project title: The Social Organization of an Interprofessional Education Program

Lead researcher: Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, nadine.ezzeddine@dal.ca, 902-412-2609

Other researchers
Dr. Sheri Price, Dalhousie School of Nursing, pricesl@dal.ca, 902-494-8831

Funding provided by: Nursing Research and Development Fund.

Introduction

You are invited to take part in a research study being conducted by Nadine Ezzeddine, a student at Dalhousie University as part of a Master of Nursing degree program. The work of this study is supervised by Dr. Sheri Price, assistant professor at the Dalhousie University School of Nursing. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your employment if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with Nadine Ezzeddine. Please ask as many questions as you like. If you have questions later, please contact Nadine Ezzeddine at nadine.ezzeddine@dal.ca, 902-412-2609. You may also contact Dr. Sheri Price at pricesl@dal.ca, 902-494-8831.

Purpose and Outline of the Research Study

This study aims to investigate what determines the interprofessional interactions that take place within the interprofessional education (IPE) program at the Dalhousie University. Two factors play an important role in shaping the IPE interactions taking place at any IPE setting. The first is the work done by the facilitators, which is determined by the IPE program set policies, rules, and documents. The second is how the students' input shapes IPE interactions. Students' input is informed by the perceptions and stereotypes they hold about their own profession and other health professions. This study will be investigating these two factors of the IPE program at Dalhousie University: 1) the institutional policies, rules, and documents that organize the facilitators' work, and 2) how the students' held stereotypes shape IPE interactions.

The data will be collected from three sources including facilitators, nursing students, and the IPE program committees. The data will be collected through observations, interviews, focus groups, and texts.
The data analysis will be conducted concurrently with data collection to provide a series of visual diagrams that illustrate the factors that organize the IPE experience.

Who Can Take Part in the Research Study?

You may participate in this study if you are a faculty member who 1) also holds title of facilitator in the IPE program at Dalhousie, 2) whose role in IPE program at Dalhousie University includes planning and facilitating a current IPE experience, 2) who employ at least one of the following teaching methods: Face to face/ blended and simulation, and 3) whose IPE experience addresses nursing students.

Data collection will take part using: observations, interviews, focus groups and texts. Each method will be associated with questions about the documents shaping your work. As a participant, you may choose to participate in one, two, or the three data collection methods. I encourage you to participate in the three methods, as this would be more efficient for me as a researcher, but the choice is totally yours. You are encouraged to consider the risks and benefits prior to your decision, which are explained below.

Screening criteria:

1) I will screen facilitators based on the teaching methods they employ, so that I have one facilitator who has employed face to face/blended and one facilitator who has employed simulation teaching method.
2) For the observations, I will screen facilitators so that I will have the chance to observe their work within the timeframe up until April2017, the timeframe for data collection of this study.

I encourage you to participate in more than one data collection method. I need to observe the work of two facilitators (one employing face to face/blended and one employing simulation IPE experience), interview two facilitators (one employing face to face /blended and one employing simulation IPE experience), and engage two facilitators in focus group discussions (also employing simulation IPE experience). As a participant, you may choose to participate in one, two, or the three data collection methods, I encourage you to participate in the three methods, as this would be more efficient for me as a researcher, but the choice is totally yours. You are encouraged to consider the risks and benefits prior to your decision, which are explained below.

Through the initial contact, you will identify the teaching method you employ and would accept to have me investigate. You will also identify which data collection method (s) you will be participating in. I encourage you to participate in more than one data collection method and this will be render the study more efficient.

What You Will Be Asked to Do

In the frame of this study, one observation, one interview, and one focus group will take place. You can choose to participate in one, two or three of these methods.

1. During observations, I will be observing you facilitating either face to face/blended or a simulation IPE activity. My observations will include at least one classroom session (for face to face/blended IPE experience) and at least one laboratory session (for simulation

IPE experience). We will agree before time which session(s) will be more convenient for you.

I will be observing over the whole classroom (for face to face/blended) or laboratory (for simulation) session. I will be focusing on the activities taking place, teaching methods employed, and educational material presented. I will be observing and taking notes (without any intervention) of the activities you facilitate.

I will be asking questions post the interview regarding the activities performed, how you planned them, what documents (references or policies) you used, who was involved in preparing these activities, and the IPE committees you communicated with. I will also ask who you report to after the IPE experience is over, what do you report and what documents dictate this process. I will be requesting access for the identified documents. Answering these questions will take 30 minutes.

