

NURSING'S ENGAGEMENT IN INTERPROFESSIONAL EDUCATION

A FEMINIST POSTSTRUCTURAL CASE STUDY OF NURSING'S ENGAGEMENT
IN INTERPROFESSIONAL EDUCATION

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the
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ABSTRACT

Nursing is a primary partner on the interprofessional team, yet there is minimal empirical evidence of nurse educators acting as architects of interprofessional education. Feminist poststructuralism (FPS) guides an exploration of nursing's engagement in interprofessional education (IPE) using Yin's (2009) case study methodology. A multiple case design investigates the following research questions: What are the antecedents of nursing's engagement in IPE; how are nurse educators/nursing faculty engaged in IPE; how does gender impact nursing's involvement in IPE development and implementation; and, how is nursing's IPE engagement impacted by contextual factors (e.g., social, political, historic) inherent in the broader health professional and academic contexts? Data to address these questions are generated from multiple sources including documents, archival records, individual and focus group interviews, field notes, non-participant observation, and demographic questionnaire in three English-language baccalaureate nursing programs in Ontario from June 2008 to June 2009. Three individual case reports and the cross case analysis report are interpreted through FPS tenets including language, discourse, subjectivity and power. Findings indicate that despite valuing IPE, nursing's IPE engagement is minimal, inconsistent, and diverse in the presence of discrepant and/or uncertain understandings of the term interprofessional. The cross-case analysis outcome speaks principally of nursing's general experience in the academy, with IPE engagement seemingly providing the vehicle to convey messages of enduring concern and tension inherent in nursing's experience in the academy. Prominent concepts uncovered include nurse academic, professional subjectivity, and professional identity. Historic, hegemonic discourses of women, nurse, and nursing's relationship with medicine impact nursing's professional subjectivity such that nurse academics' sense of professional self and professional confidence are viewed as antecedents to nursing's IPE engagement.

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Finally, to my husband and best friend, Jim, I convey my love and gratitude for being my champion as I travelled this lengthy educational path. His unwavering support, brilliant debating skill and computer expertise has sustained me throughout my entire career in graduate education!

DEDICATION

To my husband, Jim, and our daughters Kelly and Stephanie,
for their steadfast love, support, and encouragement ...

To my beloved friend, the late Susan Joan Lovell,
whose inspirational determination for living sustains
me daily ...

To my father, the late Reverend Canon William Robert Anthony,
distinguished scholar, humanitarian, and proponent of lifelong
learning who always looked forward to my *next*
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DECLARATION OF ACADEMIC ACHIEVEMENT

I, Susan Anthony, declare this dissertation to be my own work. I am the sole author of this document and no part of this dissertation has been published or submitted for publication. Guidance at all stages of the research has been provided by my supervisor Dr. Janet Landeen and my supervisory committee members, Dr. Patty Solomon and Dr. Catherine Tompkins. I alone have completed all work in this research.

I certify that, to the best of my knowledge, my dissertation does not infringe upon anyone's copyright nor violate any proprietary rights and that any ideas, techniques, quotations, or any other material from the work of other people included in my thesis, published or otherwise, are fully acknowledged in accordance with the standard referencing practices of the American Psychological Association, fifth edition manual.

I declare that this is a true copy of my dissertation, including any final revisions, as approved by my supervisor and supervisory committee and that this dissertation has not been submit for a higher degree to any other university or institution.

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PROLOGUE

Chapter One - Introduction

My nursing ontology, or way of being, is personal and professional. It is predicated on an epistemological curiosity that includes a belief in the existence of multiple truths, which may be historically, socio-culturally, and professionally derived and located. This reflexive disclosure offers a pre-understanding for the following text, providing a broad context in which to situate my study of nursing's engagement in interprofessional education (IPE). The attitude and language of this text aligns with a feminist poststructural perspective. Open-mindedness, a keen awareness of current discourses in academia and practice, and a heartfelt desire to understand the nature of participants' truths are personal principles guiding this study. Importantly, words and phrases have been chosen deliberately to convey accurate, faithful, and sensitive representations of research. This study has been an embodied and subjective experience, and as such is portrayed in the following original manuscript.

Over twenty-five years ago, as a daughter and nursing student, I witnessed the lack of communication and coordination among health professionals as they cared for an ailing cleric. While he had unfailing faith in his health care team, by the time of his hospitalization I possessed enough professional knowledge and experience to hold the opposite perspective. I observed the lack of communication and coordination, and disrespect among health professionals responsible for his care and witnessed several iatrogenic crises he needlessly experienced. Because of that defining experience, I vowed personally to make a difference professionally. As a beginning practitioner, I worked collaboratively with medical house staff to integrate biomedical patient data with a holistic perspective to provide clinically reasoned patient care. I fostered communication among health professionals, exchanging clinical knowledge and role and scope

of practice information. Later, as an intensive care unit nurse in Canada and in the United States, I continued to strive to work collaboratively with my health professional colleagues. From these collective experiences I concluded that learning with, from, and about (Barr, Koppel, Reeves, Hammick & Freeth, 2005, p. xxiii) health professional colleagues was mutually generative, that overt respect and tacit understanding of colleagues' professional responsibilities existed, and that inter-colleague tension disappeared when communication and collaboration became patient-centred. On reflection, my early professional practice incorporated rudimentary interprofessional education and practice that had been unknowingly cobbled together.

These personal and professional experiences define the origin of my IPE interest. As a nurse educator thirty years later, that interest in IPE has not diminished. Rather, the value I place on IPE is affirmed by the current academic, practice, and political interest in this approach to health professional education. Moreover, the positive influence of my early IPE experience on my recent IPE work has been affirmed as a well-recognized phenomenon among health professional faculty, particularly females (Curran, Sharpe & Forristall, 2007).

Interprofessional education, described currently as a movement within health professional education, is important because it is designed to foster collaborative practice and improve quality of health services (Reeves, Goldman & Oandasan, 2007). Interest and work in the area of IPE has exploded in the last decade with proliferation in opportunities for health professional students to learn with, from, and about each other (Barr et al., 2005) in health professional practice and in the academy. This recent growth in IPE activity notwithstanding, the concept of IPE is not new. Four decades ago, distinguished American nurse scholar, Madeleine Leininger (1971), espoused a model for interdisciplinary or interprofessional education that emerged from the contemporary reality that health professional students were expected to engage in

collaborative and cooperative practice post graduation, yet had little knowledge about their health professional colleagues' education, roles, and practice competencies. British IPE pursuit has a distinguished 50 year history (Barr, 2002) and continues to provide IPE leadership with the advent of organizations such as the Centre for the Advancement of Interprofessional Education (CAIPE). Canadian IPE history traces back to the mid 1960s (Dunn, 1966; Middaugh, 1967; Saucier, 1967) and national IPE initiatives are reported increasingly in the literature (Baker, Pulling, McGraw, Dagnone, Hopkins-Rossel, & Medves, 2008; Charles, Bainbridge, Copeman-Stewart, Art & Kassam, 2006; Charles, Bainbridge & Gilbert, 2010; Cragg, Hirsh, Jelley & Barnes, 2010; Curran, Sharpe, Flynn & Button, 2010; Hall et al., 2006; Lumague et al., 2006; Medves, et al. 2008).

Within the national context, the Canadian IPE agenda has become increasingly prominent with federal (Health Canada, 2004) and provincial (Health Force Ontario, 2008) financial support allocated to IPE development and implementation. For example, in 2005 and 2006 Health Canada funded the *Interprofessional Education for Collaborative Patient Centred Care* (IECPCP) initiative that generated 20 pan-Canadian projects related to interprofessional education and practice across all health care sectors (Canadian Interprofessional Health Collaborative [CIHC], 2008a). Provincially, offices and programs of interprofessional education have emerged at several universities including Queen's University (Office of Interprofessional Education and Practice [OIPEP]), McMaster University (Program for Interprofessional Practice, Education, and Research [PIPER]), the University of Toronto and the University of Western Ontario.

Commonly, IPE offices sponsor experiential IPE opportunities and events for health science and health professional students. Students are invited to engage in experiences outside

their curricular work, a framework consistent with the extracurricular IPE model proposed by Barr et al. (2005). At the same time, IPE course options are expanding. For example, as a Health Canada IECPCP initiative, McMaster University, the University of Ottawa, Laurentian University, the University of Western Ontario, and George Brown College together created the Institute of Interprofessional Health Sciences Education, a virtual learning centre through which seven on-line IPE course modules have been developed (Institute of Interprofessional Health Sciences Education [IIHSE], 2008). These modules address IPE and evidence-based practice, communication, ethics, aboriginal health, palliative care and pain, and community practice/health promotion. These courses are not mandatory. Rather, students are encouraged to enroll in the modules as elective courses within their chosen program of study. More recently, in 2009, the University of Toronto developed a mandatory IPE curriculum for implementation in its ten health sciences disciplines. This competency-based model allows students to develop IPE competence in areas such as values, ethics, communication and collaboration through core learning activities, including a clinical practicum (University of Toronto, 2008). The IIHSE learning models are under investigation as elective courses for students in the Faculty of Health Sciences at the University of Western Ontario (N. Fulford, personal communication, September 13, 2011). Most recently, the Office of Interprofessional Health Education and Research (IPHER) at Western's Schulich School of Medicine and Dentistry offers interprofessional voluntary learning events for a variety of health professional students across campus (IPHER, 2011).

It is evident that IPE learning opportunities are growing within Ontario health sciences universities. However, IPE does not appear to have found its way into mainstream baccalaureate nursing curricula despite financial and infrastructure support. This circumstance may be

attributed to several factors. First, the provincial fee-for-service medical model of remuneration (Reeves, 2006) may be a disincentive that precludes collaboration between physicians and other members of the health care team in practice. If collaboration among physicians and health care team members is not an integral component of clinical practice taught in professional education programs, it may be questioned why nursing programs should make IPE learning a priority in a curriculum that is overflowing. Second, because health professionals are educated and trained in different models and methods of practice (Curran, 2004), values inculcated through education and practice may be so disparate that developing and incorporating IPE in baccalaureate curriculum may seem prohibitively complex and challenging for nursing faculty members. Third, health professional curricula are so packed with subjects and concepts that are deemed essential that IPE experiences may be relegated to an ever-increasing list of competing priorities (Herbert, 2005). Finally, it is reasonable to suggest that other root causes of the IPE void in baccalaureate nursing curricula, and subsequent interprofessional disengagement in practice (Miller, Reeves, Zwarenstein, Beales, Kenaszchuk & Gotlib Conn, 2008) have yet to be determined.

Health professional scholars (Gilbert, 2005a; Kipp, Pimlott & Satzinger, 2007) maintain that collaboration among health care professionals will not develop effectively unless IPE is inculcated in mainstream health professional curricula, arguing that the value of IPE must be recognized and supported in academic circles. Leninger's (1971) insightful yet cautionary reproach foreshadows a need for change in health professional education, a belief shared by Romanow (2002) in *Building on Values; The Future of Health Care in Canada*. Romanow recognized that health professionals are educated predominantly in silos rather than together. He asserted that foundational preparation for collaborative practice must be included in health

professional's education programs because these professionals are expected to work together and share expertise in a team environment to provide patient-centred care.

Two immutable facts warrant consideration for the inclusion of IPE in baccalaureate nursing curriculum. First, historically, nursing curriculum development has responded to diverse influences that shape the professional landscape (Anthony & Landeen, 2009; Booth et al., 1997). Presently, a number of diverse influences impact how baccalaureate nurse educators and nursing baccalaureate curricula might respond to a mandate to incorporate IPE into baccalaureate nursing curricula: the political influence inherent in federal and provincial funding opportunities (Health Canada, 2004; Health Force Ontario, 2008); the scholarly influence inherent in the academic ground swell interest in IPE and its growing body of literature (Dimoliatis & Roff, 2007; Illingworth, & Chelvanayagam, 2007); the practice influence inherent in the opportunity to create better health outcomes purported to result from interprofessional collaboration and communication (Freeth, Hammick, Koppel, Reeves & Barr, 2002); and the professional influence inherent in the *National Competencies for Entry Level Registered Nursing Practice* adopted by the Colleges of Nurses of Ontario (2008) that directs nurses to establish and maintain interprofessional relationships within the health care team to promote therapeutic and culturally safe client care (p. 28). If nursing practice and education are inextricably linked (Anthony & Landeen, 2009) and if the anticipated goal of interprofessional learning is improvement in health professional collaboration and quality of care (Freeth et al., 2002), then embedding IPE in baccalaureate nursing curriculum is an educational obligation.

The second immutable fact is that nursing curricula development, including its definition and paradigm, influences the type and quality of graduates and the way nurses view their work (Bevis & Watson, 1989a). A critical mass of the current nursing professoriate has been educated

in an era when nursing curricula were grounded in a behaviourist educational paradigm (Bevis & Watson; Kirkwood, 2005). At the same time, the health professional educational culture was imbued with vestiges of the nurse-as-handmaiden script (Jinks & Bradley, 2004) and a lingering essence of nursing as women's altruistic duty to care (Reverby, 1998). If current nurse educators are influenced by the curriculum at the origin of their own practice, and if the tenets of that curriculum are vastly different than the tenets of a curriculum embedded with IPE, it is reasonable to suggest that nurse educators must reflect not only on how they view their work in developing a contemporary baccalaureate curriculum (i.e., different from that into which they were socialized) but also must reflect on their own role as an interprofessional colleague in the academy. Consideration of these immutable facts foreshadows research on nursing's engagement in interprofessional education.

Although IPE is being built into the mainstream of health professional education worldwide (Barr & Ross, 2006; Lanvin et al., 2001), integration of IPE into mainstream nursing education is indeterminant. It is unclear how IPE is present in baccalaureate education and how nurse educators in the academy are responding to calls for integration of IPE in baccalaureate education. Ironically, health professional students are not permitted to engage in any other realm of practice without an accompanying theoretical base, yet nurse academics do not appear to be the vanguard of the IPE movement to include IPE in nursing curricula. As an integral member of the academy, nursing needs to be an active presence in the drive to integrate IPE as a customary component of health professional education and practice.

Relevance of the Study

This study has relevance for several reasons. First, Barr and Ross (2006) surmise that once embedded in the mainstream, IPE will be relatively secure and stable. However, creating a

structure for sustainability is required to embed IPE in the mainstream. In order to create a structure for sustainability, it is necessary that all health professional partners engage equally. Barr and Ross affirm that for IPE to become mainstream, it must pervade the culture of professional education and be owned equally by each of the constituent professional programs. Consequently, an exploration of nursing's IPE engagement is necessary, first, to understand the status of IPE engagement and, second, to understand the resources and supports necessary to support IPE work. While an exploration of discipline specific IPE involvement is seemingly antithetical to the ethos of IPE, this exploration is necessary groundwork for successful IPE advancement that includes the nursing profession. This research is mandatory if IPE that includes nursing is to become mainstream.

Second, an exploration of the events, incidents, and contexts surrounding current nursing IPE involvement will establish baseline knowledge of the antecedents to nursing's IPE engagement, thereby providing direction for active and visible future involvement. For nursing, this exploration is a necessary step in advancing its contribution and profile as an equal and worthy partner in the growing IPE enterprise. If a goal of IPE is to improve health services via improved communication, co-operation, and professional understanding among health professionals (Allison, 2007; Cooper, Braye & Geyer, 2004; Craddock, O'Halloran, Borthwick & McPherson, 2006; Gilbert, 2005a; Herbert, 2005), then understanding the antecedents of nursing's IPE engagement may provide foundational information regarding professional communication, co-operation, and understanding.

Third, nursing is an academic and practice discipline. The discipline is grounded in a theoretical base gained first in the academic setting. Nursing knowledge and theory expand through nursing practice, education, and research. If nursing espouses that a theoretical base is

foundational to professional practice and if IPE is purported to being mainstreamed, then nursing's theoretical base must include knowledge and theory about IPE. Nursing's engagement in IPE innovation and implementation is requisite for the development of a comprehensive theoretical base. Accordingly, it is not only reasonable but also necessary to explore the antecedents in order to know the events and incidents that need to occur for nursing's IPE engagement.

Finally, this research may have implications for nursing's involvement in other professional and academic initiatives, contributing not only to the development of nursing's knowledge base but also to the larger and growing body of IPE theory and knowledge. Results of this study may have relevance, also, for a number of health professional partners.

Purpose of the Study

Nursing is a primary partner on the interprofessional team (Miller, 2004), yet there is little empirical evidence of nursing's direct involvement in IPE innovation and implementation. Accordingly, the purpose of this study is to examine nursing's IPE engagement and the antecedents, or necessary conditions for IPE work.

Chapter Summary

With this chapter begins the Prologue of nursing's IPE engagement at three Ontario university schools of nursing. As a Prologue, chapters one through four, set the stage for the case reports of chapter five and the Epilogue of chapters six and seven. In chapter one I have provided background to the study, including reflection on my personal and professional interest in IPE, description of current federal and provincial IPE initiatives, and explanation of the research purpose and study relevance. Chapter two is a 'reader' in feminist poststructuralism, a perspective that incorporates gender issues into a poststructural framework (Arslanian-Engoren,

2002; Weedon, 1997) and describes this lens through which the research is conducted. The Prologue continues with chapter three as a review of the literature, clarification of research terms, description of the study propositions, and research questions included together due to the linked nature of their relationship in case study methodology design. This chapter of the Prologue locates my research within the context of extant IPE literature. The Prologue ends with chapter four in which I present the methodology, including consideration of ethics and trustworthiness. Following the Prologue is chapter five, which presents three within-case reports (Yin, 2009) of individually synthesized data from Sites A, B, and C. The Epilogue begins with chapter six: a cross-case analysis and report in which the research questions are answered. The answers are discussed and interpreted through the major tenets of feminist poststructuralism including language, discourse, subjectivity, and power. In chapter seven, the Epilogue brings my research to a close by revisiting the methodology, my reflexivity, and feminist poststructuralism prior to a discussion of the study conclusions, implications, recommendations and limitations. Concluding comments bring the research full circle to readdress the need for the study.

Chapter Two - Feminist Poststructuralism as Theoretical Framework

In this chapter is presented an introduction to feminist poststructuralism (FPS), the theoretical framework guiding the study. Description of the history of feminism and poststructuralism precede an explanation of the emergence of FPS. The key compositional concepts of FPS, including discourse, language, subjectivity, and power, are described in reasonable detail to provide a solid platform for exploration of nursing's IPE engagement. Explanation and justification of the appropriateness of FPS for a study about nursing is woven throughout the chapter.

Introduction

Qualitative researchers use theory formatively, in the form of a conceptual model (i.e., variables and constructs in relationships) to explain behaviours and standpoints or as a lens through which the research is conducted, orienting the study around specific concepts (e.g., gender, power), and summatively, as an inductive outcome of a study (i.e., grounded theory) (Creswell, 2009). In this research, theory is used as an orienting lens (Creswell) or a theoretical framework to focus the research on a collection of inter-related concepts. In addition to focusing the inquiry on specific concepts and phenomena, the theoretical framework informs the nature of the research questions, the data collection and analysis process (Creswell), and enlightens the interpretation, discussion, and conclusions. Use of a theoretical framework in this research promotes rigorous, comprehensive, and innovative exploration of nursing's IPE engagement.

Feminist poststructuralism is the theoretical framework that guides the study and is understood as “... a mode of knowledge production which uses poststructuralist theories of language, subjectivity, social procedures and institutions to understand existing power relationships and to identify areas and strategies for change” (Weedon, 1997, p. 40-41). St. Pierre

(2000) remarks that both feminism and poststructuralism are “highly contested terms” (p. 477), a prospect which challenges but does not encumber the evolution of a standpoint that is sympathetic to both feminist and poststructural epistemological and ontological roots.

Feminism

At its origin, feminist theory embodies a paradigm in which women are valued and injustices played out against women and other marginalized groups are confronted. From its earliest beginnings in the 17th century (Bunting & Campbell, 1990), feminist theory has evolved to incorporate a variety of perspectives (e.g., radical, liberal, postcolonial) and movements described as first (19th and early 20th century), second (1960s, 1970s), and third wave (1990s to present) feminism (Kroløkke, & Sorensen, 2005). Despite expansion in feminisms, common grassroots beliefs endure. For example, epistemological tenets common across all feminisms include the realities that women are capable of knowledge production and that subjective data is valid (Bunting & Campbell; Kroløkke, & Sorensen). Ontologically, similarities include belief in a contextual orientation (Bunting & Campbell; Kroløkke, & Sorensen), a position that confronts systematic injustices based on gender (Doering, 1992), and an orientation in which power is used to emancipate rather than to subjugate and silence (St. Pierre, 2000). It follows logically that feminist research is concerned with women’s experiences (and those of other marginalized groups), which are the subject of investigation that is critical and activist in approach.

Poststructuralism

Poststructuralism has materialized from the intellectual positions (Weedon, 1997) held by 20th century French intellectuals, including Jacques Derrida (1973, 1974), Michel Foucault (1972/1969, 1980) and Julia Kristeva (1980, 1981) and their respective critiques of structuralism. Emerging in the 1960s, these positions incorporated deconstructive criticism of literary texts

with the consequent embodiment of the concept of non-fixed meaning (Derrida), reification of inherent meanings of gender and language in French feminist work (Kristeva), and historical analysis of power and discourse (Foucault). Although these poststructuralist positions may manifest differently in practical and political contexts (Weedon), their shared fundamental elements are most useful and productive for a feminist approach to this research and are those that incorporate challenges to constructs of meaning (i.e., fixed meanings exist) and assumptions about language, a unified subjectivity, and power relations (Weedon).

Feminist Poststructuralism

At their roots, feminism and poststructuralism hold seemingly incompatible philosophical positions (Aranda, 2006; St. Pierre, 2000). Poststructuralist knowledge claims stem from a plural position of multiple truths, rejecting the notion of a fixed, universal or absolute truth (Derrida, 1991; Foucault, 1972/1969, 1980), and deconstructs what Hatch (2002) refers to as grand narratives (i.e., feminism). As a critical perspective, feminism is concerned with gender and the nature of inequality and issues of power, politics and social relations. According to Lather (1992), feminism “argues the centrality of gender in shaping of our consciousness, skills, and institutions as well as in the distribution of power and privilege” (p. 91), suggestive of a universal female-centric truth. Understandably, blending feminist and poststructural perspectives may be perceived as illogical when poststructuralism rejects the very ideals upon which feminism has been founded (e.g., emancipation) (Hatch). Despite the apparent incongruence of these positions, feminist poststructuralism has emerged as a strategically reconfigured hybrid (St. Pierre) whose tenets are greater than the sum of the parts (Hatch).

A feminist poststructural perspective incorporates gender issues into a poststructural framework (Arslanian-Engoren, 2002; Weedon, 1997) and provides a critical standpoint from

which to view and analyze nursing's IPE engagement. Feminism and poststructuralism are particularly relevant to nursing, a female-dominated profession, because they incorporate the concept of the female experience and the concept of power; Feminism challenges patriarchy, gender disparities, and structures and processes that disadvantage and oppress women while poststructuralism challenges constructs of meaning, a unified subjectivity, and power relations (Weedon). Feminist poststructural assumptions claim that there is a subjectivity formed by gender that is socially, historically and politically based, that power and knowledge are mutually generative, that knowledge is developed in historical, social, and political contexts and is fallible, and that while power is exercised in relation to resistance (Foucault, 1990/1976), change is possible because the balance between power and resistance is not fixed (Doering, 1992, p. 26). Together, feminism and poststructuralism reflect the historical, social, and political contexts in which the discipline of nursing operates. A feminist poststructural perspective used in nursing scholarship is well documented in the literature (Arnold, 1996; Arslanian-Engoren; Davies, Browne, Gannon, Hopkins, McCann & Wihlborg, 2006; Doering; Gastaldo & Holmes, 1999).

A feminist poststructural theoretical framework is appropriate for several reasons. First, consideration of traditional epistemological assumptions present in health care and the academy become necessary. Second, discovery of androcentric biases within the socio-politically, culturally, and historically established institutions of health care and the academy is central. Third, academic and practice setting hierarchies and networks that use power to silence are considered. Finally, marginalizing discourses related to gender and nurses are emphasized. Specifically, a feminist poststructural lens focuses the research on the broader social and historical context, the role of language and subjectivity, and the effect of power relationships in health professional and educational cultures wherein nursing's IPE engagement is located. Since

the evolution and foundational principles of the nursing profession have been influenced by patriarchy in practice and in the academy (D'Antonio, 2005; Davidson Dick & Cragg, 2003; Ross-Kerr, 2003a, 2003b), a feminist poststructural framework (Arslanian-Engoren, 2002; Francis, 2000) has been chosen purposefully to uncover gendered discourses, structures, and processes embedded in health professional and educational cultures.

Feminist poststructuralism supports the study of nursing's IPE engagement not only because nursing reflects the perspective of a female-dominated profession but also because this perspective promotes the study of underlying culturally conditioned structures (e.g., systems of knowledge, power relationships) within which nursing's IPE engagement is located (Weedon, 1997). For example, a feminist poststructural perspective will provide a framework to examine hierarchical academic and health care structures and processes that use power to silence and marginalize nursing's evolving self-ascribed identity, roles, and discourse. This perspective will reveal divergence from the dominant, historically embedded essentialist view of nursing as a natural biologically derived gender-based role (Reverby, 1998). Discourse, language, subjectivity, and power are fundamental concepts in feminist poststructuralism (Doering, 1992; Weedon) and are discussed to promote coherence and understanding of the research and its context.

Discourse

Feminist poststructuralism incorporates the Foucauldian (1990/1976) notion of discourse referring to anything that carries meaning. Alsop, Fitzsimmons, and Lennon (2002) explain that Foucault's discourse includes phenomena such as language, stories, scientific narratives, and cultural practices which are organized and structured by the institutions and practices of the time in which they occur (Foucault, 1972/1969). A discourse encompasses subjectivity such that an

experience will have a different meaning for each person involved; one's subjective meaning of an experience is a function of how one interprets the world and how one interprets current other or competing discourses (Weedon, 1997). For example, nursing's current IPE engagement (inclusive of certain language and health professional and academic culture which defines it) represents a discourse. This discourse depends on how nurse educators interpret their role in IPE, on available discourses about nurses' roles and relationships in general, and on other (competing) discourses pertaining to nurse educators' work in the academy and health professional education. The discourse of nursing's IPE engagement is constituted not only by the ways in which nurses know and understand themselves individually and as a professional collective (Arslanian-Engoren, 2002) but also how nursing is constituted by the dominant discourses in health care and in the academy.

Dominant discourses are socially and culturally produced, constitute power by constructing objects in particular ways, and play a critical role in the interpretation of meaning (Francis, 2000). The struggles, conflicts, and negotiations that may occur between competing discourses occur through power relations among individuals and institutions. According to Foucault (1990/1976), power relations among competing discourses create change. Recognition of discourses, including women's experiences as valid sources of women's knowledge, is a feminist implication of poststructural thought (Heslop, 1997). What is most relevant to nursing's IPE engagement is that the discursive field in which IPE exists affects nurses' perception of professional identity, capability, and involvement. Discourse and language are co-dependent and mutually generative and receive close attention in a feminist poststructural reading of research.

Language

Language is fundamental to human understanding and communication and for several reasons is pivotal to a feminist poststructural analysis. First, language has preeminence because it is the mechanism by which society defines, characterizes, and internalizes concepts, structures, and processes (Arslanian-Engoren, 2002). Second, language is a constitutive force that shapes not only understanding what is possible, but also shapes preferences within the possibilities (Davies, 2000). Third, language is the common feature in an examination of constructs germane to social organization, social meaning, power, and individual consciousness (Weedon, 1997); in its essential form, language is the vehicle through which sense and meaning of one's world is derived (Doering, 1992).

The inextricable relationship between language and feminist poststructuralism is described in the literature (Arslanian-Engoren, 2002; Weedon, 1997) and stems from the intersection of feminist and poststructural roots. In poststructuralist theory, words have no fixed meanings, only specific historical and contextual meanings (St. Pierre, 2000). This understanding of language is derived from the work of structural linguist de Saussure (1959/1916) who asserted that the property of a word does not include an intrinsic meaning. Rather, words acquire meaning because of their relationship with other words. Derrida's (1974/1967) practice of deconstruction is central to poststructural theory (St. Pierre, 2000; Weedon) and when deconstruction is applied to de Saussure's notion of language, the fluid nature of words emerges; their meaning becomes context dependent, shifting with historical era, setting, and discourse. For example, historically the word nurse means to feed and to provide sustenance within the context of infant nutrition, yet in contemporary times nurse means also professional practitioner within a tertiary care institution or educator within a post secondary education context.

Poststructural thought on the discursive and context-dependent nature of language implies not only that women's self-identity is constructed through language but also that language gives voice to women's experiences, ones that do not necessarily represent the dominant discourse (Heslop, 1997). Rigid adherence to the dominant language discourse, wherein fixed meanings present a certain way of thinking or understanding, promotes dogmatic thinking and precludes acceptance of others' experiences as unique and authentic. A feminist poststructural perspective interrogates how taken-for-granted aspects of language creates certain fixed meanings and legitimizes certain knowledge (Weedon, 1997). When language is subject to feminist poststructural analysis, what can be investigated are the ways in which language shapes not only how the discipline of nursing is represented but also how language provides and limits ways for nurses to make sense of themselves. A feminist poststructural understanding of language reveals how nurses may be active participants in either reproducing or challenging their own "linguistic scaffolding" (Sowell, 2004, p. 41) that shapes the professional context within which IPE exists; a context that may include inequities of binary categories such as male/female and nurse/doctor. Importantly, a feminist poststructural understanding of language requires nurses' self-examination of complicity (St. Pierre, 2000) in maintaining dominant discourses. To explore how language is used to create reality, rather than to reflect it (de Saussure, 1959/1916; Sowell; Weedon), is to create space for change and achievement of the emancipatory ends of feminist poststructuralism.

Subjectivity

Subjectivity can be understood as embodiment of the "conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world ... which is precarious, contradictory and in process, constantly being

reconstituted in discourse each time we think or speak” (Weedon, 1997, p. 23.). Subjectivity is inextricably linked to meaning, language, and discourse. The meaning of an experience is conferred through subjective interpretation. Meaning is produced within language, rather than reflected by it (de Saussure, 1959/1916). Therefore, the meaning of language is subjectively intuited. Logically, since language creates discourse (Alsop et al., 2002), and language is subjectively intuited, a discourse encompasses subjectivity; the subjective meaning of an experience depends on an individual’s perception of self, personal interpretation of the world, and other competing discourses available at a particular moment (Weedon, 1997).

Subjectivity is an important concept in exploring nursing’s IPE engagement because how nurses make sense of themselves and understand their relationship to the academic and practice world is informed by the experience of being female and by gendered representations of the profession. These gendered representations of the profession have been acquired through social, historical and political forces (Arslanian-Engoren, 2002; Doering, 1992) that include fixed meanings, behaviours, and values of what it is to be female and a nurse. However, since meaning is not guaranteed or absolute in a feminist poststructural world (i.e., changes with context and discourse), nurses’ subjectivity is mediated by social discourses of what it is to be female and a nurse and cultural practices inherent in professional practice and the academy.

Power

Foucault’s (1980) conceptualization of power as inextricably linked with knowledge informs poststructuralism; power and knowledge are antithetical, yet mutually generative and inseparable. In Foucault’s view (1990/1976), power is not a personal trait or the property of an institution or position. Rather, it is a name attributed to a pervasive and complex strategic situation that can be manifest in any particular relation and, as such, is everywhere. Power is a

strategy or process that is exercised within everyday situations of discourse (Sowell, 2004) and is always exercised in relation to resistance (Foucault, 1980). It is in discourse that power and knowledge are joined (Foucault, 1990/1976, p. 93).

A feminist poststructural analysis is interested in exploring how discourses and power relations have reinforced and normalized certain knowledge and truths about women (i.e., women are incapable of rigorous scholarship or effective leadership) (St. Pierre, 2000), exposing “regimes of truth that operate to subjugate women and other marginalized groups” (p. 499). What becomes legitimate knowledge and what can be said and by whom is influenced and dictated by inequitable power relations because knowledge is fallible and contingent. For example, the power relation between nursing and medicine is linked to the control of scientific knowledge by both of these disciplines (Doering, 1992). If the female-dominated nursing profession is perceived as incapable of knowledge development by the dominant medical (male) culture that is at the top of the power relation, this regime of truth becomes legitimized by virtue of the power imbalance between medicine and nursing. Nursing (female) knowledge exists in relation to medical (male) knowledge and power. Power is exercised within discourses consistent with the ways in which discourses create and govern individuals and social institutions (Weedon, 1997). Medicine’s historic discourse of superiority, largely rooted in primacy of scientific knowledge development and expertise, confers this degree of greater power.

Conflict and conciliation between competing discourses occur through power relations. Power generated from competing discourses is leverage for change and knowledge development because the balance between power and resistance is not fixed (Doering, 1992; Foucault, 1980). A feminist poststructural perspective recognizes that the tension between competing discourses can be turned into a productive force, working within and against conflicting discursive

assumptions. Accordingly, power is both knowledge limiting and generating (Foucault); power generates and is served by knowledge, and knowledge reinforces and supports existing power relations.

Summary

Globally, research from a feminist poststructural perspective is committed to developing knowledge that contributes to social, political, and economic changes in structures of society that affect health and illness (McCormick & Roussy, 1997). This research is conducted from a feminist poststructuralist perspective so as to explore events or incidents surrounding nursing's IPE engagement stemming from gender and socio-cultural discourses. Conducting research from a feminist poststructural perspective has implications for increasing awareness of issues in academia that cause discrepancies and inequities for nursing faculty, a predominantly female professoriate. This research is grounded in an awareness of nursing's sociopolitical realities and historical contexts and can contribute to knowledge development about nursing's IPE engagement. This choice of theoretical perspective is deliberate so as to capture specific elements of nursing's IPE engagement that are a function of and inseparable from the context in which it is located. This theoretical perspective guides the reading of the literature, data collection, analysis, and interpretation, ethical considerations and trustworthiness. Strong researcher reflexivity is necessary when conducting research from a feminist poststructural perspective to reflect on how personal values, beliefs, and experiences influence choice of research methods, questions, and methodology, and the resultant knowledge that is constructed (McCormick & Roussy). Appropriately, feminist poststructuralism is a unique perspective from which to conduct the research and is a methodological strength.

Chapter Summary

This chapter has provided an introduction to the theoretical framework guiding the study. Feminist poststructuralism implicitly and explicitly infuses each area of the research. This theoretical framework guides a reading of the literature, presented in the following chapter.

Chapter Three - Literature Review, Research Terms, Propositions and Questions

This chapter provides a pre-understanding of the literature to inform this exploration of nursing's IPE engagement. An overview of relevant interprofessional education research is presented before a focused review of nursing-specific IPE literature. Synthesis of these bodies of literature inform the explanation of the need for the study, the study propositions, and research questions, presented at the end of the chapter.

Introduction

The purpose of this qualitative case study is to explore nursing's IPE engagement. Specifically, the study is designed to gain an understanding of nursing faculty/nurse educators' experience with IPE and the events and incidents that occur prior to and during (Walker & Avant, 2010) IPE engagement. A critical review of current IPE literature is obligatory not only for impeccable conduct of this research but also to help set a useful and appropriate path for exploration of the subject matter. The literature review component of qualitative research balances the need to explore what is known and unknown about the matter with the danger of reducing openness to and introducing bias toward emerging fieldwork data (Patton, 2002). Placement and timing of the review reflects the interaction between prior knowledge and discovery of new knowledge presented in a format that is consistent with the nature of the research approach (Bloomberg & Volpe, 2008; Creswell, 2003, 2009). In this case study approach, an initial literature review provides a picture of current IPE with specific focus on nursing's engagement. The initial review locates this research within the field of existing IPE knowledge, providing context and a theoretical base for the study while preserving the inductive nature of the research design (Creswell, 2007, 2009). Ongoing literature review and literature

application occurs throughout data collection, synthesis, and analysis and is foundational to the study's discerned themes and conclusions.

For the initial literature review, a body of IPE literature was generated from a search strategy that incorporated electronic databases, hand searching and ancestry searching. Electronic databases, including the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, SCOPUS, and ERIC, were searched using key search words nursing, education, learning, teaching, baccalaureate, curriculum, inter, multi, trans and cross - professional, and inter, multi, trans and cross disciplinary. The search terms were used separately or in combination. The literature reviewed included published IPE research from 2003 to 2008. The review focused on two areas: literature on general IPE and learning and literature written or co-written by identified nurse authors in which IPE initiatives incorporated nursing education. Literature excluded from the review were books, book chapters, dissertations, abstracts, unpublished manuscripts, published papers missing authors' professional identification, papers published by non-nurse authors only, expository papers, and literature on staff nurse interprofessional education.

