Developing Interprofessional Education in Malta:
An exploratory case study

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Abstract: Worldwide impetus for Interprofessional education (IPE) has been gaining ground, and in many countries, is well-established in health care curricula. Although collaboration in health care and health care education has been mentioned in various policy documents, IPE as per CAIPE's (2012) definition is not practised at the University of Malta. This research adopts a qualitative case study approach designed to explore stakeholders' perspectives of IPE and to encourage debate of adopting such a model of practice at the Faculty of Health Sciences, University of Malta. Data were gathered through focus group**s** and one-to-one interviews with a purposive sample of sixty-four participants. Findings yielded rich insights into participants' perceptions of IPE; while they lauded the notion in principle, they identified a multiplicity of factors that would pose barriers to its enactment. These included barriers rooted in the practical domain of operational systems of the University as well as symbolic and wider barriers of professional and national cultures. The findings were interpreted through various theoretical perspectives; in so doing this study has initiated debate on the concept of IPE at a local level and has provided deeper understandings into factors that must be taken into consideration before such innovation could be attempted.

Key words: interprofessional education, case study, professional barriers, cultural barriers

Introduction

IPE is defined as occasions when "two or more professions learn *with*, *from* and *about* each other to improve collaboration and quality of care" (CAIPE, 2010). Although seemingly logical in concept, it is complex in its definition,

purpose and method and operates "within a context of diverse stakeholder perspectives, complex power structures and economic constrains" (Cooper, Braye and Geyer, 2004 p.181). It can take place both at undergraduate and post-graduate level and is different from multiprofessional or shared learning which imply occasions when participants are learning together side-by-side. IPE can form part of various curricula however for the purposes of this paper, will be contextualised to the healthcare setting; the setting where the majority of IPE scholarship and research is located.

Stakeholders in the health and education sectors have recognised IPE as fundamental to forging collaborative practices as well as improving health care systems and outcomes. For example, in 2010, the World Health Organisation, which has for decades recognised and encouraged IPE (WHO, 1976; 1978; 1988), published *The Framework for Action on Interprofessional Education and Collaborative Practice* outlining a strategic vision for a "collaborative practice-ready workforce" with IPE forming the cornerstone of this strategy (WHO, 2010, p. 7). The Lancet Commission [1], contended that "health systems worldwide are struggling to keep up, as they become more complex and costly, placing additional demands on health workers" (Frenk *et al*, 2010, p. 1923). One of the reasons for this was a mismatch of professional competencies to patient and population needs, mostly due to "fragmented, outdated, and static curricula that produce ill-equipped graduates" (p. 4). Professional health education reforms were urgently required and IPE was identified as part of these reforms. It was argued that inclusion of IPE in health curricula could contribute towards a professional workforce which could be more competent to address the complex realities of today's health systems (Frenk *et al.,* 2010).

During these last four decades, IPE has been slowly gaining ground worldwide especially in countries such as Canada, United States, Australia, Northern Europe and the United Kingdom. The overarching motivating factor is the significance that IPE could play in addressing or mitigating some of the challenges faced by health systems worldwide so as to create, through education, a collaborative ready workforce (Masen, Acton, Ashcraft and Esperat, 2013). It is crucial though that the development of IPE must be contextualised within the socio-political context where it unfolds and should be oriented towards meeting the needs of the particular audience (Mccallin, 2001).

In view of such international developments of IPE, the absence of IPE from curricula [2] at the Faculty of Health Sciences, University of Malta, was the impetus for this doctoral study. While the concept of health care collaboration is highly regarded, the assumption and expectation, from both the educational and health service providers, seems to be that health professionals would 'naturally' learn to work together when in practice. The aims of the study were to explore how academic staff at the Faculty of Health Sciences and other stakeholders perceived and understood IPE, to explore the perceived barriers and/or enhancers of a possible IPE undergraduate initiative at the Faculty of Health Sciences and to explore how contextual factors could possibly influence IPE in Malta.

Methodology and Methods

The context of the study was the 10 departments at the Faculty of Health Sciences offering progammes at undergraduate level. These were: Applied Biomedical Science, Food Studies and Environmental Health, Midwifery, Nursing, Mental Health Nursing, Occupational Therapy, Physiotherapy, Podiatry, Radiography and Speech Language Pathology. Professional health education across these programmes is carried out in a uni-professional manner interspersed with a few modules of shared learning.