2. If you agree to participate in interviews, during the interviews you will be asked about your work planning, preparing, and delivering either face to face/blended or simulation IPE activity. Questions will also address the documents, policies and rules that regulate the planning, preparing and delivering processes. I will be asking for clarification of these documents, where they come from, how they circulate, and who they address.

   You will also be asked whether you have facilitated any IPE interaction where students expressed stereotypes about their own or other health professions. You will be asked to describe how you reacted and what informed your reactions.

   The interviews will take place in your office because it would be more convenient to access documents. Interviews will take 90-120 minutes.

3. The focus group will take place in a quiet setting, one of the collaborative study areas in CHEB. The focus group will take 60-90 minutes.

   The focus group will include you as a facilitator and two to three nursing students. These students might be participating in an IPE experience you are currently facilitating. Also, these students have already participated in a focus group, as part of this study, in this focus group they will reflect on the discussions they had in the previous focus group. During this focus group, the students will reflect on an IPE interaction that was shaped by their held stereotypes. Students will also reflect how helpful were the teaching methods employed in addressing their stereotypes. Both, students and facilitators, will be able to identify how the interaction between the teaching methods and the expressed stereotypes took place and what the outcomes were. Then both facilitators and students will agree on recommendations that can inform future planning of teaching methods.

Possible Benefits, Risks and Discomforts

Benefits:

The benefit of this study is in uncovering some of the factors that determine the investigated IPE activities, namely the activities problematized by the stereotypes students hold. This provides you with the knowledge you need to identify the factors that shape the work you do. The focus group will provide you with recommendations that are beneficial for future planning of IPE experiences and policies. Moreover, you will be equipped with knowledge and recommendations to call for changes of the IPE program policies to meet your needs and the individual needs of your students.

Risk:

The risk associated with this study are minimal.

You may feel discomfort or fatigue during the interview which may last up to 120 minutes. I will be offering light refreshments.

You may feel uncomfortable explaining the work you do and explaining why you do it in specific way. You may also feel uncomfortable participating in a focus group with students reflecting on an IPE experience you organized. This is addressed in institutional ethnography where myself as researcher will be adopting the standpoint of facilitators. Please note that this study explores institutional processes and not your own performance. Thus, during interviews and focus groups I will refrain from employing judgmental language and blame but will rather approach you as your partner. Also, the focus group with students is an opportunity to hear from students and understand the students' experience in a nonjudgmental setting that can inform future IPE experience preparation.

Compensation / Reimbursement

You will not have any cost from participating in this study. You will not be compensated for participating in this study.

How your information will be protected

Privacy: the interviews and focus groups will take place in a place where others will not see or hear. At the time of interview, only my supervisor and I would be aware of who will be interviewed.

Anonymity: Based on the subjective and interactive nature of this inquiry, anonymity cannot be assured as you will be known to me as the researcher and to my supervisor. Also, participants in the focus group will identify who you are. This will be addressed by assigning every participant a pseudonym. I will not email your identifying information to anyone at any time. I will not use your identifying information in reports, presentations, or publications. Only myself as principle investigator and my supervisor will see the records.

Confidentiality: Given the nature of this study and the use of focus groups, absolute/complete confidentiality cannot be assured. However, I will be employing several strategies to ensure confidentiality when able.

- I will be assigning you a pseudonym which will be used for all documents including the audio files, transcripts, computer files, field notes, publications or presentations.
- I will also remove your name and other identifying information from all papers and will keep them separate from the data.
- I will separate the consent forms including your name from other data or transcripts in a locked cabinet in a locked office within a securely locked building. Only one file that shows the link of pseudonyms real names will exist, and it will be stored separately from data, in a locked cabinet in a secure office and building.
- The interviews will be audio taped and transcribed and coded. Identifying information will not be emailed to anyone at any time. All data, including tapes, transcripts, field notes, demographic forms, and computer disks will be kept in a locked filing cabinet in a locked location, and all computer/electronic files will be password protected, which can only be accessed by myself and my supervisor.
- In addition, within the focus groups, I will ask all participants to keep the discussion confidential and not talk about who participated or what was discussed. However, I cannot guarantee that confidentiality will be maintained by other participants.
- I will erase audiotapes after the discussion has been transcribed and analysis is complete. All paper files related to the study with identifying information will be held for at least 5 years post-publication (Dalhousie University requirements), and then be destroyed/shredded.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to two weeks (after each piece of data is collected) if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be anonymized and analyzed.

