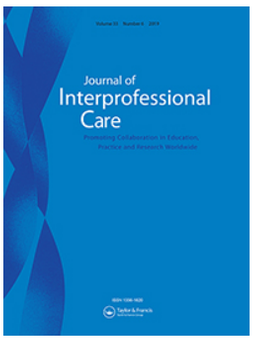

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ORIGINAL ARTICLE

Framing IPE. Exploring meanings of interprofessional education within an academic health professions institution

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ABSTRACT

This paper reports a qualitative study that explored the meanings of interprofessional education (IPE) by comparing and contrasting educational leaders' perceptions with educational policy documents at an academic health professions education institution in Scandinavia. The study used Goffman's frame analysis to identify two frames of IPE by illuminating issues related to the definition, rationale, and presentation of IPE. A directed content analysis to identify these three aspects of IPE was conducted on semi-structured interviews with nine educational leaders who were overseeing the development of IPE, as well as on the institution's regulatory IPE documentation. Differences regarding definition, rationale, and presentation of IPE between the institutional regulatory IPE frame and the IPE frame of the educational leaders were found which implied difficulties for the educational leaders regarding the implementation of IPE. Based on the study's findings, the paper argues that creating awareness of the differences in meanings of IPE between different perspectives within an academic education institution is an important factor to consider when creating future organisational structures and faculty development programmes in connection to IPE.

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Interprofessional education; leadership; power; phenomenology; frame analysis

Introduction

Interprofessional education (IPE) has been promoted throughout the world for over 30 years as one of the most important keys to a heightened quality level of patient care (e.g. Reeves et al., 2016; World Health Organization, 2010). Defined as occasions, "when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE, 2002), IPE has particularly been at the forefront of much research, policy, and regulatory activity on an international level for the past decade or so (Institute of Medicine, 2015).

The promotion of IPE is rooted in the complexity and multifaceted nature of delivering patient care in a safe (error-free) manner (e.g. Barr, Koppel, Reeves, Hammick, & Freeth, 2005; Institute of Medicine, 2015), with research repeatedly reporting that effective and comprehensive care requires timely and well-coordinated communication and collaboration. However, a number of collaboration 'failures' have been well documented in the literature, which continue to undermine the delivery of care to patients (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017). As a result, calls for expanding the implementation of IPE across classrooms, simulation environments, and clinical settings have been voiced by a growing number of policymakers as a key approach to addressing these ongoing collaboration problems.

Nevertheless, like other forms of health professions education, while the full understanding of the effects of IPE on professional practice and patient care is not yet reached, the literature has identified a growing amount of different factors which act as enablers or barriers of IPE (Reeves et al., 2016), such as organisational structures and differing views on IPE depending on profession, gender or age. A key enabler of IPE within academic health professions education is leadership. The importance of leadership has been highlighted in the literature repeatedly; earlier Ginsburg and Tregunno (2005), Steinert (2005) and Bennett et al. (2011) focused on the importance of leadership commitment to and institutional support for IPE as well as to challenge resistance and to lead IPE accountability. Support for IPE is needed from leadership to highlight tensions for change, set outcomes, provide resources and hold individuals responsible for outcomes (Barr et al., 2005; Reeves & Kitto, 2017). Brewer (2016) has also shown how the implementation of IPE requires leadership who can create both a vision and provide sense-making of IPE. Still, according to a review by Brewer, Flavell, Trede, and Smith (2016) there is an established lack of theory-based research on educational leadership in connection to IPE.

Much of the complexities regarding the implementation of IPE lie within challenging the resistance originating from stagnated health professional cultures (Barker, Bosco, & Oandasan, 2005; Reeves, Lewin, Espin, & Zwarenstein, 2010). The key to change is to be aware of how IPE is articulated and thought of (Ward et al., 2017) as well as confronting underlying assumptions about IPE (Ginsburg & Tregunno, 2005). Even though these issues of resistance to educational change are closely connected to power (Sundberg, Josephson, Reeves, & Nordquist,

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2015), there has been a lack of attention on exploring issues of power within the interprofessional field (Baker, Egan-Lee, Martimianakis & Reeves, 2011; Paradise & Whitehead, 2015).