The study employed a qualitative case study approach (Simons, 2009) with the unit of analysis being "*the possibility of IPE at the Faculty of Health Sciences positioned within the Maltese context*". Rather than generalise findings, the focus of this case study was to explore and discover holistic understandings and meanings of IPE defined by a temporal, cultural, political and social context. Such close examination of a specific case acknowledges the significance of abduction which is the development of a theoretical idea emanating from close inquiry of particular cases (Hammersley, 2007).

The data collection methods consisted of a purposive sample of sixty-four participants comprising of:

- Ten homogenous focus groups with resident academics representing the ten professions mentioned above. All resident academics from the ten Faculty of Health Sciences departments were invited to take part in these focus groups exploring and debating IPE. The decision to conduct homogenous groups was based on the researchers' insider knowledge that faculty members would feel more at ease to discuss

interprofessional issues with their own professional colleagues. The total number of participants across the groups was of fifty-three.

- One focus group with six newly qualified health professionals who represented the professions which had finished their programme of studies in the previous year from the Faculty of Health Sciences and were working as registered health professionals within the national health service. This was a heterogeneous focus group because small numbers of qualifying professions were involved.

- Five one-to-one key informant interviews with stakeholders who were crucial to an IPE initiative ever being conceptualised or implemented at the faculty. Purposive sampling was again employed and five key informants holding high office from the local health and higher education contexts were selected.

- Documentary search so as to provide the historical and current contexts of the case and to cross validate information gathered from the primary data (Noor 2008).

The open-ended and non-leading questioning routes for the 11 focus groups and 5 one-to-one interviews were based on pertinent literature and the research objectives of the study. The study was approved by the Faculty Research Ethics and Governance Committee, University of Brighton and the University Research Ethics Committee, University of Malta.

The multi-phase and interpretative data analysis process was carried out using a 'Framework' analysis approach (Ritchie and Spencer 1994) supported by QSR NVivo 10. Trustworthiness of data was achieved by employing credibility, transferability, dependability and confirmability and these included prolonged engagement in the field, triangulation, member checking, dense descriptions and an audit trail (Lincoln and Guba 1985). Researcher reflexivity which is the capacity of the researcher to acknowledge how their own subjectivities and experiences could bias the entire research process, was also central to this work. This was pertinent since the researcher was researching her own institution. Reflexivity was an enriching personal and professional process and helped navigate through the "muddy ambiguity" (Finlay, 2002, p. 212) of the research process. It also served to "unpack notions of scientific neutrality, universal truths and researcher dispassion" (Fine, 1994, p. 71).

Findings

The process of data analysis yielded a number of themes encapsulating the dominant issues and concerns voiced by the study participants. On further analysis and abstraction two overarching master themes emerged: a somewhat illusive theme entitled 'The Idea of IPE' and a second theme entitled 'The Reality of IPE' which seemed to be more rooted in participants' worlds. The relationship between the two master themes might be described as constituting two sides of the same coin, with a degree of overlap at times and tension at other times. The forthcoming section will attempt to present a snapshot of these two themes. The findings are presented as emanating from one data set reflecting participants' collective perceptions of IPE; however, each category of participant is identified for transparency [3]. The term participants implies that a large number of participants expressed the sentiments documented.

The Idea of IPE

The first Master Theme: 'The Idea of IPE' represented participants' discourses which expressed largely optimistic discourses, perceptions and understandings of IPE *as an idea*. In these discourses, participants pointed to its potential as a good mechanism for understanding the professional roles of others and improving day-to-day working relationships, for enhancing the quality of patient care and for making good use of limited resources.

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

> *I think it will be the best way forward whereby, especially if we are to acknowledge the limitations of the island and the size of the island…we would make much more effective use of resources* (Academic 34).

Some participants suggested that the diversity of professions housed within the Faculty of Health Sciences (as opposed to the former Institute of Health Care), constituted an opportunity for developing intra-faculty IPE, although, they suggested, the building's distance from the main campus might not be so convenient for developing inter- faculty IPE.

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

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

Participants anticipated that IPE could be beneficial in best serving the needs of the patient and that attaining this goal would necessitate having knowledge and understanding of other professionals' roles:

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

During discussions, participants noted that separatist approaches to contemporary health care were untenable:

The service that is being provided is becoming more specialised, requiring much more intercollaborative efforts of the different team players. Whereas in the past, people could possibly have worked in silos or isolated from each other, that today is not on (Academic 27)

Working alone is not only unacceptable but it is not sustainable, it is not doable anymore, because obviously now we're looking at the patient from a holistic point of view (Key Informant).