Feminist poststructuralism provided an orientation for this critical review. Accordingly, attention was given to discourse, language, subjectivity and power manifest in the IPE literature. For example, discourse on IPE and nursing education was understood only in the context of the historical development of IPE and nursing since discourse is contemporaneous (Gastaldo & Holmes, 1999). Similarly, embodied expressions of power relations among the health disciplines garnered attention. The literature review begins with a description of research terms to provide orientation and clarity.

Clarification of Research Terms

Interprofessional Education and Learning

Interprofessional education, as an umbrella term, refers to occasions “when members (or students) of two or more professions associated with health and social care, engage[d] in learning with, from, and about each other” (Barr et al., 2005, p. xxiii) and is the definition that informs this study. The anticipated goal of interprofessional learning, a component of IPE (Barr et al.), is improvement in collaboration and quality of care (Freeth et al., 2002). Within the context of this research, the concept of interprofessional learning refers generally to learning which arises from interaction between students of two or more health professions that occurs as a result of either deliberate, preplanned educational initiatives or by chance (Barr et al.). Specific characteristics of interprofessional learning include applying adult learning principles to interactive, group-based collaborative learning, making explicit the links between collaborative learning and collaborative practice, and applying interpersonal, group, inter-group, organizational and inter-organizational relations and processes of professionalism (Barr, 2002).

Nursing’s IPE Engagement

To engage means to pledge or to secure by pledge, to persuade or win over, to employ or occupy (Hoad, 2003, p. 149) while engagement refers to the state of being involved in something (Soanes, 2006, p. 246). Appropriately, the operational definition of nursing’s IPE engagement that informs this research refers to nursing educators’/nursing faculty’s visible and active involvement in development and implementation of interprofessional education and learning. Hereafter, this concept is referred to as nursing’s IPE engagement. Currently in Ontario, baccalaureate nursing education is required for entry to practice. Therefore, in this research, it is

understood that nursing's IPE engagement incorporates baccalaureate nursing education only.

Clarification of key terms is instrumental in understanding the following review of the literature.

Two major areas of the literature were reviewed: general IPE literature and specific IPE literature representing nursing's involvement. The review of general IPE literature focused on key IPE *elements*, including *definition, principles, models and strategies*, and consideration of IPE *context*, including, *barriers, power, territoriality, and attitudes*. The review of the IPE literature specific to nursing's engagement provides a contemporary picture of IPE co-developed and reported by nurses.

General IPE Literature

Key IPE Elements

Definition. The current body of IPE literature is vast and diverse (Dimoliatis & Roff, 2007). Since its inception, descriptions of interprofessional education have been seemingly prolific (Finch, 2000; Raftner et al., 2006; World Health Organization [WHO], 1988). While many terms to describe IPE have been used interchangeably with ostensibly precise yet variable meanings, the definition developed by Barr et al. (2005), presented earlier, is used predominantly over the last five years and is the definition guiding this research.

Principles. Research in interprofessional education is growing exponentially (Dimoliatis & Roff) with consequent expansion in IPE knowledge and theory. Oandasan and Reeves (2005a) conducted a systematic review of the IPE literature from 1990 to 2003 to assess the state of IPE knowledge and theory. Principles considered important to IPE curriculum design derived from this review include inclusion of concepts relevant to learners' current or future practice (Oandasan & Reeves), inclusion of typical health challenges that require an interprofessional approach (WHO, 1988), inclusion of clinically-based interprofessional learning opportunities

(Reeves & Freeth, 2002), and use of learning methods (e.g., small group case-based or problem-based learning) which facilitate interaction between learners from different professions (Oandasan & Reeves). These foundational principles are reflected in IPE models and strategies.

Model and strategies. Many IPE models and strategies are reported in the literature (Kippe et al., 2007). For example, Barr et al. (2005) describe two disparate models they developed for university-led pre-licensure IPE: an *extra-curricular model*, or assigned IPE that occurs outside of regular program time and a *crossbar model*, or IPE opportunities embedded in regular professional curricula. More recently, Curran and Sharpe (2007) report the development of a *continuous, early-to-late approach* in which IPE is embedded in early stages of professional education pre-licensure curricula and is reinforced formally throughout pre-licensure and post-licensure education. The continuous, early-to-late approach combines characteristics of the extracurricular and crossbar models described by Barr et al. Several other models and strategies are Baldwin and Baldwin's (2007) model for interprofessional learning and service, centred around core curriculum competencies that guide the educational process for health professional students; D'Eon's (2005) competency-acquisition IPE blueprint based on integrating learning approaches, including progressive complexity of learning tasks, best-practice cooperative learning strategies (e.g., positive interdependence, face-to-face promotive interaction, individual accountability, interpersonal small-group skills, and group processing), and an experiential learning framework; and Walsh, Gordon, Marshall and Wilson's (2005) *Interprofessional Capability Framework* based on levels of learning outcomes in four key domains (e.g., ethical practice, knowledge in practice, interprofessional working, and reflection). On a national level, Cook's (2005) overview of pan-Canadian IPE models includes a variety of informal and formal strategies including generic team building exercises, shared instruction in core content, and

specific instruction and/or experience in interprofessional education such as the *Interprofessional Rural Program of British Columbia* (Charles et al., 2006) and the *InterProfessional Initiative* at the University of Alberta (Philippon, Pimlott, King, Day, & Cox, 2005). Finally, since the evolution of diverse IPE models and strategies is reported increasingly, Clark (2006) advises the development of an overarching IPE theoretical framework in which major course concepts, learning methods, faculty and student roles, and research and assessment frameworks are identified.

It is logical that health professional students be educated together in professional programs if they will be working together post-licensure. This literature on contemporary IPE models and strategies reflects a variety of integrative and supplementary IPE initiatives wherein health professional students have the opportunity to “learn[ing] with, from and about each other” (Barr et al., 2005, p. xxiii). However, while the development of IPE principles, models, and strategies demonstrates commitment to IPE advancement, this commitment to interprofessional education begins with university faculty through their efforts in planning, organizing, and committing to this learning approach (Kipp et al., 2007). What remains unclear is university faculty members’ commitment to IPE. Faculty members’ commitment to IPE is implicit rather than explicit in reported IPE models and strategies. An exploration of the IPE context, including barriers, power, territoriality, and attitudes provides background information necessary to the understanding of faculty members’ IPE engagement.

IPE Context

Barriers. Barriers to IPE and practice have been both a general and specific focus for research and opinion papers. Oandasan and Reeves’s (2005b) systematic review of the IPE literature from 1990 to 2003 synthesized a view of IPE barriers including student, teaching, and

environmental issues that subsequently have been affirmed by others. For example, Hall (2005) examined professional cultures as barriers to IPE. Educational, systemic, and personal barriers that emerged as impediments to interprofessional teamwork have implications for IPE. Using focus groups, Clavering and McLaughlin (2007) exposed health professional's shifting professional boundaries and hierarchies emerging from participants' different perspectives, interests and world views. It is within this context, characterized in part by shifting and disparate professional boundaries and hierarchies and views, that IPE is located. Gilbert (2005b) analyzed interprofessional learning and structural barriers in higher education within the broader Canadian political and economic context. He explains how language use, communication, culture, cost of curricula and services, university policies and procedures, and other psychosocial, economic, and legislative elements create opaque and concrete barriers to IPE and learning. Gilbert suggests that these barriers, including faculty mindset, are embedded in university structure and development. While the barriers to IPE described by Hall, Clavering and McLaughlin, and Gilbert are concerning, advancement of mainstreamed IPE is contingent upon continued diligent exploration and assessment of barriers inherent in the context within which interprofessional education and learning takes place.

Power, territoriality, attitudes. Power, territoriality, and attitudes are believed to be barriers to IPE (Baldwin, 2007). Curran, Deacon, and Fleet's (2005) survey of Canadian health professional education academic administrators' attitudes towards interprofessional education reveals that this group holds a favourable perception of interprofessional education, a curious finding in view of Gilbert's (2005b) revelation about barriers to IPE posed by university structures. In a subsequent Canadian study, Curran et al. (2007) surveyed attitudes of health science faculty members toward interprofessional teamwork and education to find that while

faculty attitudes generally may be conceived as barriers to success, individual profession, gender, and prior IPE experience specifically appeared to be key attributes related to positive IPE attitudes. The nursing profession, female faculty, and female faculty with prior IPE experience reported significantly higher mean scores on attitudes toward IPE than other professions and male faculty members. Curran, Sharpe, and Forristall's findings have significance for a feminist poststructural analysis of this research. Finally, Glen and Reeves (2004) examined cultural barriers (e.g., unfavourable faculty attitudes, entrenched health professional students' stereotypes), organizational barriers (e.g., timetabling challenges, discrete discipline-specific curricula, profession-specific educational requirements), and educational factors (e.g., historical socio-political imbalances) that affect the development of pre-registration interprofessional education and that create power imbalances and territoriality.

This review of general IPE literature focused specifically on IPE foundations and context to provide a broad framework within which nursing's IPE engagement is located. Although the larger current body of IPE literature is predominantly descriptive, anecdotal, and atheoretical, a small body of research reported IPE models and strategies and IPE barriers, territoriality, and attitudes. Manifestations of power relations within the IPE context, as well as representations of discourse, language, and subjectivity and manifestations of power are implicit in the general IPE literature. Continued growth in IPE research is needed to expand not only IPE knowledge and theory, but also to make explicit or uncover discourses relevant to language, and subjectivity and power that can mutually inform and advance IPE. Research conducted from both an interprofessional platform as well as from a uni-professional or nursing-specific perspective promotes the development of comprehensive IPE models, strategies and contexts.

Nursing Specific IPE Literature

Nurse authors have contributed descriptive writing and research reports to the body of IPE literature. The focus of this section is on IPE literature that reflects nursing scholarship. The following six studies describe IPE innovations and research pertaining to IPE strategies, events, incidents, and contexts. For example, Verma, Paterson and Medves (2006) identified the core concepts and competencies shared among the disciplines of medicine, nursing, occupational and physical therapy in order to develop a common framework and language for IPE teaching and assessment. These authors suggested a model for IPE, harmonized from discipline-specific competencies, that includes six sequential stages as shared professional standards for collaborative practice: communication, consultation, cooperation, coordination, collaboration, and collaborative practice. Similarly, O'Halloran, Hean, Humphris, and Macleod-Clark (2006) described the *New Generation Project*, an IPE undergraduate curriculum model for pre-registration health professional students that incorporated content common to all professions, purposeful exposure to different professional perspectives, and experiential learning in a model that combined three pedagogies: guided discovery learning, collaborative learning, and interprofessional learning. The purposeful focus on core concepts foundational to all health professions unites the models described by Verma et al. and O'Halloran et al. in their purpose to prioritize shared learning beginning with common competencies and content.

A variety of interprofessional learning strategies, co-developed by nurses, are reported in the literature. For example, Linqvist, Shepstone, Pearce and Watts (2005) described a successful case-based small group interprofessional pre-registration learning opportunity. This learning strategy was developed specifically to study whether case-based learning in interprofessional groups is an effective IPE strategy. Similarly, Hall et al. (2006) explained how popular literature

was used in an interprofessional education course to introduce the concepts of death and dying to undergraduate nursing and medical students. This course allowed students to experience the challenges of interprofessional teamwork to achieve a common clear goal using reflective techniques that offered opportunities for group processing. The strategies described by Linqvist et al. and Hall et al. represent ways to provide IPE across a wide range of professions and is consistent with the IPE principle presented by Oandasan and Reeves (2005a) of using learning methods (e.g., small group case-based or problem-based learning) that facilitate interaction between learners from different professions.

Nursing's IPE involvement that includes co-development of interprofessional courses is represented in two initiatives. Jones, Dunn and Coffey (2004) described an IPE course in rural health and safety using multiple teaching methods, including art and literature. Field trips and orienteering were incorporated into teaching pedagogies. Later, Medves, Paterson, Chapman, Young, Tata, Bowes et al. (2008), as members of an interprofessional team, reported the development of an interprofessional course centred around rural health concepts. The course involved class and field experiences. The *Inter-Professional Initiative* at the University of Alberta (Philippon et al., 2005) is the most enduring IPE initiative in which nursing has had involvement. The initiative began as an elective case-based course focusing on health team skills for small interprofessional groups. Later, the course became mandatory for some health disciplines and a clinical team placement was added. Common among the IPE initiatives reported by Jones et al., Medves et al., and Philippon et al. is the adherence to the IPE principle of inclusion of field or clinically-based interprofessional learning opportunities suggested by Oandasan and Reeves (2005a) and Reeves and Freeth (2002).

There are two impediments to a conclusive review of current nursing involvement in IPE. First, this sample of literature describing nursing's IPE involvement was reported because specific identifying information regarding nurse authors' professional affiliation was explicit. The absence of nurse authors' professional affiliation is an impediment to recognizing nursing's IPE involvement because the inability to determine authorship prevents inclusion in the review sample, even when it is apparent that significant nursing involvement occurred in the IPE initiative reported. Subsequently, representation of nursing scholarship in IPE research appears minimal. Nursing IPE scholarship is already exceeded by other health professions including medicine. Second, the predominant focus of the paper may not have been on IPE initiative development and implementation, resulting in mis- or under-representation; the paper may have focused on the evaluation of the IPE initiative rather than giving primacy to the development and implementation of the IPE initiative. For example, the focus of Morison, Boohan, Jenkins, and Moutray's (2003) paper was on the evaluation of IPE classroom learning compared to IPE learning in the clinical area (i.e., the outcome of the IPE initiative) rather than on the development and implementation of the IPE initiative directly. The primary study focus notwithstanding, the study findings are consistent with the IPE principle that IPE must include concepts (i.e., subject and content) relevant to learners' current or future practice (Oandasan & Reeves, 2005a).

Although the focus of this review has been nursing scholarship in the areas of IPE strategies, events, incidents, and contexts, Barnsteiner, Disch, Hall, Mayer, and Moore's (2007) work on the development of criteria for full engagement of IPE warrants attention. These authors recognize the challenges of IPE facing faculty members in Schools of Nursing and suggest six criteria to enable nursing faculty's leadership in working with other health professional

colleagues in the IPE enterprise. These criteria are aligned with the IPE principles outlined by Oandasan and Reeves (2005a), with the addition of the mandate for an organizational infrastructure that fosters IPE including support for faculty time for IPE development. The paper by Barnsteiner et al. was the only literature in which support for nursing's IPE involvement was addressed.

From a feminist poststructural perspective, nursing's voice is minimally present in this literature. While inclusion of professional identification may be antithetical to IPE tenets, missing author professional identification in the presence of concrete evidence of nursing's involvement contributes to lack of rightful acknowledgement as a primary IPE partner and erroneous conclusions about nursing's IPE participation. From a subjective perspective, nursing may be making tremendous contributions to IPE as an equal partner, yet because of lack of concrete acknowledgement, these contributions are impossible to discern from an objective perspective. How nurses conceive of nursing as a rightful and equal IPE partner is mutually reflective of nursing's explicit presence in the IPE literature. A feminist poststructural perspective is considered in the following final synthesis of the literature review.

Synthesis of the Literature Review

From a feminist poststructural perspective it is acknowledged that this review of the general and nursing specific IPE literature represents a discourse that is understood only within the contexts of the historical development of the nursing profession, the historical development of IPE, and the academic culture in which IPE is located, as well as in the embodied expressions of power relations among nursing's interprofessional colleagues. Accordingly, nursing's identification as equal partner in IPE scholarship is understood as a continuation of the struggle for a professional voice and a rightful place as a knowledgeable colleague that has historically

plagued the discipline. Although contemporary nursing has developed a professional knowledge base, nurses' subjective experience, inculcated by contextual discourses, continues to be informed by nurses' struggle to develop a professional identity inclusive of a strong sense of professional capability and genuine equality in the IPE enterprise. A review of the literature is read within this context.

Since language is socially constructed (de Saussure, 1959/1916; St. Pierre, 2000), language and its use are created differently across health professional disciplines, academic settings, and in textual representations of both in the literature. In this reading of the literature, concrete knowledge of the ways in which health disciplines understand and use the term interprofessional is inconclusive and open to interpretation; understanding and using the term interprofessional is a function of how health professionals use words. In turn, word use is a function of the interaction among gender-related speaking patterns, profession-specific roles and identities, and institutional/academic dialogue (Gilbert, 2005b). In particular, gender differences in word use can set up a differential in power and status relations in IPE interactions. Language stereotypes can perpetuate power and status differentials (Gilbert). Power and status asymmetry, that creates a barrier to IPE, may or may not translate into written text. Importantly, a feminist poststructural understanding of language requires nurses' self-examination of complicity in perpetuating language stereotypes. Were nurse authors active participants in either reproducing or challenging language and its use (i.e., portraying binary categories such as male/female, doctor/nurse) that shaped the professional context within which their IPE scholarship exists? Ironically, by definition interprofessional education necessitates a context in which equality among professional partners must not only be embodied but also must be translated through language choice and use. A common understanding and use of the term interprofessional

education is apparent in the literature reviewed; a commonly held definition prevents unilateral interpretation and promotes consistent conceptual understanding and application. Transcendent meaning of words and their use was considered in this reading of the literature, from which several conclusions may be drawn.

First, although the current body of IPE literature is reported to be predominantly descriptive, anecdotal, and atheoretical, research on interprofessional education and learning is growing. Second, IPE models and strategies are diverse and there is a lack of consensus on what models and strategies should be used to promote learning with, from, and about other professional disciplines (Barr et al., 2005). Lack of consensus may be interpreted in several ways: A single IPE model or strategy may not be appropriate for meeting the learning needs of each academic health professional group or educational institution, cannot be responsive to all IPE contexts, and cannot be responsive to all settings because health professional students represent a small portion of the diverse health workforce in each setting. Moreover, Cook (2005) frankly asks about existing evidence that suggests the ascendancy of one IPE strategy over another. Notwithstanding the outcome of Hammick, Freeth, Koppel, Reeves, and Barr's (2007) systematic review of best global evidence of IPE precursors, processes, and products from 1964 to 2005, perhaps it is advisable that IPE initiatives adhere to a common IPE definition such as that proposed by Barr et al. in view of the potential uncertainty about, or inappropriateness of, a single effective IPE model or strategy. In turn, common IPE goals (i.e., increase knowledge of professional core competencies and scope of practice) and principles (Oandasan & Reeves, 2005a,b) are derived to promote sustainability of IPE programs and portability and transferability of health professional skills sets across many health care contexts in which health professionals practice. Third, the literature includes research about IPE models and strategies,

IPE context, and evaluation of both. Reports of the events and incidents necessary for nursing's IPE engagement are implied or absent in the literature; evidence of the antecedents to nursing's IPE engagement is inconclusive. Finally, none of the interprofessional literature reviewed used a feminist poststructural perspective.

Using a feminist poststructural perspective necessitates asking how this inconclusive reporting should be interpreted. Are nursing faculty engaged in IPE and not reporting? Are nursing faculty engaged in IPE but not identified in the literature as authors? Are nursing faculty not engaged in IPE and therefore not represented in the literature? Are nurses not at all engaged in IPE? Since commitment to interprofessional education begins with university faculty (Kipp et al., 2007), examination of the events and incidents necessary for nursing faculty's IPE engagement is warranted. The absence of research reporting the events and incidents necessary for nursing's IPE engagement represents a gap in the IPE literature and supports the need for this study.

Need for the Study

The need for the study is fourfold: to address the gap in the literature, to gain an understanding of the events and incidents necessary for nursing's IPE engagement in order to promote nursing's equal and rightful participation in IPE development and implementation, to contribute to a comprehensive theoretical practice base, and to enhance potential for IPE as mainstream in nursing education

Interprofessional education has been held as a promise to improve health services (Allison, 2007; Cooper et al., 2004; Craddock et al., 2006; Gilbert, 2005a; Herbert, 2005). That IPE has fulfilled this promise has not yet been proven although links between IPE and improvement in interprofessional collaboration, communication and co-operation are reported in

the literature (Carlisle, Cooper, & Watkins, 2004; Hylin, Nyholm, Mattiasson, & Ponzer, 2007).

It is not within the scope of this research to evaluate the best evidence of IPE outcomes.

However, it is acknowledged that this research is located within the context of positive speculation about the value of IPE in improving health services and positive reports of improvement in interprofessional collaboration, communication and co-operation. Consequently, it is reasonable to gain support for this research from this literature. This review of the literature informs the study propositions and research questions.

Study Propositions and Research Questions

Yin (2003) recommends that propositions are an integral component of case study design and as such “directs attention to something that should be examined within the scope of the study” (p. 22). Several propositions have been developed from a review of the literature, from a priori knowledge of contemporary baccalaureate nursing curricula, and from observation of nursing faculty’s interprofessional interactions. These propositions guide the development of the research questions.

Propositions

Interprofessional education has not made its way into the mainstream of baccalaureate nursing curriculum. Faculty may not be knowledgeable about or have opportunities to engage in IPE. Historically, the nursing profession has struggled to establish itself as an autonomous and independent discipline. Nursing’s relationship with medicine has evolved from a history grounded in patriarchy, dominance, and conceptualized as *power over* (Falk Rafael, 1996). Increasingly, nursing is simultaneously acknowledging itself and being recognized as an academic discipline, with its own knowledge and power base. IPE will require nursing to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge

and power. Baccalaureate curriculum development is recorded in committee minutes and represented by course and other academic documents. Nursing students' IPE involvement is reported in the literature, yet few nurse scholars are published authors of research on development and implementation of IPE in nursing education. Nurse scholars' representation as architects of IPE curriculum development and implementation is minimal.

Research Questions

Adherence to Yin's (2009) case study framework, instructs that the research questions are posed to the investigator (p. 86). Accordingly, four questions guided my research:

- What are the antecedents of nursing's engagement in interprofessional education? (RQ1)
- How are nurse educators/nursing faculty engaged in IPE? (RQ2)
- How does gender impact nursing's involvement in IPE development and implementation? (RQ3)
- How is nursing's IPE engagement impacted by contextual factors (e.g., social, political, historic) inherent in the broader health professional and academic contexts? (RQ4)

Chapter Summary

The literature review of this chapter has set the stage for the research, helping to identify the need for the study and to develop the study propositions and research questions. The research methodology appropriate for answering these specific research questions is described in the following chapter.

Chapter Four - Research Methodology

Introduction

This chapter contains significant and essential details of the research methodology and process, beginning with a brief overview of the history of case study and its multiple uses and subsequent rationale for choice of methodology in this research. Following Yin's (2009) framework for qualitative case study, the multiple case design, elements of the case, including description of the case, its context, and boundaries, and multiple sources of data collection are outlined. These elements lead to a description of the case study data base, data management and analysis strategies. Consideration of reflexivity, ethics approval and consent, and trustworthiness conclude the chapter.

Case Study Methodology

Case study is a research strategy with roots in the social sciences (DuFour & Fortin, 1992; Hatch, 2002; Salminen, Harra, & Lautamo, 2006; Yin, 1992). In the 19th century, LePlay, Malinowski and the Chicago School (Salminen et al.) reportedly used data generating strategies, generally viewed as hallmarks of qualitative methodology, in their sociological and psychological research (e.g., observations, open-ended interviews, and collection of printed documents) (Anthony & Jack, 2009). For many years, case study methodology was subjugated to quantitative methodology because of concerns about validity. In the 1960s, case study re-emerged due to renewed interest in the qualitative paradigm (Anthony & Jack; Salminen et al.).

Confounding views of case study linger due to misconceptions surrounding its nature and purpose (Anthony & Jack, 2009). For example, case study has been called a research strategy (Jones & Lyons, 2004), a data collection tool (Gangeness & Yurkovich, 2006), and a teaching technique (Henning, Nielsen & Hauschildt, 2006). Not only are these ostensibly diverse views

valid (Yin, 2009), but also they share the common characteristic of fostering insight (Gerring, 2007). From a feminist poststructural perspective, taking a fixed view of case study may be unwise for several reasons. First, mandating a fixed view or meaning for case study eliminates its utility across multiple academic, practice, and sociopolitical settings. Second, discussion about case study meaning and purpose may become so convoluted so as to render the understanding meaningless or at the very least “... lost in the play of discourse” (St. Pierre, 2000, p. 477). Third, dogmatic thinking is promoted and acceptance of other unique and authentic uses of case study is precluded with a rigid adherence to a dominant language discourse, in which fixed meanings present a certain way of thinking or understanding case study. Since the property of a word does not include an intrinsic meaning (de Saussure, 1959/1916), it is accepted that case study is one term with multiple meanings, all conveyed differentially through language, as the vehicle by which context, sense, and meaning are created. Accordingly, from this theoretical perspective, where fixed meanings are challenged, case study *is* understood as a function of its context, which is to say as a teaching case, a research tool, or a form of record keeping (Yin, 2009).

In this research, case study is constituted as a research methodology located within the qualitative paradigm, a denotation inherent in the term case study in the remaining text. Yin’s (2009) work provides the design and framework for this exploratory case study that subscribes to Yin’s definition of case study as empirical inquiry of contemporary phenomena within inseparable real life contexts. Yin’s work has been chosen because of the alignment between the study’s theoretical framework and consideration of multiple case study meanings, because of a definition that incorporates the notion of empirical inquiry necessary for exploration of nursing’s IPE engagement, and because of the representation of within and cross-case design appropriate

for a multi-site study. Qualitative case study methodology incorporates the theoretically informed framework of research in the qualitative paradigm, its intrinsic epistemological assumptions (Harding, 1986), and the appropriate methods for gathering and generating evidence (Harding). Although qualitative methodologies are recent additions to research in educational contexts (Hatch, 2002; Merriam, 1998), qualitative case study has evolved as a comprehensive research strategy suited to address complex issues in nursing practice (Arnaert & Ciccotosto, 2006; Duhamel, Dupuis, Reidy, & Nadon, 2007; Forneris & Peden-McAlpine, 2007) and education (Baxter & Rideout, 2006; White, 2007). A research methodology, such as qualitative case study, that acknowledges the subjective and contextual multiple realities and truths inherent in nurse educators' experiences is aligned paradigmatically with the feminist poststructural theoretical framework guiding the study.

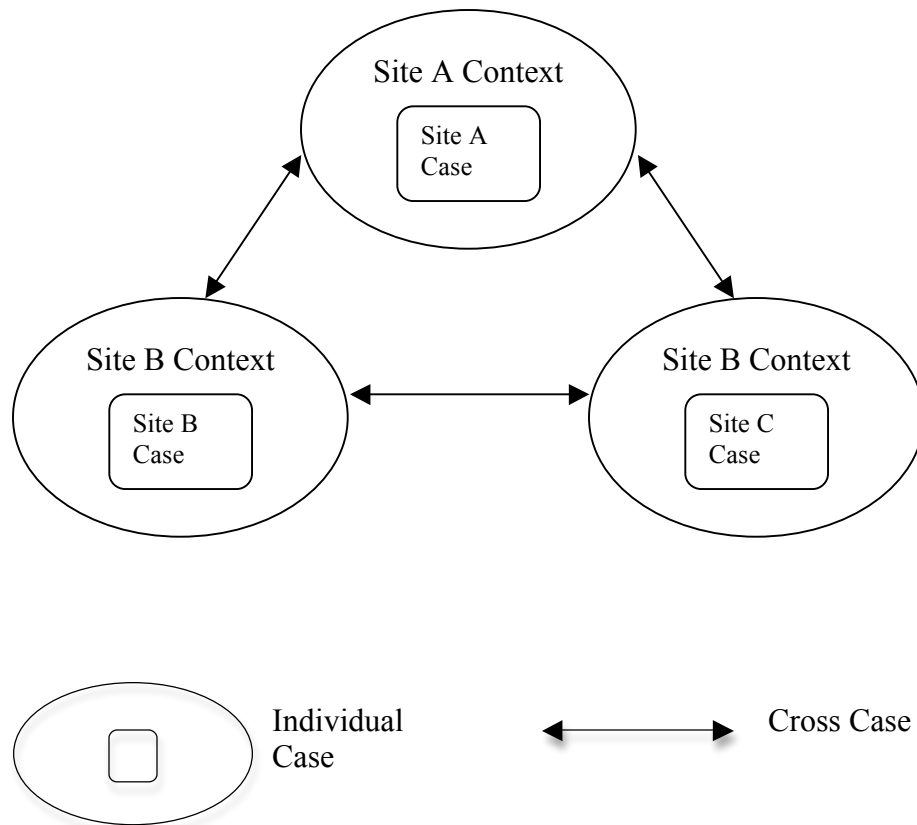
Case study is the specific methodology of choice in this research for several reasons. First, it is most appropriate for studying the real-life case of nursing's IPE engagement within its real-life context (Yin, 2009) of academia and health professional culture. Second, case study is an appropriate methodological choice when the context cannot be separated from the phenomenon of interest, or the case (Yin). In this study, the case of nursing's IPE engagement cannot be separated from the health professional and academic context within which it is located. Third, qualitative case study is an appropriate methodology when little is known about the antecedents of nursing's IPE engagement and the situation surrounding the case is complex (Scanlon, 2003). Fourth, Merriam (1998) suggests that qualitative case study is ideal for exploring, understanding, and interpreting educational phenomena, such as nursing's engagement in interprofessional education. Yin recommends case study as an appropriate research strategy when 'how' questions are central to an investigation and 'what' questions guide

exploration (p. 9), as in this research. Finally, although there are similarities between the chosen methodology and critical ethnography (e.g., critical perspective, understanding culture), at the outset the primary research focus was not the relationship between nursing's engagement and the culture in which it is located or to expose the historicity and construction of the case and social relationships.

Study Design

A multiple-case design is used in this research (Figure 1). Described below, the individual cases at Ontario universities, Sites A, B, and C, have been explored first, followed by cross case exploration from data convergence among the three cases. Yin (2009) and others (Gerring, 2007; Hatch, 2002; Merriam, 1998) acknowledge that challenges in designing case study research include the absence of a pre-existing register of case study designs from which to choose and the false perception that case study is a variant of another research design.

Figure 1 Multiple Case Design



While this reality is a challenging prospect, at the same time it is a reality consistent with a FPS perspective that supports creation of a design customized to explore the unique nature and elements specific to the case of nursing's engagement in IPE in its real-life academic context. Additionally, the study design promotes coherence and integrity, graphically and conceptually directing logical flow from research question development to data generation, analysis, and interpretation and back, ensuring that the evidence links with the research questions (Merriam; Yin). From a design perspective, evidence from multiple cases may be considered more compelling (i.e., than evidence from a single case) and contribute to the robustness of the interpretation (Herriott & Firestone, 1983; Merriam) - a distinct methodological advantage.

The rationale for using a multiple case design is the desire to explore nursing's IPE engagement from a provincial perspective, to choose cases that had contrasting characteristics in hopes of strengthening case findings, and to contribute to the robustness of interpretations (Yin, 2004; 2009). A multiple-case design is appropriate for this exploration of three cases. Yin (2009) explains that replication logic, not sampling logic, is the process used with a multiple-case design. Accordingly, I followed the logic of literal replication: the conditions of Site A university have been replicated with Site B and C universities, with minor alterations at Site C (e.g., context exclusive of a collaborative baccalaureate nursing program) and Site B (a satellite non indigenous medical school) traits in an attempt to reveal similar findings among contextual disparity. Research at Sites A, B and C universities are considered individual studies. Convergent evidence from Site A university was sought regarding the case facts and conclusions and was the information requiring replication in Sites B and C. Using the logic of literal replication in case study research contributes to the study's transferability (Guba, 1981; Lincoln & Guba, 1985;

Miles & Huberman, 1994), defining subsequent domains to which case study findings can be generalized (Yin, p. 43).

In the broadest sense, replication logic promoted purposeful selection or sampling to maximize what could be learned (Creswell, 1998, 2007) not only about nursing's IPE engagement, but also about the context for engagement in each case. Blending with replication logic, purposeful sampling of the three university baccalaureate nursing programs Sites was informed by a priori knowledge of these Ontario programs and universities. Therefore, the sampling criteria included purposefully choosing Ontario universities that have four-year baccalaureate nursing programs, one or more health and social care disciplines including medicine, dentistry, occupational therapy, physical therapy, speech and language pathology, audiology, social work, and clinical psychology, and are known to have a range of levels of current IPE involvement. Academic contexts including and excluding medical school programs native to the university were chosen purposefully in order to explore nursing's IPE engagement within both cultures. Sites A, B, and C universities met these criteria. These universities and their inseparable real-life cases were informationally representative (Sandelowski, 1995a) and permitted ample data generation for the creation of rich and thick textual representation (Wolcott, 1994) as case reports.

The components of this multiple-case study design include the research questions and propositions of the previous chapter, the case study elements described below, the logic connecting study data to the propositions, and the empirical findings, interpretations and conclusions (Yin, 2004, 2009) presented later.

Elements of Case Study

Case study elements from which data are drawn (Yin, 2004) include the case or the unit of analysis and set of real-life events, case boundaries, data generation methods, analysis, and interpretation (Yin, 2009). These elements provide the framework of the case study and are described below.

Unit of Analysis and Context

The Case

The entity comprised of nursing's engagement in IPE is the unit of analysis or the case under investigation. Three cases are explored; one at a south-central Ontario university, one at a western Ontario university, and one at an eastern Ontario university, hereafter referred to as Site A, B, and C universities, respectively, for purposes of anonymity and confidentiality. Due to the differences in university structures, Site A and C universities represent Schools of Nursing and Site B university represents a Faculty of Nursing. For clarity, the term School of Nursing is used in all cases. The cases are presented in narrative detail as case reports in chapter five.

Case Context

Case study research is useful to investigate real-life phenomenon when the boundaries between the phenomenon and context are indistinguishable and inseparable (Yin, 2009). The relationship between case and context inherent in Yin's definition implies that the context is integral to understanding the case. This degree of attention placed on context is consistent with the importance that feminist poststructuralism places on context (e.g., historic, political, social) in women's experiences. An overview of the case contexts is included in chapter five as a component of the case reports in order to situate each case within its respective context.

Case Boundaries

According to Yin (2009), the establishment of case boundaries is essential for the development of a discriminating case description and aids in the scope of data collection. Within Yin's framework, case boundaries include case study time frame, the group and organization under investigation, geography, priorities for data generation and database, and data management and analysis. Defining the case using boundaries helps distinguish between the elements, events and persons to be included in the case (i.e., the direct focus of the case study) from those that are outside it (i.e., the case context) (Yin, p. 30). I have included reflexivity as an additional boundary because as the researcher responsible for the creation of a discriminating case study informed by feminist poststructuralist tents, I am especially obligated to consider not only my "awareness of being aware" (Finlay, 2003, p. 1), but also how this double awareness informs, impacts, and enhances the research. Nursing's IPE engagement is the case studied within these boundaries.

Time Frame

Data collection and generation began in June 2008 with review of public domain university nursing program documents accessed using the world wide web. This phase of the research process concluded in June 2009 with member checking interviews.

Group

Full and part time educators at university sites of baccalaureate nursing programs as well as other health professional and social care faculty members involved in IPE at Site A, B, and C universities created an appropriate case boundary because full time (e.g., tenured, tenure-track, limited term) as well as part time (e.g., sessional, limited duties) nursing faculty are involved in baccalaureate nursing and health professional curriculum development. Additionally, common

among current university structures are health sciences faculties comprised of several health and social care disciplines. Collaboration among health professional colleagues' is encouraged across faculties and schools. Therefore, it is appropriate to include participants from other disciplines to (e.g., anatomy, occupational therapy) involved in the development of IPE curriculum development for all health and social care disciplines, including nursing.

Organization

University sites of four-year baccalaureate nursing programs. Although baccalaureate nursing education in Ontario is delivered collaboratively by universities and partner Colleges of Applied Arts and Technology, university Sites only at A and B universities, were explored because universities lead curriculum development, set educational benchmarks, and are the contexts that include education of other health and social care professionals. Additionally, Colleges of Applied Arts and Technology provide health service programs beyond the boundary of health professional programs offered at universities (e. g., respiratory therapy).

Universities with one or more health and social care programs. Following from the definition of IPE, it was necessary to bound the case by the other university programs in health and social care that provide the opportunity and context for IPE and learning. Accordingly, the case is bound by the professional programs in health and social care disciplines (in addition to nursing) at Site A, B and C universities, including medicine, dentistry, occupational therapy, physical therapy, speech and language pathology, audiology, social work, and clinical psychology.

Geography

Ontario. Exploration of nursing's IPE engagement is restricted to Ontario. This was a pragmatic design decision based on my a priori knowledge of provincial nursing education, the

desire to complete the study within a reasonable time frame that precluded taking the study beyond provincial boundaries, and a desire for a manageable scope. This decision was made to foster integrity of the research process and to promote the creation of a coherent and comprehensive account of nursing's IPE engagement.

English language environments. The decision to include English language environments was practical and based on the need for thorough data collection by limiting the design to three cases from English language environments. Inclusion of contexts that incorporate bilingual learning environments is an area for further study.