Both leadership and the ability to create awareness about perceptions of IPE are two determinant factors for successful implementation of IPE. Hence, the aim of this study is to explore different meanings attached to IPE within two organisational entities at an academic health professions educational organisation: among educational leaders and the institution's educational policy documents. The study will address the following research question: How can the perception and implementation of IPE within an academic health professional institution be understood from the starting point of the two concepts of power and resistance?

In this study, it is also possible to visualize the transition of the educational phenomenon of IPE between two different organisational levels: the institutional policy level and the educational leadership level. This kind of transition is a perspective which has been encouraged in the interprofessional education research field (Suter et al., 2013).

Methods

As highlighted by Crotty, it is important to make sure that there is an alignment between basic elements of the research process, such as methodology and methods (Crotty, 2010). The study adopted a phenomenological methodology to address its aim of exploring meanings attached to IPE. This qualitative research approach was employed as it seeks to understand social phenomena from the perspective of those who have experienced it (Husserl, 1931). The choice of methodology enables the possibility of a qualitative study design. The design explores both the subjective experiences of educational leaders engaged in IPE through in-depth interviews and the content of official regulatory documents referring to IPE. The focus of the researcher is not solely on the phenomenon or the individual but instead on the dialogue between the individual and the context (Van der Mescht, 2004); the researcher is the actively engaged and subjective research process facilitator (Illing, 2010). The paper presents data from a Ph.D. study which explores issues related to leading change in health professions education with the starting point in the two sensitizing concepts of power and resistance (Sundberg et al., 2015; Sundberg, Josephson, Reeves, & Nordquist, 2017).

Study setting

The setting selected for this study was an academic health professions education institution in Scandinavia. At this organisation, IPE has officially been decreed from an official institutional level since 2010, even though IPE learning environments and projects had been established since the late 1990s. At the time of the conducted interviews, the institution offered several health professions educational programmes and IPE was officially included as a learning activity in the curricula for both the undergraduate medical programme and the nursing programme, as well as other programmes. The five and a half year undergraduate medical programme (330 European Higher Education Credits) had a curriculum with a thematic and integrative character including attachments in primary care and hospitals. The 3-year nursing programme (180 European Higher Education Credits) had a thematic and integrative character including clinical rotations within academic hospitals.

In 1998 the concept of interprofessional education (IPE) was introduced at the institution and as a result, three clinical education wards were established at three different teaching hospitals. A few years later a clinical education emergency department was also established (Ericson et al., 2017; Ponzer et al., 2004). These IPE learning environments for students from both the undergraduate medical programme and the nursing programme were well established and integrated within the organisation at the time of the study. Here students had the opportunity to work in teams around the patients under supervision and a two-week IPE course based on official IPE learning outcomes was made mandatory for all medical, nursing, occupational therapy and physiotherapy students (Ericson et al., 2017; Ponzer et al., 2004). In addition, other IPE activities such as simulations, seminars were also integrated within the undergraduate medical programme as well as the nursing programme.

According to the institutional website at the time of the study, the organisational structures for strategic development organisation for IPE was disseminated throughout the organisation to several organisational levels and units. Examples of units and levels were the Board of Education, an IPE panel, an IPE working group, IPE-promotors (teachers) within the different educational programmes, an educational development center, programme Boards, a clinical education center and several clinical IPE environments located at different teaching hospitals. The mission of the IPE panel was to support and stimulate the integration of IPE in the educational programmes on all levels by suggesting actions to the Board of Education. The IPE promotors held the task of clarifying the departments' educational mission regarding IPE and had their own internal networking structure.

Data collection

Interviews

A purposeful sampling approach was conducted in two steps. First, all educational leaders within the undergraduate medical programme and the nursing programme were identified with the assistance of the programme administrators and the official programme websites. These educational leaders were responsible for overseeing curricular developments in their respective programmes. Therefore, their roles were focused on communicating with teachers and initiating and/or coordinating implementations of educational change. In total, 35 educational leaders were identified via the website as a first stage. Thirty-two of them were indeed active and invited by email to be interviewed for a Ph.D. study focused on exploring the issue of leading educational change; 24 accepted. Second, the nine educational leaders within the cohort who were engaged in IPE projects – initiated by themselves or others – were identified. The identification was made with the assistance of the interviewees themselves during the interviews. Six of the educational leaders engaged in IPE projects were connected to the undergraduate medical programme, two to the nursing programme and one person was connected to both (see Table 1).

Table 1. Participant profile.