Participants deliberated as to whether IPE should be part of the academic-based curriculum or form part of the clinical placement process and seemed to agree that IPE within the clinical context would be more practical. However, introducing IPE within the clinical context would mean having to take account of everyday service realities, which participants perceived as almost running counter to the concept of collaboration:

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

As discussions unfolded, it was noted that although participants spoke of learning and working together as the ideal scenario, there was nonetheless a palpable sense of doubt and mistrust towards the whole concept of IPE.

> *Is it worth the struggle with regard to the outcomes (Academic 23)*
> *I am not dead set against it but I'm not all for it either (Key informant)*

The Reality of IPE

The second Master Theme, 'The Reality of IPE,' consisted of strong discourses on IPE, this time however contextualised to participants' worlds. Whist IPE was an interesting concept to talk about, the possibility of such a pedagogical change was fraught with trepidation and uncertainty.

> *We need to be careful because in the ideal world IPE is the great thing and it's the way forward; but in everyday life what is going to happen with the programme* (Academic 40)*?*

> *IPE is an unorthodox way how to educate health professionals* (Academic 39).

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

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

At the outset, they pointed to a wide range of factors, in the symbolic and practical realms, they perceived as posing challenges and barriers to IPE. In the practical domain, they suggested that IPE would, mostly likely, add to logistical and resource problems they were already facing on a daily basis, such as: lecture scheduling problems, overburdened workloads of academics and students, accreditation issues, large numbers of students in courses and lack of adequate physical spaces to accommodate delivery of IPE.

> *But trying to drip-feed IPE into undergraduate is very difficult because we all have our targets, our assessments, our courses, our priorities in terms of*

the curricula for our own particular discipline, so trying to find commonalities is another piece of work that we would have to do on top of all the existing considerable amount of work that we have to do (Academic 28).

Well in an ideal world you could perhaps get it started at some point, but the hurdles along the way are so major that I wouldn't even want to contemplate it (Key Informant).

Participants recognised that good teamwork cohered by strong leadership would be a fundamental prerequisite to the development and success of any IPE initiative, however, drawing on their everyday experiences and observations, concluded that teamwork is generally poor in Malta. They expressed concerns about a lack of collaboration at the Faculty, between faculties, between the Faculty and the health service, in clinical practice, and across most of the health services. Participants were critical of work practices in the clinical setting, suggesting that it would be "*useless*" to expose students to IPE at the Faculty when, in their clinical placements, they would observe and experience practices that run counter to the development of teamwork and interprofessional collaboration:

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

In the less tangible or symbolic domain, the question of professional identity emerged as a recurring issue of significance in analysis of participants' discourses. Primarily they expressed a strong sense of dissatisfaction with medical dominance in the health and academic sectors, as well as in wider society; a dynamic they perceived as incompatible with IPE. They argued that the strong medical dominance permeating the local health services has a negative impact on their students' developing sense of autonomy, competence and worth:

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

Participants also spoke about rivalries and battles for hegemony in between health professions, about the question of identifying and maintaining conceptual territories and boundaries, and about the possibility that IPE could manifest in the dilution of health care professions.

I mean the professions themselves - are we looking at each other as threats? (Academic 8).

That change will take even longer in this area because the attitude I see right now in the health professions is we are too much defensive towards our own professions (Academic 51).

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

Participants also spoke talked about characteristics, traits and behaviours they perceived as inherent in the local culture that would run counter to the principles of IPE.

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

A participant talked about a sense of insecurity in the workplace as a feature in Maltese culture that would be at odds with IPE in practice:

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

Another Academic identified Maltese 'self-consciousness' as one such cultural trait that could work against IPE:

I think it's also our culture that we do not like to perform in front of others. I feel it that as [a] Maltese, we are very conscious of ourselves. I think we are not assertive enough as a nation, and we may not be sure and confident enough (Academic 41).

Over the course of discussions on Maltese culture, participants shifted their focus beyond factors they identified as national traits and behaviours to considering national systems and structures that may inhibit the development

and growth of IPE. Indeed, participants spoke of IPE as requiring a "*paradigm shift*" and that bringing about such a paradigm shift would call for wide-ranging interprofessional dialogue and exchange of ideas as a vital component in developing innovative educational practices.