Data Generation and Database

Consistent with the research paradigm and characteristics of case study, qualitative data were generated from multiple sources. Data generation methods, study methodology, and theoretical perspective are interdependent and are represented in this text as such. In this case study approach, data generation is inextricably linked with data analysis, and participant recruitment (Patton, 2002; Yin, 2009), a consideration that informed the research process.

At the outset, Yin's (2009) three principles of data collection or generation were followed to enhance the trustworthiness (Guba, 1981; Lincoln & Guba, 1985; Miles & Huberman, 1994) of the study. These principles include using multiple sources of data, creating a case study database, and maintaining a chain of events or an audit trail. A distinguishing feature and unique strength of case study is the use of multiple sources of evidence beyond what might be used in other qualitative methodologies. For example, documents, archival records, individual and focus group interviews, and observation are well known features of data collection in case study research (Yin; Merriam, 1998). Seven data collection strategies are used in this study: non-participant observation, focus group and semi-structured individual interviews, document review,

archival record consultation, field notes/audit trail, and a demographic questionnaire. These methods are described in the following detail.

Multiple Sources of Data

Non-participant observation. In keeping with Foucault's (1979/1975) proposal that new knowledge is produced through observation, non-participant observation is a valuable data generation method in case study. According to Miller and Crabtree (1999a), observation is a paradoxical data generation method: most available yet most time intensive. The type and degree of structure of the observation method (e.g., participant, non-participant) was a function of the research questions and the goal of the research. In this study, the goal was to observe the context within which nursing's IPE engagement occurred. Therefore, non-participant or direct observation (Yin, 2009) of the "natural setting of the case" (p. 109) was purposeful when in School of Nursing buildings and university campuses, and during individual and focus group interviews. Specifically, nursing school environments and their broader academic contexts were observed in each Case, with particular attention paid to expressions and representations of gender and subjectivity, language use, and power relationships. Observations included environmental data (e.g., office surroundings, building location), presence or absence of faculty members, students, and staff, human interactions, communication patterns (e.g., frequency of comment and idea), and use/choice of language, and faculty/school infrastructure. During focus group interviews, it was observed if participants encouraged others to speak via gestures and facial expressions (e.g., interaction data). Tone and intensity of voice or opinion, and non-verbal communication (shrug, head nod, laughter) in individual and focus group interviews was documented in field notes and incorporated into interview transcripts for analysis (Duggleby, 2005). Additional opportunities that occurred in the field included observation in faculty lounges

in all cases and a tour of the new satellite medical school program building at Site B. Place, day, and time of observation was noted to provide comprehensive data collection. Unobtrusive observation was the goal, although faculty members and administrative staff readily asked if I was lost as I walked around and through buildings. Field notes, in contrast to maps or scales, adequately captured the observations. Observational data is included in the narrative form in the case reports presented in chapter five.

Semi-structured individual interviews. Interviews are considered to be the most important (Yin, 2009) and common data generation method (Merriam, 1998) in case study research. In this study, semi-structured individual interviews, rather than structured inquiry, filled the need for guided conversation in order to provide evidence of embodied, subjective experiences, such as faculty's experience with nursing's IPE engagement. Accordingly, semi-structured interviews of approximately one hour duration took place with participants including IPE Directors, full and part time nursing faculty members, and Deans/Directors of nursing programs. Select key informants from related disciplines involved with health professional and social care education participated also.

All interviews were conducted in locations convenient for participants at their respective university Sites. Locations were chosen to optimize participants' privacy and confidentiality. Most participants preferred to be interviewed in their offices while a few chose rooms in other campus locations (e.g., library, business school) and volunteered to book these rooms.

The identical interview protocol was followed for each case: introductions, review of the combined Participant Information Letter and completion of Consent Statement (Appendix A), including affirmation of privacy and confidentiality processes for data files, completion of the brief demographic questionnaire (Appendix B), and clarification of any participant questions or

issues. The information letter and consent statement in Appendix A carry the original name of the research project,¹ subsequently amended to reflect the nature of research once it was in motion (Yin, 2009). Conversation about nursing and IPE unfolded prompted by the interview guide (Appendix C). Importantly, conversation veered in new directions determined by real-time thoughts and ideas from participants and researcher. Interview questions were developed so as to directly link to the research questions, ensuring that all research questions were satisfied. For example, each interview began with a general question asking participants to describe their definition and understanding of IPE because the response is germane to answering the research question, How are nurse educators/nursing faculty engaged in IPE? Logically, if participants are unaware of or uncertain about the concept of IPE it could be interpreted that the likelihood of their engagement is small.

Several modifications and accommodations were made throughout the interview process. First, modifications were made to the demographic questionnaire to accommodate other health professional disciplines since not all participants were nurses. The phrase ‘in nursing’ was replaced with the phrase ‘in your chosen discipline’ where appropriate in each item. Second, the interview guide, by definition, inherently permitted flexibility and latitude in determining, in real-time, how and where a line of discussion could go in order to honour participants’ experiences and answer the research questions.

Miller and Crabtree (1999a) describe the interview as a data generating approach “that seeks to create a listening space where meaning is constructed through an interexchange/co-creation of verbal viewpoints in the interest of scientific knowing” (p. 89). This practice of generating research interview data is an exercise of an ethical and sensitive nature (Seibold,

¹The original study name has been maintained on documents in Appendices A, B, and G to promote the integrity of this doctoral work.

2000) for many reasons. By virtue of positionality between researcher and participant, a power imbalance is presumed at the outset (McCorkel & Myers, 2003): the researcher initiates the process (Miller & Crabtree, 1999a), holds the position of knowing the interview questions and research rules, and has in-depth knowledge of the broader research agenda – a position of control. From a feminist poststructural perspective, sensitivity to power relations in the researcher-participant relationship was paramount (McCormick & Roussy, 1997) and monitored throughout interviews. To mitigate power imbalance, participants were shown the interview guide questions and provided with a broad overview of the context of the line of questioning prior to starting the conversation. Additionally, participants were encouraged to ask questions and share their stories. Even though the interviews involved inter-exchanges and co-creation of viewpoints (Miller & Crabtree), participants' guided the pace of the interview and their voices predominated. The assessment of context and perspectives relevant to exploring nursing's IPE engagement was maximized throughout the interviews. Also throughout the interviews, ongoing or process consent (Usher & Arthur, 1998), or periodically confirming consent verbally, was incorporated in to the interview protocol. Mindfulness of privacy and confidentiality measures continued to be paramount and all participants agreed to have their interview audio-taped.

Focus groups. Focus group interview is a valuable qualitative research tool that generates data from the interaction among participants, data that is otherwise unavailable through individual interviews (Clavering & McLaughlin, 2007). Not only did focus group interviews provide group dynamic data, but also they were opportunities to observe faculty colleagues who are employed by and work within the same academic structure of health sciences faculties and universities. Barriers to group interaction have been debated and attributed to heterogeneous group composition with respect to culture and position (Robinson, 1999; Ruff, Alexander, &

McKie, 2005) among other characteristics. In research with health and social care professionals, there is continued advocacy for homogeneous focus groups, (Barbour, 2005; Robinson) (i.e., many who are female) in part because of “concerns over the silencing impact of hierarchies among medical professionals” (Clavering & McLaughlin, p. 402). The debate surrounding homogeneous focus groups among health and social care professionals has implications for feminist poststructural analysis of this research.

Focus group composition at Sites A, B, and C was homogeneous, comprised of female nursing faculty colleagues of similar age who were usually known to each other. According to Barbour (2005) this type of safe environment promotes free speech and fosters sharing experiences. Furthermore, as Kamberelis and Diamolitis (2005) explain that since meaning is derived from group traits and interactions, then inherently the homogeneous nature of the group not only permits free speech but also “reveal[s] unarticulated norms and normative assumptions” (p. 903) on a conceptual level.

Optimal size of focus groups has been debated with a range of participants varying from four to 20 (McLafferty, 2004). A recommended ideal is six to eight participants (Brown, 1999) so that the value of the focus group interaction is not defeated. Three focus groups, one per Case, took place over the course of the study. Although six to eight participants per group was the study guideline, three to four participants per group resulted due to last minute cancellations. Participants self-scheduled their focus group attendance according to times that were convenient. In all Cases, focus groups took place on respective university campuses in pre-booked convenient locations (e.g., small conference rooms) where protection of privacy and confidentiality was guaranteed.

An interview guide, identical to that used in the individual interviews promoted group discussion. The identical interview guide was used because the same interview questions were predicted to illicit different outcomes (e.g., group interaction data) based on the different natures of individual and focus group interviews. Mindful of Duggleby's (2005) cautionary note that focus group interaction is an underreported source of data, diligent attention was paid to informational context and group dynamics. Word use, stimulus for response, voice tone and intensity, stability and change in points of view, frequency of a comment or expressed idea, extensiveness or prevalence of an idea among participants, intensity or strength of opinions, specificity (e.g., personal experience) or generality (not related to a person), and what was not discussed or said (Sandelowski, 2008, p. 27) were significant sources of focus group-generated evidence. The consent process was completed at the beginning of each session. All focus groups were audio-taped with participants' consent.

Archival record and document review. Although Yin (2009) recommends that documentary evidence is useful to every case study, at the same time he issues a warning that documents should not be accepted literally as representations of events and that the primary purpose for which documents have been written is not the current case study, but rather for a different audience. Indeed, the nursing documents sourced for this study represent the material world and culture (Sandelowski, 2003) of the schools and faculties of nursing in the cases. With this background knowledge in mind, documents have been used in this research to corroborate (or contradict) evidence from other sources (e.g., interviews), to provide contextual information (e.g., nursing program goals, nursing degrees offered), and to offer insight and inferences from interview data (Yin).

Sources of documentary evidence included historic records from a university's archive department, on-line public domain material from university websites and local newspapers, and printed material provided by Case participants during field work. The electronic search for relevant documents was approached in a systemic fashion. For example, after accessing university websites and nursing school/faculty sites, documents describing nursing schools/faculties and baccalaureate programs, including program goals and variety of available programs, were collected for each Case. Specifically, public domain documents published on the website of schools/faculties of nursing were accessed to provide uniform background and contextual information. University and faculty websites were scrutinized for information about IPE infrastructure, offices, and initiatives. Several unanticipated types of documentary evidence materialized while in the field, including local newspaper website stories of a work stoppage in Case B and archival records of an interprofessional clinical health sciences masters degree program offered by Case A. Use of documents from the public domain is consistent with a feminist poststructural perspective that promotes public disclosure as opposed to supporting primacy of access to text. Similar to the principle underlying the use of a question guide to support data generation from interviews, questions for the documents were created (see Appendix D) in order to hear this mute evidence.

Although I planned to incorporate nursing course syllabi in the document review, these were not explored for several reasons. First, nursing faculty members' decision to protect their intellectual property (i.e., personally developed course material) was respected. Second, within the prevalent educative-humanistic educational philosophy (Bevis & Watson, 1989a) adopted by schools/faculties of nursing, prescriptive instructions about how to engage in IPE are not included in course documents. Third, because of the nature and variety of teaching modalities

(e.g., clinical practice, virtual, simulated, self-directed, planned, serendipitous) present in contemporary health professional and social care programs, including nursing, specific IPE goals and learning activities may not be included as formal elements in academic documents.

The documents used in this research were a valuable and stable source of evidence because they provided precise information that could be reviewed repeatedly (Yin, 2009) in order to support evidence from other sources. To help with retrieval, documentary evidence was organized and filed according to date and type.

Field notes. Field notes are a valuable permanent source of detailed information about field experiences including contextual (e.g., description of physical environment, people and things, social processes) and affective (feelings, preconceptions, perceptions, biases, reflections) data (Miller & Crabtree, 1999a). Field notes were created throughout the research process and data collection, completed either during or immediately after each data generation event. Throughout individual and focus group interviews, words and phrases were jotted down and used as memory aids for creating field notes following the interviews. Importantly, attention was given to accuracy in capturing participants' word and phrase choice because from a feminist poststructural perspective language shapes meaning and is contextually and subjectively constructed. The field notes include reflection on this learning experience and the intellectual, ethical, and emotional journey through the research. A chronicle of the chain of events and decisions was incorporated in the field notes, and as such, provided an audit trail, contributing to the dependability of the research (Guba, 1981; Lincoln & Guba, 1985; Miles & Huberman, 1994).

Demographic questionnaire. Knowing participants can be achieved, in part, through the use of a demographic questionnaire. In general, this knowledge contributes to a pre-

understanding of case contexts. Specifically, personal contexts (education, experience, age) contribute to understanding nursing's IPE engagement. Minor changes were required to the questionnaire to reflect inclusion of participants from health and social care disciplines beyond nursing. For example, where required and appropriate, the term nursing was replaced with 'your chosen discipline'. Participants in all cases completed the brief demographic questionnaire. Tabulated questionnaire outcomes are presented individually and collectively in Appendix E.

The data generation strategies were designed to create a repository of information that describes context, events, and incidents embodying nursing's IPE engagement and its inseparable academic and practice contexts. Use of these multiple sources is a tactic that increases opportunity for multiple measures of the same phenomenon and promotes triangulation of data, or corroboration of the same phenomenon, increasing study dependability (Miles & Huberman, 1994), considered below.

The Database

Creation of a case study database contributes to the confirmability (Miles & Huberman, 1994) of the study so that, in principle, other investigators could review the evidence directly in order to draw independent, yet similar conclusions (Yin, 2009). Yin considers that there can be four elements in a database: notes, documents, tabular material, and narratives. Notes may take a variety of forms (e.g., memos) and are generated from the analysis of the raw data resulting from interviews, observations, document review, and field notes. Creation of narratives as a database component, while not required, is a particular analytic practice suggested by Yin where the researcher creates answers to the research questions from the existing research evidence in order to "converge upon the facts of the matter or their tentative interpretation" (p. 121). Notes from the analysis of the comprehensive, rich, and thick descriptive interview data, field notes and

document review, together with the documents, and the tabular material generated from the demographic questionnaire constitute the case study database. Narratives were not included as part of the database because it was inconsistent with the theoretical framework in which the voices of the study participants have primacy. Consistent with the tenets of qualitative research (Patton, 2002), data generation, management, analysis, and interpretation (see chapter 6) occurred concurrently and in an iterative fashion.

Data Management and Analysis

Yin (2009) affirms that analysis of case study evidence is an underdeveloped and challenging component of case study research. Not surprisingly, he extols the importance of developing a general analytic strategy for case study analysis. Following Yin's case study framework, two complimentary analytic processes were used: the general analytic strategy of linking study propositions to research questions and data, and the specific analytic technique of examining rival explanations for data-derived emergent themes and patterns. The theoretical propositions helped to focus attention on certain data in order to answer the research questions. In this process, pattern matching was used to judge data-derived patterns I discerned against existing empirically based patterns or theories (i.e., evident in chapters five and six). Importantly, pattern matching for explanations that rivaled emergent patterns occurred concurrently, using data to refute rival explanations. Although a feminist poststructural perspective is inherent in the individual and cross cases analyses of chapters five and six, a third level of analysis was developed for this research and included in chapter six: the primary perspective of the elements of feminist poststructuralism (e.g., subjectivity, language, discourse and power) were used as a portal for interpretation of the cross case analysis data and its links to the research questions, propositions, and extant literature. The same analytic strategy was followed for the individual

and cross case analyses processes. Appropriately, the same research questions were applied to both individual and cross case analyses (Yin). As suggested by Yin to facilitate effective cross case analysis, a word table (Appendix F), with columns headed by the same section headings used in individual case reports, was constructed using collated individual case report data. These collective analytic techniques were followed to contribute to the study's trustworthiness (Yin).

Miller and Crabtree's (1999b) strategy for data management and analysis provides a second framework, complimentary to and overlapping with Yin's (2009), to guide this phase of the research. Miller and Crabtree claim that analysis is part of the larger interpretive process that includes the inextricable links between data collection and analysis as well as the research results represented as an account of what has been learned. The phases of Miller and Crabtree's analytic process include describing, organizing, connecting, corroborating/legitimizing and representing the account. The describing phase occurred throughout the research as data was generated and the case database was created. Pragmatically and logically, the organizing phase occurred simultaneously with the description phase to promote unencumbered data generation throughout the research. In this phase, the database became the text, or the substance that is the basis for the analysis (Yin).

In preparation for analysis, individual and focus group interview audio transcripts were transcribed verbatim using Microsoft Word® word processing software. Following transcription, I listened to the audiotapes and read the transcripts simultaneously to mitigate transcription errors such as misinterpretation of content, use of incorrect terminology, or liberties taken by the transcriptionist (MacLean, Meyer, & Estable, 2004; Poland, 2002). Data transcription was augmented by field notes when inaudible sections or emotional and ethical content were encountered. Field and document review notes were typed as Word documents and together with

the Word documents from interview transcripts comprised the data base or research text. The text was uploaded to Atlas ti® computer-assisted qualitative analysis software used for categorizing and coding the text generated from these multiple data sources. While computer-assisted analysis software is becoming increasingly sophisticated (e.g., theory and conceptual network building) (Miller & Crabtree, 1999b; Patton, 2002), it remains an assistive device that enables the human researcher to work the data with greater finesse, depth, and efficiency compared to the toil of manual coding and categorizing. Moreover, computer-assisted software promotes fair treatment of evidence and has an intrinsic capacity for fluid and effortless data manipulation (Miller & Crabtree).

Merging Miller and Crabtree's (1999b) editorial and template organizing styles was most appropriate for coding the text. Using a template style, text passages were read, highlighted, and coded by Atlas ti® according to categories and codes derived a priori from the theoretical framework and informed by the theoretical propositions. Using a feminist poststructural perspective necessitated codes related to gender (McCormick & Roussy, 1997), systems of knowledge, social structures of meaning and language, nurses' self perception and agency (i.e., subjectivity), power relationships, professional discourses, and sociopolitical and historical context. Following an editorial style (Miller & Crabtree), additional codes evolved directly in response to the needs of the text (i.e., data-derived). Codes and their researcher-developed descriptions were recorded using an analysis software function. Text from each case was re-analyzed when necessary to ensure that no new codes had been developed and that all codes were available for analysis of every piece of text.

A feminist poststructural perspective necessitated understanding that the primary research data is inextricably located within historic and contemporary discourses about power, gender,

and the nursing profession. For example, this theoretical perspective required acknowledgment that participant's data represented one of the many stories that could be told (Hatch, 2002). In addition, consciousness about sources of analytic error contributing to misappropriation of codes included researcher subjectivity, misperception, data fabrication, misinterpretation and discounting (Miller & Crabtree, 1999b). To honour the notion that data represent one of many possible stories and to mitigate the researcher-induced errors described, I met with an expert in qualitative analysis to review the initial coding scheme. After interview transcripts were analyzed, a second, independent qualitative research expert reviewed the coding scheme and two researcher coded transcripts. After discussion, review, and refinement of the final coding scheme, differences in our coding were reconciled. Subsequently, the text was recoded to promote trustworthiness (Guba, 1981; Lincoln & Guba, 1985) of the research. Miller and Crabtree's (1999b) connecting phase of analysis in which themes and patterns are uncovered and discovered aligns with Yin's (2009) analytic technique of pattern matching, described above. The corroborating/legitimizing phase of Miller and Crabtree's analytic framework is addressed in the section on trustworthiness.

Creation of individual and cross case reports (Yin, 2009), or accounts of the research represent the final phase of analysis and are presented in chapters five and six. The case reports include understandings of nursing's IPE engagement derived from the text and are authentic representations of the research process, the participants, and the case contexts. A feminist poststructural perspective is inherent in these narrative accounts. Data management and analysis were informed continuously by the research questions, the text, and the naturalistic, constructionist tenets of qualitative methodology.

Reflexivity

Finlay (2003) writes that reflexivity in qualitative research has been practiced in multiple guises (e.g., introspection, critical realism, postmodern deconstructionism) over the last century. Reflexivity, the critical self-reflection and unmasking of feelings and forces that may shape our worldview, and by association our research (Finlay, 2002), has become, arguably, a defining characteristic of qualitative research (Bannister, Burman, Parker, Taylor, & Tindall, 1994) in contemporary times. Reflexivity was important to this study for many reasons. First, as the researcher I was the main individual guiding the study and therefore had the greatest influence on data, selection of sources, generation methods, and interpretative process (Finlay). Second, it is acknowledged that researcher demeanor affects participants' responses and thinking, and influences the direction of the study such that understandings established between researcher and researched within the context of this research and the geographic parameters of the university institution would be a different story told with a different researcher and within a different context (Finlay). Third, because inductive and naturalistic inquiry was used, it was necessary to make my perspective explicit (Patton, 2002) and to add it to that of the participants in this grassroots approach. Finally, because this research used a feminist poststructural perspective, one that presumes the importance of gender, it was important as female researcher to reflect on how my gendered subjectivity shaped and affected my actions and understanding throughout the research. For example, critical reflection on my subjective position was chronicled in field notes throughout interviews as I was acutely mindful of the solidarity I might feel with female participants due to shared sex, discipline (i.e., nursing and female-dominated professions), and positions (i.e., nurse educator at a university School/Faculty of Nursing). Furthermore, when interviewing female and male participants I was mindful that using a feminist poststructural lens

carries with it an embedded message of the importance of gender and I was cognizant of my word choice, language use, and positionality when posing questions and guiding the interviews.

Seibold (2000) advises that researcher reflexivity is an important safeguard against abuse of power. Therefore, throughout the interviews I was mindful of the nature of the researcher – researched relationship and its potential effect on knowledge construction. For example, I was particularly sensitive to differences (McCormick & Roussy, 1997) (e.g., education level, academic and employment status) between myself and the participants. This awareness included not only the differences between myself as a doctoral student interviewing masters and baccalaureate prepared health and social care professionals, but also differences between myself as a doctoral student and experienced doctorally-prepared researchers and scientists, and physicians. I had deliberate awareness of the potential influence of my identity as a nurse educator at a university site of a collaborative baccalaureate nursing program, and as a former Chair of undergraduate nursing programs. Indeed, I had an acute awareness of my own and others' subjectivity as a function of educational preparation and experience. Any problems derived from the privilege or difference assumed by participants by virtue of my identity contributed to insights regarding nurse educators' professional subjectivity and esteem as it pertains to nursing's engagement in IPE that I would otherwise not have had. Within reflexivity there is space for "multiple readings [available] from a single text" (MacMillan, 2003, p. 248), a position that aligns with FPS tenets and one that I embraced throughout this research enterprise.

Informed Consent and Ethics Approval

Permission to carry out the research was granted by the Research Ethics Boards (REB) in all Cases. Written agreement and permission to carry out research at the three Schools/Faculties of Nursing was provided by the their respective Deans and Directors. The participant information

and consent process for all sites followed the protocol required by Case A. Accordingly, the combined Participant Letter of Information and Consent Statement documents included a description of the study purpose and goals, the voluntary nature of participation, and specific requests for involvement in data generation methods, followed by a brief consent statement. The consent process occurred at the beginning of individual and focus group interviews and was reviewed periodically during data generation consistent with process consent format described by Lawton (2001).

Participant Recruitment

Brown (1999) recommends a variety of participant recruitment methods including posting notices and purposefully selecting participants who are reported to have interest in the topic. An REB approved research poster (Appendix G) inviting participation in focus groups was posted around nursing, health professional and social care program buildings at each research Site. Similarly, the poster was distributed electronically to full and part time nursing faculty with help from key stakeholders including Deans/Directors. As gatekeepers to the research, Deans/Directors suggested names of potential nursing, health professional and social care faculty participants. In many instances the Deans/Directors offered to make initial contact with potential participants. Additionally, participants were identified through focus group interaction. Interestingly, the majority of participants responded to electronic recruitment rather than the posted advertisement, a curious discovery given the personal and relationship nature of health and social care.

Trustworthiness

In general, rigor in qualitative research is a source of continued and heated debate (Davies & Dodd, 2002; Onwuegbuzie & Leech, 2007; Patton, 2002; Sandelowski, 1986, 1993).

Conventional understanding of rigor in the quantitative paradigm, is demonstrated in qualitative research by applying features of trustworthiness, or efforts to optimize visible, accountable, and faithful accounts of participants' experiences (Davies & Dodd, 2002; Sandelowski & Barroso, 2007).

Trustworthiness (Guba, 1981; Lincoln & Guba, 1985; Miles & Huberman, 1994) is addressed in the corroboration and legitimization phase of Miller and Crabtree's (1999b) analysis framework which acknowledges, also, that there are many strategies available to “corroborate multiple truths or perspectives voiced in the text” (p. 136). Miller and Crabtree's perspective of corroborating/legitimizing research findings fit well with a feminist poststructural perspective in which multiples truths and realities, as well as context and socially constructed meaning, are acknowledged in interpretation. Lincoln and Guba's measures to optimize trustworthiness are used to corroborate/legitimate the research finding and were considered.

To be trustworthy, research must be credible, dependable, confirmable, and transferable (Lincoln & Guba, 1985). Credibility involves determination of the authenticity of the study findings from the perspective of the researcher, the participants, and the reader and is a key component of the research design (Creswell, 2003, 2009; Mason, 2006; Merriam, 1998; Miles & Huberman, 1994). From a feminist poststructural perspective, participant data is understood and respected as a textual representation of their world; for that reason, credibility was achieved by member checking (Denzin & Lincoln, 2005) or asking a proportionate number of participants in each Case if the preliminary findings represented their experience accurately. All participants involved in member checking interviews could find themselves in the preliminary interpretations, agreeing wholeheartedly that their experiences were well represented in the preliminary findings. This form of member checking was encouraging and provided assurance

me that I had done justice to the participants' (i.e., women) stories, an important consideration from a feminist poststructural perspective. Credibility involves also scrutinizing the match between the logic of the methodology to the research questions. According to Yin (2009), case study is an appropriate research strategy to answer the 'how' questions of this study. In addition, asking what questions are consistent with an exploratory case study and with the nature of this research (Yin). Using multiples sources of evidence from multiple methods enhanced the credibility of this research because corroboration or triangulation (Yin) of data was possible and the creation of a comprehensive and rich picture of nursing's IPE engagement was promoted. Following Yin's analytic technique of pattern matching as well as the occasional use of metaphor as interpretive techniques (Sandelowski, 1998) for the study findings contributed to the study credibility.

Dependability is concerned with the soundness of the study and how well the research path could be followed if replication is desired. Dependability asks whether the findings are consistent and dependable with the evidence generated (Lincoln & Guba, 1985). Dependability is a function of the care and consistency with which the study is conducted and how conscientious the researcher is in taking account of multiple perspectives and multiple realities (Miles & Huberman, 1994; Patton, 2002). Presenting a detailed description of the study and its methodology as well as keeping diligent, chronicled field notes and incorporating an audit trail of the events, influences, decisions, and actions involved in the research contributed to dependability. To promote dependability, consistent use of coding schemes and categories was scrutinized by two experts in qualitative research. In addition, memoing during analysis of interview transcripts incorporated analytic and interpretive decisions. That this research follows the case study framework of a well-respected case study expert (Yin 2003, 2009) enhances study

dependability. Confirmability is concerned with whether the research path can be followed and whether the study outcomes reflect participants' experiences and study conditions and not those of the researcher (Miles & Huberman). Creation of a database and development of rich and thick descriptions of events, interactions, and context coupled with keeping field notes/audit trail were measures used to enhance the potential for another researcher to draw comparable conclusions and contributed to the confirmability of the study findings. Researcher reflexivity contributed also to the confirmability of this study by accounting for decisions regarding origins of data and their path to interpretation. Transferability is considered only in the interest of enhancing the transfer of study data to similar professional contexts (e.g., occupational therapy) or nursing programs. Transferability of the study data was promoted by the development of rich and thick descriptions of events, interactions, and context in order to promote relevance in a broader context.

Finally, Yin (2009) described several case study features that promote trustworthiness, including a multiple case design and replication logic, multiples sources of evidence, establishment of a database, and review of case reports (data) by key informants. These features were incorporated into this research to promote trustworthiness.

There are several implications of the conventional concept of rigor from a feminist poststructural perspective. First, because no universal truth exists it is understood that participants' data represent multiple truths (Hatch, 2002). These multiple truths are subjective and contemporaneous, grounded in their respective socio-historical contexts (i.e., to serve those in power), and cannot be privileged over another (Hatch). Second, because truth is subjective, as the researcher, I do not have direct access to participants' actual experience. Consequently, participants' data is understood and respected as a textual representation of their world. This

understanding coupled with the fact that representation of participants' stories requires strong researcher reflexivity posed a great challenge to the creation of an authentic representation of participants' text. Consequently, the conventional concept of rigor is challenged and may be considered antithetical to this theoretical perspective. Third, because there is not one fixed meaning of rigor from a feminist poststructural perspective, rigor, itself, is viewed as contextual and subject to interpretation depending on discourses (Sowell, 2004). Consequently, the concept of trustworthiness in the qualitative paradigm is aligned most appropriately with the theoretical perspective of this research.

Chapter Summary

In this chapter, a tour of the research methodology and process has been presented as a methodological map to guide reading of the case reports of chapters five and six. This chapter concludes the Prologue to the study. Following in chapter five are the individual case reports as the first layer of analysis of the research text (i.e., data).

Chapter Five - Site A, B, and C Case Report²

Introduction

This chapter presents individual or within-case reports for university Sites A, B, and C, introduced by chapters one through four as Prologue. Throughout each case report, participants' exemplars are embedded via footnote to animate and amplify the findings of each individual case. Additionally, several footnotes provide background information needed for textual comprehension. This chapter is a necessary bridge between the Prologue and the Epilogue of chapters six and seven.

Mindful of Yin's (2009) grievance that failure to make a distinction between the database and case report too often results in misrepresentation of case study data *as* the narrative case report, I have crafted each case report to present the empirical findings as they pertain to the research questions. Each report of the case of nursing's IPE engagement incorporates answers derived from the database in a convergence of data from the multiple sources consistent with the concept of data triangulation (Yin). This convergence of data is an analytic strategy that optimizes trustworthiness (Guba, 1981; Lincoln & Guba, 1985; Miles & Huberman, 1994), particularly credibility and dependability (Miles & Huberman; Patton, 2002). Each case report is informed by the study propositions that direct attention to particular aspects of the case (Yin,

² The compositional nature of the case study reports fulfills several obligations. First, the reports, together with the other chapters of this document, are the text of my doctoral dissertation, in partial fulfillment of the degree, Doctor of Philosophy. As an academic obligation, the reports incorporate and reflect due diligence in adhering to Yin's (2009) case study methodology, the theoretical framework of feminist poststructuralism, and care with which the entire study was carried out. Second, as a professional obligation, the reports create a picture of what is known about three university schools of nursing and their IPE engagement. As such, the reports provide nursing faculty and baccalaureate nursing education with practical, real-life IPE information that has potentially significant implications for nursing's deeper involvement in the scholarship of IPE teaching and research. Third, as an academic and professional obligation, the creation of these reports fed my passion for nursing and education, satisfied my infinite quest for knowledge, and accommodated my need to seek, uncover, and legitimize the concept of multiple truths. Finally, the reports are a tangible recognition of a fulfilled personal obligation to shed light on issues in IPE so as to contribute to improvement in professional collaboration in order to raise the quality of patient care.

2009). No uniform or stereotypical format exists for case reports (Yin), creating flexibility for each case to be responsive to the unique data generated. Textual representations of participants' voices, with corroboration from other data sources where appropriate, exemplify and illustrate the findings (Sandelowski, 1994) where the intent is to "vitalize the research" (Sandelowski, p. 482), generating 'thick' description by providing information in a context, rather than providing reams of data (Wolcott, 1994). Importantly, I have considered the data from a FPS theoretical perspective such that the case reports incorporate theoretical and conceptual inferences about gender, discourse, language, subjectivity, and power discussed in chapter two.

To provide historic context for the case reports, I acknowledge that my profession has evolved from an era when nursing was considered women's natural and altruistic duty to care (Reverby, 1998), to the present era in which formal nursing education is firmly entrenched (Anthony & Landeen, 2009). A professional mindset of "I see and am silent" (Mack Alumni Association, n.d.) is being replaced by a professional culture of "I see and am silent no more," since nursing curricula, by necessity, incorporate concepts such as political and professional advocacy in response to the diverse influences impacting the professional landscape (Anthony & Landeen; Booth et al., 1997). Currently, nursing faculty face an educational imperative to include IPE in undergraduate nursing curriculum, directed by their respective schools' strategic plans and program goals. The following case reports reflect nursing's IPE engagement in response to the research questions and guided by a feminist poststructural lens. The case reports are constructed within the case boundaries described in the Prologue, chapter four.

Case Report Site A University

Introduction

From the archival holdings of the health sciences library at Site A university I uncovered historical records of an interprofessional health professional program whose presence sets an intriguing stage for this case report of interprofessional engagement. Nearly four decades ago (1972-1984), an interprofessional, clinically based Masters of Health Sciences (MHSc) degree³ existed at Site A university. The program was predicated on a philosophy that interprofessional learning establishes the basis for effective teamwork in future health care practice, enhancing individual health professionals' future collaborative contribution to health care delivery. Most significant to this case report was the discovery of a foundational MHSc program principle declaring that practitioners require an interprofessional perspective to gain a critical sense and understanding of alternate professional behavioural patterns and to experience practicing in a manner different from their accustomed ways (i.e., multidisciplinary practice). This foundational principle of the early interprofessional MHSc degree, is aligned with contemporary IPE philosophies and perspectives well documented in current Canadian literature (Curran & Sharpe, 2007; Gilbert, 2005a; Herbert, 2005). Not only is this early MHSc program a striking example of innovation and forward thinking at Site A university, but also it is a harbinger of the IPE movement in progress at the same university nearly four decades later. In

³ This innovative degree was established in recognition of the need to have an integrated program to provide graduate education in the health sciences, at the time inclusive of nursing, occupational therapy, and physical therapy predominantly. The faculty members teaching the MHSc program were interprofessional, consistent with the nature of the program. At the time, it was thought that this challenging program offered much in the way of experimenting with new educational programs in health sciences. Unfortunately the interprofessional clinical MHSc program was not sustainable and met its demise after a decade (anonymous, personal communication October, 2008). (archival records, Site A university, 1974 - *Summary of Proposal for an Interdisciplinary Graduate Program Leading to the Degree Master of Health Sciences [M. H. Sc.]*).

contrast to the era of the early interprofessional MHSc program, a different structure in academic nursing exists today at Site A university and is represented in the following text.

The Case and its Context

The case of nursing's IPE engagement at Site A university is a contemporary phenomenon that exists within its inseparable health professional and academic context (Yin, 2009). Integral to understanding this case is the fact that Site A university's nursing and health professional faculty member participants are considered inseparable from their academic context by virtue of their university position that defines their role and dictates the nature of their work. Attending to Site A university's case context is consistent with the importance that feminist poststructuralism places on context in women faculty members' experiences, particularly when these experiences lie in contexts located in specific institutional (i.e., university) structures and historical and material moments (Olesen, 2005, p. 256). In particular, nursing faculty's knowledge construction and behaviour are informed and influenced by the values inherent in the context of Site A university (Lincoln & Guba, 1985; Schwandt, 2000). Accordingly, an overview of the context of nursing's IPE engagement at Site A university situates the case findings and contributes to their understanding.

As member of a moderate sized southern Ontario university community, Site A School of Nursing (SON) is an integral partner in a Faculty of Health Sciences (FHS) that incorporates Schools of Medicine and Rehabilitation Sciences, including occupational therapy and physical therapy and a Midwifery program. A physician assistant degree inaugurated September, 2008, is the newest program offered within the faculty. The Faculty of Social Sciences incorporates the School of Social Work. Site A's nursing program is a part of the rich 80 year history of its parent university; Like other burgeoning university nursing programs at the time, the early development

of nursing within a university framework (i.e., Site A) was hindered by public and professional acceptance of nursing as a university discipline (Alderson, 1976). In spite of public and professional uncertainty, the early vision and work of nurse and academic leaders began an enduring affiliation between nursing education and Site A university, now into its seventh decade.

Physical sprawl of Site A parent university, located within the west end of a large metropolitan city, parallels the growth of the SON's physical environment, currently embedded within the warren of the city's Health Sciences Centre/Children's Hospital (HSC/CH). Not only have SON administrative and teaching space requirements increased dramatically over the last five years, but also educational facility requirements have expanded to incorporate a state-of-the-art clinical simulation laboratory shared with the other FHS professional programs. Adjacent to the HSC/CH, constructed on Site A university property, is an Institute for Applied Health Sciences, a unique partnership between the local Community College and Site A university.⁴ Site A university School of Rehabilitation Sciences is co-located in the Institute along with several Community College health sciences programs, including the baccalaureate nursing program offered collaboratively with Site A university. In addition to its nursing education partnership with the local Community College, Site A SON provides collaborative baccalaureate nursing education with a second Community College, located an hour west of the university.