Professional responsibilities	Number of participants	Gender		programme engagement		
		M	F	Medical programme	Nursing programme	Both programmes
Educational leadership responsibilities on an overarching programme level	2	0	2	0	1	1
Educational leadership responsibilities within the programme	7	6	1	6	1	0

The interviews for this study were conducted by the first author. The interviews were performed at the offices of the participants and were recorded; the average full interview lasted approximately 55 min. The interviews were semi-structured in nature, and the interviewees were asked four main questions, whereof two (question no 3 and 4) were derived from the sensitizing concepts of power and resistance: (1) Describe IPE in your own words, (2) Describe your IPE project in your own words, (3) What creates possibilities when implementing your IPE project? and (4) What creates obstacles when implementing your IPE project? The questions were followed by probing questions on, for example, clarification on content and context of the projects. All interviews were transcribed verbatim by the first author, except for one which because of technical difficulties was only recorded and transcribed verbatim halfway through. The second half of the interview was analyzed based on interview notes.

Documents

Information regarding policies on IPE at the study setting was undertaken by the collection of official institutional regulatory documents. The identification of relevant regulatory documents was made through the study institutional website where the three most central documents were presented: the national Higher Education Act (69 pages), the 2009–2012 Education strategy (10 pages) and the 2011 Operational plan for the Board of Education (10 pages). In addition, two other official regulatory documents connected to IPE were identified and included: the 2009–2012 Research and education strategy (14 pages) and the official IPE learning outcomes decided on November 24, 2011 by the Education Board (1 page).

Data analysis

The study employed Goffman's (1974) frame analysis to help illuminate the nature of the findings. The concept of frames and frames of reference or interpretive frames is well developed within the social sciences (Benford & Snow, 2000; Brooks, 2007) and according to Goffman (1974) the term "frame" means a "schemata of interpretation" which individuals use to perceive, identify, locate and label occurrences (Goffman, 1974; Snow, Rochford, Worden, & Benford, 1986). Hence, frame analysis is an approach which explores different idea elements through a specific question: what holds these idea elements together? By answering this question and unpacking different packages of meaning, it is possible to identify different frames (Creed, Langstraat, & Scully, 2002). Frame analysis has been found useful when studying the transition of a policy/phenomenon between different organisational levels (Caldwell & Mays, 2012). Even though Goffman's theoretical frameworks have been used earlier within research regarding interprofessional care and IPE, they have then focused on impression management (Lewin & Reeves, 2011). Frame analysis has however been used earlier within educational leadership research (Gray & Williams, 2012; Retallick & Fink, 2002) as well as health policy research (Pope, Glenn, Bate, Le May, & Gabbay, 2006). The application of Goffman's theoretical framework (1974) will contribute to the facilitation of the transferability of the findings to other contexts.

The data analysis was conducted in the following two steps:

Step 1. Data analysis was guided by Pope et al. (2006) application of Goffman's frame analysis; an approach which in this study guides the exploration and unpacking of three specific aspects of the IPE frame: definition (the presented defining characteristics of IPE), rationale (the presented purpose of IPE) and presentation (the means by which IPE is represented). These three frame aspects were explored both in the interviews and in the official regulatory IPE documents through a directed content analysis.

Step 2. The frame analysis approach can be conducted through different types of data analysis methods; the choice for this study was a qualitative, directed content analysis. The starting point of the directed content analysis was the three aspects of the frames: definition, rationale, and presentation. The concepts were used as predetermined codes when analyzing the data both from the interviews and documents, in order to explore and identify frames. To initially increase familiarisation all transcripts and documents were read and discussed by the three out of four authors who shared the same first language; the conducting language of the interviews. The data analysis was then conducted by the first author on both the documents and the interviews (separately), and the results were discussed and processed among the other authors. This joint process enhanced the credibility of the data analysis and ensured analytical triangulation which in turn enhances the trustworthiness of the results.

Ethical considerations

Ethical approval for this study was applied for at the Regional Ethics Review Board in Stockholm with the returning decision (reference number: 2011/550–31/5) that it was not applicable due to the non-sensitive nature of the interview data and hence not affected by the national law for ethical approval. Informed written consent was obtained from all participants before taking part in the interviews. Transcripts were anonymized to avoid possible identification of the participants.

Results

The results from the analysis of the document data and interview data are presented in relation to and the order of the

three different frame components: (A) definition IPE, (B) rationale of IPE, and (C) presentation of IPE.