Discussion

This research set out to explore attitudes, understandings and perceptions of Faculty of Health Sciences academic staff and other stakeholders regarding the possibility of IPE at the University of Malta. The analysis of the faculty's and key stakeholders' perceptions of IPE reflected international literature in that although perceptions of IPE are largely positive (Barker, Bosco & Oandasan, 2005: Carlisle, Cooper, & Watkins 2004: Curran, Sharpe, Flynn & Button, 2010 : Matthews *et al*, 2011: Mueller, Klingeler, Paterson & Chapman, 2008), IPE faces many challenges at a micro (individual level), meso (institutional) and macro (socio-cultural and political level) (Oandasan & Reeves, 2005).

IPE seemed logical in concept, but participants feared it faced insurmountable implementation difficulties because it went against the way things were done at university (and practice settings) as well as the way things were done in Malta. Despite the positive yet somewhat illusive discourses about IPE, there was a gap between how participants espoused IPE and how they saw it unfolding in practice. This phenomenon could imply that although participants endorsed 'The Idea of IPE' cognitively (in principle), they were also ambivalent and/or resistant to it, due to their emotional and/or intentional attitudes indicating that the real-life challenges to it were too immense. This interpretation is similar to Hofstede's idea of tension between "the desirable" and "the desired", that is, between "how people think the world ought to be versus what people want for themselves" (Hofstede, Hofstede & Minov, 2010, p. 28). This ambivalence and indeed resistance seemed to be emanating from both organisational practices as well as from deep-rooted values.

The process of untangling the various factors which could have contributed towards this chasm involved looking for underlying leitmotifs emerging from the findings. On a superficial level, participants perceived that creating integrated curricula would be challenged by lack of time, lack of space, curriculum rigidity, curriculum cram and overall university bureaucracy. These operational challenges requiring tangible solutions at the level of the organisation are excluded from these discussions as they would need to be addressed differently within every organisation.

At another level, the findings highlighted the presence of explicit professional hegemonies both between medical doctors and other health professionals as well as between the health professionals themselves. Participants spoke about their sense of dissatisfaction with medical dominance in the health and academic sectors, as well as in wider society; a dynamic they perceived as incompatible with IPE. This resonates with the sociological work of Friedson (1988, 1994) who was critical of the medical profession, particularly in the way it wielded its' power so as to increase its members' self-interests. Indeed, Freidson argued that occupations engaged in what Weber termed 'social closure,' the practice of preserving their privileges by restricting access to resources and rewards to the specialised few: those who would have undergone extended years of schooling and acquired knowledge that was too complex and scientific for the layman to execute and evaluate. These professions then negotiated a special relationship with the state and the public so as to ensure that their specialised knowledge and skills remained solely within their control. The successful outcome of this relationship was state registration or license to practice. It was also a means of controlling the profession by the professionals' own self-governing organisations and by their members. Ultimately being a member of a profession was a societal contract granting that profession a monopoly of its services and the privilege of self-regulation. In return, society would be assured of professional competence in services rendered. The medical profession was the first health occupation to successfully engage in this process becoming powerful enough to be able to dominate other professions engaged in health care activities (Larkin, 1983; MacDonald, 1995); and this is akin to the findings of this case study which have showed that medical dominance, professional territoriality and boundary issues are all prevalent today.

These traits run counter to the philosophical ideal of an egalitarian foundation on which IPE can be built and it is only in recent years that that the way interprofessional hierarchies and imbalances have originated and how they continue to be perpetuated has been given prominence in the IPE literature (Baker, Egan-Lee, Martimianakis & Reeves, 2011; Cameron, 2011; Khalili, Orchard, Laschinger & Farah, 2013; Kitto, Chesters, Thistlethwaite & Reeves, 2011). Understanding these dynamics goes a long way in demystifying professional hierarchies which is essential during the development of IPE or indeed any other interprofessional working.

At a yet deeper level, the barriers seemed to be attributable to the small size of the island. Sultana and Baldacchino (1994), in their sociological analysis of Maltese society, suggested three themes, *intimacy*, *totality* and *monopoly*, which, individually and/or collectively, capture the essence of a "microstate syndrome" (p. 14) characterised by small size and small scale. The last two themes *totality* and *monopoly* have direct relevance to this work as they provide further insights into the findings, particularly in relation to participant discourses coded to the overarching theme: 'The Reality of IPE'.