⁴ Over twenty years ago, the presidents of Site A university and the local Community College shared a vision for a joint health sciences campus to promote collaboration among post-secondary institutions and to encourage seamless post-secondary education from college diploma, to university degree and beyond. To materialize the vision and to alleviate space issues at both educational institutions, the Institute for Applied Health Sciences (IAHS) project was born; the IAHS, which sits on land owned by Site A university, was developed by a joint steering committee, and continues to be jointly owned and operated by the two institutions, offering programs from each parent educational institution (R. Knechtel, personal communication, March 3, 2010).

Site A SON offers doctoral, masters, and baccalaureate level nursing education as well as nurse practitioner studies. Approximately 462 undergraduate students are enrolled in the four-year baccalaureate program; female-identified students (93%) outnumber male-identified students (7.6%). The nursing programs are delivered by 58 full-time faculty members (n = 54 female-identified, n = 4 male-identified) and approximately 125 part-time faculty members (n = 118 female-identified, n = 7 male-identified) who teach clinical and theory courses; the annual number of part time faculty members is responsive to student enrollment. Male-identified faculty colleagues (i.e., full and part time) are a minority (6%).

A commitment to interprofessional approaches to education and practice is affirmed in a preamble to the baccalaureate curriculum overview in the 2008-2009 undergraduate program handbook. Included is a statement that nursing is the scientific and humanistic activity of professional caring that may include working with other members of the interdisciplinary health care team; a program goal expresses that nursing graduates will engage in the full range of care (i.e., assessment, planning, evaluation) with an interprofessional care team. Of note, is the use of two disparate terms - interdisciplinary and interprofessional - in the program information. Confusion of terms aside, that interprofessionalism is articulated as a program goal demonstrates IPE intent and is an objective aligned with the definition of IPE provided by Barr et al. (2005) that guides this study. Consistent with the goal to embrace interprofessional care, final level nursing students clinical performance evaluation incorporates criteria related to interprofessional communication, and its impact on nursing as a discipline.

Interprofessional education is an integral contextual component at Site A university. IPE is a formal FHS program with practice, education, and research opportunities supported by university and provincial research monies. This program incorporates a well-structured website

that communicates a variety of IPE information, including explanations about IPE, research offerings, and descriptions of interprofessional learning opportunities designed to foster IPE competencies at exposure, immersion, and mastery levels. The IPE program has a director and an advisory body to guide its development. Because of value held for IPE within the faculty, IPE program offerings are mandatory for some and it is anticipated that all health sciences students soon will be expected to demonstrate some extent of interprofessional competence before graduation; Currently, IPE competencies are mandatory in five of the six professional programs (BScN program excepted). To achieve IPE competencies, students engage in a variety of faculty-developed learning opportunities including, but not limited to, communication skills labs with standardized patients and simulation laboratory activities. Additionally, FHS students have access to interprofessional learning through IPE on-line course modules collaboratively developed with faculty from other Ontario universities. Faculty development in the area of IPE is a valuable component of the IPE program; the FHS Faculty Development Program assists faculty in developing curricula that promote interprofessional education and practice.

Case Study Findings

The case study findings are discussed within boundaries created by full and part time nursing, health professional, and social care faculty members at an English-speaking Ontario university site of a four-year baccalaureate nursing education program as well as rehabilitation sciences, midwifery, medical, physician assistant, and social work programs. Data were generated between June 2008 and June 2009. Participants' demographic data are depicted graphically in Appendix E. Participants were predominantly female-identified (n = 11) (male-identified n = 1) and the majority (n = 9) fell within the 45 to 65 year age bracket. Nursing participants were in the majority (n = 11; n = 1 rehabilitation sciences). Among nurses, years in

the profession ranged from 11 to 40 (average 26.3). Experience in nursing education generally, averaged 18.2 years (range 9 - 32), with an average of 16.5 years at Site A university specifically. Among all participants, 16.5 years was the average for teaching in the health professions at Site A university specifically (range 5 – 32 years). The composition of Site A participants in individual and focus groups interviews appears in Table 1.

Table 1 Composition of Site A Individual and Focus Group Interviews

Interview type	Number	
	Interviews	Participants
Individual	9	9
Focus Group	1	3

As I began to explore nursing's IPE engagement at this site, the data led me to reason that faculty first needed knowledge of and understanding about IPE in order to engage this learning modality (i.e., to develop and implement IPE in mainstream baccalaureate nursing curriculum, and to engage in scholarly activity and publish in IPE literature). Following this logic, I first explored nursing's IPE knowledge and understanding prior to exploring nursing's IPE engagement. This decision was supported by the research proposition that faculty may not be knowledgeable about IPE. My determination to explore IPE knowledge and understanding lies appropriately and logically within the case boundary of full and part time educators at university sites of baccalaureate nursing programs.

IPE Knowledge and Understanding

Interprofessional education has a clear presence at Site A SON. This IPE profile is attributed primarily to the diligent work and championship of the faculty's IPE leader. Other influential factors include the provincial funding support for IPE research and the subsequent influence of a growing critical mass of scholarly literature (e.g., empiric and expository). Although generally a well-known concept, there was a mixture of specific IPE knowledge and understanding, beginning with language choice. Nursing's language choice is a reflection of IPE knowledge and understanding since language is a fundamental societal mechanism by which concepts, structures, and processes are defined, characterized, and internalized (Arslanian-Engoren, 2002). Several different words were used synonymously to describe IPE; The terms interprofessional, multidisciplinary, and interdisciplinary were used interchangeably by some with no distinction made between these seemingly similar yet distinctly different terms. For others, sustained vigilant use of the term interprofessional, as defined by Barr et al. (2005) prevailed, yet curiously was coupled with examples that were multidisciplinary in nature.

In health professional practice and education a collection of terms is used interchangeably to describe practice teams comprised of different health professionals working together for optimal patient care and to refer to educational endeavours and shared learning initiatives for health professional students (Dyer, 2003; Garrett, 2005; McKinlay & Pullon, 2007; Mitchell, 2005; Redman, 2006). The collection of terms has been described as a "semantic quagmire" (Bar, Koppel, Reeves, Hammick & Freeth, 2005, p. 31) with seemingly infinite combinations of prefixes (inter, multi, cross/trans) and suffixes (professional, disciplinary) to describe and designate the work and learning interaction between and among health professional practitioners/student. The most commonly used terms are multidisciplinary, interdisciplinary and

interprofessional. Multidisciplinary implies two or more disciplines working together to address a common problem/goal from respective disciplinary perspectives (Redmond, 2006) while maintaining the essence of each discipline, and is likely the typical interaction in most contemporary health care settings. Interdisciplinary expands on the concept of multidisciplinary through focus on collaborative communication (Dyer, 2003). Perhaps it is the focus on collaborative communication that results in an outcome of interdisciplinary interaction described by Redmond: The sum of interdisciplinary effort, by his definition necessitating the involvement of two or more disciplinary perspectives, “is greater than how each discipline [alone] might interpret a situation or what each discipline might produce individually” (p. 105). In contrast to multidisciplinary goal development, interprofessional describes the relationship among various professions as they purposefully interact, work, and learn together to achieve a common goal (CIHC, 2010). Barr et al. (2005) define interprofessional education as the engagement, by members (or students) of two or more professions associated with health and care, in learning with, from, and about each other.

In spite of terminology confusion, pride was conveyed in the notion that as a profession, nursing is intrinsically interdisciplinary and likely interprofessional. I wondered if faculty members’ understanding of interprofessionalism was conflated with the concept of collegiality, and if faculty viewed interprofessionalism as synonymous with simply being pleasant and collegial; An agreeable, accommodating, and acquiescent ontology is consistent with the behaviour typical of nursing’s professional roots that may be described as lacking in professional empowerment, or what Belenky, Clinchy, Goldberger and Tarule (1986) describe as silent knowing (Appendix H) and Falk Rafael (1996) describes as acting from a position of ‘ordered’ caring (Appendix I). Regardless of academic or practice context, perhaps provision of nursing

education is subconsciously described as interdisciplinary rather than interprofessional because the nature of interaction among nursing and other health professionals is parallel and siloed rather than interprofessional.⁵ Conceivably, the use of the terms inter and multidisciplinary, rather than interprofessional, is historically ingrained by the culture and structure of health professional education and practice.

Perspectives on IPE encompassed blunt opinion and concrete conceptualization. At one end, the spectrum of opinion conceived IPE as an abstract academic concept more easily envisioned in a clinical context⁶ and at the other end, conceptualized IPE concretely as a dynamic, interactive process inherent in formal and informal opportunities when health professionals and health professional students come together to learn with, from and about each other in any context (i.e., academics, practice and/or research) in contrast to static parallel learning with no opportunity for interaction. The former opinion is consistent with Reeves and Freeths's (2002) position in favour of obligatory clinically-based interprofessional learning opportunities and the latter opinion is consistent with the IPE definition offered by Barr et al. (2005) that guides this research. Perhaps the inference that the nature of IPE is context dependent (i.e., native to academia or practice) is not a reductionist view; rather, it is a realistic view because the nature of IPE is a function of the mix of health professions present in a given situation *and* the concomitant contextually indigenous and legitimate sources of knowledge

⁵ *Not certain what it means to be interprofessional. I think nurses by the nature of their work have to work with other disciplines. But whether it's interprofessional work or parallel play – sometimes I'm not certain.*

⁶ *So I think from a clinical hat, people think of IPE as being more than one profession coming together to learn about each other. But if you are in academia, I look at IPE as being multiple professions coming together for almost a different purpose in that it's probably, may be curriculum driven, such as how to work together in a curriculum that is shared. So I think depending on whose defining it, it can be ... it's kind of abstract right now just what IPE is and even in my own mind I see it in a clinical way and I see it in the broader context of education.*

including practical, empiric, personal, esthetic, and ethical (Carper, 1978), social interaction (Wenger, McDermott & Snyder, 2002) and/or gossip (Chin, 1990). Moreover, the nature of IPE is dependent on the broader health professional and academic context with its inherent political, people, and power characteristics.⁷

Disclaimers expressing lack of IPE knowledge frequently preceded IPE opinions and conceptualizations, raising speculation whether disclaimers were expressing inadequacy, concern about being wrong, or fear of judgment? Within an academic context of health professional education, fear of judgment and reprisal, although a tacit cultural characteristic (McNamara, 2009; Jackson, Peters, Andrew, Salamonson & Halcomb, 2011), suggests lack of professional self-esteem. Despite disclaimers, IPE consideration was significant and inclusive of several points of view. First, IPE was viewed not as a new concept, but rather as a new label with a new emphasis that requires new eyes (Proust, 1993) to see explicitly an IPE ontology already present.⁸ Pragmatically, the new emphasis may require a paradigm shift from conceiving curriculum development as a static entity to conceiving curriculum development as an inevitably dynamic and evolutionary process moving toward a new normal, a perspective aligned with Kuhn's (1970) view of paradigm shift. Second, while uni and interprofessional curriculum development are not mutually exclusive, inculcation of an IPE ontology that values all professional perspectives is a mandatory component of the IPE culture. Third, there was global

⁷ *I mean this involves, you know, power, gender ... communication, decision-making, team building. I mean it's a marriage ... as well as scopes of practice;* It's not enough for us [nursing] to say who are the other team members and what is your role but it is also how you are learning with those other people as an equal learner because that changes the balance of power.*

⁸ *We know that there are isolated pockets of people who have experience whether they realize it or not that they practice in an interprofessional collaborative way; The thing is, it's [IPE] not new; it's a new label and a new emphasis ... you know IPE is relatively, I don't want to say new, but the concept has been around maybe not labeled as well.*

**When present, multiple voices in the same footnote are separated by a semicolon.*

concern that IPE is the newest educational bandwagon (i.e., following the evidence-based practice bandwagon) or buzzword,⁹ one that is gaining current popularity, but one that may also lack stability and sustainability. Concern about IPE is inherent also in the tension created by a simultaneous desire to embrace and normalize, yet fear IPE because it is too complex an undertaking¹⁰ for current limited fiscal and human resources. A rival explanation for the recent surge in IPE as the newest bandwagon and buzzword may be the impetus from a collective of features including good leadership, financial initiatives, and genuine value held for IPE and its merits. Finally, perspectives of IPE strike a paradox; views incorporated cynicism about IPE origin, intent¹¹ and sustainability yet definitions and opinion relayed value for IPE, citing Romanow's (2002) foresight that health professionals need to learn and work together to foster collaborative patient-centred care.

To embody professional competence and membership on the interprofessional team it is logical to expect that nurses know about and understand their professional role in order to enact their practice and academic responsibilities. Consideration of nurses' role knowledge and understanding is well within case boundaries and consequent analytic periphery (i.e., place

⁹ *Well it seems to be that it's the latest bandwagon and ... I mean, we had the evidence-based practice bandwagon and now we've got the IPE bandwagon and then we had the nursing process bandwagon. I mean we get on them and then they drop by the wayside. But I think there is enough evidence to say that good interprofessional practice improves patient care and safety; It's a buzzword right now. I hope it's not just a buzzword, that it's something that actually has substance to it. These things seem to be buzzwords and moneymakers. And I don't think people really understand the Ministry's perspective and maybe, maybe if the Ministry then hadn't been putting all this money out for supporting interprofessional education, it would be even less of a buzz word.*

¹⁰ *I see IPE as coming from a good place ... but I think we have to be thoughtful and you know careful about doing it or it could become so complex that we just throw up our hands and say it is too hard. Let it all happen when they are done and out there. Let hospitals look after it because we can't do it here. So it's so big that I think you know ... I think there is a risk that it can implode because it's too big.*

¹¹ *[IPE] is the next window to look through to stop our universal problems like fragmentation and ... health human resource issues. They [federal and provincial governments] feel the IPE window is now what is going to solve everything.*

beyond which data have little relevance to the case), and of particular relevance to the case study because beliefs and perspectives about nursing are not only foundational to how nurses understand and perceive IPE but also are integral to nurse educators' enlightenment about IPE in nursing education. At the same time, nurses' individual and collective role perspectives are significant because of the harmful inferences (potentially) inherent in nurses' views of their own discipline, of their respective chosen professional role, and of the teaching-learning process, all of which have potential implications for nursing's IPE engagement. Furthermore, the relevance of exploring how nurses know and understand roles is supported by the study propositions which conjecture that historically, the nursing profession has struggled to establish itself as an autonomous and independent discipline, that nursing's relationship with medicine has evolved from a history grounded in patriarchy, dominance, and conceptualized as power over (Falk Rafael, 1996), that increasingly nursing is simultaneously acknowledging itself and being recognized as an academic discipline, with its own knowledge and power base, and that interprofessionalism will require nursing to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge and power. These reasons together with the inextricable link between nursing in the academy and in practice (Anthony & Landeen, 2009) support a preliminary exploration of how nurses know and understand their professional role.

Knowing and Understanding Own Nursing Role

Not unexpectedly, multiple perspectives and understandings of nursing's roles were articulated; nurses embodied their professional roles and views, passionately speaking their minds while health professional colleagues views were more candid. Ironically, emic (inside the profession) and etic (from outside the profession) perspectives differ, yet are mutually influential. From an emic perspective, knowledge and understanding about our nursing role is a

function of several factors. First, our emic perspective undergoes normative change with age and career trajectory¹² (MacIntosh, 2003). For example, the view of younger nurse academics in the early career stage did not incorporate gender bias as an impediment to professional role and identity. Seasoned, older nurses held views that described a learned attitude of ‘poor me’ with the concomitant inference that the primacy of medicine marginalizes nursing deliberately. Yet, in some instances, experience spoke wisely, advising the replacement of an attitude of inferiority with a positive stance as equal partner in order to be treated as such.¹³ At the same time, an enduring cynical and reductionist emic attitude regarded nurses exclusively as skilled handmaidens¹⁴ seemingly excluding the significant tacit intangibles of our professional roles such as critical thinking, integrating care, and collaborating as interdependent health professional colleagues. These collective emic positions suggest that nurses do not necessarily share similar knowledge and understanding of their own professional practice and education. Unfortunately, traces remain of an historic perspective that asked why time and money would be spent on educating nurses when, according to physicians, “nurses were better off with a little education ... but not too much to make them bored with the mundane tasks of caring for the sick” (Kirkwood, 2005, p. 183). Importantly, this vestigial perspective together with other emic views drives

¹² ... early on in my career I was much more tentative. And I have a certain amount of personal power now so that I can speak from a power base, also a sense of both, as a woman, and as a nurse, and as an academic.

¹³ I think as nurses we learn to work with that [male MDs in positions of university administration and leadership] and be politically astute. But you can't go there with the “Poor me. Poor me, you are out to get me.” You can't go there. To go there with an attitude is a part of this. I have something to offer and I'm not going to get everything I want but I'm going to make some inroads. I'm an equal partner. Yeah, and you get treated as an equal partner when you have that, I feel that way, when you have that attitude.

¹⁴ We have trained all of these people in various disciplines and we've given them skills that are a magnitude from what they actually distilled down to doing everyday. I mean look at what the school of nursing has students learn and it's enormous compared to working on a floor and giving people meds and bed baths.

change and promotes the development of relevant, contemporary nursing education inclusive of new pedagogies such as interprofessional education. It is troublesome that a prevalent, grassroots view is of nursing adopting specific attitudes to find their voice, a perspective that calls in to question not only how nurses, new and seasoned, understand their profession but also how professional identity is constructed as a function of this understanding.

A second factor contributing to the emic perspective about our nursing role is derived from and nurtured by historic and gender-based professional stereotypes,¹⁵ ontologies, and ideologies handed down in a seemingly never-ending cascade through generations of nurses. This cloning perspective of production presumes not only that a received view of nursing is predominant and still relevant, but also that newer perspectives are not necessary. On the contrary, IPE requires intraprofessional reframing of this entrenched view and supports a model of nursing education that is interprofessional from the outset so as to mitigate or eliminate entrenchment in an extant detrimental culture generated by historic and gender-based professional stereotypes, ontologies, and ideologies.¹⁶

A third factor contributing to an emic role perspective is that nurses typically understand and describe their role as a function of practice context.¹⁷ Perspectives of university site nurse academics' responsibilities (i.e., case boundary) are diverse yet have key elements in common, including opinions on university structures (e.g., contractual workload allocation), realities of

¹⁵ *So if we are assertive, we are defined as bitchy. If we are complacent, we are defined as ditzy. So it is really hard and we are fighting constantly the stereotypes of the sexy, single nurse or the stern starched matron.*

¹⁶ *[I] have seen a shift in how we view our own [I] role and how our role is understood – from the hierarchical model to a more collegial, collaborative model – change has been in the last 15 years.*

¹⁷ *You ask any nurse what they do and they don't say to you 'I identify and resolve problems where nursing can have a highly effective outcome.' They will say, I work in CCU or I work in emerg. So, I think it is incumbent upon us to teach them how to say what they do well. It is all about socialization ...*

ubiquitous and competing demands of the role, and marginalization by the university. These key elements are considered in detail due to their integral connection with the concepts of nursing subjectivity, self-esteem, and professional identity considered in the cross-case report of chapter six.

University Structures and Competing Demands

Conventional university structures contribute to the academic culture and context that nurse academics experience. For example, knowledge and understanding of nurse academics' role is influenced by the conventional university structure for faculty contracts that allocate percentages of workload toward teaching, research, and service.¹⁸ Inevitably, contractual percentages for workload allocation at a university do not translate exactly into the magnitude of workload in all contractual areas. Consequently, nurse academics feel stressed and stretched not only by the volume of workload but also by the ubiquitous and competing demands of academic life (e.g., committee work, mentorship with collaborative program partners, maintenance of practice relationships, curriculum development/revision and accreditation).¹⁹ For nurse academics with predominant teaching responsibilities, professional good will is compromised

¹⁸ Conventional structure for university faculty contracts allocates percentages of workload toward teaching, research, and service as a function of contract type (i.e., a tenured/tenure track faculty member workload of 40% teaching, 40% research, 20% service). The general academic culture of a university is generated through discovery, communication, and preservation of knowledge through teaching, research, and scholarship to serve professional, social, cultural, and economic needs of individuals, communities and society. In contrast, the academic workload structure at community college Sites of a collaborative nursing program evolves from the Standard Workload Formula (SWIF) that places explicit parameters on teaching contact hours, preparation, evaluation, and complementary functions. The general academic culture of a community college is generated from the delivery of education and training for employment across business, health, industrial and services sectors. (Source: Collated website information from Ontario University and Community College mission statements, August, 2011)

¹⁹ ... everybody is so stretched with what they want to do that, again, even though it's [IPE] something that we probably all agree is a good thing and would love to do, it's kind of like it's one more thing on top of, you know ... ; We find ourselves so busy that you know we let things fall by the wayside. I do know that people can only stretch so far. On the other hand there is a difference in perception of workload and what is an acceptable workload.

when managerial and leadership responsibilities of teaching workload are augmented because research time is privileged over teaching responsibilities, a reality consistent with the primacy of research within a university structure.²⁰ In contemporary times, an historic construction of professionalism in the academy that assumes implicit expectations for faculty,²¹ inclusive of unquestioned conformity with all university structures, in addition to relentless identification and exploration of areas of interest, automatic engagement in all facets of the academic unit responsibilities, and limitless work hours is problematic for many nurse academics.

Marginalization by the university. Nurse academics experience feelings of insignificance and lack of value akin to marginalization due to imposition of university structures.²² This impression of marginalization pertains to many components needed for nursing education such that without a culture of acceptance and equality as well as without appropriate resources and supports, curriculum development generally and nursing's engagement in IPE specifically cannot grow. Absence of marginalization in this area of academic responsibility is attributed to the nursing's success securing research funding and highlights the privilege of research within the university structure. Strategic academic credentialing valued by the academy (i.e., doctoral

²⁰ ... if you think of the number of faculty that as well as the shift in full-time faculty with being released to do research and so that if they are doing research that then means they are bought back from part-time people who are not as engaged in the overall ... Well the pool amongst whom you can get to do that with an interest with an educational focus has shrunk ... and there are so many different competing demands. IPE is one.

²¹ ... in the past ... [s]omeone just came forward and did it. It wasn't part of your assigned workload. You didn't need to have, you didn't need to be freed up from teaching in order to think about interprofessional education or any other topic. It was assumed that this was part of what you should be doing - identifying areas of interest and continuing to explore them, that is part of your understanding ... or part of your academic role.

²² And I see in the university where I've got a limited appointment, a contract appointment. I see nursing marginalized. Totally marginalized in terms of what kinds of facilities they have. What kind of space they have. They have to work twice as hard ... Remember what Charlotte Whitton said, "Women have to work twice as hard to be thought half as good. [Thankfully this is not difficult]."

preparation) mitigates nursing's sense of lack of value and insignificance, enhancing empowerment, voice, and professional accountability.²³ Curiously, that which enabled the voice of the nurse academic (i.e., doctoral education) also may be complicit in the development of an insular, perhaps protective ontology,²⁴ as nursing strives to embrace its rightful place in the academy.

Finally, nurses' professional roles are defined not only by that which is a visible workplace requirement, but also are defined by tacit, invisible attributes such as critical thinking and collaborating. Although knowing about and understanding our own nursing role evolves over time, impacted by myriad personal (e.g., choice of career trajectory) and professional factors (e.g., advent of university faculty association, creation of new academic programs), how we know about and identify our professional role is requisite to understanding nursing's place in and contribution to interprofessional education; In order to work collaboratively and interdependently, interprofessionalism requires nursing to acknowledge itself as an academic discipline, with its own knowledge and power base, a challenging undertaking hampered perhaps by nursing's relatively recent membership in the academy and the consequent implications.²⁵

²³ *I think the PhD helped. I think getting tenure helped because, at some point I realized that I not only had the luxury of being able to speak my mind, I had the moral responsibility to do that because I was able, because I was protected so that with getting tenure became a certain level of freedom and responsibility then to challenge the status quo ... but also referential power too. So I have power within my role so I am more secure talking out and speaking up ...*

²⁴ *They [nursing faculty] tend to be PhD nurses who have spent a lot of time in nursing education and nursing research so still very insular in their thinking compared to the outside [clinical practice]. I have found, since we [nursing] came here [university], that we are very insular, nursing is, and we are not prepared to really branch out as much as we tout and I am surprised at that ... how insular we were in both our thinking and our education models. Nursing is it. Nursing is what it is all about. That's their vision, they only see nursing, they don't see the total picture; I think we need to ... broaden ourselves a little bit.*

²⁵ Compared to the long history of most disciplines within the academy in Canada, nursing's arrival in 1919 is relatively new. A prototype, nonintegrated nursing curriculum was established in 1919 at the University of British Columbia (UBC). This institution refused to assume any financial or administrative

By introducing baccalaureate nursing curricula to the academy, was a tension created between assimilating academic and practice roles? Were nurses in the academy forced to make a choice between academic and practice nursing because of the stringent parameters of academia that do not incorporate or accommodate nursing faculty practice?²⁶ How does the nurse academic marry the clinical roots of the profession with the historically, stringent structures of the academy?²⁷ How does a nurse in the academy define her/his role? Have university structures (i.e., research and tenure mandate) created divisiveness among nursing faculty because roles are identified and

responsibility for the middle few years of hospital-based nursing content ‘sandwiched’ between freshman and senior years of university study in the liberal arts (Ross-Kerr, 2003a). Governance of university nursing programs and departments fell under the auspices of the greater university until a radical innovation in 1942 at the University of Toronto (U of T). Russell, a contemporary nurse leader, (Ross-Kerr), proposed an autonomous nursing department, with full responsibility by nursing faculty for students’ entire nursing education. Severing administrative and service indenture to universities and hospitals represents a bold departure from the original service/apprenticeship model of nursing education. Nursing curriculum development in the early 20th century continued to be burdened by tortuous relationships with social perceptions of women’s roles, fluid and undefined nursing curricula, and financial and administrative responsibility.

²⁶ Faculty practice is a term used to describe an arrangement whereby nurse academics combine significant clinical practice with their academic role. As nursing moved into academia, the traditional role of the nurse teacher changed from sole focus on clinical education, often as a clinical practitioner her/himself, to an expectation of academic credibility through active research and publication (Rattray, 2004). According to the priorities in academia, clinical practice became somewhat devalued at the same time that criticism arose from practitioners over lack of clinical contact and growing distance from practice by nurse academics. It became increasingly impossible for nurse academics to stay current with clinical practice details (Ramage, 2004) and to meet the academic agenda of research output and funding success (Rattray). Merging academic and practice roles is mandatory for faculty to maintain a credible role as an educator in a practice profession (Bartels, 2007). Rather than being an informal arrangement stemming from a nurse academic’s personal desire to stay clinically current and to integrate the academic trinity in a practice discipline, nurse academics’ formal workload arrangements need to broaden to incorporate professional practice as part of the service component, an academic arrangement that has grown among nursing schools in the United States (Miller, Bleich, Hathaway & Warren, 2004). After all, embracing critical inquiry and knowledge development through multiple ways of knowing, including practice *and* research, is at the heart of nursing’s membership in the academy in the first place.

²⁷ *Our nursing schools need to rethink nursing education and this whole practice area about IPE ... in the movement that is on right now, every faculty member should have a practice of some sort whether it’s engaging in a hospital or doing consultation or ... It doesn’t have to be practicing, it could be quite abstract but at least engaged and not just doing research. And here, the only people we see getting tenure track positions are those that want to be research scientists.*

worth is measured by university contract and program of teaching?²⁸ Does the academic structure foster creation of a nursing ontology that is antithetical to grassroots nature of the human profession of caring?

The answers to the questions generated here are explored in depth in the cross-case report of chapter six where the central concepts of FPS are used as an analytic lens. However, preliminary assessment reveals that a feminist poststructural synthesis of the diversity inherent in knowing and understanding emic perspectives on nursing's professional roles concurrently provides and preserves authenticity in accounts of participants' experiences, acknowledges and honours each participant's narrative as one possibility of multiple realities inherent in their experience, and understands that the realities and truths of nurse academic and health professional participants are contextual and subjective. With this explanation as preface, collective perceptions are discerned from individual accounts. For example, a common insightful perspective describes our own nursing role as chauvinistic and our attitude toward knowledge and territory as proprietary,²⁹ characteristics not attributed exclusively to nursing (Baldwin, 2007). At the same time, common opinion holds that there is an emergent shift in how nurses identify their own role from silent "doer of tasks" for a passive patient, to professionally confident critical thinker and collaborator' focused on nursing outcomes.

²⁸ *So it's just if you are wanting to do research, obviously there is, it's very difficult if you are trying to move toward a tenure track stream you have your PhD and you are wanting to build some research and focus on a program of research to build some, you know, moving forward for tenure, it's very different or hard to do if you have a whole undergraduate course load. So that I know some faculty have said it's very hard.*

²⁹ *We are very chauvinistic as a profession, the nursing way is the only way! ... we are still protecting us. We are still protecting our [nursing practice] domain. There is no doubt about that; The whole political climate and people protecting turf [academic] and worried that people are taking over each other's jobs. So everyone is worried about turf.*

At this juncture, it is important to distinguish two fundamental truths related to knowing and understanding our own nursing role. First, diversity inherent in knowing and understanding our nursing role should not be misconstrued as inability to know and understand because there are authentic challenges to nurses' role knowledge and understanding. These challenges are made clear by rival explanations, including changes in scope of practice with concomitant growth in professional knowledge and nursing scholarship (e.g., emphasis on evidence-informed practice and nursing research), an increasingly informed public whose historic and media-driven entrenched etic perspective of nursing is difficult to deconstruct, and the relatively recent membership in the academy of a female-dominated profession in evolution. Second, a distinction can be drawn between how we know and understand our own nursing role and how we enact our way of being in that role, or our ontology. How do we enact or see our professional self? To some extent the ontology of nurses in academic roles is defined by low professional self-esteem, lack of professional confidence³⁰ and feelings of professional inferiority³¹ articulated by male and female faculty members alike. Likely the source of nurse academics' professional ontology is multifocal, including the overwhelming entrenchment of university culture and structures, the legacy of an historic handmaiden role and an historic, media-driven entrenched etic perspective of nursing.

³⁰ *I think we still, historically [are] still aligned with, I mean it's that old thing, "I look, I see you, and I am silent"; So the stronger we feel about ourselves and the more we understand about where we make a difference with our role, in collaboration with others, the easier it will be for our confidence to be maintained, our reputation to be solid, and for us to build the profession in that way.*

³¹ *Well, I think nursing has been predominantly a key profession in health care but we also have an inferiority complex. And we haven't had the level of education preparation that other professional groups have and we are starting to get there but there is the typical feminist thing, we are fighting all of the time to be noticed.*

At the same time, it must be asked what responsibility nurse academics hold in development of an ontology and professional identity. For a health profession striving to establish itself as a rightful discipline in the academy, a paradox is established by a self-imposed mandate (i.e., perfectionism, ubiquity, being all things to all people) for acceptance and recognition that instead fosters professional inferiority and an environment of separation and mistrust. Furthermore, academic life that is time-centred,³² geographically isolating, and driven by competition for research funding does not necessarily foster development of supportive environments; overwhelmingly unified opinion expresses that nursing faculty work in silos.³³ A siloed ontology is antithetical to the roots of a profession grounded in relationship development and an historic female ontology that characteristically is relational (Gilligan, Ward, Taylor, & Bardige, 1990). A siloed ontology encumbers not only development of a professional academic role but also encumbers development of relationships necessary for nursing's IPE engagement.

Knowledge and understanding of our profession filtered through our own professional bias, gossip, historically generated and embedded discourses, stereotypes, and ontologies does not foster clear articulation of or instill confidence in our professional place and role. A passive aggressive professional ontology that incorporates outward confidence, competence, and collegiality with an inward sense of persecution, protectionism, and constant need for external

³² ... you have to get along. That is a big issue. And most people don't have much time to get along ... everybody is off on their own. Every body is off and so busy doing their own thing they don't have time to open the window and check out somebody else. That's the other thing – we are so busy now that we have not time to stop and find out what other people are doing.

³³ What we have created is silos in learning in the health disciplines. I am struck by the fact that we educate nurses in a silo and then we go into a hospital that has program management where the silos continue ... I perceive that sometimes in meetings, it's very much a silo. I don't know how you break down those silos. If it's history, if it's these perceptions and gender issues perhaps ... we then created silos because we had our own thing ... as professionals, we were evolving. We created these silos. To my understanding we are still in silos as far as the academic work goes.

validation/recognition³⁴ is detrimental to the establishment of a solid professional foundation for nursing's IPE engagement. This consideration of how nurses know and understand their roles lays the groundwork for an exploration of nursing's IPE engagement since beliefs and perspectives about nursing not only inform nursing's understanding and perception of IPE but also are integral to nurse educators' enlightenment about IPE in nursing education.

IPE in Baccalaureate Nursing at Site A

Guided by the proposition that IPE has not made its way into mainstream undergraduate baccalaureate nursing education, my attention was directed toward listening for curriculum-based IPE in participants' stories, observing for IPE opportunities, and looking for indicators of IPE in program documents. Subsequent analysis of IPE occurrence was focused by two research propositions: first, that faculty may not be knowledgeable about or have opportunities to engage in IPE and, second, that interprofessionalism will require nursing to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge and power.

Between June 2008 and June 2009 serendipitous, informal, and formally planned elective or volunteer IPE activities predominate. For example, clinical evaluation forms incorporate criteria related to IPE experience, yet how the experience is manifest is a function of tutor's or preceptor's IPE knowledge and experience. Moreover, an IPE experience is manifest, in part, as a function of the non-prescriptive curriculum paradigm. Additionally, several elective or volunteer opportunities stem from IPE research projects and other diverse learning modalities,

³⁴ *I will speak from the female-dominated professional perspective of which I am also one. So many of us have worked long and hard to develop our profession, to develop our scope of practice to be recognized for having certain skill levels and so particularly through some of who may have been trying to do this for many years and so the thought of know saying " Hey, we are going to have to be more collaborative. You know there is going to be more role blurring here. We need to be, to think of not so much turf wars but sharing and thinking about the patient as the centre of focus." For many, that is quite threatening. And many have fought long and hard to be recognized for certain skills and are not prepared to give that up.*

including interprofessional (IP) small group work in volunteer case-based communication workshops and on-line elective modules designed to promote exposure to, immersion in, and mastery with IP concepts. Within this case study time boundary, completion of the IPE modules was not mandatory for baccalaureate nursing students. A formally planned, credited IPE opportunity is open to a small group of students who choose a particular clinical rotation in mental health outreach and community based practice wherein IPE is mandatory. Given the nature and degree of these activities, IPE cannot be considered mainstream in the baccalaureate curriculum in spite of IPE goals and objectives printed in program and course documents.

Available IPE opportunities are attributed to the strong leadership and funding success of the FHS IPE program, the value that faculty place on IPE, and the support from nursing's educational administration. Looking forward, there is sound intent and commitment to incorporate mandatory IPE in the upcoming revised curriculum. For example, potential is seen in clinical simulation using interprofessional learning teams, both as a way to incorporate IPE in the nursing curriculum and as a strategic plan by nursing to generate operational funds for a simulation lab built with nursing's governmental capital funding. There is no promise of either government or university operational funding³⁵ for the simulation lab. This funding model is an example of a political and educational funding structure that challenges the potential for IPE integration in nursing education.

Articulation of the value for IPE is pervasive. General statements regarding interprofessional learning, practice, and relationships in the school's mission statement, program goals, and clinical evaluation forms corroborate the value placed on IPE. Paradoxically, value for

³⁵ *The other whole area and potential that we have not even talked about is clinical simulation and I see that is really pushing that area as interprofessional teams and a real possibility, a natural. When we got the nursing money for simulation ... I knew we didn't have enough money for support and ongoing running of it and set it up as an interprofessional lab rather than nursing lab.*

IPE is expressed even in the presence of uncertainty about the concept and despite common conflation of the terms IPE and multidisciplinary. Since language is a fundamental societal means by which concepts, structures and processes are understood (Arslanian-Engoren, 2002), the way in which nurse educators choose their words reflects their level of understanding about the concept of IPE (Gilbert, 2005b); failure to distinguish between the terms interprofessional, multidisciplinary, and interdisciplinary obstructs understanding IPE, impeding IPE engagement. Gilbert (2005b), among others (Sheehan, Robertson & Ormond, 2007; Steinert, 2005), agrees that there are implications of language use for IPE.

Enthusiasm toward IPE is offset by concern about increased workload, overwhelming logistics, and other problematized constructions involved in introducing IPE in to a curriculum.³⁶ Despite individual reports of IPE activity, among faculty collectively there is fragmentation in knowing the reality of IPE in the curriculum; Firm belief in the absence of IPE in the baccalaureate curriculum³⁷ coexists with counter belief in the presence of IPE in the curriculum.³⁸ Consequently, there is no unified understanding among faculty about the type and existence of IPE in clinical practice, theory courses, and curriculum development. Fragmented faculty knowledge about IPE in the curriculum is an uneven foundation for IPE development, and a potential impediment to cohesive, collaborative nursing faculty IPE engagement.