How to Obtain Results

You will be invited to attend the dissertation defense where the study, results and discussion will be presented. You can have access to the thesis by accessing the dissertations and thesis database at Dalhousie libraries once it is uploaded. If you wish to receive a copy of the final report for this study, please provide an email or
Mailing address where you would like the results sent. Moreover, I will be more than happy to present and discuss the findings with you in person. In this case I will need you to contact me for that.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Nadine Ezzeddine at 902-412-2609, Nadine.ezzeddine@dal.ca) or Dr. Sheri Price at 902 494-8831, picesl@dal.ca)] at any time with questions, comments, or concerns about the research study (if you are calling long distance, please call collect). We will also tell you if any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 20XX-XXXX)."

Other

This study has attained approval from the Undergraduate Nursing Program and the Nursing Research committee at Dalhousie University for recruiting nursing students.
This study also attained approval from the IPE program at Dalhousie University to recruit facilitators and committee members.

Signature Page- Observation

Project Title: The Social Organization of an Interprofessional Education Program

Lead Researcher: [Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, 902-412-2609, nadine.ezzeddine@dal.ca]

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an observation. I choose to participate in an observation.

I understand that the observation will occur at an IPE experience I will be facilitating employing _____ teaching method. I understand that notes about the work I will be doing and about interactions will be recorded. I also understand that I will be asked about the work observed and the related documents and texts and that I will be asked to provide the researcher with access to those documents. I understand that information I will be giving will be investigated without identifying me. I agree to take part in an observation. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 3 weeks after the observation.

_____ _____ _____"

Name Signature Date

Signature Page- Interview

Project Title: The Social Organization of an Interprofessional Education Program

Lead Researcher: [Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, 902-412-2609, nadine.ezzeddine@dal.ca]

"I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an interview which is 90-120 minutes long. I choose to participate in an interview.

I understand that I am interviewed regarding the work I do in development and implementation of an IPE experience while employing _____ teaching method. I also understand that I will be asked about the documents I utilize when preparing and delivering an IPE experience, and that I will be asked to provide the researcher with access to those document.

I understand that my participation will occur at a location acceptable to me, and that those interviews will be recorded. I understand direct quotes of things I say may be used without identifying me. I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 2 weeks after my interview is completed.

_____ _____ _____"

Name Signature Date

Signature Page- Focus group

Project Title: The Social Organization of an Interprofessional Education Program

Lead Researcher: [Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, 902-412-2609, nadine.ezzeddine@dal.ca]

"I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in a focus group which is 60-90 minutes long. I choose to participate in an interview.

I understand that my participation will occur at a location acceptable to me, and that focus group will include nursing students, and that the focus group discussions will be recorded. I understand direct quotes of things I say may be used without identifying me. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 2 weeks after focus group is completed.

_____	_____	_____"
Name	Signature	Date

Appendix K

CONSENT FORM – Nursing Student

Project title: The Social Organization of an Interprofessional Education Program

Lead researcher: Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, nadine.ezzeddine@dal.ca, 902-412-2609

Other researchers
Dr. Sheri Price, Dalhousie School of Nursing, pricesl@dal.ca, 902-494-8831

Funding provided by: Nursing Research and Development Fund

Introduction

You are invited to take part in a research study being conducted by Nadine Ezzeddine, a student at Dalhousie University as part of a Master of Nursing degree program. The work of this study is supervised by Dr. Sheri Price, assistant professor at the Dalhousie University School of Nursing. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your studies if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with Nadine Ezzeddine. Please ask as many questions as you like. If you have questions later, please contact Nadine Ezzeddine at nadine.ezzeddine@dal.ca, 902-412-2609

Purpose and Outline of the Research Study

This study aims to investigate the interprofessional education program at Dalhousie University. The study will focus on the interactions that take place during an IPE experience. Two factors determine what takes place during an IPE interaction: 1) the work planned and done by facilitators, and 2) students' input into the IPE interactions. IPE facilitators are faculty members of the Faculty of Health Professions, who have participated in the development and implementation of one or more current IPE experience at Dalhousie University. Facilitators' work is achieved by following the instructions and policies set by the people in charge of the IPE program. Students' input during an IPE interaction is partly determined by the planned flow of the IPE activity, but mostly by the perceptions students hold. Perceptions that students hold about their own profession and about other health professions, determine students' input into IPE interactions. This study will be investigating: 1) the policies, rules, and documents that organize the facilitators' work, and 2) how the students' held perceptions shape the IPE interactions.