Definition of IPE

Official regulatory documents

While none of the documents analyzed for this study provided a formal definition of IPE, the following elements were identified to implicitly construct the presented defining characteristics of IPE. For example, in the national overarching regulatory document, the Higher Education Ordinance (1993), a joint learning outcome for medical and nursing students on a programme level was stated:

"The student shall show capacity for teamwork and cooperation with other professions" (SFS 1993:100, p. 41; p. 54)

In addition, in the 2009–2012 Educational Strategy (Karolinska Institutet, 2007) formulated and determined by the Board of Education, IPE was mentioned under the headline "Strategic ventures 2009–2012"/"Quality assurance and quality development in education":

"Interprofessional education will be strengthened by creating and developing environments that support cooperation between educational programmes with a healthcare profile". (Karolinska Institutet, 2007, p. 5)

Again, however, while there is support for IPE no formal definition was presented. This was also found in the 2011 Board of Education Operational Plan (Karolinska Institutet, 2011b) included the following operational goal:

"Interprofessional education (IPE) is prioritised at the institution" (Karolinska Institutet, 2011b, p. 4)

Although this document also stated that several IPE activities were taking place at the institution, no apparent definition of IPE was provided in the document. In contrast, the official 2009–2012 Research and Education Strategy, offered no mention at all about IPE.

Educational leaders

In general, these educational leaders viewed IPE as a type of activity that was important and sought after, both within the institution's undergraduate medical programme and the nursing programme. IPE was considered to be an educational element that however had to be introduced differently across educational programme/cultures. The strategy for implementing IPE into the undergraduate medical programme was described by the leaders as at times somewhat more forceful than the strategy for the nursing programme. This was due to the tradition where the undergraduate medical programme faculty were perceived as more protective of their specific subjects, which contrasted to the nursing programme faculty who appeared to be more willing to adapt to educational innovations as a result of the nursing programme having a better pedagogical quality and longer tradition of pedagogical development:

> Because they [the nursing programme leaders] have come further than we [medical programme leaders] have, and therefore we must learn from them. (Educational leader no 8)

Gender was also mentioned as a reason for introducing educational change, such as IPE, in different programmes. The male and hierarchical environment among the undergraduate medical programme faculty seemed to demand a more direct approach for implementation of IPE, while the more female environment of the nursing programme faculty was perceived as to call for other types of approaches. As one participant stated:

> The undergraduate medical programme. At least here, you have to forcefully instruct:" this is where IPE goes!" Bam! Or else nothing happens. You can reason within the nursing programme and try to see where it fits best. They are much more flexible. (–). I try to be more subtle there. There are a lot of men in the Medical Programme. It is my perception that hierarchy is very important there. Men are easier to work with in that aspect: they listen when a superior speaks. (Educational leader no 1)

IPE was also referred to as an element of educational change by both types of educational leaders. However, IPE was not the only element of educational change that had to be considered, and hence brought into the curricula of the respective programmes. IPE was viewed as embodying the same intrinsic change characteristics as other overarching educational development areas, and as a result had to compete for space and attention with other areas, within the curricula.

> Interprofessional education is a topic that I have tried to introduce. Then of course a lot of people are trying to direct your attention towards their own interest areas. And… in the end, you have a list of several interest areas, a list of perhaps 9–10 areas such as equality, sustainability, gender, you name it. A long, long list. (Educational leader no 1)

However, the introduction of IPE was also described as seen by some as a 'threat' to the professional role of the physician: something 'unknown' that was stealing time from more important things. This was a perceived threat that had been acknowledged both among established physicians who tried to make things complicated for fellow physicians who advocated IPE – denying resources – and among medical students who worried that IPE would steal time from their clinical/technical medical training:

> Well, it's mostly within my own profession, among physicians. And some even tried to trip me over in the beginning. And I believe it is to some extent about…I don't want to mention individuals, but it is about the fact that they…well, they weren't in charge of this, or it was perceived as a threat. Threats – that's one of the things. It is a change and as a result some people feel threatened. (Educational leader no 8)

In relation to this issue, IPE was on one hand perceived in a positive way as challenging the accepted role of the physician as always having the right answer or solution and being in charge, and on the other hand as "a sacred cow" promoted by nurses on their professional terms. An example of IPE being something mainly in the interest of nurses and nursing education was that nurses were seen as having the power to decide solely from their interests and professional perspective what was to be deemed a successful IPE learning environment; the needs of medical students

were in this type of learning environment perceived to be ignored.