³⁶ ... everybody is so stretched with what they want to do that, again, even though it's [IPE] something that we probably all agree is a good thing and would love to do, it's kind of like it's one more thing on top of, you know ...

³⁷ I'm not even aware that we really talk about it, the need for interprofessional, but that's the extent of my experience. I don't know that we try to. We don't do courses. If you do do a course with other groups, it's just by circumstance; No, I have to say I think it's a lot of talk at this point in time; Nursing is not, we are not on board yet. Out of all the faculties, we are the largest profession and we are not on board.

³⁸ I think there are lots of little pockets of IPE that are happening and, so, I think we need to bring all of that forward because sometimes you get caught up in your couple of courses and you are not aware of what may be happening or what may be new that is happening because so much has changed over time.

IPE engagement is in its infancy, for the most part linked to the FHS IPE initiative and a few pockets of opportunity in specific courses and clinical workshops. Future IPE engagement centres around development of the revised baccalaureate curriculum. Within the university and FHS context, several additional challenges are present for the introduction of IPE. First, developing criteria for crediting diverse experiences is not a straightforward, prescriptive exercise given the nature of IPE.³⁹ Second, challenging logistics include, orchestrating IPE experiences for a large number of baccalaureate nursing students within the purview of Site A university (non-collaborative and collaborative program students) and coordinating diverse timetables for health and social care students⁴⁰ from departments with different priorities. Third, circulating concerns that IPE will require an increase in workload stem from viewing IPE as a curriculum ‘add on’ rather than as a replacement activity, as an integrated experience,⁴¹ or as a necessary shift in educational pedagogy. In summary, the gap between faculty’s perception and the reality of IPE in the curriculum may be exacerbated by the siloed professional ontology in academia, a time-centred, communication-challenged university environment, a need to focus on

³⁹ ... I think they were looking at what is the experience and how do we credit it - sitting in a group of this with four different disciplines learning about Ms. Smith’s COPD. So we call that immersion, so you actually merge the groups and then we are looking at doing something a little bit more interactive where you actually have students involved in a project that work together and learn about the project, and through the process of the project and through the content of interprofessional education and then we are looking at something much more involved over a longer period of time. So there how do we give credits, one credit for the immersion and ... three credits for mastery and how many credits do students need before they graduate?

⁴⁰ The realities of trying to get learners into the same room at the same time in meaningful groups when they are mixing at different levels ... given timetables and priorities, that is the hugest stumbling block.

⁴¹ ... our curriculum is jammed. It has to be integrated into the curriculum and not additional work ... I don’t think you could add without taking something out and I don’t have any immediate ideas about what you could take out ... We could look and say – What’s really a priority here and if we truly believe interprofessional education is a priority then we’re going to have to take something away.

existing curriculum, or a sense of being overwhelmed by the challenges and complexities inherent in an educational milieu.

Nurse Educator/Nursing Faculty IPE Engagement

The global challenges and complexities of contemporary baccalaureate nursing education are apparent in the stories of nurse academics and health professional colleagues. When probing their accounts of IPE specifically, my attention was focused by three propositions relevant to their personal and professional contexts and experiences: first, that IPE has not made its way into mainstream undergraduate baccalaureate nursing education; second, that faculty may not be knowledgeable about or have opportunities to engage in IPE; and third, that interprofessionalism will require nursing to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge and power. In light of these propositions, it is clear that progressive effort to include IPE in the baccalaureate curriculum is afoot. However, the nature of nurse educators' roles/engagement in this IPE development and implementation is nominal; Nursing's IPE engagement involves few nursing faculty members and is concurrently varied, serendipitous, and planned, yet barely visible. For example, apart from a one faculty member secondment by the FHS IPE program one day per week for SON IPE development and research, there is minimal active IPE; A few nursing faculty by choice integrate IPE within mental health outreach and community-based nursing courses. However, statements about curriculum revision work do provide indication that nursing is engaged in developing IPE within the program.⁴²

Although evidence of IPE engagement does exist, relative to the number of nursing faculty

⁴² *Yes, we are in the development phase and there is different levels of that [IPE] and so yes at level one, first year, it's being looked at in terms of course manuals and ... we are going to have some more discussions about our scenarios that we use in our problem-based learning, person-based learning of making sure that IPE then gets woven in as one of the areas of focus for some of the scenarios that we do and that will continue to roll out ... in level four like having some more objectives about interprofessional and that match the Faculty of Health Sciences objective of exposure.*

members and their collective workload, nursing is marginally engaged in IPE. Importantly, this finding is consistent with the study proposition that nurse scholar's representation as architects of IPE curriculum development and implementation is minimal.

Nursing's minimal IPE engagement is attributed to several factors simultaneously connected to nursing's professional subjectivity and self-esteem. First, there is a tacit understanding that IPE is an undergraduate mandate exclusively; Nursing career scientists and many tenured faculty members with significant research portfolios teach exclusively in graduate programs, having less interest in or time to incorporate in their portfolios the type and magnitude of work inherent in baccalaureate nursing education.⁴³ This common dichotomized teaching arrangement, not necessarily unique to the advent of IPE, imposes an artificial divide among nurse academics, creating tension in managing an academic workload that privileges research over teaching. Because research is the university currency that brings greatest prestige (Bartels, 2007; Lucas, 2006), compared to teaching and service, many nurse academics are compelled to give research primacy and in so doing, assimilate the historic academic and (male) power structures of disciplines (e.g., medicine) (Anthony & Landeen, 2009) that preceded them into the academy. Accruing prestige within academia, contributes positively to nurse academics' professional subjectivity by boosting professional self-esteem. At the same time, a structure that privileges research over teaching creates a divided rather than a unified ontology for nurse academics. Inflicting a research culture that incorporates separate knowing (Appendix H)

⁴³ *They have gotten career awards and so they are seen as ... and they are teaching in the graduate program not in the undergraduate program and so they are seen as separate and removed and do not have any input or interest in undergraduate education, so IPE is just one piece of the larger shift that is happening. So it's just if you are wanting to do research, obviously there is, it's very difficult if you are trying to move toward a tenure track stream you have your PhD and you are wanting to build some research and focus on a program of research to build some, you know, moving forward for tenure, it's very different or hard to do if you have a whole undergraduate course load. So that I know some faculty have said it's very hard.*

(Belenky et al., 1986, 1996) upon nurses in the academy cultivates a professional ontology that is inconsistent with nursing's ethos defined by connected knowing (Appendix H) and caring, relational roots. A divided ontology is detrimental to nursing's professional subjectivity, fostering uncertainty and insecurity rather than commitment and confidence needed for IPE engagement.

Aside from the impact of the academic culture, commitment and confidence toward IPE engagement may not be manifest because of fear of change to new and ostensibly unknown pedagogies. Perhaps lack of IPE knowledge and understanding mitigates IPE involvement because IPE is perceived to be too complex or requires abdication of professional identity, knowledge, power, and domain. Two rival explanations for lack of nursing's IPE involvement are plausible: First, self-proclaimed overwhelming workload and other demands of academic life may render nursing impotent for IPE engagement; and second, within the culture of academia, nurses' reticence to ask questions that demonstrate lack of IPE knowledge and understanding may be motivated by fear of reprisal by FHS colleagues (i.e., medicine *and* nursing), including inter and intraprofessional labeling with negative historic and gendered professional stereotypes, or fear of losing nursing's professional identity within the interprofessional team and rightful place in the academy. These rival explanations for lack of nursing's IPE engagement notwithstanding, professional self-deprecation lowers professional self-esteem,⁴⁴ creating a weak, powerless, and vulnerable platform from which to launch nursing's IPE engagement.

Realistically, the arbitrary nature of nursing's IPE engagement may be a necessary beginning step toward evolving nursing faculty member's intended and sustained responsibility to embed

⁴⁴ *So the [IPE] naysayers that say 'oh we worked so hard to be our own person' - it seems to cloister us, would do us a disservice.*

IPE in the new revised curriculum. A coherent, coordinated, and deliberate faculty IPE engagement plan is needed.

Lack of Nursing IPE Engagement

Connections between level of nursing's IPE engagement and professional subjectivity and self-esteem are evident. At the same time, exploring contextual factors surrounding nursing's IPE engagement promotes faithful adherence to case study research methodology that places primary importance on context. Accordingly, lack of nursing's IPE engagement is considered within several contextual factors inherent in the health professional and academic culture in which IPE engagement exists. Contextual elements inherent in nursing's professional and academic culture that are impediments to nursing's IPE engagement have been called barriers (Clavering & McLaughlin, 2007; Hall, 2005; Oandasan & Reeves's, 2005b), although challenges might be a more appropriate term (Gilbert, 2005b). Site A nurses face a diversity of challenges within their professional and academic culture, as defined by the case boundaries, including collaborative nursing program's problematic constructions, university and practice setting structures and cultures, and nursing faculty mindset, explored below.

Collaborative nursing program. Partnership with two community colleges, across two geographic sites, in the development and delivery of a collaborative baccalaureate nursing program is an integral yet challenging component of Site A context because of the implications of program size and equity across multiple educational locations.⁴⁵ The mandate for collaborative baccalaureate nursing programs, including the need to navigate two diverse

⁴⁵ *Which brings me to the next barrier is the fact that we are three sites and we cannot do to one site and not to three. And knowing that the partners of our two college sites have both different priorities and different interprofessional partners and I have said that I would not make IPE mandatory for the nursing students at our college sites when it is not mandatory for their interprofessional partners. So how can you mandate one group in isolation?*

educational cultures and administrative structures, increases faculty members' workload and energy expenditure. The requirements of collaboration compete for faculty members' fixed time and energy available not only for teaching, research and service but also for engagement in IPE.

University and practice setting. The logistical challenges present in collaborative partnership achievement overlap with several challenges encountered navigating university and practice setting structures and cultures. First, creating a seamless learning interface between the university and practice setting is compromised by differences in cultural paradigms between the two institutions and their respective competing demands (Gilbert, 2005b). Nurse academics may be disinclined to engage in developing and implementing a new pedagogy whose essence gets lost in translation between the academic and practice setting.⁴⁶ Second, the complex and time-consuming task of navigating logistics, including timetables and curriculum differences,⁴⁷ to create mutual learning/meeting time seems prohibitive and may dissuade IPE engagement at the outset. Third, fiscal and human resource needs for existing programs compete for time, money, and primacy with innovative pedagogies such as IPE.⁴⁸ A politicized educational culture, created

⁴⁶ *The competing demand seems to be between educating nursing students in a way that will create the best possible outcome for patients and educating them for a system driven by a philosophy of skill excellence, professional hierarchy, and time/risk management. The nursing education system does have to be practical – as a self-regulated profession there have to be measureable outcomes that help to determine competence so in a sense the educational paradigm needs to communicate with the pragmatics of the regulatory system – the two are not mutually exclusive because the new CRNE exam format is not system or medical model based any longer.*

⁴⁷ *The curriculums are so varied. Like our curriculum follows a standard. Everybody is following their own; ... It has been suggested that one of the impediments to IPE really are the logistics around bringing students together, the scheduling ... what I'm getting at ... it's logistics, scheduling of courses. You would need to tear it down and to plot them all and find out what you can shift here. I know it's a pain.*

⁴⁸ *... other programs wanting nurse educators – for example the PA program. They are getting nurses to be preceptors to the PAs. Taking them away from us; And so if I was to go to programs now and say 'Listen, I need a per capita tithe on each of your students so that I can continue to develop [IPE] things for your curriculum' I don't know how that would go over; They will argue at the university level as to who should house that [IPE] because it is all about money. Money and numbers, right?*

in part by academic structures that foster competition for fiscal and human resources, is an unfavorable climate for innovation generally and a deterrent toward nursing's IPE engagement specifically. An academic culture that values and promotes inter-faculty cooperation rather than competition is needed to foster nursing's IPE engagement. Finally, ever-present competing demands inherent in academic workloads and within the profession denude focus and energy for pioneering work, including IPE. For example, when academic and professional competing demands encroach on faculty's experience of available time,⁴⁹ accommodating new innovations, such as IPE, seems prohibitive on top of an already overflowing workload.⁵⁰

Nursing faculty mindset. A collective of opinion and beliefs about IPE constitute a faculty mindset that precludes nursing's engagement. For example, when IPE is viewed as too big, risky, and seemingly involving threats to gender, to power and to ongoing establishment of nursing as an academic discipline,⁵¹ IPE engagement may not be in the forefront of nursing's academic agenda. Additionally, IPE-averse inclinations may stem from a belief that only when an

⁴⁹ ... it is a bit reductionist to sort of say time is a barrier but I think it is realistic. I'm not sure how much more [time] once it's [IPE] developed, that it's going to take any more time than what we are already doing, but I think that the time to conceptualize it to ensure that something whatever it needs to be is well developed. So that's a huge barrier for me, not being given a little bit of extra time to help make this [IPE] happen because this is not going to be an easy task.

⁵⁰ ... so IPE I think is just one of the many competing things that we should be doing and I do know that people can only stretch so far. And I understand where they are coming from because it is, it's a nightmare to even think you know how to even begin to think where I would start with all the issues that I'd have to tackle. The different sites, you know the different number of students, the curriculum and timetables. It's a ton of work which we don't have time to do ...; There is just so much on the professional plate that this [IPE] hasn't risen to the top of the agenda.

⁵¹ And many have fought long and hard to be recognized for certain skills and are not prepared to give that up. And it is not just nursing, it's other primarily female-dominated professions that have been in the hierarchy for many many years and have been trying to flatten that hierarchy. So I think that's a threat; IPE is a threat to many.

empirically derived evidence-base is created can legitimacy and worth be conferred.⁵² Empiric IPE research is in progress (e.g., Bradley, Simon & Cooper, 2009; CIHC, 2008b; Gaudet et al., 2007) and IPE research from other paradigms (e.g., naturalistic/constructivist) is growing (e.g., Kvarnström, 2008). The discourse surrounding primacy of evidence (Daly et al., 2007; Mantzoukas, 2007; Sandelowski, Voils, Barroso, & Lee, 2008; Thorne, 2009) notwithstanding, a rival explanation for lack of IPE engagement is that nurses are not comfortable engaging in activities that lack an empirically-derived evidence base for fear of judgment and reprisal by intra- and inter-faculty colleagues who hold the dominant empiricist view of the primacy of evidence. In an academic culture wherein new curricula must be vet and sanctioned by a university committee structure entrenched in the dominant evidence-based culture, the presence of a proven evidence base may be thought to facilitate curriculum approval. A faculty mindset constituted by this collective of opinion and beliefs not only bears some responsibility toward lack of nursing's IPE engagement but also contributes adversely to the development of an innovative educational culture. Gilbert (2005b) reasons that development of such faculty mindsets are embedded in university structure and development.

The genesis of challenges to nursing's IPE engagement is in nursing's professional subjectivity, in nursing's professional self-esteem, and in features of the case context, including collaborative nursing program matters, university and practice setting structures and cultures, and nursing faculty mindset. Challenges to nursing's IPE engagement born of the case context confirms the importance of context to case study methodology and provides evidence to inform

⁵² *I think the fact that there is not a lot of evidence to support it is a barrier for some - evidence to support that if we teach students interprofessionally that at the other end of the spectrum there is going to be better patient outcomes. Well, surprise! There is not a lot of evidence. Because now I think how hard it is to make that leap and to prove that, how are you going to make a randomized controlled trial? So when they have a Cochrane review saying you know there is no evidence ... well, of course there is no evidence.*

changes necessary to improve nursing's IPE engagement. Consideration of nursing's lack of IPE engagement sheds light on the supports and resources necessary to engender nursing faculty members' evolving IPE roles and responsibilities.

What is Needed for Nursing's IPE Engagement

Discovery of current IPE work and exposure of lack of IPE engagement is prerequisite to understanding the resources and supports needed for nursing's IPE commitment. Study proposition six, that interprofessionalism will require nursing to work collaboratively and interdependently, rather than subjugating its discipline-specific knowledge and power, provides a lookout from which to sight the resources and supports necessary for nursing's IPE engagement. If increasingly, nursing is simultaneously acknowledging itself and being recognized as an academic discipline (proposition five) and if nursing values IPE, then sighting requisite resources and supports is essential for growth in nursing's IPE engagement.

Ironically, suggestions for IPE supports and resources invariably start with passionate dialogue about barriers to IPE, prompting deeper scrutiny as to what distinguishes resources and supports necessary for IPE from resources and supports needed for any other academic innovation or change. Conceptions of IPE resources and supports incorporate tangible or visible constructions, intangible constructions, and in-between constructions. Tangible or visible constructions include human and fiscal resources, faculty development, time, academic structure/culture (shift), and professional/educational structures. Intangible constructions include good will, role confidence, open-mindedness, and personal knowledge base. In-between constructions straddle both conceptual categories and include nursing leadership, intraprofessional relationships and communication that manifest ostensibly as tangible support and resources, but whose generativity is contingent on intangible supports and resources.

Tangible, visible supports and resources. Resourcing nursing education programs is an escalating problem (Canadian Nurses' Association & Canadian Association of Schools of Nursing [CNA, CASN], 2010) potentially exacerbated by university structures that seemingly place nursing school/faculty human resources in competition with fiscal resources (Gilbert, 2005b). For example, the cohort of full time faculty available for IPE engagement may be denuded by the primacy of research inherent in a promotion and tenure structure, when fiscal resources from research funding are used to replace teaching in favour of research time. Consequently, teaching replacement comes from a shrinking pool of human resources and therefore, by design, faculty selection based on availability preempts faculty selection based on IPE knowledge and strength. Nursing human resources, robust in number and IPE knowledge, are vital if nurse scholars are to be architects of IPE curriculum development (research proposition nine). Regardless of the irrefutable reality of nursing schools/faculty's competition for fiscal resources, financial support for nursing resources and IPE development and research across school/faculty and provincial/federal levels is imperative.⁵³

Collective opinion affirms what is well reported in the literature (Steinert, 2005), that faculty development opportunities are equally necessary as fiscal resources in supporting nursing's IPE engagement. Since clinically-based interprofessional learning opportunities must be included in health professional curricula (Reeves & Freeth, 2002; Reeves & Oandasan, 2005a), IPE faculty development for clinical as well as theory teaching is mandatory in part due to the increasing and ever-changing cohort of part-time faculty hired to teach clinical courses

⁵³ *If the leaders in the programs try out something because they are all congruent in how they see [IPE] things, then maybe we inch our way forward. However, if you put some money around it, they will inch a little faster; ... government has to support it [IPE]. Not just, just not – and they support it as our statements and they are supporting some research on that. But I think they also have to support the schools, the educational institutions with some funding to move in that direction. That has to be done.*

who may be unfamiliar with the concept of IPE. Fiscally supported faculty time dedicated to IPE faculty development as well as IPE curriculum development and implementation is a worthwhile investment necessary for growth in nursing' IPE engagement. This investment is an integral component of a comprehensive plan deemed necessary to inculcate a culture of interprofessional education.⁵⁴

An IPE culture needs to be supported in the broader context by university and faculty structures that promote interprofessionalism, in both the academic and practice setting. For example, a university or faculty that models interprofessionalism with practice partners, not only generates a platform conducive to IPE, but also conveys explicitly an expectation for IPE engagement. Furthermore, a health sciences faculty that allocates supports and resources to support an IPE leader, a formal IPE program of research and learning opportunities⁵⁵ for its health professional students, including nursing, recognizes the value of IPE, sending a clear message of the importance of IPE engagement.

Intangible, invisible supports and resources. Internal resources are intangible characteristics manifest in nurse academics professional embodiment (i.e., required for enactment of the role as nurse), professional ethos, and nursing's subjectivity. How nurses regard themselves as a professional resource is varied; that nurses may not at all regard themselves as a

⁵⁴ *So we need to educate people. We need to put that word [IPE] in their head. It's not something that somebody over here is doing, and you know there is a meeting to day and maybe I'll go if I have time but I'll see what happens. It needs to be a part of our vocabulary, a part of who we are and part of that is talking about it in large groups, in small groups, in faculty groups, with students right from the get go so that people understand that it is here and this is the reason it is here and this is a positive outcome ... but they need to be able to understand and be able to thrash it out.*

⁵⁵ *I think the fact that health science values the development and the existence of this group [name of faculty IPE and research program], I think to me has made a significant impact and can potentially move this forward further if indeed that structure continues and I think the presence and involvement of it more so may advance it [IPE].*

professional resource is apparent. At the same time, a particular ontology is desirable for IPE engagement inclusive of open-mindedness and a robust professional self-esteem (i.e., sense of worth and belonging as a nurse).⁵⁶ A solid IPE knowledge base is preferred, yet, ironically, nursing faculty successfully incorporate IPE (i.e., aligned with the study definition of IPE) in clinical teaching in spite of self-professed lack of understanding and knowledge about IPE. Exercising professional good will, breaking away from siloed behaviour, and finding common ground⁵⁷ are intangible resources needed to support nursing's IPE engagement. However, the primary internal and intangible resource needed for nursing's IPE engagement is nursing faculty's confidence in their own role as a nurse academic.⁵⁸

In-between constructions. Dichotomizing resources and supports as internal and external is not only reductionistic, but also artificial in part because this view fails to capture valuable features generated by the inextricable relationship between the two constructions, or the in-between resources and supports. For example, professional good will, collegial behaviour, and willingness to find common ground typify the leadership sorely needed for IPE and nursing's

⁵⁶ *I think so much depends on the individual and how they [nursing faculty member] move forward with it [IPE], ... because I have to say I have been very supported with whatever discipline I've had interaction with so far but yet others may have had a different experience; Well, part is feeling included at the outset.*

⁵⁷ *Probably the good will of everyone to actually make it happen rather than saying we can't do it because we already have this many credits in the course; That's what I think is needed - that people just tear down the walls and really mean that they are interested in this and finding common ways of building it.*

⁵⁸ *So there is bringing together these models to actually you know look at and it begins with people who are really comfortable in their own role; So the stronger we feel about ourselves and the more we understand about where we make a difference with our role, in collaboration with others, the easier it will be for our confidence to be maintained ...*

engagement,⁵⁹ leadership that will value IPE and promote its entrenchment.

Although a variety of resources and supports are needed to foster nursing's IPE engagement, what is co-requisite with resources and supports, inarguably, is a culture shift for all health professionals,⁶⁰ including nurses' embodiment of an academic role⁶¹ and nursing curriculum development that inculcates IPE philosophy and values. In an era dogmatized with evidence-informed practice ideology (Grypdnock 2006; Holmes, Perron, & O'Bryne, 2006; Rycroft-Malone, 2006), embracing new pedagogy requires a shift from sole adherence to proven strategies to a culture of trust in educational innovation, not only by nurse academics but also by the broader university and clinical partners, in the absence of prospective evidence that IPE does enhance patient care and outcomes.

Case Report Summary

This case report of nursing's IPE engagement at Site A university has presented nursing's IPE knowledge and understanding and nursings' understanding of its own role as a necessary first step in the exploration of nursing's IPE engagement. The nature of IPE in nursing curricula preceded exposure of nursing's IPE engagement, including consideration of lack of IPE

⁵⁹ *It takes really strong leadership and you have to like each other, you have to get along. That is a big issue; ... but I can say that I have noticed, when I look as who is taking up [IPE] leadership across the country, it is not nursing. I don't want to say that they are not doing it but just in terms of the number of nurses that are out there that I know who are very capable and excellent leaders and could take a role. They are not stepping up to the plate in the same way other professions are; If that person ... sees the whole picture that we all need to work together and that vision or value statement feeds down so you don't have your top, say we have to fight medicine for every cent we get, you see the leader saying, 'We're equal partners ... ; Really what I'm hearing is the leaders have to value this. It all goes down to that whole sense of valuing, respect.*

⁶⁰ *We [all disciplines] all have to be on the same page, all professional groups. I think it can't just be mainstream among nurse educators. If it's all nursing, then we are going to lose that battle; ... well what are we talking about – culture change. That is what we are talking about. IPE is all about culture change.*

⁶¹ *... so we've come of age as nurses and now we have to be pushed out into the world and be part of the whole and so that takes a learning curve.*

engagement. The report concludes with consideration of resources and supports in favour of nursing's IPE engagement. The presence of research propositions has been made explicit and case findings have been animated through participants' exemplars.

Case Report Site B University

Introduction

Two unrelated but equally significant events occurred at Site B university in September 2008. First, the university became home to a satellite campus for a medical program whose parent program and campus is 200 kilometers east at one of Ontario's leading research-intensive universities. Consequently, Site B university experienced a transformation in academic profile from a mid-sized, internationally-oriented university at the periphery of the country to a university known also for a satellite medical program and its dedicated multi-million dollar building. Second, when members of Site B University Faculty Association and librarians voted over 90% in favour of a strike, an 18 day faculty and librarian work stoppage resulted, thrusting the university into the provincial public eye. The work stoppage, the second in university's nearly 50 year history, disrupted graduate and undergraduate studies and created work and safety challenges for staff and administration.

These two events impacted this research study in equally significant, yet different ways. Pragmatically, I was unable to collect data during the work stoppage itself and for a few weeks following when morally I felt compelled to wait a period of time mindful of the physical, emotional, and professional impact of this experience on faculty. At the same time, I was cognizant that one of the contentious strike issues was the university's decision to preferentially hire sessional rather than full time faculty and the potential impact that this decision held for

academic nursing. These events provide background for the exploration of nursing's IPE engagement represented in the following text.

The Case and its Context

The case of Site B university nursing faculty's IPE engagement is a contemporary phenomenon that exists within its inseparable health professional and academic contexts (Yin, 2009). The reason for exploring the context of this case follows similar logic offered in the Site A case report: inseparability between the case and context (Yin), transferability of the study findings (Munhall, 2001), alignment with FPS importance placed on context, and situating case findings to promote understanding. At the outset, case boundaries were satisfied: Site B university is an Ontario, English-speaking institution home to a four-year baccalaureate nursing program as well as a School of Social Work, a program in clinical psychology, and a satellite medical school. Data were generated from July 2008 to June 2009 with volunteer participation of full and part time nursing, health professional and social care faculty members. In contrast to Sites A and C who have School of Nursing designations within health science faculties, Site B has Faculty of Nursing designation.

The context of Site B incorporates physical location, international student orientation, awareness and encouragement of diversity, and appreciation of difference in ethnic backgrounds, cultures, and academic aspirations. Seventy percent of the student body is drawn from the university's local geographic area. The Faculty of Nursing shares space with other university programs in a new health education centre located on the campus' main thoroughfare. The Faculty of Nursing space includes an administrative office, individual offices for most full time faculty, a faculty lounge, a nursing skills laboratory and a state-of-the art simulation laboratory. With the faculty space bursting at the seams, office space for part time faculty is negligible and

classroom space is at a premium, in some cases unable to accommodate all students enrolled in particular courses.

Grafted on to the side of the health education centre, with direct internal access between floors, is a new medical sciences building, home to the satellite undergraduate medical education program. Ironically, this close geographic proximity generates competition for space *and* potential for collaboration and interprofessional teaching and research at the same time. Although the satellite medical program has been on site for a short time, seemingly it has a big presence that is reported to be influencing the university milieu generally and the academic nursing environment specifically.⁶²

It was merely a decade ago that the Faculty of Nursing was created from nursing programs formerly under the auspices of the Faculty of Science. The creation of its own faculty promoted acceptance of nursing as a true, legitimate discipline of the academy at Site B. During the time of this study, the Acting Dean of nursing was a faculty member with a master's degree in library and information sciences (MLIS), seconded from library administration. The Faculty of Nursing is comprised of approximately 21 full time members (n = 20 female-identified, n = 1 male-identified), three sessional instructors (n = 3 female-identified), and approximately 75 part time clinical instructors. Over the last ten years, program offerings have grown to include a four year baccalaureate program (BScN) in collaboration with two community colleges at three sites and two master's level degree programs. A doctoral program is anticipated. Post baccalaureate certificate programs are offered. Approximately 860 undergraduate nursing students are enrolled across all undergraduate programs (n = 639 full time, n = 120 part time); in total, female-identified students (n = 732, 85%) outnumber male-identified students (n = 128, 15%).

⁶² ... a lot of energy and focus from the Board of Governors is going into massaging the wellness and thriving of the medical cohort. Everything is to the medical cohort, our guest on campus.

According to the 2008-2009 Faculty of Nursing website, their mission is to prepare graduates who practice in partnership with clients, families, communities, groups and service providers to facilitate the promotion, achievement, and maintenance of optimum levels of health. Program goals for graduating students articulated in the undergraduate calendar (on-line version) include integrating nursing and multidisciplinary knowledge into nursing practice and collaboration with clients, their families, communities and members of the health care team. However, neither vision or mission statements mention or make reference to interprofessional education. The faculty's philosophy of learning/teaching includes a statement that the curriculum is multidisciplinary. Given the linguistic confusion surrounding word choice and intent when considering the concept of students from two or more health disciplines learning with, from, and about each other (Barr et al., 2005), it is difficult to know the precise meaning intended by faculty member's choice of the term multidisciplinary. (This difficulty is further apparent when exploring nursing's understanding of IPE in the following text.) Using as a benchmark, the study definition of IPE proposed by Barr et al., IPE is not an integral component of the undergraduate nursing program context as evidenced by its absence in the vision, mission and philosophy statements.

An event very integral to the case context is the faculty strike, or work stoppage that occurred just prior to the data generation phase of this study. The strike created physical and emotional distress for faculty to the extent that they chronicled their stories as pre and post work stoppage.⁶³ This defining experience had significant temporal and phenomenological meaning for them as they reconstructed their professional lives after the strike, picking up and reconnecting the dropped threads of their teaching and research.

⁶³ *It's really difficult for me to say because we had the work stoppage and it just made me have this tremendous loss. I don't know what happened and I can't remember the before part.*

Case Study Findings

The case study findings are discussed within the identical boundaries specified in Site A case report and described in chapter four. Participants' demographic data are depicted graphically in Appendix E. Participants at Site B were predominantly female-identified (n = 10; male-identified n = 1). Roughly half of the participants (n = 5) fell within the 45 to 65 year old age bracket. The nursing profession represented the majority (n = 7; n = 2 health professions librarians, n = 1 health science). Among nurses, years in the profession ranged from 10-41 (average = 21.1). Average experience in nursing education, generally, was 13.6 years (4 – 35 years), with an average of 9.4 years teaching in the health professions at Site B university, specifically (range = .3-35 years). The composition of Site B participants in individual and focus groups interviews appears in Table 2.

Table 2 Composition of Site B Individual and Focus Group Interviews

Interview type	Number	
	Interviews	Participants
Individual	8	8
Focus Group	1	3

The justification for a preliminary exploration of participants' knowledge and understanding of IPE follows the rationale and logic explained in case A report: A pre-understanding of IPE is foundational to IPE engagement. Similarly, this decision was supported by the research proposition that faculty may not be knowledgeable about IPE.

IPE Knowledge and Understanding

IPE knowledge and understanding straddles perception and reality (i.e. reality as defined by the study definition of IPE). Within this perception/reality vortex there is not a shared, unified understanding of IPE. Words used synonymously to refer to IPE include interprofessional, multidisciplinary, and interdisciplinary - seemingly similar yet distinctly different terms. For the most part, language choice is unintentional, however, in one particular instance the term interdisciplinary is chosen intentionally to convey a view of IPE that extends beyond health and social care to encompass all helping professions (e. g., education, law, and law enforcement) in order to distinguish a university's mandate as an incubator of expansionary thinking.⁶⁴ An apparent misalignment between language choice and IPE knowledge and understanding exists in spite of language's fundamental nature and importance (Arslanian-Engorgen, 2002). Within this context of language variation and confusion, IPE descriptions are confluent with perspectives or themes on IPE. Some IPE definitions align vaguely⁶⁵ with the study's IPE definition proposed by Barr et al. (2005). Other IPE definitions align strongly with a misconception of IPE as opportunities where non-nursing faculty guest lecture a nursing course or are members of

⁶⁴ ... I mean we are interdisciplinary or interprofessional. I like to say interdisciplinary because it may be more than professions, but I mean really, to me, is what a university is about. That's what to me makes the difference between a community college approach to things and what a university approach should be. We should be the expansionary thinkers. We should be the inclusionary embracing actors I guess.

⁶⁵ You learn from, with, and about the professions ... in general would be just bringing the professions together for shared learning experiences with the idea that it is not one person learning from the other but learning together ... there will be a significant amount of interaction in terms of the learning that they would do ... so that by the time they are finished they are totally used to working with a whole range of other professions. They know what they do. They do value them and they fully understand that aspect of how you collaborate to work together to deliver care.

nursing students' graduate committees and programs of study,⁶⁶ and where nursing students and non-nursing students study the same course provided by nursing faculty⁶⁷; these descriptions are not, by definition, interprofessional. Rather, they convey a sense of parallel learning, lacking the intersecting and interactive components between and among students inferred by the study definition.

Perspectives on IPE extend beyond its definition and include IPE as a long-standing pedagogy,⁶⁸ a curriculum add-on, an extended classroom, professional socialization, mutually exclusive with nursing education, and a government cost-cutting strategy. It cannot be presumed that a perspective of IPE as a long-standing pedagogy is founded on an understanding aligned with the study definition. Perspectives of IPE as a curriculum add-on⁶⁹ stem from a belief that timing and manner of IPE integration is critical and are aimed at replacing a perception of IPE as an inconsequential frill with a perception of IPE as a legitimate and valuable pedagogy. As a philosophical approach to education, IPE is an extended classroom where faculty, health

⁶⁶ *So we have it [IPE]. We have interprofessional with social work. We've tried lots with them. Because we are a small university and we get to know everybody on this campus really the faculty. We use each other too, we do reading courses with students who want to do something special and unique and we ... last time we did this, we brought six different professors to work with one student on issues of social justice and health care. We had a law professor. We had a nursing professor. We had a social work professor. We had a women studies professor. It was amazing.*

⁶⁷ *Well we have also courses in our faculty of nursing that are considered options, nursing options for our students that the whole university can come to. So we have a health care issues ... course which now has over 80 students in it, maybe half of them are nurses and half are not ... I have almost every faculty representation in my class.*

⁶⁸ *So I don't think the idea of interprofessional based learning is brand new. There have been attempts at it for at least 40-50 years maybe. I think it has been happening in the academy for a long time.*

⁶⁹ *... I would be concerned that IPE if you don't start right away, is also going to seem like something that is added on – those add-ons seem less important; ... we need to build support within the faculty because they can't present it to them as something that is an add on ... everybody is working so hard that adding anything on is not something, is not the way to sell it [IPE]...*

professionals, and health and social care students of all levels and disciplines encompass the scholarly enterprise of the academy; IPE is dynamic, opportunistic, inclusive, and non-hierarchical. It is through this approach to education that understanding, value and respect for other professions are engendered. Furthermore, development of learning partnerships provides opportunity for shared professional socialization, promotes team functioning, and mitigates siloed ontologies.⁷⁰ Although an understanding of potential for peaceful coexistence of uni and interprofessional education prevails, an undercurrent lack of understanding of IPE implies competition and mutual exclusivity between nursing and IPE⁷¹; there is fear that IPE may subvert uniprofessional education, jeopardizing nursing students success with national nursing competencies.

Knowledge and understanding of IPE is plagued further with uncertainties and cynical views about IPE. For example, concerns exist about IPE requiring nurses to relinquish an ontology that defines who we are as a profession. At the same, cynicism exists regarding the

⁷⁰ ... *interprofessional education would be a partnership with another discipline for the purpose of learning from each other but also to develop some ... socializing of the professions together. So my vision of it would be that instead of us working in silos when we are employed in different health agencies or in education ... that we would embrace the other disciplines ... It's a lot about the socialization process, so that when we do work together, we are truly functioning as a team.*

⁷¹ *Well I'm back on the clarity around the term though because if we are talking about, and I think this is where people go off in their own view of what it means, interprofessional education, so if we are talking about lets say just doctors and nurses without getting into the other groups because we could bring them all together in the class, I don't think it's realistic to get them together because we learn different things and I mean you know I understand that there are certain concepts that we learn but in general, we are learning them in different ways for different reasons and so I don't even know that it's realistic; It's[IPE] not something that you are going to be at everyday, all the time, doing this kind of thing and so it's going to take you away from your work.*

government's motivation to fund IPE development⁷² as a cost-cutting measure rather than as a means to develop new pedagogy for health professional students aimed at enhancing patient care. How uncertainties and cynicism about IPE affect nursing's IPE knowledge and understanding is a question germane to an exploration of nursing's engagement and is considered later in this report. Uncertainties and cynicism notwithstanding, there are IPE champions with a genuine desire to promote integration of IPE into the baccalaureate curriculum, although majority support is for IPE in theory. Paradoxically, IPE is championed in spite of lack of IPE knowledge, in the presence of misunderstandings about the concept, and in the absence of active IPE work.