Totality, implies that the smaller the country, the larger the state features in its economy and society. Sultana and Baldacchino (1994) suggest that a small state government is characteristically present in the day-to-day lives of the people and one of the many consequences could be the screening and withholding of information for oneself. This implies that a professional who would have acquired professional expertise in a particular field would be very careful not to share this special information or to do so only within the 'in-group.' Hence, *totality* could render sharing of information more difficult; and indeed the study's participants, although espoused to collaborative practices, were paradoxically concerned that IPE would necessitate them imparting their knowledge to other professionals. *Totality* also implies a rigid adherence to role specificity (Sultana & Baldacchino, 1994), which again goes against the notion of flexible working across professional and organisational boundaries.

Monopoly implies that if there is a desire to withhold information to oneself (*totality*), there is also a desire to secure and retain *monopoly* power, usually in the form of knowledge or expertise (Sultana & Baldacchino, 1994). If a person develops even a modest amount of expertise, most especially in a new domain of knowledge, there is an almost spontaneous and unavoidable inclination to proclaim oneself as the expert in the field. It thus becomes "relatively easy to become a big fish when one operates in a small pond" and, particularly in the social sciences community, this self-proclaimed authority "induces individuals to indulge in centrifugal adventures, locked within their own staunchly defended research pursuits, often in splendid isolation" (Sultana & Baldacchino, 1994, p. 18).

Another issue of note is the small geographical context of Malta, coupled with the high density of people. Boissevain (1994), a Dutch social anthropologist who, for over half a decade, studied Malta's social life, argued that Malta's

small size and intensely interrelated population contribute to high degrees of competition in all spheres, giving rise to factionalism. He suggested that factionalism (such as in sports, village feasts and national politics) is one of the dominant cultural themes of Maltese society and is undeterred neither by rising prosperity nor by education. The findings identified factionalism (in the form of competition and rivalry) both in academia and within the health sector as strong underlying discourses. Manifestations of this factionalism included both implicit and explicit hegemonies and territorial rivalries with the medical profession, and between professions represented at the Faculty.

At another level, the dissonance seemed to emerge from deep seated values prevalent across participants. This was the most basic level which reflected the unconscious and "taken for granted" values and seemed to encapsulate "the general sprit of a nation" (Montesquieu, as cited in Hofstede et al.,2010); in other words, the culture of a nation. The essence of a culture are those unconscious and shared beliefs, actions, norms and values held by the individual within an organisation, community or society and which influence the way things are carried out (Hofstede *et al*, 2010). Hofstede, an organisational anthropologist, developed a model of cultural dimensions' and identified six dimensions or values that distinguish country cultures from one another. These are *power distance, uncertainty avoidance individualism/collectivism, masculinity/femininity, long term orientation and indulgence versus restraint.* Hofstede scored a number of countries using a scale of 0 to 100 for each dimension; the higher the score, the more that dimension was exhibited in societies. Although the dimensions [4] are based on correlations and are *relative* scores, they do nonetheless imply that characteristics highlighted in particular dimensions are more often present in citizens with a common mental programme, and the collective behaviour of a particular society might include those characteristics and reactions which at times may seem perplexing to other groups (Hofstede *et al.,* 2010)

Hofstede *et al.* (2010) emphasise that the two dimensions of *uncertainty avoidance index* (defined as the extent to which the members of a culture feel threatened by ambiguous or unknown situations) and *power distance index* (defined as the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally) are critical to the way individuals think about organisations, that is, group beliefs and cultures. Indeed, in my data analysis, these dimensions were the most relevant and I employed them to understand how they could have influenced participants' discourses [5].

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With a score of 96, Malta ranks as the sixth highest country globally in *uncertainty avoidance* and fourth highest European-wide, implying that people in Malta, together with other southern European countries, may tend to feel more threatened by uncertain or unknown situations. This was perceptible and evident in the findings. For example, in discussing IPE in tangible terms as a possible reality, the participants evoked seemingly insurmountable challenges, such as its introduction would require an "*evolution in the culture*" and an "*Arab Spring.*" Some participants suggested that IPE would cause 'an upheaval' and bring with it a high degree of uncomfortable uncertainty; others perceived IPE to be unorthodox which reflects Hofstede's observations that societies with high uncertainty avoidance seem to be intolerant of unorthodox behaviors and ideas.