> It's like a sacred cow at this institution, that isn't… you can't disturb it. It is totally on the nurses' terms. (Educational leader no 2)

Rationale of IPE

Official regulatory documents

Only one analyzed document out of six provided an explicit rationale for IPE. In 2011, the Board of Education formulated three overarching IPE learning outcomes to be used in connection to different IPE activities (Karolinska Institutet, 2011a). Two out of the three overarching learning outcomes included the following rationales for IPE:

"The student shall be able to cooperate with other professions to achieve better health and more effective care and rehabilitation"
(Level 2) (Karolinska Institutet, 2011a, p. 1)

"The student should be able to analyse and reflect upon how cooperation between different professions contribute to increased safety and improved health"
(Level 3) (Karolinska Institutet, 2011a, p. 1)

However, a precursor of a rationale could be identified in the featured headlines in the Education Strategy (Karolinska Institutet, 2007): "Strategic ventures" and "Quality assurance and quality development in education" (p. 4). Cooperation between educational programmes was to strengthen interprofessional education per se, but no benefits for health care were mentioned or made within this official document.

Educational leaders

The rationale for IPE was described among the leaders as patient safety, efficient problem solving across profession boundaries, decrease of errors, insight into the competences of other professions and as a tool for the increase in job satisfaction and avoidance of silo mentality between professions:

> We will stand together on a ward or in an emergency room or in an ambulance or on an accident site. And then we have to learn… No, not learn. We have to have knowledge about each other's competencies so that we can make use of them in the most effective way. (Educational leader no 5)

IPE activities were described as sometimes seen as interrupting clinical work among physicians or not being high fidelity enough regarding professional aspects of the physicians' tasks. To engage in IPE activities was often experienced as important but there was also among some of the leaders a perceived lack of believable and professions stimulating tasks, mainly for physicians, within the activities.

> So it's a very unnatural workplace for a physician to be there all day long. The nurses are forcing my students to be present. And that's why I get student evaluations semester after semester, where the students express that there is so much downtime. They lose so much as a result of this. Because nothing happens. (Educational leader no 2)

It was also reported that IPE was well received on an idea level, at the same time as difficulties connected to the implementation of IPE within the educational programmes were common and often were connected to practical issues such as logistics or the threat of an increased workload.

> So, it was… and as usual when it is an interprofessional learning activity that is the most difficult thing, really. You know, everyone wants to do it, but the most difficult thing is the logistics. To find a time that is suitable for both programmes, that is the one most difficult thing. Because everyone had, you know… both really wanted it. (Educational leader no 6)

Presentation of IPE

Official regulatory documents

The analysis of the six documents related to the presentation of IPE was scarce. The explicit official presentation was to be found only through the three institutional overarching IPE learning outcomes stated by the Educational Board in 2011 (Karolinska Institutet, 2011a):

"The student shall be able to identify and describe the competencies among those professions that they will cooperate with in their future work.
(Level 1) (Karolinska Institutet, 2011a, p. 1)

"The student shall be able to cooperate with other professions to achieve better health and more effective care and rehabilitation"
(Level 2) (Karolinska Institutet, 2011a, p. 1)

"The student should be able to analyse and reflect upon how cooperation between different professions contribute to increased safety and improved health"
(Level 3) (Karolinska Institutet, 2011a, p. 1)

Educational leaders

The presentation of IPE was most distinctly found through the IPE learning outcomes and the actual IPE environments and activities such as wards, simulations and seminars. A common experience among the leaders was that the practical and logistical hurdles to arranging IPE were several, especially when IPE was initiated by the nursing programme. This was described as due to aspects of scheduling privileges for the medical students, such as planned holiday breaks, that the nursing students did not receive and/or expect.