Nursing's IPE knowledge and understanding is critical to active IPE work and engagement. Fundamental to this exploration of how nursing does or does not engage IPE is knowing and understanding our professional role considered in the following text. Similar to Case A report, my decision to explore nursing's knowledge and understanding of professional role is prompted by the academic context of the case, the inextricable link between nursing in the academy and practice (Anthony & Landeen, 2009), and three interrelated propositions: First, that historically the nursing profession has struggled to establish itself as an autonomous and independent discipline; second, that increasingly nursing is simultaneously acknowledging itself and being recognized as an academic discipline, with its own knowledge and power base; and third, that interprofessionalism will require nursing to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge and power.

⁷² ... interprofessionalism ... maybe the government may be seeing it as the newest way of providing cost effect education leading into service, hoping that everybody will be working together; I mean that, to them [government], it would be the only thing that would appeal to them. Why on earth would they want to, they can get everybody in one room instead of splitting off and having two or three students taught by a highly paid professional, right?

Knowing and Understanding Own Nursing Role

Well within case boundaries and analytic periphery and of particular relevance to all cases in this research is consideration of how nurses know and understand their own nursing roles; Beliefs and perspectives about nursing are not only foundational to how IPE is understood and perceived but also are integral to nurse educators' enlightenment about IPE in nursing education. For example, when nurses are professionally socialized to hold elitist ontologies about nursing territory, power, and control,⁷³ collaboration not only in clinical practice, but also in the academy is compromised, creating a paradox; How can nurses profess to be collaborators and territory protectors at the same time? It is unclear whether this paradox stems from historic roots of subjugation of knowledge and power (i.e., proposition six),⁷⁴ from more recent acquisition of professional power and right to professional self-regulation (College of Nurses of Ontario [CNO], 2009), and/or from most recent membership in the academy with its obligatory acquiescence to male-determined historic power and tenure structures. Perhaps the knowledge that health professions, in general, have a proclivity toward territorialism and boundary protection (Baldwin, 2007; Jones, 2007) and toward establishing power and control⁷⁵ rationalizes nurses' territorial positions. Interestingly, language choice conveys a significant degree of fervor in describing nursing's contemporary professional role and ontology.

⁷³ *So we have been trained in schools where we pretty much learn with each other among a common singly focused professional identity and ... I think there is an elitism that it develops. I also think there is a territorial attitude that develops about what not only your profession that you've studied should be doing but where you have the control or should have the decision making power.*

⁷⁴ *We have some very strong territorial [territory] that we have earned, that we've claimed over the years, areas of the unit, and of the community that we don't like people dabbling with and there is always the schism where we get ... two professions like social work and nurses and you know its usually the weaker one that backs off or one whose busier backs off ...*

⁷⁵ *... everybody is out creating territory and domains, and power and influence and unless you have trust, nobody is going to sit down and give away any of the aspects that define them as a profession.*

Notwithstanding acknowledgement that from a FPS perspective multiple understandings of nursing's role exist, critical reflection on nursing's professional role is a necessary step in the development of robust professional subjectivity not only in practice but also in the academy.

Understanding our own nursing roles to develop professional subjectivity, involves intra and interprofessional perspectives and incorporates concepts such as blurring professional boundaries and reinforcing hierarchies (Claverling & McLaughlin, 2007; Masterson, 2002) among health professionals. Concern exists that assimilating interprofessionalism as a trait of nursing will not only blur professional boundaries between nursing and other health professionals whose skills and knowledge overlap, but also will cause serious erosion of professional ground⁷⁶ that nursing has gained both in practice and in the academy. There is palpable fear for the loss of nursing's professional identity with the advent of a satellite medical school⁷⁷; hegemonic perspectives, including a hierarchy among health professionals (i.e., primacy of medicine)⁷⁸ (proposition four) and an historically entrenched nursing-medicine dichotomy (Arnold, 1996; Henneman, 1995; Parse, 2006) encumbers nurses' view of their roles.

To this day, hegemonic perspectives on nursing's roles are rooted deeply in an historical context (Bates, Dodd, & Rousseau, 2005; Bunting & Campbell, 1990). Nursing's professional subjectivity has been and continues to be impacted by societally developed scripts (e.g.,

⁷⁶ ... we are at a place where we don't want to see any erosion of nursing. I think there is a perception amongst some people [nurse colleagues] that I have talked to that why are we going to give away something before we absolutely know for sure that we are not going to be a victim of having given that away.

⁷⁷ There are some who are hesitant and I don't know that it's they don't value it as much as that they have a hard time with the disparity between nursing and medicine and are worried that nursing will get sucked into what is being taught by medicine.

⁷⁸ ... this [IPE] is bigger than us [nursing] and I think we can do our part and I think we can start but there's this hierarchy out there and it's hard to overcome.

handmaiden, battleaxe) (Jinks & Bradley, 2004). If nursing's role is defined externally only by that which is visible or blatantly obvious⁷⁹ such as helping physicians do their job,⁸⁰ it is reasonable to accept that nursing's role understanding has been influenced by the broad societal context (Scott & Thurston, 2004) in which the profession has existed. While it is difficult to compete against years of cultural history that have generated a singular view of nursing, it must be asked whether nursing inadvertently has played a part in perpetuating the handmaiden stereotype – visible helper possessing an assistant's body of knowledge rather than an autonomous practitioner as equal partner on the health care team? Perhaps nursing's embodiment of holistic practice and patient advocacy,⁸¹ rather than political/professional lobbyist, has been understood by society as an act of omission instead of an act of commission and a deliberate choice putting patient's needs ahead of professional identity promotion. Although these two positions can be mutually inclusive, judgment from a historic perspective holds that nursing cannot be caring and powerful at the same time (Falk Rafael, 1996). To entrench a perspective of

⁷⁹ ... as nurses, we need to advocate for ourselves and we need to project that image out there. However even when you do, there are individuals that have a very different perception and one of my mother's best friend said, "Oh why would you want to go into nursing so that you can clean up bedpans and clean up vomit." So that's the perception out there. Not by everybody but there is a perception. You would never hear that perception of a physician and so I think that's part of it [how we view our role] as well.

⁸⁰ I think that medicine ... the perception I get is that they value the other professions, however, they are seen as helping professions. Helping them [medicine] do their work ... nursing often feels disrespected or not valued, but I think that, unfortunately, they are valued but a value that they are actually helping the doctor do their work. Right? So it's their [MD] domain. So doctors would say absolutely ... these nurses are great, I can't do my job without them ... to me that's very much a subordinate helping role, helping them [MD] to do their real work.

⁸¹ I also think that we spend very little time on lobbying and political action and I think that because most of us are not interested in that as much as we are interested in caring for our patients. I also think that our focus on caring has not been business focused or business and politically savvy, that our focus has been on our patients and caring for them and so promoting the role of nursing and that whole political action has not been focus of many nurses.

modern nursing as an autonomous profession⁸² challenges nurses to reflect on current practices and subjective positions, and then requires us to clearly articulate academic roles and responsibilities and scopes of clinical practice.

Regrettably, intraprofessional role confusion and tension arises from difficulty in articulating scopes of practice within the profession at large,⁸³ perhaps to the detriment of developing collaborative relationships and IPE engagement. At the same time, some subjective descriptions convey role understanding in terms of relationships with others, frequently medicine. For example, relationships with medical colleagues are described using terms such as power structure, rebel, and rebellious,⁸⁴ words not historically associated with nursing's caring ontology (Falk Rafael, 1996). Still further, subjective positions blame nursing, citing nursing's complicit behaviour⁸⁵ as a factor contributing to current role understanding, including lack of

⁸² *If you speak just from nursing, it is to gain an understanding of our profession, to understand its scope of practice and therefore to utilize our services appropriately and to value us not by any other constraints such as gender or by any other traditional ways they would look at the nurse but by the strengths that we have as a very powerful group.*

⁸³ *Because I think if you look at the RN versus the RPN, who we still consider a nurse, versus the NP versus the nurse anesthetist, there is such varying degrees of roles and scopes of practice that I think when we talk about interdisciplinary, while its within the same discipline, I think there is some work that we can do appreciating the roles within nursing.*

⁸⁴ *But I realized that what is the rebel part of me and I know I've used this in class, is rebellious to, no its more living what I believe exists, that there is equality. I'm not going to stand for any perception less than I'm equal to the physician in my ability to make decisions. I live it professionally. I will not be put aside ... If we expect nurses ... to be treated equally to other professions and certainly now with us being a much higher rate of university graduates ... that's caused a lot of other professions to at least take notice that some of us have university degrees, whether that should even matter, but it seems to other professions.*

⁸⁵ *Well I think we have to take ownership of that [our plight]. We have to take ownership of it. Again, the historical perspective is there. But you know we really have a lot of unproductive and unhealthy interpersonal hang-ups. We are insecure. We are frustrated. We are having very poor self-esteem. We are super envious. So lack of recognition, all these things that tend to ... give us the perception that we are devalued and ineffectual. I think it just ties in so that we are getting reinforcement externally and we are reinforcing it internally.*

professional self-value⁸⁶ and victim-posturing that hints at oppressed group behaviour (Daiski, 2004; Peter, Macfarlane, & O'Brien-Pallas, 2004). Nonetheless, understanding our own nursing role has shifted from an historical externally defined position of silent knowing (Belenky et al., 1986) inherent in the motto of the first Canadian School of Nursing, *Video et Taceo*, translated as I see and am silent (Mack Alumni Association, n. d.), to a contemporary position where nursing itself is found complicit in the creation of nursing's roles and ontology.⁸⁷ That nursing bears responsibility for creating negative role perspectives is a shared belief among diverse subjective positions, giving rise to concern regarding development of a professional identity in both practice and the academy. Without role understanding and a sense of professional identity necessary for collaborative practice, nursing's IPE engagement is compromised.

Generally, nursing is a practice and an academic discipline. Yet, among some nurses it is felt that colleagues in academic practice are not real nurses when judged against a standard of recent clinical experience.⁸⁸ This judgment typifies intraprofessional marginalization and may develop from nursing colleagues' failure to consider the multiple requirements and roles imposed on the nurse academic within the university structure, an experience confirmed in the literature (Kenny, Pontin & more, 2004; Rammage, 2004; Rattray, 2004). Nonetheless, intraprofessional marginalization undermines nursing's academic role when they, as the newest member of the

⁸⁶ *I see that nurses actually don't recognize that they are valued at all and then, in the end, they are actually not valuing their own work as part of that ... I think there is always a struggle to make an identity for yourself [as a female centred profession] ... actually being more valued for their unique skill set ... I think that comes from women in general belittling what we bring to the table.*

⁸⁷ *... my personal opinion [is] we are our own worst enemies. We have been our own worst enemies and I've sat around too many tables where nurses cannot articulate what it is they do and what they can offer and they'd let physicians take over.*

⁸⁸ *... of course, as you might know, or expect from the literature and I have lived this, is that the people who give me, give us the hardest time are nursing ...*

academy, are working ardently to be taken seriously as a true academic discipline.⁸⁹ How nursing has evolved its status as a legitimate member of the academy is attributed to adherence to an historically-developed conventional benchmark or prime academic credential of the academy through the advent of nursing doctoral studies.⁹⁰ Adding a research mandate to nursings' other roles as caring practitioner and educator may impose role competition for a nurse academic's finite time and energy resources. At the same time, the advent of nursing doctoral studies is viewed as making a female-dominated profession attractive to males while simultaneously contributing to nursing's legitimate role in the academy.⁹¹ A reasonable speculation is whether the presence of male colleagues, who are attracted to the profession because of doctoral studies, confer legitimacy to academic nursing merely by virtue of their presence.

Nursing's understanding and experience in the role of nurse academic is impacted by several factors. For example, existing as a female-dominated discipline within a male-generated and dominated institution may marginalize nurse academics, engendering a sense of disenfranchisement⁹² and diminishing professional self-esteem. Moreover, when there

⁸⁹ *Because the nursing profession is still trying to become, we are trying to become in the eyes of the nursing profession, a true discipline of the academy in the same way that any other long standing disciplines are; ... I actually think this faculty becoming a faculty really did help it move into acceptance of the discipline, true discipline of the institution.*

⁹⁰ *... in this role [nurse academic], we, as nurses, are very young in having our PhD and research is the component that, it's more advanced than it would be with a master's degree and so I feel that we sort of have a role to bring that part of our role forward because it distinguishes us and that's why we did it.*

⁹¹ *... I just think that it's become part of the norm now and it's expected that you are going to hire a PhD or you are going to have a PhD. Well, at that level I think what it is doing is attracting more males because it has reached that kind of maturity and because I really do think that we have a lot more males students applying for nursing in the first year and I think they see it as a real viable discipline.*

⁹² *... and I think in an academic setting, we try and be that academic oriented but ... nursing has taken a second seat ... it's just another, to me, disenfranchisement really of women and academics, so for women in academia [it's the] same thing. So a lot of these things are just creating an unfulfilling and unproductive environment.*

simultaneously is a sense that nursing's presence in the academy is viewed differently from other disciplines, perhaps by reason of its hospital-based educational origin,⁹³ the cumulative effect can adversely challenge nurses' sense of equality, role as a legitimate member of the academy, and ensuing embodiment of the role of nurse academic.⁹⁴ Consequently, the nature of professional existence for a nurse in an academic role may be infused with professional insecurity and vulnerability. Exacerbated by past experience⁹⁵ with marginalization, nurse academics' judgment of and interest in IPE engagement may be coloured. Together, these factors affecting nursing's understanding and experience in the role of nurse academic have the potential to influence nurse academics' role confidence and subsequent IPE engagement.

The connection between role understanding and role confidence is conveyed in a variety of remarks. First, it is thought that embodying a less insular, more open demeanor⁹⁶ might stimulate security within our role. Second, garnering intra and interprofessional equality and respect may bolster a sense of professional self-esteem and confidence, thereby invoking an

⁹³ *I think if you look at medicine, pharmacy, social work, they all come from requiring an education at a university ... and I think that also was one of the reasons why we are viewed differently.*

⁹⁴ *... you look around at some of the other professional disciplines [e.g., physiotherapy] and you see the struggle they've had and we are in the midst of it so when you come in to the academy with that experience, especially though some of our faculty have been here for a few years, they are not going to willingly open up themselves to someone else really looking at their discipline in a way that they might not come out in a positive way.*

⁹⁵ *... my colleagues that don't support it [IPE] and promote it tend to be ones that have been around a little longer, who have tried so many times to make things work and have seen nursing always take the short end of the stick. I mean, I think, as nurses ... we always are the ones who try and make things work. We are also often the ones who take the brunt of anything that goes wrong and that we are the ones who get pushed aside ...*

⁹⁶ *So you know you look at these parameters of caring ... and would that make a difference if we lived it. If we lived it, would that make a difference in our openness and engagement with other professions? Would we be less insecure?*

optimistic rather than a pessimistic mindset.⁹⁷ Third, acknowledging and affirming value for our role, our capabilities, and our strengths as a unified practice and academic discipline⁹⁸ builds confidence and fosters solidarity for future success.⁹⁹ Shedding the encumbrance of our history of silent knowing (Belenky et al., 1986) to embody a position of constructed knowing (Belenky et al.) can contribute to role confidence. For the university-based nurse academic, finding voice as a constructed knower may not only provide a means of gaining role confidence, but also is an integral contextual component in light of the provincial model of collaborative baccalaureate nursing education.

Finally, there is a tacit understanding of ‘nurse-as-doer-and-fixer’ inherent in all roles, regardless of context.¹⁰⁰ While it might be understandable that by virtue of assimilating the role as ‘doer’ and ‘fixer’ that nursing naturally has become elitist and territorial, but perhaps a shift in perspective about our roles and how we enact them is necessary in a contemporary context.¹⁰¹

⁹⁷ *I think that nursing deserves to be an equal partner and I think we all want to be an equal partner and I think if we are embraced as an equal partner at the table from the get go, it will be good because nurses will, you know nurses, we will invest and we will give, but we won't give if we are fearful of being harmed or that we will lose what we have.*

⁹⁸ *We are stronger. We are more unified. All the universities in this province have a consortium. We [university schools of nursing] are bigger in numbers. We now talk to each other. We share. We are supporting each other. We are sharing with each other and we will be reckoned with together...*

⁹⁹ *We [nurses] are in trouble if we don't, as a profession, figure out what to do with respect to all working together in this education piece because I don't feel that we are where we need to be for long term survival.*

¹⁰⁰ *I think we are just lifesavers. We are system savers, always. If we look at what we accommodate as nurses and what we try and do with so little, that's part of what we do whether we are out in practice or we are in education. I mean you always make do and you don't complain about it but it hasn't afforded us with much luxury because we always make it work. I mean if the system broke, it would have to be fixed, when you continue to make it work and we do on a regular basis. We make it work and we really are our own worst enemies.*

¹⁰¹ *... I think now we are being forced by financial constraints and other constraints, social and otherwise, as we become more client focused, ... to drop the territorialism that we all have kind of evolved.*

Shifting from an historically entrenched uniprofessional mindset to an interprofessional way of thinking, requires a shift in understanding, knowing, and enacting our own nursing role. Even though these independent and interdependent role perspectives are not mutually exclusive,¹⁰² guarding and respecting nursing's unique role¹⁰³ is necessary not only for the preservation of the profession but also for building role confidence. In an interprofessional context, role confidence incorporates willingness to share power,¹⁰⁴ a challenge when nursing's professional roles develop in paradoxes: Historically we are educated in silos yet work in teams to provide patient-centred care *and* both in practice and in the academy we work in an hierarchical environment, yet promote team work among health professional students and faculty.¹⁰⁵

The challenge of knowing and understanding our own nursing role is impacted by our significant professional history, our fickle professional subjectivity, and our evolving relationship with the contemporary health professional culture, among other elements. These elements, beliefs, and perspectives about my own profession are integral to nurse educators'

¹⁰² ... they are not mutually exclusive ... just like out in the clinical world, we have our own discipline but we work together. We can have similar co-created curriculum that still enhances what we know as part of our discipline but we can still learn together and appreciate where each of us is coming from.

¹⁰³ If we are going to have interdisciplinary and we are going to align ourselves with medicine and social work we have to be firm and say – this is where nursing is, this is for the good of nursing, this is where we need to be going ...

¹⁰⁴ ... the person who is most confident in their role and expertise ... may be the most likely person to practice interprofessionally because they are quite happy to give away that power. So it's tied to power...

¹⁰⁵ ... I do think that, as professions, as disciplines, whether medically oriented or social service, whether hospital or community, we are working more and more in teams and yet we have been trained in silos.

enlightenment about IPE in nursing education¹⁰⁶ and may impact nursing's IPE engagement.

Advisedly, these elements, beliefs, and perspectives are kept in mind when exploring IPE in the baccalaureate curriculum.

IPE in Baccalaureate Nursing at Site B

Description of the presence of IPE in the curriculum is predicated on a few mitigating factors. First, descriptions of shared learning are aligned more with a multidisciplinary rather than with an interprofessional perspective that is consistent with the study definition. Therefore, various understandings about IPE must be taken into consideration when reading the text. Second, the baccalaureate curriculum is grounded in a humanistic-educative paradigm (Bevis & Watson, 1989a) such that student and faculty are partners in a learning enterprise that incorporates flexibility so as to capture real-time learning opportunities¹⁰⁷ not necessarily available in a prescriptive behaviourist-driven model (Anthony & Landeen, 2009). Third, a Site B baccalaureate program key competency is expressed as “integrate[ing] nursing and multi-disciplinary knowledge into nursing practice ... and collaborate[ing] with members of the health team ... for the promotion of achievement and restoration of optimal health” (Site B program document¹⁰⁸) rather than using language that incorporates either the term interprofessional or mention of the IPE process.

¹⁰⁶ *Well I wish that we could learn together. I wish that we could have some way of being together like clinically as learners so that we can break down these sort of hierarchical barriers that are kind of invisible but they are there and I wish that we could because then it would make care happen so much better and a lot more quickly and you could just put all the baloney to the side and get right to it.*

¹⁰⁷ *... I think a lot of that depends upon whose teaching. We have 75 sessional instructors that you know are given a skeleton of what the outcomes are for the particular week, but our program allows flexibility so that an individual session could develop different learning activities to meet those same outcomes.*

¹⁰⁸ The name of Site B program has not been included to protect confidentiality.

Definitional challenges and curriculum paradigms aside, value for IPE is articulated at the outset despite curricular territorialism.¹⁰⁹ A range of perceptions about the presence of IPE in the curriculum include claims that IPE does not exist even though value is articulated,¹¹⁰ that IPE is definitely in the planning stages¹¹¹ with the upper echelon of nursing faculty, that interprofessional collaboration, subsumed as IPE, is haphazard and occurs by happenstance rather than by design,¹¹² and that IPE has been present for a long time.¹¹³ These diverse perspectives of curricular IPE come from members of the same faculty group involved in nursing education. Lack of a cohesive story about IPE in the curriculum prompts speculation about IPE status as well as the nature of communication among the faculty group. Confusion about IPE status and incoherent faculty communication hinder nursing's IPE engagement. When access to IPE curricular knowledge and communication is linked to location in the university's

¹⁰⁹ *In academia is interprofessional education valued? I think that there is talk that it is valued. I mean there are many people who say, oh yes it is valued, when push comes to shove. I think many people are extremely territorial of their own curriculum and what they want to do ...*

¹¹⁰ *And while it is a buzz word and it should be promoted and I think many people say, Oh yes this is really important, I'm not sure that many people, that there are many of them that truly are passionate about it and believe in it because in my experience, when you are actually asking for it to be put in to action, that breakdown doesn't, the talk is there, the next step isn't.*

¹¹¹ *I don't hear the word often. I do hear it when I go to faculty meetings and that would be because it would be something that's probably talked about at administration and I'm not at that level because I'm such a junior faculty member, you know, so I think that certainly that it's in the works and that there are, there is some, there is thinking around developing that and moving forward with this but, on a day-to-day basis, no.*

¹¹² *What has happened up until now has been happenstance and whatever individual faculties have managed to do through either their own research and contacts ... And I really have to say I agree ... that we give it lip service. It's in the course outline. They are supposed to do it. Students give all sorts of examples of it but they are not focused attempts to engage that. I think it is happening haphazardly ...*

¹¹³ *I just think that this interprofessional education is not as new as we tend to maybe think it is and the way some people think it is. I think it has been happening in the academy for a long time, especially been happening in clinical placements for our students because they do interact or they see interactions so they are getting educated but I think a more formal way of doing that within this discipline would be very helpful, very beneficial to the students and to our patients.*

hierarchical structure, a context of privilege may be conveyed that unintentionally imposes ‘gate keeping’ of information necessary to enact nurses’ academic role, subsequently impeding nursing’s IPE engagement.

A range of ostensible IPE involvement is described, however two particular IPE curricular opportunities include classroom, or theory, and clinical practice learning. In the classroom, IPE is understood as students from varied disciplines learning together in the same course, irrespective of mention about how students would engage in interaction to enable learning with, from, and about each other (Barr et al., 2005); this joint learning, born out of fiscal pragmatism, is an example of structure imposed by the university, rather than deliberate choice to promote IPE. Clinical practice IPE opportunities are a result of student initiative, consistent with the curricular philosophy of joint responsibility for learning; however, how students are exposed to the IPE concept, how clinical IPE opportunities are identified, and how clinical IPE experiences are captured are unanswered questions. Curiously, literature on students’ self-directed IPE learning is not substantive.

More prominent than discussion of classroom and clinical IPE opportunities are discussions about potential plans and hopes for IPE simulation learning. Although optional IPE simulation lab experience for nursing and medical students met with moderate success,¹¹⁴ the concept of IPE simulation is well received and provides a foundation for future IPE development. Concurrently, discussion about general integration of IPE across the curriculum is

¹¹⁴ *We had ... open sim lab time where we actually had case scenarios of each patient and both medicine and nursing students could come in and actually learn about the patients. There was a profile provided of their patients ... the first time we ran it all the med students came, all 24. The second time we had 12 medical students and that stayed consistent while we ran it. The nursing students changed, so it fluctuated.*

prominent with consideration for introduction of a new pedagogy that provides future nurses with a solid foundation for collaborative practice.¹¹⁵

The proposition that IPE has not made its way into mainstream undergraduate baccalaureate nursing education is fulfilled in this case; Seemingly, operationalization of IPE is not occurring. Fostering collaborative practice through IPE engagement at the baccalaureate level needs purposeful and attentive nursing faculty involvement. The nature of nursing's IPE engagement is described in the following text.

Nurse Educator/Nursing Faculty IPE Engagement

My attention to nurse educator/nursing faculty IPE engagement was heightened by two proposition: that nurse scholars' representation as architects of IPE curriculum development and implementation is minimal and that faculty may not be knowledgeable about or have opportunities to engage in IPE. At the same time, I was mindful that disparate IPE knowledge and understanding (i.e., different from this study's definition) should be considered when exploring nursing's stories of IPE engagement. In light of this information, evidence of nursing's IPE involvement became apparent predominantly as preliminary IPE discussion. Understanding nurse educators' involvement in IPE discussion is mitigated by the uncertain nature of communication among the faculty group, a situation also potentially responsible for the lack of shared storyline regarding nursing's potential or actual IPE involvement. Opportunity for engagement in IPE discussion is viewed to some degree as a function of the nature of nursing's

¹¹⁵ ... we are really much more conscious now that we need to do this in a more planned way to give our students in nursing a better experience in learning ... When they graduate and go out into the hospitals or the community sector ... they have to work closely with social workers, with doctors, with every other health profession. It strikes us that we need to actually provide that experience in the learning opportunity time when they are in their courses and in their clinical situations in a more formalized way

relationships and communication with other disciplines.¹¹⁶ Here, it is noteworthy that the Canadian Interprofessional Health Collaborative (CIHC) (2010) cites interprofessional communication as an IPE competency.

Although the exact nature of involvement in the preliminary IPE discussion is not straightforward, some discussion includes declarations about the current academic climate that is ripe for IPE due to the presence of the many, willing disciplines and the apparent support from the university's senior administration.¹¹⁷ The satellite medical program appears in IPE discussion in several ways: first, in the context of developing a symbiotic relationship for resource sharing; second, as an opportunity for interprofessional learning; third, as a potential IPE liability due to lack of curricular flexibility as a satellite program; and finally, in relation to the notion that Site B was leaning toward IPE prior to the medical program's arrival. Interprofessional research is part of the IPE discussion in so far as IPE is seen as a link to developing interprofessional research relationships. Perhaps within this latter context, IPE is considered the next piece in securing nursing's rightful membership in the academy. Despite the fact that nursing has achieved and maintained faculty status, realization of its rightful place in the academy has been overshadowed somewhat by the arrival of the satellite medical program.

¹¹⁶ *We have good collaborative relationships on the ground with the teaching teams [in other disciplines] ... We have worked together for many years and if we don't discuss politics or numbers, we are fine! I know that our Dean, our acting Dean, she has very strong close collaborative relationship with the person that has been instrumental in having the medical school built and at that level I know and I think with our assistant Dean as well there is a relationship there and I think our clinical [simulation] learning specialist, yes, she really has been involved in that area.*

¹¹⁷ *It is great because he [new president] is very much in support of this kind of activity and ... we have the faculty of nursing, we have the faculty of human kinetics, we have the faculty of arts and social science which houses psychology and social work ... the potential for those kinds of partnerships and what we could do with it through curriculum development.*

It is apparent that nursing's preliminary IPE involvement predominantly takes the form of discussion. How IPE can be made manifest in the classroom, in simulated learning, and in clinical practice is understood as a function of multiple factors within a context inclusive of barriers or challenges to nursing's IPE engagement described in the following text.

Lack of Nursing IPE Engagement

Connections between nursing's IPE engagement and IPE barriers, or challenges (Gilbert, 2005b) are uncovered through exploration of contextual factors inherent in the health professional and academic culture in which IPE engagement exists. Diverse challenges within the case boundaries of professional and academic contexts include historic professional ontology, curriculum paradox, nurse academics' workload, university factors, and nursing's professional subjectivity.

Historic professional ontology. Historically, nursing has been socialized and educated toward a nursing-centric ontology.¹¹⁸ The influence of this entrenched ontology is pervasive and manifests in several ways. First, fear is generated such that by engaging in IPE the essence and value of nursing may be eroded in favour of medical primacy,¹¹⁹ a pessimistic mindset that erroneously presupposes mutual exclusivity of uni and interprofessional perspectives but also hints at professional insecurity. Moreover, this mindset is antithetical to the proposition that IPE

¹¹⁸ *So we have been trained in schools where we pretty much learn with each other among a common singly focused professional identity and I think out of that comes a strong valuing of your profession. There is, whether it's nursing, dietitians, physicians, pharmacists, I think there is an elitism that it develops. I also think that there is a territorial attitude that develops about what not only what your profession that you've studied should be doing but where you have control or should have the decision-making power.*

¹¹⁹ *... there might be some who are going to resist it [IPE] based on a history of being burnt and not wanting to have anything erode where nursing has been able to come ... nurses will, you know nurses, we will invest and we will give, but we won't give if we are fearful of being harmed or that we will lose what we have.*

will require nursing to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge and power, raising speculation that lack of nursing's IPE engagement stems, in part, from professional insecurity and fear.¹²⁰ Second, entrenchment in a nursing-centric ontology that includes a history of oppression (Reverby, 1998) induces skepticism that professional equality is possible. Third, professional comfort, ironically comfort with oppression and lack of empowerment as the status quo of nursing's professional ontology,¹²¹ is shattered by changes understood by nursing to be seemingly necessary for interprofessionalism. Professional mistrust and discomfort may undermine professional confidence necessary for IPE engagement. Finally, stepping out of an historic professional mold to embrace a new professional pedagogy with a potentially requisite shift in professional identity and attitude, is challenging for a profession whose entrenched ontology historically incorporates personal inferiority and powerlessness conferred by gender. Nursing's historic ontology is a component of the context in which nursing's IPE engagement occurs. Individually and collectively, the factors inherent in this ontology that evoke professional insecurity, fear, and mistrust, influence nursing's IPE engagement by creating impediments to a professional ontology, imbued with security, trust, and confidence, necessary for collaborative and interdependent work wherein nursing's discipline-specific knowledge and power is realized.

¹²⁰ *We are at a place where we don't want to see any erosion of nursing. So they would want to be defending nursing and there might not be the trust there ... There are some people who do not trust that nursing will come out of this as an equal partner; We've got to focus in on the basic expectations for our disciplines. Right? It's [IPE] still seen as a frill, it's still seen as a frill and ... everybody is out there creating territory and domains, power and influence, and unless you have trust, nobody is going to sit down and give away any aspects that define them as a profession.*

¹²¹ *We're afraid that we can be successful. We are afraid that we can actually get out there and make a difference and so we, its uncomfortable from the status quo of not feeling empowered because we'd have to change.*

Curriculum paradox. The non-prescriptive nature of the baccalaureate curriculum allows for flexibility in clinical learning, accommodating serendipitous IPE. At the same time, the curriculum does incorporate essential nursing theory and skills that ostensibly are in a curricular competition with IPE opportunities. If IPE is regarded as competition for curriculum space with what are perceived as more essential skills,¹²² nursing's inclination toward IPE engagement is compromised. When IPE and learning essential nursing skills are regarded as mutually exclusive, not only is the resulting mindset not conducive to IPE engagement, but also it represents a fundamental misunderstanding about IPE in general. Furthermore, if curriculum is viewed from a checklist mentality with competitive ranking of elements, the opportunity for nursing's IPE engagement may not be considered a priority.

Nurse academics' workload. Regarding the university's academic trinity of teaching, research, and service, workload requires nurse academics to be all things to all people. Juggling the expectations of an academic position while maintaining commitment to a professional practice discipline, the very reason for which the academic program exists in the first place, creates multiple challenges, most predominantly a heavy workload.¹²³ A workload that is already maximized by meeting existing teaching, research, and service expectations leaves little

¹²² *We've got to focus in on the basic expectations for our disciplines ... you shouldn't have to sacrifice one thing for another.*

¹²³ *We are all struggling right now because we can't just do it [IPE], it's [workload] so heavy. What support? I mean really, we give lip service to it but there is no course release. There is no time. There is not anything dedicated toward it. If I look at the academic surrounding, I think nursing, and if we go back to the whole power and female dominated profession, if I look at our workload compared to our counterparts', it's way heavier ... If we look at what we accommodate as nurses and what we try to do with so little, that's part of what we do, whether we are out in practice or are in education.*

room for engagement in new initiatives.¹²⁴ However, testaments¹²⁵ convey a message that nurses ably manage heavy workloads and more. A paradox between workload complaints and capability is created in part by nursing's complicit behaviour in both, perhaps diminishing the potential for nursing's IPE engagement because of the untenable situation.

University related factors. Development and implementation of a new academic initiative, such as, IPE requires careful consideration not only of general university parameters, but also of the logistical and pragmatic parameters specific to IPE.¹²⁶ In this case, parameters related specifically to nursing's IPE engagement include faculty/student time and learning space, fiscal and human resources (including the strike impact), students numbers, the collaborative program, and intraprofessional communication. Seemingly, the nature of these parameters creates impediments to nursing's IPE engagement. For example, the negative net effect between the necessary and available energy and effort required for navigating IPE time and timetabling¹²⁷ strains nursing's finite energy and good will, jeopardizing nursing's IPE engagement.

¹²⁴ *All the reading that I have done on interprofessional education, the applying for grants for interprofessional education, it's all come on my own time – evenings, weekends. I mean ... It's hard enough to find time to teach your own courses, to deal with your students in the day to day basis that you have, and so, if you really wanted to develop a sound interprofessional education program that is formalized, you would need time and that would need to be built into your workload and it would need to be protected.*

¹²⁵ *You have known nurses obviously for a long time. They all work very hard. As it turns out, it doesn't seem to matter how much work you give them, they seem to manage to do it and so my colleagues in nursing are very much like that ... they already had a full day before they started to do any of these things but they can somehow manage still to do it in the same length of day.*

¹²⁶ *...because of the set up of lectures and timetables and space allocation, availability of profs and students. You look at people's timetables and to even get a meeting together for a fun event to planning something. It just can't seem to do anything across disciplines so everybody, - my feeling is we'd love to be doing more and can probably see that there would be some benefits and but I think the silos are still creating barriers, just the logistics of it.*

¹²⁷ *... so I think you know there are some voiced supports for it [IPE] and as I say some philosophical and valuing of it that is shared. But, you know there really, the follow through, the constraints of institutions, timetables and literally time you know just precludes it.*

Additionally, inadequate teaching space for current programs,¹²⁸ never mind new pedagogies, encumbers IPE potential and nursing's engagement. In the short time that the satellite medical school has been on campus, it has generated a big presence. This presence includes the construction of its own building currently underutilized by a small medical cohort, yet not shared with anyone, including a growing nursing cohort in the linked, adjacent building. In this instance, failure to share space represents primacy of medicine, marginalization of nursing,¹²⁹ and paternalistic control of higher education (Anthony & Landeen, 2009). One implication of marginalization is that nursing may have to work harder than other health disciplines (i.e., medicine) to overcome the inconsistencies among allocation of university resources and supports.

Challenges to fiscal and human resources compromise IPE engagement despite nursing's will to explore and develop new pedagogy. In reality, financial cutbacks prior and subsequent to the strike present nursing with a twofold problem that hampers nursing's IPE engagement: inadequate funds to support faculty growth and increased workload for existing faculty. Ironically, if IPE is the subject of a research study, then funding may be available to support nursing's IPE engagement by way of research.¹³⁰ Additionally, for an already heavily burdened

¹²⁸ *Like we have, we have one of the hugest enrollments on campus and I'll be very frank with you, it's very difficult to do the kind of teaching and pedagogy that you know would give the students the best experience when you are faced with a class that has 260 people in it. You can't do the things that you know would really make it interesting and meaningful ...*

¹²⁹ *The presence [medical school] is there. The dollar resource allocation is, you know, funneled right into that without any, you know, for us to be fighting for space in a building that is right adjacent to us is abominable. So simple things that show respect, that show a real desire to not be perpetuating this paternalistic control of education and health care which are the two principle things involved in systems.*

¹³⁰ *Well it depends on who espouses it [IPE], whether it brings in money. Is it the flavour of the month and/or is it going to be cost effective? That, right now, is the mantra. Is it going to allow and increase the research potential and productivity of the professoriate? If not, if you are just going to be swirling around and doing course development and focusing in on classroom teaching ...*

full time faculty, a human resource model that relies heavily on part time clinical faculty is not a sustainable framework for IPE engagement¹³¹; cost saving through increasing the part-time professoriate was one university mandate that provoked the strike. The impact on nursing faculty of the fall 2008 university-wide strike cannot be underestimated. Not only did the strike outcome result in aggressive funding reallocation, but it also cost nursing faculty and students' teaching/learning time, physical health and morale, denting IPE engagement potential.