The data will be collected from three sources including facilitators, nursing students, and the IPE program committees. The data will be collected through observations, interviews, focus groups, and texts.

Who Can Take Part in the Research Study?

You may participate in this study if 1) are currently enrolled in the nursing program and 2) have participated in at least four IPE activities including face to face and simulation activities. You will be asked to participate in two focus groups. The first focus group is with other five to nine nursing students. The second focus group is with other two to three nursing students (members of first focus group) and one facilitator (who is faculty member who facilitates an IPE experience). In case you are currently engaged in an IPE experience led by a facilitator participating in your focus group, this does not affect your eligibility to participate in the focus group.

What You Will Be Asked to Do

In the frame of this study, you will be asked to participate in two focus groups. Focus groups will take place in a quiet setting, one of collaborative study areas in *Collaborative Health Education Building* (CHEB). Each focus group will take 60-90 minutes.

Your participation involves participating in two types of focus groups. One includes nursing students alone, and the second includes one facilitator and two to three nursing students.

- The first focus group will take place with other nursing students, for a total of six to ten nursing students. During the first focus group, participants' perceptions of nursing as a profession and other health professions will be discussed briefly. Discussions will focus on how the IPE interactions you had impacted the perceptions you hold.
- The second focus group involves one facilitator and two to three nursing students (from the first focus group). During this focus group, you will reflect on the first focus group discussions. You will be presenting to the facilitator how a specific IPE interaction influenced the perceptions you hold. Then students and the facilitator will discuss these specific IPE interactions and come up with recommendations for change if needed.

Possible Benefits, Risks and Discomforts

Risk:

The risk associated with this study are minimal.

You may feel discomfort or fatigue during the focus group which may last up to 90 minutes. I will be providing light refreshments.

You may feel discomfort explaining and reflecting on your perceptions of your profession and other health professions. You may feel challenged to identify the impact of the IPE experience you had on your perceptions, or to identify how your perceptions shaped the IPE interaction. You may also feel discomfort participating in a focus group with a facilitator reflecting to him/her the impact of an IPE activity he/she designed.

I need to emphasize that your participation is voluntary. I have already attained approval for recruiting students from Nursing Research Committee and I assure you your input does not influence your academic evaluation. Please be comfortable that there is no right or wrong answer, and that your participation is not an evaluation of their IPE work. Your participation and input will help in improvement of IPE. And please be sure you will never be identified through the data you provide.

Benefits:

There may be no direct benefit for you at this level.
However, the focus group and investigation of your perceptions might be a good experience for you to identify your own learning needs.

The joint activity of reflecting face to face to a facilitator and working jointly with him/her to establish recommendations for change in IPE program is empowering. This equips you with the knowledge of and skills to contribute into structuring of your own learning experience.

Compensation / Reimbursement

Your participation in this study may result in parking or transportation cost.

You will be compensated with a $10 gift card to Starbucks that you will receive at the time of the first focus group, and a $15 gift card that you will receive at the time of the second focus group.

How your information will be protected

Privacy: the focus groups will take place in a place where others will not see or hear. At the time of focus group, only my supervisor and I would be aware who is participating.

Anonymity: Based on the subjective and interactive nature of this inquiry, anonymity cannot be assured as you will be known to the researcher and supervisor. Also, participants in the focus group will identify who you are. This will be addressed by assigning you a pseudonym. I will not email your identifying information to anyone at any time. I will not use your identifying information in reports, presentations, or publications. Only myself as principle investigator and my supervisor will see the records.

Confidentiality: Given the nature of this study and the use of focus groups, absolute/complete confidentiality can be assured in observation and interviews but not in focus groups, as participants may share the discussions outside the focus group. However, I will be employing several strategies to ensure confidentiality.

- I will be assigning you a pseudonym which will be used for all documents including the audio files, transcripts, computer files, field notes, publications or presentations.
- I will also remove your name and other identifying information from all papers and will be keep them separate from the data.
- I will separate the consent forms including your name from other data or transcripts in a

locked cabinet in a locked office within a securely locked building. Only one file that shows the link of pseudonyms real names will exist, and it will be stored separately from data, in a locked cabinet in a secure office and building.