> The undergraduate medical programme doesn't do things like the other programmes at the institution. Their semester… their course weeks don't align and suddenly their students have a - sports day exclusively to their programme. Well, it's like that, you know. And then you suddenly have to put up with that instead of them adjusting to the rest of us. (Educational leader no 7)

Factors such as change fatigue, tribalism, and silo mentality within the institution as well as lack of support of IPE in regulatory documents and from the institutional senior leadership level were also mentioned as obstacles to the implementation of IPE among some of the leaders in the study:

> A lot of people are talking about IPE but not a lot is happening because it is difficult to get people from the different programmes to get together, logistically. And there is not enough support for

> IPE in the course plans and the curricula because people are sitting in their ivory towers trying to protect their own territory. There can only be a change if this question is raised at the highest level of the organisation and the vice-chancellor puts the foot down. (Educational leader no 4)

Another obstacle experienced among some of the leaders to the implementation of IPE was the fact that specific competencies and professional values were reproduced among the students within the nursing programme and the undergraduate medical programme. This, in turn, was seen as potentially creating problems since professional competencies and values seldom were discussed or highlighted in connection to IPE learning activities, which created problematic situations.

> And then suddenly everyone has to get along. And I believe that the differences in basic professional values lead to most of the problems. You don't have the same perspective; you don't have the same way of approaching a problem or solving a problem. And then it becomes more difficult. So I believe there is a lot to win there. Not that I want to merge all educational programmes, but we need more elements of interprofessional problem solving. (Educational leader no 5)

Discussion

By exploring the connections to and discrepancies between the IPE frames on an official regulatory level and among educational leaders, we can start to understand how IPE as an educational phenomenon is perceived and implemented within an institution. As presented above, even though the institution's official educational documents do not hold a specific definition of IPE it is suggested that IPE is something that is prioritized on an idea level within the official and regulatory IPE frame. However, the perceived lack of an official definition potentially presents both more freedom to shape the definition of IPE within the IPE frame of educational leaders and less guidance and support. The results suggest how these educational leaders view IPE as a type of activity that is both important and sought after, regardless of their professional background. Perceived characteristics of IPE within the IPE frame of the educational leaders arguably focused mostly on implementation characteristics as well as of IPE as something that is challenging the traditional professional roles of the physicians and the nurses; the latter which in turn seemed to demand a certain degree of cultural competence regarding implementation of IPE in the two different educational programmes. But the lack of a specific definition of IPE in official documents can be said to potentially contribute to "cultural blindness" regarding implementation. When there is no official definition of IPE to rally round, it makes it more difficult for both the medical programme and the nursing programme to find mutual benefits across the borders of the two professions and hence facilitate practical and joint implementation. Within the IPE frame of educational leaders, IPE was also perceived to represent educational change which has shown often triggers different types of resistance within health professions education environments (McGrath et al., 2016; Velthuis et al., 2018), and the study suggests that it becomes problematic to implement change without perceived support from the senior level leadership. The need for senior organisational support to successfully implement and sustain IPE is a key issue which has been widely reported in the IPE literature (Barr et al., 2005; Bennett et al., 2011; Brewer, 2016; Ginsburg & Tregunno, 2005; Reeves & Kitto, 2017; Steinert, 2005). As indicated in this study, without support it becomes harder to overcome the organisational resistance and change fatigue as described by educational leaders. In this situation, the official IPE learning outcomes are viewed as helpful tools in the implementation process by the educational leaders.

Apart from the lack of a definition of IPE on an official policy level, the choice of a decentralized model for the responsibility of IPE had been approved by the Board of Education, as noted above. The model, on one hand, brings IPE closer to different levels of the organisation, but on the other hand, potentially shies away from pinpointing the organisational responsibility for IPE. The model may be said to contradict the experiences of educational leaders who expressed a wish for more support from the senior leadership level at the institution regarding IPE. However, the inclusion of IPE promotors – i.e. teachers involved in different health professions educational programmes at the institution with and without leadership responsibilities – could, on the other hand, be interpreted as an institutional attempt to involve IPE champions for successful implementation as shown as important by King et al. (2017). But in alignment with the findings of others, for example, Ginsburg and Tregunno (2005), Steinert (2005) and Bennett et al. (2011) some of the educational leaders requested more explicit leadership support from the senior level to be able to challenge resistance properly.

Regarding the rationale for IPE, the IPE frame of educational leaders emphasized issues of clinical relevance such as increased patient safety and better cooperation between the medical students and nursing students. But the results also reveal a disconnection from the IPE frame on an official regulatory level, since it was difficult to identify a rationale for IPE within the official documents; IPE is rather described as a strategic educational means of its own. However, the evidence contained in the official regulatory documents is clear: there is an importance attached to the implementation of IPE in the study setting. The rationale behind it may, however, be perceived as more vaguely communicated, along the lines of IPE portrayed as "common sense" as shown by Chesters, Thistlethwaite, Reeves, and Kitto (2011). The only connection to a clinical relevant rationale for IPE is through the actual official learning outcomes. As shown earlier by Ward et al. (2017) it is important to be aware of how IPE is articulated for successful implementation and that the results show that there is room for improvement regarding this within the official regulatory frame of IPE at the institution.