From a pragmatic perspective, control over the number of students admitted to the nursing program as well as the differential between number of nursing students, compared with student numbers in the other health and social care programs, are challenges for IPE development and implementation.¹³² The collaborative BScN program contributes not only to the large nursing cohort but also creates other impediments to nursing's IPE engagement. For example, the time and energy needed to maintain the collaborative relationship, including educating, mentoring, and monitoring functions¹³³ eclipses opportunity to develop other

¹³¹ *They were not full time members. They weren't always attending things. It was a steeper learning curve for them because they weren't in the environment all the time, and so, and I have seen things when they [students] go into the clinical site with their clinical instructors, things just falling off, the wheels just falling off. And I would be really concerned that IPE would completely fall off when released into the clinical instructors hands ...*

¹³² *... there is an ongoing issue that there are 1200 nursing students and 24 [medical students] and how do you, you can't select nursing students to be paired up. You can't deny people. You can't rotate them because that's obviously very time consuming on the medical students and so the education, the numbers, there is such a disconnect in the numbers of students. I think that is going to be an ongoing challenge.*

¹³³ *... we have been crippled by the collaborative program because of the amount of work that has had to go into building a relationship with our collaborative partners. We have not got time and energy to focus on all of the wonderful things that we want to do because we are building capacity so that we can provide equal opportunity for all students on all sites and that's a lot of work. We had to focus on collaboration and ... our partners. There is a huge investment into maintaining that relationship, nurturing and fostering them down that educational road, making sure that the same level of standardization and competency is being delivered and there are some excellent educators there but the view that they have is very different ... And so a lot of time is invested in that ... Collaboration, it's in addition to everything, right?*

academic programs and compromises development of new pedagogical initiatives such as IPE. Furthermore, lack of meaningful, respectful, and open intra-professional communication, not only across the collaborative nursing program sites, but also among Site B faculty, undermines global awareness of ongoing work and of opportunity for future initiatives, including IPE.¹³⁴

Nursing's professional subjectivity. Challenges to nursing's IPE engagement may be perceived as barriers depending on contextual, professional, or philosophical lens. Mindful of this perspective, a relevant question is whether barriers to IPE are unique or are similar to the usual barriers nurse's encounter in developing new initiatives? One barrier unique to IPE is that component of nursing's professional subjectivity wherein nurses own responsibility for the creation of their status or position relative to other members of the health care team.¹³⁵ This complicit behaviour pervades development of professional knowledge and power, affects professional self-esteem, and undermines professional confidence. As a result of complicit subjectivity, nurses create their own barrier to IPE engagement; however, development of complicit behaviour is justifiable by virtue of the historic relationship (i.e., discourse) between nursing and medicine wherein nurses were valued solely as handmaidens. Etiology aside, contexts in which nurses feel marginalized and disenfranchised are not optimal for nursing's IPE engagement.

¹³⁴ *Right, so I think sometimes you have strong personalities who come in and take over ... I wish that we could have some way of being together and working together like clinically as learners so that we can break down these sorts of [intraprofessional and interprofessional] hierarchical barriers that are kind of invisible but are there ...*

¹³⁵ *There is no work being done with it [IPE]. No, not happening because you can imagine, they are perpetuating in nursing that power imbalance but it's not the physician's fault. It's a concrete example of what happens. You've got this medical school that has 20 students that already is the pinnacle of this university. We have a faculty of nursing 10 feet away that is invisible. It's not the medical school's problem.*

Summary. Lack of nursing's IPE engagement is understood within a context of multiple realities inherent among nurses' experiences with professional and academic contexts, historic professional ontology, curriculum and academic workload, university factors, and professional subjectivity. That seemingly contradictory understandings and information are present within the same academic setting is understood as an uncertain footing on which to build IPE engagement. The interplay of multiple realities and multiple influences is a function of the intersection of professional (e.g., nursing's professional subjectivity) and academic contextual factors (e.g., university related factors, intra and interprofessional interaction). What distinguishes the effect of this interplay on IPE engagement from the effect of the same interplay on nurse academics' work in general is yet to be determined. Nonetheless, this exploration of challenges to nursing's IPE engagement rooted in context, creates a platform for the exploration of the supports and resources necessary for nursing's IPE engagement.

What is Needed for Nursing's IPE Engagement

Discovery of the resources and supports needed for nursing's IPE work is informed not only by an understanding of the challenges to nursing's IPE engagement, but also is guided by the propositions that interprofessionalism will require nursing to work collaboratively and interdependently, rather than subjugating its discipline-specific knowledge and power and that nursing's relationship with medicine has evolved from a history grounded in patriarchy, dominance, and power-over. In addition, uncovering the resources and supports necessary for IPE engagement may provide support also for the promotion and recognition by self and others of nursing's legitimacy as an academic discipline (proposition five) and for promotion of nursing's rightful membership in the academy.

A reading of the following text must be prefaced by two truths. First, the resources and supports proposed for nursing's IPE engagement are presented using a framework that seemingly dichotomizes elements as internal and external to nursing. The intended use of this analytic framework is to promote textual coherence rather than to convey reduction of data into binary categories; understanding resources and supports for nursing's IPE engagement as dichotomous in nature is fundamentally artificial since reality conveys the overlaps among and in-between the nature of elements perceived as IPE resources and supports. Second, paradoxically what is perceived from one perspective as an IPE barrier or challenge is perceived from a different perspective as an IPE resource or support. This latter perspective is built on the concept of value: value for IPE such that IPE is made an integral component of curriculum,¹³⁶ value for IPE at all academic/administrative levels,¹³⁷ and value for our knowledge and work as health professionals.¹³⁸ Once embraced, value held for IPE can be leveraged as a primary resource to promote nursing's IPE engagement.

Elements external to nursing. Best intentions and desires to act on the value held for IPE can be thwarted by pragmatic realities external to nursing per se, but central to the resources and supports present within the broader university context. For example, supporting IPE

¹³⁶ *So when you are teaching whatever you are teaching whether its community health it's not necessarily an IPE unit or something, it still has to be reflected, that IPE stream still has to be reflected. I think it can't be again something outside that's an add on, but it has to be really, it does need to be a stream throughout and it has to be valued and everyone really has to be on board and understand what the purpose is. Those conversations have to come out in all forums.*

¹³⁷ *... I think we are trying but I agree with ... that there has to be some perception of value. It's got to be valued not only within our own faculty but if we are going to do this the way how we've described across our various departments and faculties then there has got to be buy in not only from our own Dean, but from the president of the university and from the supporting agencies that our students here utilize.*

¹³⁸ *How we, and I think how you build interprofessional is teaching people to value what they do ... to know, to say I make a difference, that I have knowledge and expertise, that I especially ... I have something to offer.*

development by specific allocation for this work within faculty workload contracts not only increases the probability of nursing's engagement but also contributes potential for the entrenchment and sustainability of IPE within nursing curricula; Protected time for IPE coupled with fiscal resources dedicated specifically to IPE curriculum work substantially supports nursing's IPE engagement. A university administrative/political infrastructure¹³⁹ that articulates theoretical and tangible support for nursing's IPE enhances engagement and visibly strengthens the discipline's profile and place within the academy.¹⁴⁰ Moreover, a shift in the tower of academic administration from a siloed or uniprofessional to an interprofessional perspective of education among health and social care disciplines fosters a model of inclusion conducive to nursing's IPE engagement, rather than perpetuates the historically entrenched hegemony of male-dominated/derived educational structures and practices (i.e., primacy of medicine) that is neither conducive to IPE generally or to nursing's IPE engagement specifically. For nursing's IPE engagement to take root,¹⁴¹ grass roots modification in educational structure and approach both in the academy and practice is needed to inculcate a culture of IPE.

Development of an academic culture, inclusive of an expectation of IPE, that visibly and openly fosters development of inter and intraprofessional relationships necessary for IPE (CIHC, 2010), supports nursing's IPE engagement. Inter and intraprofessional relationship building

¹³⁹ *Yes, from the Deans, from the senior administration. I think having a president ... and a provost whose really trying to see this [IPE] happen on our campus on a more formal presence ...*

¹⁴⁰ *... the leadership and the support that we give as an institution that this [IPE] is going to be a good thing for the discipline of nursing and that it will make it stronger and not take away because I that is sort of some of the concern.*

¹⁴¹ *If there was a milieu that could commence from the bottom up like a little germ, if you could grow it. I don't think it's [IPE] something that you can attach to something. For it to be totally grafted ... the graft would never be as strong as something that was ... germinated.*

predicated on trust¹⁴² and respect encourages IPE engagement; garnering respect for the discipline as an equitable, rightful member of the academy is integral to nursing's IPE engagement.

Elements internal to nursing. Several elements specific to nursing in the academy are necessary to foster nursing's IPE engagement. First, as a primary and pragmatic activity, intraprofessional faculty development opportunities, as dedicated and protected time focused on learning about IPE theory and practice, mitigate IPE knowledge deficit, promote intraprofessional relationship development, and instill confidence in embracing a new pedagogy. Importantly, attendance at faculty development events by the large cohort of part time clinical instructors is necessary for current, accurate, and seamless transfer of IPE tenets from the classroom to clinical practice. Second, creation of a virtual faculty community for IPE teaching and learning across schools of nursing wherein IPE-involved research (e.g., IPE in simulated learning) and other IPE initiatives could be shared¹⁴³ promotes intraprofessional communication and knowledge sharing; participation in a virtual community of this nature is concurrently an example of IPE engagement and a practical, effective and readily accessible resource to support engagement. Third, in addition to support for IPE engagement provided by a virtual community,

¹⁴² *I think there are great opportunities but I think we have to be patient. We have to ask the questions and we have to, we have to build this relationship of trust between others.*

¹⁴³ *A community of learners where [someone says] we've tried this at our institution and have found that this has helped. We have tried this, we have done research into our sim set up and have found these are the results from the physician pool, these are the results from the nursing pool, this is where the change of attitude has happened or where we've seen a change of attitude or we haven't. So sort of evidence that it's [IPE] going to make a difference for what learners, where, and then a sharing of ideas ... a listserv where interprofessional education, where you would actually have a chance to share that this worked, this didn't work.*

IPE champions within actual academic nursing communities¹⁴⁴ contribute to nursing's engagement. An IPE champion who has intraprofessional respect not only can innovate change but also may draw attention to IPE and attract nursing colleagues by virtue of attraction to a great reputation built on professional success; nursing faculty are likely to align themselves with such a champion. Interestingly, from an institutional ethnographic perspective wherein everyday experience is socially constructed (Smith, 2005), faculty alignment with an IPE champion, whose reputation may derive exclusively from uniprofessional construction, may be necessary for nursing's IPE engagement.

Finally, a necessary condition for nursing's IPE engagement is a shift in nursing's professional culture and attitude, moving away from professional chauvinism and exclusivity toward an inclusionary and shared professional culture of mutual value and respect for difference. To achieve a professional culture¹⁴⁵ and attitude shift¹⁴⁶ requires diligence in many areas including ensuring essence of time and thoughtfulness,¹⁴⁷ avoiding patchy, incoherent IPE

¹⁴⁴ *Need to look at about how change is brought about in education in general and my experience certainly is that you need a local champion and you need a champion in each of the groups that you want to bring together. It's not enough just to have somebody who thinks, well, this would be a great idea and I have to go and get a whole lot of groups of people to come and do this. It can certainly start like that but it is doomed to failure unless there is somebody locally respected within the group that you want to recruit.*

¹⁴⁵ *... I think we should make every attempt to continue as educators to be open ... this is all part of growing as a profession, is opening ourselves up to different ways that others think about the world. Knowledge doesn't change behaviour. You need a culture of its really what's expected, that you believe in this culture ...*

¹⁴⁶ *I also think that you need to have a change of attitude, by both nurses and physician educators depending on who is teaching and what views they come from. Some are much more willing to collaborate and to look at ways of trying to offer opportunities together. There are some who very much think, 'Oh no, this is medicine. You know, we need to protect our own or we don't want to be sucked up by medicine and so that attitude needs to change.*

¹⁴⁷ *... if you are going to take on something as big as in changing a whole mindset with multiple disciplines it absolutely has to be thoughtful and time has to be dedicated to it and energy ... to change mind sets in multiple disciplines and get everybody on board is just not a seminar in the evenings.*

learning, finding reliable role models to lead the way forward,¹⁴⁸ and having robust professional confidence¹⁴⁹; Leveraging professional confidence enables nursing to become expansionary and inclusionary thinkers, transporting nursing from its historic, chauvinistic ontology steeped in poor professional self-esteem to a new interprofessional academic context wherein nursing's engagement can blossom. Although nursing learns and practices in an evolving societal context, understandably changing society's view of nursing is a professional challenge when competing against years of cultural history in which society's view of nursing has remained static.

Case Report Summary

To promote textual coherence of the individual case reports and subsequent analysis across the cases, this case report has adhered to the identical report structure and format used in Site A case report. Similarly, Site B participants' exemplars, embedded via footnote, animated and amplified the case findings and the presence of research propositions was made explicit.

Case Report Site C University

Introduction

Site C university's SON possesses a unique characteristic. When baccalaureate level nursing education became the provincial minimum requirement for entry to practice in 2005, unlike other provincial university schools of nursing, Site C university did not sign a Memorandum of Understanding (MOU) with its neighbouring community college for the

¹⁴⁸ *One of the problems, of course, is role modeling and if you leave it too late, the role model that they will see is one that doesn't collaborate, that needs to be the leader and that doesn't really work in terms of team function.*

¹⁴⁹ *... you have to have confidence in your knowledge and expertise ... and who you are and that you are added value.*

collaborative development and implementation of a baccalaureate nursing program¹⁵⁰; Site C university's SON does not offer a baccalaureate degree in collaboration with a community college. The absence of a collaborative program imposes a significant difference in case traits between Site C and the other two cases in the study. This difference generates analytic relevance (Yin, 2009, p. 54, 61) arising from the inexact case replication and is considered in the cross-case report in chapter six.

The Case and its Context

The case of Site C nursing's IPE engagement is a contemporary phenomenon that exists within its inseparable health professional and academic contexts (Yin, 2009). The reason for exploring the context of this case follows similar logic offered in Site A and B case reports. At the outset, case boundaries were satisfied: Site C university is an Ontario, English-speaking institution, with a four-year baccalaureate nursing program as well as medicine, occupational and physical therapy, and clinical psychology programs. Data were generated from July 2008 to June 2009 with volunteer participation of full and part time nursing and health professional and social care faculty members. In contrast to Sites A and B, who have collaborative baccalaureate nursing programs, Site B does not. Similar to Site A yet different from Site B, Site C SON is partner in a

¹⁵⁰ Immediately prior to the provincial mandate, university schools of nursing and community college diploma nursing programs worked together to develop and implement baccalaureate nursing education. Collaborative university-community college partnerships arose across the province and collaborative baccalaureate nursing programs became the established norm. Memoranda of agreements legalizing the marriage of two educational institutions in the baccalaureate nursing education enterprise were signed by a majority of universities and community colleges. In contrast to the events taking place across the rest of the province, Site C University and its neighbouring community college did not sign a Memorandum of Understanding (MOU) (D. Walker, personal communication, September, 2004). Despite the absence of a binding MOU, Site C's SON faculty and community college colleagues developed and implemented a baccalaureate nursing program with intake through the university exclusively. A few years later, the community college entered into a binding collaborative relationship with another Ontario university, severing professional and academic ties with Site C University. This status remains and Site C University SON does not have a collaborative baccalaureate program.

Faculty of Health Sciences. Knowledge construction and behaviour are informed and influenced by the values inherent in the context of Site C university (Lincoln & Guba, 1985; Schwandt, 2000), therefore, an overview of the context of nursing's IPE engagement at Site C university situates the case findings and contributes to their understanding.

Site C university is a moderate-sized academic institution providing undergraduate, graduate, and postgraduate opportunities for approximately 23 000 Canadian and international students annually. The university is located centrally within its partner community with whom it has shared a close relationship for over a century and a half. In 1998, the SON was joined with the Schools of Medicine and Rehabilitation Sciences (e.g., occupational therapy, physical therapy, masters program in rehabilitation science) to create a Faculty of Health Sciences. Although geographically the SON building lies on the periphery of the campus, the school is a central partner in the provision of health professional education with a distinguished history of academic excellence, beginning in 1941. The 1960s era building has close proximity to the university's health sciences library and the city's only tertiary care hospital facility. In addition to faculty and administrative offices and a few small conference rooms, the building houses a state-of-the-art simulation learning laboratory, described as the "crown jewel" in the SON's holdings.

Site C SON offers doctoral, masters, and baccalaureate level nursing education. Approximately 300 undergraduate students are enrolled in the four-year baccalaureate program; four percent of students are male-identified and 96 percent are female-identified. The nursing programs are delivered by 18 full-time faculty and an ever-changing, large number of part-time faculty teaching clinical courses. During the time of the study, there were no full-time male faculty members in the SON.

The mission of Site C university is to advance learning and scholarship in the discipline and profession of nursing through educational, scholarly, and clinical pursuits of nursing students, faculty, and alumnae (Site A program document). The nursing program's philosophy encompasses an epistemology wherein the sciences and the arts are foundational to the development of exemplary nursing practice. Importantly, this philosophy includes a belief statement that students should have the opportunity to learn interprofessionally with, from, and about each other. This statement mirrors the definition of IPE by Barr et al. (2005) that guides this research. An integral contextual component at Site C university is a dedicated IPE and IPP office. Separated from the university campus by the downtown core, this office supports all FHS schools to promote IPE opportunities through participation in clinical simulation, in opportunities available at a centre dedicated to clinical education, and in clinical practice settings.

Lingering within the context of Site C university FHS is a hierarchy and culture of power that places medicine in position of primacy,¹⁵¹ a vestige of the historic relationship between medicine and nursing (Anthony & Landeen, 2009). It is acknowledged that health care continues to be steeped in the traditional medical model of illness and a narrow view of health. The hegemony of this traditional model of health care is imposed on the establishment of an IPE educational culture because of the obligatory relationship between practice and health professional education. Additionally, the entrenched culture of academia prevails and

¹⁵¹ *And I think that you know we talk about the hierarchy within. Say we want to get rid of the hierarchy within the professions but I think that exists in academia as well ... we are still very much fighting that in the academic setting where we are trying to get people to collaborate, not just professionally, but where you sit on the power ladder within the university; I think when things get stressful or tense that they [medicine] do still somewhat control interactions even though someone of a certain title and I would have expected that they [nursing] would say something and stand up. They don't maybe because they are not medicine and still feel like there is a bit of a difference there.*

administrative IPE support across the faculty is pragmatically a function of fiscal and space resources. The politics of education at Site C university are woven throughout the cloth of IPE development and implementation.

Case Study Findings

The case study findings are discussed within the boundary created by full and part time educators within Site C university baccalaureate nursing programs as well as other health professional and social care faculty members involved in IPE. Participants’ demographic data are depicted graphically in Appendix E. All participants were females ranging in age from 25 to 65 years, with six falling in the 45 to 65 age bracket. Professions represented included nursing (6), medicine (1), occupational therapy (1) and education (1). Among nurses, years in the profession ranged from four to forty years (average 27.2). Experience in nursing education generally, averaged 14.4 years (range .3-25 years). Among all participants, 7.2 years was the average for teaching in the health professions at Site C university, specifically (range .3-20 years). The composition of Site C participants in individual and focus groups interviews appears in Table 3.

Table 3 Composition of Site C Individual and Focus Group Interviews

Interview type	Number	
	Interviews	Participants
Individual	7	7
Focus Group	1	2

Following the analytic path established in the case report of Sites A and B, an analysis of nursing’s knowledge about and understanding of IPE precedes an analysis of nursing’s IPE

engagement. Similar to the construction of Site A and B case reports, data led me to reason that faculty need knowledge about and understanding of IPE in order to develop and implement IPE in mainstream baccalaureate nursing curriculum, to engage in scholarly activity, and to publish IPE research. Also consistent with case reports A and B, I was mindful of the research proposition that faculty may not be knowledgeable about IPE.

IPE Knowledge and Understanding

The importance of language choice has been confirmed (Arslanian-Engorgen, 2002) so it is noteworthy that nursing's language choice is linked to IPE knowledge and understanding. Several different words are used synonymously with the term interprofessional: multidisciplinary, interdisciplinary and interprofessional are used interchangeably with no distinction made between these seemingly similar yet distinctly different terms. The way in which nurse educators' choose their words reflects their IPE understanding (Gilbert, 2005b); failure to distinguish between the terms multidisciplinary, interdisciplinary, and interprofessional obstructs IPE understanding, consequently impeding IPE engagement. There is agreement in the literature (Dyer, 2003; Gilbert) that the use of a variety of descriptions challenges academic and practice endeavours, inclusive of IPE.

Candid IPE views reflect a diverse range of IPE knowledge and understanding. Views on IPE exposure, reflected by a recent nursing graduate and new faculty members,¹⁵² contrast with seasoned IPE leaders' fluid, effortless recollection of the formal, mainstream IPE definition¹⁵³

¹⁵² ... *I hadn't even heard of it [IPE] until you e mailed me to be quite honest. I didn't know there was anything specific. I thought that it was something that, as soon as you graduated, you learned what the other professions were and what their place was.*

¹⁵³ *Well, the CAIPE definition ... certainly from that perspective, the idea of learning from, with, and about ... The three of those truly embraces what interprofessional education is. And so what that means ... would be people within a setting where not only is what is being presented and who it's being presented by is interprofessional but also that the learners are from different professions ...*

pioneered by Barr et al. (2005) that informs this study. The definition by Barr et al. represented the ideal versus reality of IPE knowledge, understanding and subsequent activity. It is toward this ideal that faculty strive in full recognition that flexibility combined with a variety of strategies are needed to achieve the ideal. That IPE does not preclude uniprofessionality represents a balanced perspective of IPE: uni and interprofessionality are understood as complementary rather than mutually exclusive concepts that require abdication of core, discipline-specific educational practices and traits. Although IPE can be informal or serendipitous, planned or formal, explicit attention should be incorporated throughout the experience regarding how and where IPE is inherent.

A singular model of IPE shared by health professional disciplines does not exist. IPE may be provided through modules developed interprofessionally but taught to a uniprofessional group by a health professional who has an understanding of the roles and responsibilities and dimensions of other health professionals. At the same time, IPE may exist as a hidden curriculum (Bevis & Watson, 1989a) depending on what is discipline-specifically modeled. The ideal experience of learning with, from, and about health professional colleagues (Barr et al., 2005) engaged with material created and delivered interprofessionally is different than what occurs in reality.

Interprofessional education not only benefits future health care professionals, but also promotes health professional faculty collaborative engagement in the full spectrum of the scholarly enterprise (i.e., teaching, service, research¹⁵⁴) through which collegiality and respect

¹⁵⁴ ... hopefully for IPE education, it also means that in terms of the whole scholarly process that there is planning of how this is going to work, the evaluation of how it's working and the publication – so the research that would be linked to that.

can be engendered.¹⁵⁵ Interaction among health professional students, when they can be brought together around common learning areas such as anatomy, physiology, or ethics, in small groups and in simulation experiences is considered the actual place where IP learning occurs.

Professional socialization that occurs by virtue of learning interactions (i.e., differentiated from personal socialization that occurs by virtue of social activities) created for IPE purposes fosters mutual appreciation for the nature and rigor of discipline specific education programs.

At the same time, skepticism about IPE validity, sustainability, and longevity exists. This perspective is manifest in two ways: First, by modern vernacular terms such as the *warm fuzzy stuff*, the newest *buzzword*, and the *flavour of the month* reportedly used by some nursing professionals to refer to IPE; and second, in reported articulations of the stark contrast between the vague and unproven concept of IPE and the perceived, more reliable entrenched concept of evidence-based practice (EBP). Skepticism surrounding IPE includes questions as to whether IPE is yet another innovation (i.e., EBP and the advanced practice movements) that has high adoption and profile initially, but that becomes attenuated over time due to lack of knowledge and understanding on one hand, dogmatic approaches on the other hand, and critical counter-culture in reaction to both.

Diverse views on IPE prevail wherein it is understood both as an addition to an already overflowing¹⁵⁶ or additive curriculum (Diekelmann & Smythe, 2004; Ironside, 2004) and as a replacement rather than an ‘add on.’¹⁵⁷ Concurrently, an alternate perspective regards nursing as

¹⁵⁵ ... so you teach it together ... you know that you'll have a little bit more respect. You are not afraid of the other person.

¹⁵⁶ ... my impression is that people would offer varying levels of support for something like this [IPE] and one of the things they might say is well, where are we going to find the time. Okay, you tell me what I'm going to take out of my curriculum to put this in and then maybe I'll look at it.

¹⁵⁷ ... the faculty somehow have to see it as a positive accomplishment, not you know as an ‘add on.’

interdisciplinary at its inception, given the profession's roots in a melding of other disciplines including anthropology, sociology, psychology, anatomy, and others. This alternate perspective is incongruent with the prevailing received view of IPE.

Although IPE knowledge varies and IPE skepticism exists, paradoxically there is overriding belief in the value of IPE¹⁵⁸; IPE may not be understood but it is valued! Despite reports of high and intense workloads, those involved in IPE do so because they believe in this learning modality and the quality of the projects, thereby making IPE a priority. Corroboration of the value placed on IPE appears in the SON mission and philosophy statements regarding the integration of IPE throughout its programs and specific criteria related to nursing students' development of knowledge and skills in partnership with other health care professionals. Information about and awareness of the roles of health professional colleagues and the nature of within and cross-disciplinary interactions is necessary, but is thought to be less germane to nursing's IPE knowledge and understanding. Not unexpectedly, nursing's IPE knowledge and understanding is inextricably related to professional characteristics including role identity, or knowing and understanding own nursing role.

Knowing and Understanding own Nursing Role

Assimilated personal beliefs and perspectives about nursing's roles are not only integral to understanding nursing IPE engagement but also enlighten nurse educators' beliefs IPE about nursing. For example, that nursing students need first to be inculcated in the ways of their chosen discipline for successful interprofessional learning or that nursing student maturity level impedes interprofessional interaction is an arguable matter (Adams, Hean, Sturgis & Clark, 2006;

¹⁵⁸ *I'm 100% behind IPE ... it makes you wonder why ... we are doing it now and not 30-40 years ago!" ... so why are people going to all this extra trouble if they weren't committed ...*

Anderson & Thorpe, 2008) of significant proportion because it calls in to question how nurses in practice and the academy view their own discipline, their respective chosen professional role, and the teaching-learning process.

A common and unified understanding of nursing's professional role is missing. Difficulty in articulating our professional roles is widespread¹⁵⁹ (Buresch & Gordon, 2000) and varied understandings of our professional role, or embodiment are abundant. Nursing has become both ubiquitous¹⁶⁰ and diversified. As an academic and practice discipline, nursing is experienced, in part, as a function of professional context; primary nursing roles in a clinical environment or in the academy determine roles and responsibilities, inculcating professional culture. For example, institutional practitioners may assume ultimate patient responsibility because of the twenty-four hour bedside nature of work life.¹⁶¹ Possessiveness and a gate keeper perspective¹⁶² about practice domain fosters professional chauvinism. From a gender perspective, perhaps professional chauvinism is a natural consequence of nursing's broader historical context; nursing has evolved from women's assumed natural altruistic duty to care (Anthony & Landeen, 2009).

Ironically, professional chauvinism exists alongside difficulty in articulating professional role. Inability to articulate professional role does not prevent professional territorialism.

¹⁵⁹ *Ours [nursing] is not, it's nebulous. I find nursing – we are not defined.*

¹⁶⁰ *Nursing I find, it kind of fills in all of the spaces, don't you think? You are going to be everything. It's kind of like, I don't want to say mother because it gets in to that whole female thing ...*

¹⁶¹ *Nursing is there all the time. You are the social worker when the social worker isn't there, You are the nutritionist ... you are the pastoral care person ... ; ...they [nurses] are often the one at the bedside all the time. But somehow it's perceived that that's their domain.*

¹⁶² *In fact, we do often become the gatekeepers because for the 60% who work in institutions, we are with the patient 24 and 7. We are the people who actually know and people forget that the only reason you are admitted to a hospital is because you need 24 hour nursing care. If you don't need 24 hour nursing care, you can be looked after at home.*

Professional chauvinism and territorialism are antithetical to the collaboration that is necessary to, but not sufficient for interprofessional education development. Baldwin (2007) and Gilbert (2005b) agree that professional territorialism is a significant barrier to IPE. Additionally, IPE, by definition, requires that nurses know about and share information about their professional roles. An educational process that includes IPE may be compromised if nurses are unable to articulate what they do.

Primary role as a nurse in the academy, determines specific roles and responsibilities, inculcating a professional culture different from that experienced by colleagues in primarily clinical practice. Nurse academics, must dovetail the entrenched characteristics and nature of a practice discipline (i.e., providing holistic care, developing therapeutic relationships) with the entrenched characteristics of a patriarchal academic structure (Anthony & Landeen, 2009) and didactic responsibility that includes not only providing service to the university but also engaging in the scholarship of discovery, or research (Boyer, 1990; Stull & Lanz, 2005). In contrast to colleagues in primary institutional clinical roles, nurse academics experience the pressures of a ubiquitous workload. Multiple roles required of a position in the academy merge with an ontology that is consistent with the profession's practice roots inclusive of clinical knowledge so as to inform academic work.¹⁶³ In part, professional identity for nurses in the academy is related to responsibility for developing discipline-specific curriculum.

Professional chauvinism exists among nurse academics but is manifest differently than professional chauvinism among nurse colleagues in primary institutional roles. For example, development of nursing curricula is considered by nursing to be the domain of the profession.

¹⁶³ *If you are going to be teaching within a health discipline, I think that it calls for you to have been clinically in the clinical world at some point in time. ... But it's from working within the clinical setting that your case studies, for instance, your examples come and they are going to ring truer if you are speaking from experience.*

This current position evolved in reaction to the historical development of ordered and assimilated nursing curricula (Anthony & Landeen, 2009) in which physicians and medicine played a prominent role¹⁶⁴ and nurses did not have power and control over nursing curriculum.

Paradoxically, an attitude of professional chauvinism is not aligned with the collaboration necessary for IPE engagement, yet collaboration is considered a founding principle, intrinsic to the nature of the discipline. From a gender perspective, women are more collaborative and involved in IPE in greater numbers than male counterparts, but have not achieved positions of primacy held by male academic colleagues.¹⁶⁵

The current culture of academia is constituted by inter and intra-professional silos¹⁶⁶ of work. A siloed ontology is not only counterproductive to the development of collegial relationships among nurse academics, but also is not conducive to inter and intra-professional collaboration required in IPE development and implementation. Moreover, this ontology undermines the development of professional self-esteem needed by nurse academics to embrace a rightful place as an IPE partner. Professional self-esteem, or nurses' sense of professional

¹⁶⁴ *Why does everybody think that they can have an opinion about nursing yet we would never dream of telling the physicians, well, we don't think you need four years of undergraduate education. You should be able to do it in three. We need control over our own curriculum - we remember being taught by MDs and learning a curriculum that was determined by those outside the profession ... now we've got control [of the curriculum], now you want us to share. Oh, I don't think so.*

¹⁶⁵ *Women in general seem to be more collaborative and we certainly have more women involved in the [IPE] stuff that we do than men. We'll comment if there is a man in the room. ... we work with some fabulous women and they are true collaborators. But usually they are not people who are in power. They aren't the people in those key positions or on top.*

¹⁶⁶ *Most people ... I think come to the programs after a lot of competitive hard work and they are used to being competitive as opposed to collaborative and I think the same can be said of the faculty – that people strive to get into programs to climb the ladder of academia. It's not that easy, as you know, it's not easy, and people by and large work in silos.*

worth and confidence, among nurses in general is reportedly low.¹⁶⁷ Among nurse academics specifically, professional self-esteem is compromised by others' opinion that nursing curricula is inadequate, an opinion that is often inferred by nurse academics as derisory work on their part.¹⁶⁸ As a presence in the academy, the discipline of nursing does not have a high profile,¹⁶⁹ perhaps related to its short history as a rightful member of the institution. Lack of recognition in the academy does not foster professional self-esteem. From a gender perspective, men in nursing have been described as having a different perspective¹⁷⁰ and accordingly may experience higher professional self-esteem than their female colleagues.

By definition, interprofessional education implies the need for collaboration. While the definition of IPE by Barr et al. (2005) infers the concept of collaboration among disciplines, nursing has been considered a collaborative profession from its inception, respectfully incorporating the theories and perspectives of other disciplines (e.g., anthropology, psychology, anatomy among others) into its knowledge base. That nursing needs to be collaborative in order to be interprofessional is an impertinent inference given that collaboration is considered a founding principle, intrinsic to the nature of the discipline.

Nursing's professional embodiment (i.e., professional chauvinism and self-esteem) not only informs but also confounds nurse's understanding and perception of IPE. Nursing's professional

¹⁶⁷ *It could be just my experience but I always think, as nurses, we feel inferior ...*

¹⁶⁸ *What's fascinating and I don't know whether you find this anywhere else, is that nursing schools are always so worried that their standards ... are not as high as anybody else's and you know that standards are slipping and we don't teach as well as we used to and the bigger classes you know we are not turning out the nurses we used to and they used to know have x number of thousands of hours of clinical practice ...*

¹⁶⁹ *... we [School of Nursing] are very small, and it's hard to know whether it's just because you don't have eyes and ears out there, that you don't know that other people don't know that you exist ...*

¹⁷⁰ *They [men in nursing] are like, I see this as my career and they have more respect for themselves.*

chauvinism, territorialism, and low self-esteem colours nursing's IPE knowledge and understanding, undermining IPE engagement as a consequence. Nursing's IPE knowledge and understanding is inextricably linked to professional identity, or understanding one's own nursing role. Nursing's knowledge of and understanding about the roles of health professional colleagues is derived from preconceived and stereotyped notions as well as experiential data. Replacing preconceived ideas about the roles of health professional colleagues with first-hand accounts inherent in the definition of IPE is integral to nursing's IPE engagement.

IPE in Baccalaureate Nursing at Site C

IPE has not made its way into mainstream undergraduate nursing curriculum (proposition one). IPE is present in the curriculum, however is patchy at best¹⁷¹ and cannot be considered mainstream. Several IPE learning opportunities were planned formally and informally using diverse modalities. For example, a shared classroom activity was organized for nursing and occupational therapy students to study concepts common to both disciplines. This activity was not written in any curriculum document. Rather, this occasion was created by two IPE champions from each of the respective disciplines who made IPE a priority by reorganizing and restructuring existing class time in a format where students could learn with, from, and about each other (Barr et al., 2005). A second opportunity was provided in the high fidelity simulation laboratory where third and fourth year nursing students learned with medical residents and other health professional students about how to manage patient resuscitation, the birthing process, and infection control. Shared clinical, rather than interprofessional competencies guided the IPE simulation scenarios developed collaboratively by nursing, physical therapy, and medicine.

¹⁷¹ *I think what is happening are little bits and pieces and gems of IP education but not yet an overall coordinated approach.*

Engaging in IPE simulation scenarios was mandatory clinical practice for upper year nursing students.

Site C university does not have a community college collaborative partner in developing and implementing baccalaureate nursing education. Absence of a collaborative partner streamlined management of IPE simulation development and implementation, including management of the logistics of accommodating year three and four students' timetables and faculty's workload. The IPE simulation opportunity was funded by research money. How the IPE simulation learning would be sustained, or become mainstream, once research funding ceases was uncertain. Research monies flowing to the IPE/IPP office funded a third IPE example; a variety of learning opportunities for all students in the faculty included interprofessional clinical placements and social events. Despite success, these activities had a tentative future linked to uncertain funding¹⁷² and infrastructure (i.e., staff clinicians and nurse academics).