- The interviews will be audio taped and transcribed and coded. All data, including tapes, transcripts, field notes, demographic forms, and computer disks will be kept in a locked filing cabinet in a locked location, and all computer/electronic files will be password protected, which can only be accessed by myself and my supervisor.
- In addition, within the focus groups, I will ask all participants to keep the discussion confidential and not talk about who participated or what was discussed. However, I cannot guarantee that confidentiality will be maintained by other participants.
- I will erase audiotapes after the discussion has been transcribed and analysis is complete. All paper files related to the study with identifying information will be held for at least 5 years post-publication (Dalhousie University requirements), and then be destroyed/shredded.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to two weeks (after each piece of data is collected) if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be anonymized and analyzed.

How to Obtain Results

We will be invited to attend the dissertation defense where the whole work is presented. You can have access to the thesis by accessing the dissertations and thesis database at Dalhousie libraries once it is uploaded. If you wish to receive a copy of the final report for this study, please provide an email or
mailing address where you would like the results sent. I will be more than happy to present and discuss the findings with you in person. In this case I will need you to contact me for that.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Nadine Ezzeddine at 902-412-2609, Nadine.ezzeddine@dal.ca) or Dr. Sheri Price at 902 494-8831, picesl@dal.ca)] at any time with questions, comments, or concerns about the research study (if you are calling long distance, please call collect). We will also tell you if any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 20XX-XXXX)."

Other

This study have attained approval from the Nursing Research Committee for recruiting nursing students.

Signature Page

Project Title: The Social Organization of an Interprofessional Education Program

Lead Researcher: [Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, 902-412-2609, nadine.ezzeddine@dal.ca]

"I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in two focus groups: 1) focus group with other five to nine nursing students, which takes 60 to 90 min., and 2) focus group with other two nursing students and one IPE facilitator which takes 60-90 minutes. I choose to participate in the two focus groups.

I understand that my participation will occur at a location acceptable to me, and that the first focus group will include six to ten nursing students and the second will include another two to three nursing student and one facilitator, and that the focus group discussions will be recorded. I understand that direct quotes of things I say may be used without identifying me. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 2 weeks after each focus group is completed.

_____	_____	_____"
Name	Signature	Date

Appendix L

Consent Form – Committee Member

Project title: The Social Organization of an Interprofessional Education Program

Lead researcher: Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, nadine.ezzeddine@dal.ca, 902-412-2609

Other researchers
Dr. Sheri Price, Dalhousie School of Nursing, pricesl@dal.ca, 902-494-8831

Funding provided by: Nursing Research and development Fund

Introduction

You are invited to take part in a research study being conducted by Nadine Ezzeddine, a student at Dalhousie University as part of a Master of Nursing degree program. The work of this study is supervised by Dr. Sheri Price, assistant professor at the Dalhousie University School of Nursing. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your studies if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with Nadine Ezzeddine. Please ask as many questions as you like. If you have questions later, please contact Nadine Ezzeddine at nadine.ezzeddine@dal.ca, 902-412-2609

Purpose and Outline of the Research Study

This study aims to investigate the interprofessional education program at Dalhousie University. The study will focus on the interactions that take place during an IPE experience. Two factors determine what takes place during an IPE interaction: 1) the work planned and done by facilitators, and 2) students' input into the IPE interactions. IPE facilitators are faculty members of the Faculty of Health Professions, who have participated in development and implementation of one or more current IPE experience at Dalhousie University. Facilitators' work is achieved by following the instructions and policies set by the people in charge of the IPE program. Students' input during an IPE interaction is partly determined by the planned flow of the IPE activity, but mostly by the perceptions these students hold. Perceptions that students hold about their own profession and about other health professions play determine students' input into IPE interactions. Thus, this study will be investigating these two factors: 1) the policies, rules, and documents that organize the facilitators' work, and 2) how the students' held perceptions shape the IPE interactions.

The data will be collected from three sources including facilitators, nursing students, and the IPE program committees. The data will be collected through 1) observations, 2) interviews, 3) focus groups.

Who Can Take Part in the Research Study?

You may participate in this study if you are currently a member if any of the following three committees: IPE governance committee, IPE operations committee, and IPE executive advisory committee.
You will be asked to participate in an interview which will take 60-90 minutes.