Additional features of the rationale were also found within the IPE frame for this sample of educational leaders. The frame refers to IPE as an educational idea, as shown earlier by Meads (2006). In addition, IPE is identified as an educational element of change which has to compete with several other educational elements of change on the educational arena. The implementation problems within the IPE frame of the educational leaders that are perceived as the most complex to solve, are those that are felt to potentially threaten the professional identity of the physician and the power balance between physicians and nurses; a feeling of threat that can be perceived both by and among the educational leaders themselves as well as among their colleagues and the medical students. Hence, this suggests IPE is seen as a potential threat to the balance between professional roles, as highlighted by Kuper and Whitehead (2012). However, IPE is also seen as a potential threat to gender relations, as shown by Bell, Michalec, and Arenson

(2014) and Falk Lindh, Hammar, and Nyström (2015). The arena for these professional power and gender imbalances are the actual IPE learning environments and activities; the results show how these environments and activities are the means that express IPE within the IPE frame of educational leaders. But here the perceived lack of stalwart support from regulatory documents and the organisational senior leadership may become a problem within the IPE frame of the educational leaders in this study. As a result, very few of the important tasks for successful senior leadership in connection to the implementation of IPE are hence able to be fulfilled: to set outcomes, highlight tensions for change, provide resources and hold individuals responsible for outcomes (Barr et al., 2005; Reeves & Kitto, 2017).

Without an official institutional definition of, or clear rationale for, IPE combined with an organisational model for IPE that does not pinpoint clear bearers of responsibility, the IPE frame of educational leaders seems to suffer in its implementation attempts/presentation of IPE learning activities and within IPE learning environments. This phenomenon has been highlighted earlier by Clark (2011) by pointing out the differences between the unproblematic task to endorse IPE on a general level and the more complex and problematic task to implement IPE within the organisation. The IPE frame of the educational leaders seeks senior-level leadership support and clarity through official policies, i.e. a vision and sense-making of IPE as shown by Brewer (2016). This was however somewhat challenging to find at the time of the study.

While there are challenges with the disconnection between the IPE frame on an official regulatory level and the IPE frame of educational leaders, it is important to apply an overarching time perspective; frames hold a temporal dimension. They often change over time which in turn creates new connections and disconnections between them (Pope et al., 2006). In this sense, new perceptions of IPE and as a result new prerequisites for implementation of IPE can be created and accepted within the institution in the future, but one has to create awareness of the connections and disconnections between the official presentation and the IPE frame of educational leaders in order for this to be possible.

Finally, the study contains a number of limitations. First of all, the choice of collecting interview data has several challenges, such as statements in interviews being filtered through social contexts of the interview as well as through the memory of the interviewee (Reeves, Lewin, & Zwarenstein, 2006) and interview statements being second hand data (Peräkylä & Ruusuvuori, 2011). In addition, the collected data size was limited, since both the number of steering documents referring to IPE and the number of educational leaders involved in IPE was small. This may, in turn, imply that there could be limitations connected to the conclusions drawn from this study, as well as the applicability to other health professional institutions.

Concluding comments

The aim of the study was to explore different meanings attached to IPE within two organisational entities at an academic health professions educational organisation: among educational leaders and the institution's educational policy documents. The usage of Goffman's frame analysis together with the starting point of the two concepts of power and resistance has made it possible to show how underlying differences of meaning attached to IPE within an organisation can, in turn, create potential difficulties regarding the implementation of IPE. This is especially true regarding power and gender imbalances between the educational and professional domains of medicine and nursing. For successful implementation of IPE, educational leaders hence request distinct and clear senior level leadership support for IPE. The differences in meaning attached to IPE and their implications for implementation of IPE within an institution are important themes to highlight and include in future faculty development programmes for faculty and educational leaders involved in IPE. To create awareness around sense-making of IPE among different stakeholders, for example, through frame analysis, is a potential key to achieve successful implementation.

Disclosure Statement

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

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