The relatively high *power distance index* shown by Hofstede's scores for Malta (56) is also significant because it suggests that there is a hierarchical order in which everybody has a place and which needs no further justification. In high *power distance* societies, the system is based on existential inequalities and organisations tend be centralised with power in the hands of the few. The major threat in such societies is the competition of other groups for the same territory and resources (Hofstede *et al,* 2010). Such tendencies were identified in this study's findings such as the domineering influence of the medical profession, both in academia and the health services, as well as explicit and implicit interprofessional rivalries. (Hofstede *et al.,* 2010).

The way particular dimensions of culture come together could be also significant. For example, the lack of good teamwork might be partly explained by the high *uncertainty avoidance index* and relatively high *power distance* index scores. Teams *per se* rely on the collective effort of team members and within a high *uncertainty avoidance* culture, this could be experienced as stressful and ambiguous as people with a high *uncertainty avoidance* index tend to feel more comfortable in structured environments (Hofstede *et al.,* 2010). One way of avoiding possible uncertainty arising from teamwork would be to rely on oneself, thereby avoiding the uncertainty of having to deal with others in pursuit of common outcomes and goals; this would translate as either being a poor team player or engaging in non-collaborative practices. Moreover, with a relatively high *power distance* index, there is a high preference in Malta to complacently accept and expect a hierarchical order, which contrasts with low *power distance* countries in which

team members expect to be consulted in decision-making processes, and subordinates are more likely to question and challenge leaders or authority figures (Hofstede *et al.,* 2010).

Hence, whilst it is recognised across the literature that ambivalence and resistance to change and innovation could reflect a clash between the cognitive and emotional responses and/or between the 'desirable' and the 'desired' (Ellsworth, 2000; Fullan, 2007; Hofsede *et al.,* 2010; Piderit, 2000), my analysis suggests that particular cultural factors in Malta tend to make collaborative working more difficult. This reflects the literature which posits that, even though national culture may not be a power in itself, it permeates the behaviours and conduct of individuals, contributing to differences in behaviours between countries (Geertz, 1973; Jippes *et al.,* 2013).

Conclusion

This paper addressed a knowledge gap in presenting perceptions of academic and health stakeholders regarding the possibility of IPE in Malta; a knowledge gap which has unearthed the complexity of potential IPE within the socio-cultural context of the Faculty of Health Sciences at the University of Malta and beyond. Participants seemed to laud IPE as an idea but were resistive of it as a possible reality; a metaphorical chasm between the ideal and the reality. The findings were interpreted through various theoretical lenses unpacking potential influences on the possibility of IPE, many of which go well beyond the level of the individual and involve the whole distribution of power in the professions and society at large. The inherent role of national cultural was also a strong influential factor on potential IPE. Taking a long-term view, this study has initiated debate on the concept of IPE, and issues and concerns raised in this debate could provide insight into challenges that any future attempt at IPE would face. Although the analysis and conclusions are particular to Malta, the implications from this case study can make a wider contribution to the scholarship on IPE and innovations in higher education especially for European mini-states and other nations that share similar contextual features.

Limitations of this study

This study primarily focused on IPE at the Faculty of Health Sciences, as opposed to including other faculties at the University of Malta. Whilst acknowledging that this was an artificial boundary for IPE, widening data

collection other than from the Faculty of Health Sciences would have brought to fore a number of variables between faculties which would have been difficult to reconcile during data analysis. The Faculty of Health Sciences was unique in the sense that there was a certain amount of commonality amongst its departments; nevertheless, widening the scope of my research would likely have generated more complete conclusions.

Endnotes

[1] A worldwide commission who developed a shared vision and strategy for the education of health professionals.

[2] There is a degree of shared learning in undergraduate curricula at the Faculty of Health Sciences.

[3] The five key informants are not given an identification code for anonymity purposes but are simply identified as 'Key Informant.'

[4] In the last edition of Hofstede's book, dimensions are listed for seventy-six countries and these are partly based on replications and extensions of the IBM study on different international populations and by different scholars (Hofstede et al., 2010).

[5] My interpretative arguments do not imply that a cross-cultural study of IPE was conducted; they are based on my reflections using Hofstede's dimensions to illuminate particular trends in the findings.

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