What You Will Be Asked to Do

In the frame of this study, you will be asked to participate in one interview. The interview will focus on the texts and documents which the committee (you represent) issue and utilize. For example, For example, texts may include committees' terms of reference, IPE program policies, frameworks, IPE courses application forms, IPE courses' approval and evaluation forms, facilitator's training material, facilitator's evaluations, and the IPE program plan.

The interview will ask about the role of this committee, and the nature of documents the committee utilizes. Questions will focus on what type of texts the committee deals with, where the documents circulate, and who is involved. Interviews will address all the work done around the texts. You will also be asked how the texts you use intersect with or depend on other texts in same location or other locations. I will be asking for copies of the texts for further analysis.

These interviews will take place in a location convenient to you, but also where access to documents is easy.

Possible Benefits, Risks and Discomforts

Benefits:
There may be no direct benefit for you at this level. However, the findings of the study will uncover some relations that are shaping current IPE experience. These relations may be areas for future focus for changes in the IPE program.

Risk:

The risk associated with this study are minimal.

You may feel discomfort or fatigue during the interview which might take up to 90 minutes. I will be providing light refreshments.

You may feel discomfort in explaining your work practices and your communications with facilitators and other committees. Please note that this study explores institutional processes and not your own performance, and that I will not be using any judgmental language.

Compensation / Reimbursement

You will not have any cost from participating in this study. You will not be compensated for participating in this study.

How your information will be protected

Privacy: the interviews and focus groups will take place in a place where others will not see or hear. At the time of interview, only my supervisor and I would be aware of who will be interviewed.
Anonymity: Based on the subjective and interactive nature of this inquiry, anonymity cannot be assured as you will be known to the researcher and supervisor conducting the interviews. This will be addressed by assigning you a pseudonym. I will not email your identifying information to anyone at any time. I will not use your identifying information in reports, presentations, or publications. Only myself as principle investigator and my supervisor will see the records.
Confidentiality:

- I will be assigning you a pseudonym which will be used for all documents including the audio files, transcripts, computer files, field notes, publications or presentations.
- I will also remove your names and other identifying information from all papers and will be keep them separate from the data.
- I will separate the consent forms including your name from other data or transcripts in a locked cabinet in a locked office within a securely locked building. Only one file that shows the link of pseudonyms real names will exist, and it will be stored separately from data, in a locked cabinet in a secure office and building.
- The interviews will be audio taped and transcribed and coded. Identifying information will not be emailed to anyone at any time. All data, including tapes, transcripts, field notes, demographic forms, and computer disks will be kept in a locked filing cabinet in a locked location, and all computer/electronic files will be password protected, which can only be accessed by myself and my supervisor.
- I will erase audiotapes = after the discussion has been transcribed and analysis is complete. All paper files related to the study with identifying information will be held for at least 5 years post-publication (Dalhousie University requirements), and then be destroyed/shredded.

Privacy: the interview will take place in a place where others will not see or hear. At the time of the interview, only my supervisor and I would be aware who is participating.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to two weeks (after each piece of data is collected) if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be anonymized and analyzed.

How to Obtain Results

We will be invited to attend the dissertation defense where the whole work is presented. You can have access to the thesis by accessing the dissertations and thesis database at Dalhousie libraries once it is uploaded. If you wish to receive a copy of the final report for this study, please provide an email or
mailing address where you would like the results sent. I will be more than happy to present and discuss the findings with you in person. In this case I will need you to contact me for that.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Nadine Ezzeddine at 902-412-2609, Nadine.ezzeddine@dal.ca) or Dr. Sheri Price at 902 494-8831, picesl@dal.ca)] at any time with questions, comments, or concerns about the research study (if you are calling long distance, please call collect). We will also tell you if any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 20XX-XXXX)."

Other
This study have attained approval from the Nursing Research Committee for recruiting nursing students.

Signature Page

Project Title: The Social Organization of an Interprofessional Education Program

Lead Researcher: [Nadine Ezzeddine, MN student, Dalhousie University School of Nursing, 902-412-2609, nadine.ezzeddine@dal.ca]

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an interview which is 90-120 minutes long. I choose to participate in an interview.

I understand that I will be asked about the texts that organize the processes of IPE program at Dalhousie University, and that I will be asked to provide the researcher with access to texts. I understand that my participation will occur at a location acceptable to me, and that those interviews will be recorded. I understand direct quotes of things I say may be used without identifying me. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 2 weeks after my interview is completed.

_____	_____	_____"
Name	Signature	Date