Perspectives are discrepant about the nature of IPE in the curriculum. Perceptions of those directly involved in curriculum development share a story of growing IPE initiatives in contrast to the opinion of those less connected to curriculum development that, apart from simulation, there is little IPE integrated throughout the baccalaureate program. Lack of a universal IPE perspective on knowledge and understanding of IPE in the undergraduate curriculum specifically, raises the question regarding the level of knowledge, generally, about other curriculum components and how realistic it is to expect universal comprehensive curriculum

¹⁷² *When we did the first research project ... at the interprofessional placements we had staff from our group, our research group, going into the clinical sites doing tutorials, doing the reflections, giving students information, organizing it with the help of a little bit of staff liaison there but we did all that. The team was very happy to have that. They learned a lot. The clinical team, the students loved it. The feedback was very positive but as soon as our research ended, that ended.*

knowledge among faculty members. These questions notwithstanding, IPE is part of undergraduate nursing education at this Site. Proactive efforts to develop and embed IPE in the baccalaureate curriculum are underway and are consistent with clinical evaluation criteria, the program goals, and the school's mission statement. It is hoped that IPE in baccalaureate education will grow and flourish to the extent that eventually it becomes normalized.¹⁷³

Nurse Educators/Nursing Faculty's IPE Engagement

That proactive efforts to include IPE in the baccalaureate curriculum are underway is confirmed. However, the nature of nurse educators' roles in this IPE development and implementation is less straightforward; Nursing's IPE engagement is concurrently visible and varied, planned and serendipitous, and involves few nursing faculty members. For example, nursing faculty are involved in the development, implementation, and evaluation of preplanned, structured interprofessional simulation learning initiatives in contrast to the involvement of a faculty member who, by virtue of clinical instructor role and assigned placement, became involved in an interprofessional clinical experience not by plan or design. Similarly, an isolated IPE learning opportunity for nursing and occupational therapy students was created by an IPE champion and nurse educator in the absence of a cohesive, coherent and integrated curricular plan. Although these examples are consistent with the study proposition that nurse scholar's representation as architects of IPE curriculum development and implementation is minimal, the arbitrary nature of nursing's IPE engagement may be a necessary and logical initial step toward evolving nursing faculty member's intended responsibility in the development of nursing

¹⁷³ ... in a way I think we'll know interprofessional is a part of it when it is no longer needing to be a statement in a mission statement because it will be the new normal and you won't need to have an office of interprofessional education and practice because it will just be the way you function. You won't need to have people saying, who is your interprofessional education champion. You won't need it because it will just be the new normal then we'll know we have done it.

curricula that include IPE. However, a coherent, coordinated, and deliberate faculty engagement plan will be needed to foster sustained IPE in baccalaureate curriculum. Consideration of nursing's lack of IPE engagement sheds light on the supports and resources necessary to support nursing faculty members' evolving burgeoning IPE roles and responsibilities.

Lack of Nursing's IPE Engagement

In the course of exploring nursing's IPE engagement it is imperative to examine what engagement is happening currently, however, it is instructive, also, to consider lack of nursing's IPE engagement. Nursing may not be engaged in IPE for several reasons related to contextual factors inherent in the health professional and academic cultures in which IPE engagement exists. First, the structural logistics, policies, and requirements of academia (Gilbert, 2005b) may conflict with the educational obligations of a professional discipline, precluding the time and collaboration required for IPE. Second, university contracts presume infinite dedication¹⁷⁴ and workload documents cultivate faculty fatigue and foster competing priorities¹⁷⁵ that engender non-collaborative, potentially contentious relationships. Third, a health professional learning culture created from divergent professional perspectives (epistemologies and ontologies) is a complex, ostensibly incoherent foundation on which to develop IPE. For example, perspectives that privilege entrenched ways of learning (e.g., empiricist, evidence-based learning modes) because they are aligned with medicine's ontology and are easier to evaluate than IPE, thwarts innovation and acceptance of new pedagogies. A nursing mindset of professional chauvinism

¹⁷⁴ *It's [IPE] additional workload for them. It's not counted as part of their, in their teaching agreement. It's not at that point yet so they are overworked and others who aren't involved don't have to be. There is no directive that you must do this. There will be once it becomes a legislated competency but we are not there yet. So it's all based on a lot of voluntary work I would say.*

¹⁷⁵ *I think nurses are saying, we have enough things that we need to be dealing with which is developing PhD programs and getting more people into master's programs, strengthening baccalaureate programs*

amidst a professional and academic culture of medical primacy¹⁷⁶ is antithetical to the collaboration and power sharing required in IPE.

Finally, nurse academics may not consider themselves constructed knowers (Belenky et al., 1986) capable of developing knowledge and exercising their voice and embodying the belief that we see and are silent no more! Consistent with the proposition that historically the nursing profession has struggled to establish itself as an autonomous and independent discipline, low professional self-esteem contributes to a sense of professional inferiority, undermining nursing's professional voice and rightful place as an equal partner in the IPE enterprise.

Several concurrent elements impact nursing's IPE engagement. First, nursing IPE partners' diverse views and varied levels of knowledge and understanding about IPE affect the degree of IPE adoption. Second, nursing's contextually derived roles and responsibilities in practice and in the academy, in tandem with professional chauvinism and self-esteem, determine nurse academics' perception of IPE capacity and capability. Third, reasons behind nursing's lack of IPE engagement, inclusive of cumbersome academic structures of privilege and power, attenuate nursing's voice and challenge equality in the IPE partnership. Finally, revelations about elements that impact nursing's IPE engagement offer valuable pre-understanding of the supports and resources needed for nursing's IPE engagement, a necessary step toward determining the resources and supports needed for this activity.

What Is Needed For Nursing's IPE Engagement?

Two equally true yet seemingly disparate study propositions share a unique relationship: Although increasingly, nursing is simultaneously acknowledging itself and being recognized as

¹⁷⁶ *Well, they don't want to give up the power. For some people it [IPE engagement] means giving up some power; I mean traditionally medicine has much larger pots of money than the other schools ... So if we get funding, typically it has to come from them and they may want to use it for other things.*

an academic discipline with its own knowledge base and power (proposition five), nurse scholars, or academics, representation as architects of IPE curriculum development and implementation is minimal (proposition nine). Nursing's IPE engagement exists in small pockets manifest in the baccalaureate curriculum as initiatives developed and implemented by a few nurse academics in conjunction with other health professionals, IPE champions and support from the IPE/IPP office. If increasingly nursing is simultaneously acknowledging itself and being recognized as an academic discipline and if IPE is valued at Site C university, what is needed for growth in nursing IPE engagement?

The supports and resource for nursing's IPE engagement can be conceived as external and internal in nature. External resources and supports are tangible, visible elements including fiscal resources, leadership from within the profession as well as from senior university administrators, professional accreditation, and institutional and academic infrastructure. Internal resources are intangible characteristics manifest in nurse academics professional embodiment (i.e., required for enactment of the role as nurse academic), professional ethos, and nursing's subjectivity.

External supports and resources. Lack of adequate fiscal resources is a chronic academic plight. Though realistically an IPE targeted budget line would increase resource capacity, nursing faculty are loath to add their voice to the belief that more money allocated for teaching would enhance nursing's IPE engagement because they recognize that internal (i.e., personal and professional) supports and resources are equally, if not more vital, to IPE development.¹⁷⁷

¹⁷⁷ *You can throw as much money at something but unless you've got people who are really dedicated and committed, it doesn't matter.*

Leadership and support from senior faculty administrators¹⁷⁸ as well as from the discipline¹⁷⁹ is not universally apparent and is cited as a necessary condition for nursing's IPE engagement.

Two formal and structured paths of disciplinary support are suggested: professional program accreditation and legislated professional competency. Program accreditation, a type of support unique to health professional education, is regarded as instrumental in mainstreaming IPE in nursing education. New criteria about the presence of IPE in nursing education incorporated into the formal and structured process of baccalaureate program accreditation¹⁸⁰ by the Canadian Association of Schools of Nursing is believed to be critical to nursing's IPE engagement. Currently, there is no explicit professional directive or competency regarding interprofessional practice. Development of a new legislated competency, mandated by the College of Nurses of Ontario, the provincial licensing body, is regarded as necessary to drive nursing's IPE in practice with concomitant IPE in baccalaureate programs.¹⁸¹

¹⁷⁸ *It [IPE] needs to be integrated and so that takes a lot of, that takes, I think, leadership and also collaboration among ... the different faculties and that is not easy to get ... I think that is why you have to have leadership from the top who says it's a priority and kind of gets people somehow on board with it so that they are not kind of arguing between themselves and one poor champion is trying [to lead the charge]; But it needs very strong leadership from the top. We have one Dean, we have one Faculty of Health Sciences so it's not just that you need strong leadership with the Director of the School of Nursing. It absolutely has to come from the Dean's office as well and it has to be at every level that it comes down ...*

¹⁷⁹ *I have heard from others who are not nurses that generally across the country nursing is not being as supportive of IPE as it could be, that there is not a lot of leadership in nursing to do this.*

¹⁸⁰ *I think accreditation is going to drive this [IPE]. So from an accreditation point of view, if nursing, physio, OT, and medicine require interprofessionality and the accrediting board is saying where is it in your curriculum, demonstrate it to us ... That is the way for programs then to say to the university, this is demanded of us, we need to therefore deliver education in this way and therefore we need the facilities to do it.*

¹⁸¹ *There is no directive that you must do this. There will be once it becomes a legislated competency but we are not there yet. So it's all based on a lot of voluntary work I would say.*

Changes to the university and academic infrastructure are needed in tandem with the advent of changes to program accreditation and professional competencies. Research has long been regarded as the prime currency in academia. A cultural undercurrent of primacy that privileges research and undervalues teaching¹⁸² does not promote IPE engagement. Changes in university and academic infrastructures, including hiring practices and workload structures,¹⁸³ are necessary for the integration and assimilation of IPE into nursing and other health professional education programs.

Tacit professional and academic hierarchies prevail,¹⁸⁴ contributing to the perpetuation of entrenched power structures in practice and education contexts.¹⁸⁵ University promotion and tenure grids, created from an entrenched historic masculine perspective in an era when the discipline of nursing was not part of the academy, may be misaligned with nurse academics' professional and academic roles and responsibilities and contribute to perpetuating a culture of

¹⁸² *Education in general is not valued. Teaching is not valued. Teaching IP[interprofessional] is not valued.*

¹⁸³ *You support it [IPE infrastructure] and you reward it. Now the reward may be that ... periodically you are able to release them from a three-credit course and say this is your opportunity to get together with your colleagues to redevelop or to do whatever to look for opportunities. You can make it more or less mandatory for new faculty coming on board and how you do that is that when you advertise, it's part of what you are looking for. It's part of your skill set. It has to be; But it has to be written in to their job description. Unless someone is designated and has that written as part of their job description ...*

¹⁸⁴ *I say old boys club all the time in the context of this university. I say that and I think by that I mean the tradition of the way things get done. And there are a lot of women now in those positions of power but it still seems like the old boys club is alive and well in the way things are done. It's as if the women stepping in to the roles assume those kinds of characteristics that are typically associated with men.*

¹⁸⁵ *And I think that you know we talk about the hierarchy within. Say we want to get rid of the hierarchy within the professions but I think that exists in academia as well ... we are still very much fighting that in the academic setting where we are trying to get people to collaborate, not just professionally, but where you sit on the power ladder.*

medicine's¹⁸⁶ primacy, dominance, and power (Anthony & Landeen, 2009). New academic structures that recognize and incorporate the obligatory, unique professional and academic roles and responsibilities assumed by nurse academics provide support necessary for nursing's IPE engagement.

Internal resources. Intangible characteristics manifest in nurse academics professional embodiment, ethos, and subjectivity can be conceived as internal resources necessary for nursing's IPE engagement. Several characteristics integral to enacting the role of nurse academic generally, and engagement in IPE, specifically, are suggested. First, communication competence particularly related to managing conflict, discerning content versus intent, accommodating egos, and respecting different views is essential to IPE. Second, a professional ontology, or way of being, that includes attitudinal and intellectual flexibility is integral to interprofessional work. Nurse academics' flexibility in attitude and approach toward new learning modalities is necessary to achieve the goal of IPE in nursing. At the same time, intellectual and attitudinal flexibility may be perceived as requiring risk-taking behaviour. Comfort level with risk taking may determine degree of IPE engagement and subsequent changes necessary to embed IPE in baccalaureate education.¹⁸⁷ If IPE is perceived as risky and unproven, in contrast to entrenched, positivist concepts including evidence-based practice, then modifying the risk-taking capacity of nurse academics and supporting nursing IPE champions may be essential for IPE engagement.

¹⁸⁶ *I think, I certainly notice that where you know I've sort of expected people to speak out or say something because thinking, well they have a certain position within that school [nursing]. But I think there are some stereotypes that are still alive and well even though people are pretty good at pretending they don't exist. I think when things get stressful or tense that they do still somewhat control interactions even though someone of a certain title I would have expected that they would say something and stand up. They don't maybe because they are not medicine and still feel like there is a bit of a difference there.*

¹⁸⁷ *I think you have to be able to take risks if you want to do well in an IP world and fight against their [medicine] tradition. It's easy to just stay with the status quo and complain or moan and get lots of support for that but unless you are willing to speak up and take a risk nothing is going to change.*

Third, as an internal resource, professional subjectivity must incorporate strong professional self-esteem, a pervasive attitude of empowerment toward academic roles and responsibilities, and a sense of entitlement rather than unworthiness of a position in the academy. Robust professional subjectivity is consistent with research proposition five in which it is claimed that increasingly, nursing is simultaneously acknowledging itself and being recognized as an academic discipline with its own knowledge and power base. Implications for deep-seated, protracted professional subjectivity are inherent in proposition seven which maintains that interprofessionalism will require nurses to work collaboratively and interdependently rather than subjugating its discipline-specific knowledge and power.

Finally, an analysis of internal resources necessitates self-reflection in which it needs to be asked whether, as nurse academics, we need to see ourselves differently in order to engage in IPE. Importantly, the profession needs to maintain its foundational hallmarks of caring, relationship development, and health promotion. However, changing or ‘unlearning’ (Munhall, 1993) an entrenched way of being derived from an historical legacy of regimented learning modalities, gender bias, deference to medical colleagues, and historic discourses (Jinks & Bradley, 2004) while difficult, is necessary in order to embrace the profession’s rightful place in the academy and an ontology for IPE engagement. Admittedly, changing an historically-derived, entrenched ontology that has long been inextricably linked to nursing’s professional identity in practice and the academy is daunting and may engender a sense of professional vulnerability. To overcome professional vulnerability and to embrace a way of being necessary for IPE engagement, nurse academics must view themselves as a resource. In the role as self-resource, nurse academics’ mindfulness about discourses (i.e., nurse-doctor relationship) are perpetuating historic discourses through language (e.g., verbal and non-verbal) choice and use. Use of self-

deprecating language to refer to nursing's professional role and denial of nursing's valuable gender-derived traits does the profession a disservice, undervalues nursing's role in society, and undermines professional subjectivity.¹⁸⁸ Vigilance in promoting change from within mitigates old, harmful discourses that lack current relevance and creates an academic and professional context imbued with value for the nursing profession, intra and inter-faculty collegiality, and shared power among interprofessional partners. To strengthen internal resources, engagement in professional self-reflection promotes robust professional self-esteem and affirms that as members of a female-centred profession with a long and distinguished history we don't have to try twice as hard to be thought half as good (Whitton, cited in Weekes, 2007) as our male health professional colleagues.

At Site C, the case of nursing's IPE engagement encompasses several interrelated and contingent concepts including nursing's knowledge and understanding about IPE, understanding professional role, and identifying with professional subjectivity. Nursing's professional embodiment at the same time informs and confounds nurse's understanding and perception of IPE. Nursing's professional chauvinism, territorialism, and low self-esteem not only colours nursing's IPE knowledge and understanding, but also may undermine IPE engagement as a consequence. Nursing's IPE knowledge and understanding is inextricably linked to professional identity or understanding one's own nursing role. Nursing's knowledge of and understanding about the roles of health professional colleagues is derived from preconceived and stereotyped notions as well as experiential data. Replacing preconceived ideas about the roles of health professional colleagues with first-hand accounts, inherent in the definition of IPE, is integral to

¹⁸⁸ ... we work with some fabulous women and they are true collaborators. But usually they are not people who are in power. They aren't the people in those key positions or on top, or they may be seen as rebels.

nursing's IPE engagement. IPE knowledge and professional subjectivity notwithstanding, proactive efforts to develop and embed IPE in the baccalaureate curriculum are underway.

Case Report and Chapter Summaries

This case report has adhered to the identical report structure and format used for Sites A and B case reports. Similarly, Site C participants' exemplars, embedded via footnote, animated and amplified the case findings and the presence of research propositions was made explicit. This chapter has included the findings of the exploration of three individual cases of nursing's IPE engagement, providing the substance for the Epilogue to this research, presented in the following text of chapters six and seven.

EPILOGUE

Chapter Six - Research Questions - Answers and Interpretation

This chapter presents the cross-case analysis of the individual case reports (i.e., within-case) of nursing's IPE engagement at Sites A, B, and C, the university sites of four-year baccalaureate nursing programs, situated in the real life context (Yin, 2009) of their respective academies. As Prologue, chapters one through four set the stage for within and cross-case analyses, providing the background, theoretical framework, preliminary literature review, and methodology of the study. This chapter begins the Epilogue. Answers to the research questions are provided. The concepts of feminist poststructuralism provide a structure for interpretation and discussion of the answers to the research questions. The Epilogue opens with consideration of researcher reflexivity as a case boundary and re-visitation of FPS as theoretical framework.

Reflexivity Revisited

Researcher reflexivity is a crucial case boundary because as the researcher responsible for the creation of a discriminating case study informed by feminist poststructuralist tenets, I am especially obligated to consider not only my “awareness of being aware” (Finlay, 2003, p. 1), but also how this double awareness informs, impacts, and enhances the research. According to Lather (1991), reflexivity takes in to account the personal investments of the researcher in generating this evidence and the interest of those who accept this particular information as evidence. Although a major goal of this research was to reduce data while amplifying participants' voices (Sandelowski, 1998), at this juncture it is necessary to consider subjective and intersubjective views as shaper of this evidence (Chinn, 2008). Accordingly, I have placed myself in the data generation, analysis and interpretation processes (Savin-Baden, 2004) in several ways. At the outset I am a doctoral student researcher and as such I sought to hear and

interpret participants' stories as they talked about IPE, nursing's IPE engagement, and academia as context for both. At the same time, I was a co-inquirer as I participated in uncovering discovery of their IPE knowledge, thoughts about IPE engagement, and reflections on academia as context. I was a confidante, a captive listener sworn to protect their privacy and confidentiality, thereby perhaps emancipating thought and promoting disclosure of information important to them in their professional roles: I made and respected space for their voices to be heard. Finally, for many I was a fellow doctoral student and nurse academic who could relate to and sympathize with their experiences by virtue of our mutual challenges in both professional and student roles. It was through both of these roles that my own biography simultaneously resonated with and differed from participants' experiences.

Awareness of my position heightened the importance of doing justice to participants' stories, presenting their data honestly and credibly, and respecting the risks inherent in qualitative interviews (Morse, Niehaus, Varnhagen, Austin & McIntosh, 2008). At the same time, I was cognizant of the importance placed on context by FPS, which further impelled me to be mindful of my situatedness when listening to individual perspectives that shaped their contexts (Savin-Baden, 2004; Savin-Baden & Major, 2010), particularly when language and power are vital study concepts. As the research progressed, my perspective on the data and its interpretation didn't change from my initial propositions. Rather, I became more enthusiastic, almost strident in my attempts to loyally represent participants' experiences and issues and to explore the ways in which both were mutually informed by past and present contexts we shared as (female) health professionals and doctoral students. In short, I was mindful that how I perceive my professional ontology affects my interpretation of my professional world (Aluwihare-Smaranayake, 2010) and, by extension, the professional world of participants in our

mutual experience of ongoing historical, socio-cultural, political, professional and educational contexts. My interpretations and the meaning I ascribed to participants' text/stories are, in part, a function of my experiences that I carry with me. Reflexivity was a faithful, yet complex companion throughout the study.

The individual case reports in chapter five presented the data and its interpretation within the context of each case. The amount of data generated within each case was generous, at the very least, and I resisted restructuring “the messiness of the data” into oversimplified “bland categories that are a ‘catchall’ ” (Savin-Baden, p. 369) simply to make the data manageable; in contrast I wanted to represent all stories! To resolve this dilemma and to promote credibility in the data reconstruction and interpretation phases of both chapters five and six, I let the complexity of the data emerge. Especially in this chapter, in which study findings are interpreted through a FPS lens, complexity of the data is vividly apparent; interpretation of data overlaps and intersects FPS tenets (e.g., nursing's power related to historic discourse, historic discourses of nursing related to nursing' subjectivity and power related to both nursing's subjectivity and historic discourse), highlighting the multidimensionality of the study findings. It was from this place of data liberation, interpretation, and multidimensionality that I had an illuminative epiphany (Denzin, 1989) giving me insight into the problematic constructions for nursing's IPE engagement.

As cross-case analysis and interpretation began I was attempting to balance data description, analysis, and interpretation, mindful of Yin's (2009) caution that too often case study reports simply recount study data devoid of analysis and interpretation. Choices about what to emphasize were made to fit the research purpose and method while rendering study findings in the most enlightening and straightforward way (Sandelowski's, 1995b; Yin). What follows is the

interpretation and discussion of the discoveries of the cross-case analysis predicated on three understandings: first, that consistent with the tenets of FPS, this interpretation is derived from data representing one of multiple realities inherent in participants' experiences; second, that realities and truths of nurse academic and health professional participants are contextual and subjective; and third, that interpretation is itself a political and social practice (Aluwihare-Samaranayake, 2010) wherein the study outcomes are themselves temporal, subject to context and to the educational-political realities of the study period.

Feminist Poststructuralism Revisited

Feminist poststructuralism for several reasons has been a relevant theoretical framework to emancipate information about nursing's IPE engagement. First, as a paradigm of disclosure and advocacy (Lather, 1992), FPS provided a conceptual lens to sight, unmask, and explore the complexity, historical preconditions, and social procedures and institutions surrounding IPE engagement of a female-dominated health profession in academia (i.e., social, historic, and institutionalized discourses of nurses and their professional roles). Second, in keeping with feminist research tenets (Seibold, 2000), FPS concepts have induced forward thinking about supportive strategies to change/enable nursing's IPE engagement. This theoretical lens has facilitated exposure of patriarchy, structures and processes disadvantaging women academics, constructs of meaning of interprofessionalism, nursing's professional subjectivity, and power relations specific to the academic context in which nursing's IPE engagement is situated. Third, that women (i.e., nurses) are capable of knowledge production and that subjective data is valid, tenets common across all feminisms (Bunting & Campbell, 1990; Kroløkke & Sørensen, 2005) are realities that have been emphasized by the theoretical framework. FPS precipitated the emergence of new realities and discourses (e.g., nursing in the academy), perhaps disrupting

enduring historic socially-constructed discourses about nursing, what Foucault might have termed regimes of truth (Foucault, 1980). An important caveat is that these emergent realities and discourses are not substitutes for historic extant platforms, or successor regimes (Harding, 1986). Rather, they are conceived as temporal and contextual, producing awareness of the transitory and changeable nature of the customs we develop to discover self truths (Harding). Finally, the importance of context to both feminist poststructuralist positions and case study as empirical inquiry has been a methodological strength and productive for this research since challenges to nursing's IPE engagement are situated in professional practice and academic contexts imbued with historic, socio-cultural discourses of a female dominated health profession.

Feminist poststructuralism has provided a unique perspective from which to conduct the research. Accordingly, answers to the research questions are interpreted through the concepts of language, discourse, subjectivity and power. It might be assumed that because the research has been conducted through a gender lens, that this concept does not warrant individual consideration also. On the contrary, given the nature of nursing as a female-dominated profession living a legacy of socio-historic discourses rooted in biological sex, gender is considered as well. Answers to and interpretation of the answers to the research questions constitute the cross case report for this multiple case study. Answers to the research questions arising from the cross-case analysis are presented first.

Cross-Case Analysis

Cross case analysis has been facilitated through creation of a word table (an example is provided in Appendix F), generated from individual Site A, B, and C case reports. For cross case analysis, Yin (2009) recommends displaying individual case data using a uniform framework. Accordingly, the five subheadings of the individual case reports (e.g., IPE knowledge and

understanding), specifically designed to relate to one or more of the research questions, provided a logical framework for cross case data display. Using a word table and a uniform framework contributes to the trustworthiness of the cross case analysis.

Ayres, Kavanaugh, and Knafl (2003) express concern regarding data decontextualization when they are separated from their case of origin. However, for several reasons data decontextualization was not a central concern in this cross case analysis. First, Yin's (2009) case study methodology mandates an inextricable relationship between the case data and context (i.e., contextually intrinsic data) mitigating concerns about data decontextualization. Second, common case boundaries have been imposed on all individual cases such that data share some degree of contextual likeness, thereby leveling a similar degree of data decontextualization. Third, all case data have been generated using the identical theoretical lens, promoting data contextualization from a theoretical perspective, a context they do not shed when extracted from their origin. Finally, cross case analysis data is reintegrated into themes according to the analytic framework (i.e., headings) of the individual case reports, promoting data repatriation or bringing data back to its original context.

In this exploratory case study, there are four research questions (Table 4). The primary research question begins with the word *what* in order to evoke data about what can be learned (Yin, 2009) about nursing's IPE engagement. The remaining questions begin with the word *how* in order to evoke data related to the primary research question by exploring, further, specific areas prompted by the research propositions (e.g., research question one linked to propositions one and two) and the theoretical framework (e.g., research questions three and four linked to FPS). Logically, research questions two, three, and four are answered first to inform the answer to the primary research question.

Table 4 Research Questions

Number	Question
1	What are the antecedents of nursing's IPE engagement?
2	How are nurse educators/nursing faculty engaged in IPE?
3	How does gender impact nursing's involvement in IPE development and implementation?
4	How is nursing's IPE engagement impacted by contextual factors (e.g., social, political, historic) inherent in the broader health professional and academic contexts?

Research Question Two (RQ2)

The operational definition of nursing's IPE engagement features nursing educators/nursing faculty. To be consistent with this operational definition, the second research question uses the same nursing descriptor to ask: How are nurse educators/nursing faculty (hereafter termed nursing) engaged in IPE? In the early data generation phase, I reasoned that nursing needs to know and understand IPE in order to engage this learning modality: How nursing is engaged in IPE is a reflection of IPE knowledge and understanding. Although there is a vivid awareness across all Cases of the term IPE, nursing's specific IPE knowledge and understanding (i.e., consistent with the study definition) reflects a mixture of universal perception, specific knowledge and real experience using a variety of terms (e.g., multidisciplinary, interdisciplinary, interprofessional) to refer to learning among health professional students. In spite of pervasive definitional uncertainty, commonly held views of IPE as the latest educational 'bandwagon' or curricular 'add-on', and in view of Gilbert's (2005b) position that the way in which words are chosen reflects level of IPE conceptual understanding,

nursing is engaged in IPE. This engagement is manifest to varying degrees, levels, and ways commensurate with each individual's unique understanding of the concept. Seemingly, lack of IPE knowledge and understanding did not mitigate engagement for some, although there is no common engagement pattern. How nursing is engaged, or the nature and type of IPE engagement, creates a spectrum: rare, formal IPE development and implementation by design (i.e., workload); frequent voluntary IPE work because of interest; rare serendipitous, infrequent involvement by virtue of teaching location; in-camera IPE discussion; and prospective work via curriculum revision. Unfortunately, nursing's own awareness of its IPE engagement is fragmented and incoherent, with the exception of acknowledgement across all Cases that simulation learning is an extremely suitable vehicle for nursing's involvement in IPE.

Following the same rationale provided in the individual case reports, how nursing is engaged in IPE is linked to how nurses know about and understand their professional role and enact their practice and academic responsibilities. Seemingly unaffected by age, nursing's professional role understanding is not well articulated; a unified narrative of nursing is absent and in its place is a variety of descriptions of a profession that is ubiquitous and diversified in location, context, and scope of responsibility. Nursing's role knowledge and understanding carries vestiges of historic, socially constructed, hegemonic perspectives of nursing despite its move to the academy and the advent of a baccalaureate entry to practice. At the same time, a chauvinistic, proprietary attitude toward knowledge and practice domain is pervasive among nursing roles in practice and in the academy. Collectively, nursing's professional role perspectives have created a fragile platform for IPE engagement, a platform imbued with concern for professional identity and status. That nursing is complicit in the creation of this platform is acknowledged.

Despite many intraprofessional uncertainties, concerns, and challenges, one immutable fact prevails; Nursing's value for IPE is strong across all Cases. At this point in time, nursing is engaged in IPE in diverse yet minimalist ways: minimal not only empirically, but also minimal relative to nursing's individual workload and the IPE work of other health professional colleagues (e.g., PT, OT, and medicine) as represented in the IPE literature. Is nursing's minimalist IPE engagement linked to gender? The impact of gender on nursing's IPE engagement is the focus of research question three.

Research Question Three (RQ3)

This research is conducted from a feminist perspective of poststructuralism and as such, research question three asks an obligatory question: How does gender impact nursing's involvement in IPE development and implementation? That nursing's IPE engagement is minimal has been established. If gender impacts the nature and degree of nursing's IPE minimal engagement, there is insufficient data generated to support an exact claim. Several reasons (i.e., rival explanations [Yin, 2009]) surface to provide an understanding of this inexact claim. First, perhaps a gendered professional ontology is so ingrained in nursing that it is difficult for some to *see* a gender impact; a gendered professional ontology is accepted as normative because female has an historically fixed identity position (Pullen & Simpson, 2009) and female has been an identifier for nursing such that the two concepts are conflated. Over time, has nursing become so desensitized to its gendered professional ontology that it is not until given a reason to question structures that ostensibly construct a gendered identity, that the impact of gender on nursing's IPE engagement may be entertained? Younger nurse academics in the early career stage may not incorporate gender bias as an impediment to professional role (i.e., IPE engagement) and identity construction. Perhaps the contrast between younger and older nurse academics' experience of

gender impact on professional role is attributed to length of time in the profession, generational changes in health professional and academic cultures, or differences in individual and/or collective lenses through which nursing knows about and understands its own nursing role. Of greater concern than gender's impact on IPE engagement is the impact on younger nurse academics of older nurse academics ingrained gendered professional ontology handed down in a seemingly never-ending cascade of generations of nurses who presume the relevance of the received view of nursing inclusive of historic gender stereotypes. Furthermore, does the received view of nursing silence or marginalize women (Knights & Kerfoot, 2004) nurse academics who are unwilling to accept unconditionally the assumptions and values held by privileged masculine-derived academic institutions, disciplines (i.e., medicine), and discourses, and are thereby deemed troublemakers (hooks, 1994)?

The impact of gender alone on nursing's IPE engagement may be difficult to isolate. Rather, the impact of gender on IPE engagement may be embedded in the impact of gender on the broader health professional and academic context as a collective, with its inherent political, people, and power characteristics. In the absence of exact stories, the impact of gender on IPE engagement may be conceived generally as steeped in the historic intersectionality (Hancock, 2007) of woman and nurse.

Second, and a corollary to the first interpretation, is nursing's strong beliefs about the impact of gender pertaining to nursing's general work and presence in the academy rather than IPE work specifically. Professional inferiority or low professional self esteem linked to dual membership in a female-dominated profession and masculine-derived institutions might create an impediment to nursing's rightful engagement as a member of the interprofessional team and induce subjugation of professional knowledge and power: A faculty mindset that views IPE as

involving threats to gender and to ongoing establishment of nursing as an academic discipline precludes nursing's engagement. Paradoxically, the majority of health professional faculty participants at IPE meetings reportedly are women, who, from a gender perspective, are more collaborative and involved in IPE in seemingly greater numbers than male counterparts, but have not achieved positions of primacy held by male academic colleagues (van den Brink & Stobbe, 2009).

Finally, gender impact on nursing's IPE engagement may be minimalist simply because those who are not seeing gender problems may not be so involved in IPE. Appropriately as an exploratory rather than an explanatory case study, the exact details of participants' direct IPE engagement was not sourced. Additionally, it was not possible within the scope of this study to explore specifically male participants' view of gender impact on IPE work from the perspective of men doing traditional female-dominated and feminized work (Pullen & Simpson, 2009). However, the male participant perspective did not cite gender as a direct impediment to IPE engagement. Rather, the male perspective shared female nurse colleagues' perspective that effect of gender on IPE engagement is embedded in the impact of the collective, broader health professional and academic contexts, considered in research question four.

Research Question Four (RQ4)

In case study methodology and in feminist poststructuralism the importance of context is prominent. Accordingly, research question four asks: How is nursing's IPE engagement impacted by contextual factors (e.g., social, political, historic) inherent in the broader health professional and academic contexts? Because the case of nursing's IPE engagement cannot be separated from its real life context (Yin, 2009), the case study data is intrinsically contextual; the data derive meaning from their context (Aluwihare-Samaranayake, 2010). The importance of

context in this study is affirmed by the overwhelming convergence of individual context-embedded case report data, the relative magnitude of data from nursing's varied and enduring experiences in professional and academic contexts, and the considerable connections between experiences and professional academic contexts drawn deliberately by participants.

The multiple challenges to nursing's IPE engagement, born of the case context, are derived from inextricably linked historic and contemporary political, academic and professional conditions. First, imposed on nursing are general historic, socially constructed stereotypes (e.g., handmaiden, battleaxe [Jinks & Bradley, 2004]) and discourses in which nursing is depicted as silent knower (Belenky et al., 1986; Hamilton, 1994) whose ontology is grounded in an understanding of gender (i.e., biological sex) imbued with characteristics including an altruistic duty to care and an inferior, subordinate, and powerless position in a hierarchy of health professionals that privileges medicine (Hamilton). These negative ideological stereotypes and discourses are hegemonic perspectives thrust upon nursing which mitigate a solid platform of professional identity and confidence from which to launch nursing's IPE engagement. Nursing's experiences working against the neap tide of entrenched historic, socially-constructed stereotypes is apparent in the answer to the primary research question.

Surrounding nursing in the academy are hegemonic discourses originating in a male-derived and dominated institution (Anthony & Landeen, 2009; van den Brink & Stobbe, 2009). Discourses of traditional academic power relationships (Bevis, 1989) created by the prevailing patriarchal ideology of academia require nursing's acquiescence to male-determined historic institutional structures (e.g., promotion and tenure). For example, nursing has evolved its role as a member of the academy in part by developing doctoral studies understood as the primary academic credential (Bartels, 2007; Jackson et al., 2011). Achievement of legitimate status in the

academy through adherence to conventional, historically developed university credentials (Jackson et al.) that assimilate male modes of power and dominance may inadvertently impel nursing to subjugate or recontextualize its knowledge and power in ways that are antithetical to nursing's grassroots professional ethos and raise concern for nursing about professional identity in the academy. A promotion and tenure structure that fosters intraprofessional workload competition (i.e., research privileged over teaching) creates a divided rather than unified ontology needed for IPE. Existing as a female-dominated discipline within a male-generated and dominated institution populated with hegemonic discourses and cumbersome academic structures of privilege and power attenuates nursing's voice, creates gendered barriers and bureaucratic structures (Bird, 2011), engenders a sense of disenfranchisement, and challenges equality in the IPE partnership. Furthermore, when nursing education, as a female-dominated social structure directly linked to a formalized health system, is embedded in a university structure that is based on patriarchal and bureaucratic practices, relational practice required for the development of IPE partnerships is not supported (Scott & Thurston, 2004). At the same time, when an historic uni-professional nursing-centric ontology, burdened by a history of oppression (Reverby, 1998) and socially constructed negative historic discourses of nursing and nursing's relationship with medicine (Arnold, 1996), is located within a male-derived and dominated context, concern is produced for the preservation of nursing's professional autonomy and identity and for forced abdication of professional knowledge and power after years of struggle to achieve both. Professional and academic contexts in which such challenges for nursing exist do not mobilize interest in and confidence toward IPE that demands, respect, collaboration, and inclusivity (CIHC, 2010).

Two additional contextual considerations warrant consideration: first, neither the presence nor absence of a collaborative nursing program is distinguished as having a direct or unique impact on nursing's IPE engagement but is experienced as contributing to the totality of an already overwhelming workload; and second, administrative configuration as a Faculty or School of Nursing is not expressed as an advantage or disadvantage within academic contexts defined by a medical presence and paternalistic control of higher education. A politicized academic context defined by medical primacy, competition for fiscal and human resources, and presumption that sameness across disciplinary promotion and tenure structures is acceptable, diminishes value for the uniqueness and difference among the health professionals, undermines development of collaboration, and promotes an ontology that is antithetical to relational ethos necessary for interprofessional work (CIHC, 2010; Suter, Arndt, Arthur, Parboosingh, Taylor & Deutschlander, 2009).

Emergent concepts professional subjectivity and nurse academic. I would be remiss if a consideration of context's impact on nursing's IPE engagement did not pose a critical question, which is to ask what distinguishes challenges to nursing's IPE engagement from the challenges faced by nursing in the general course of their work in academia. The data converge on two distinguishing features or emergent concepts: nursing's professional subjectivity and nurse academic. Nursing's professional subjectivity in the role as nurse academic is chronicled throughout stories of working in a female-dominated health profession in an academic context. Nursing's professional subjectivity embodies a range of thoughts, positions, and understandings of self-as-nurse and collective-as-nursing at the grassroots level, in practice, and in the academy. Professional subjectivity is not a static or singular concept. Rather, it is a dynamic concept, constituted and reconstituted over time impacted by myriad personal and professional factors to

create multiple subjectivities. For example, nursing territorialism and nursing chauvinism are subjective positions present in participants' stories as nursing's tacit imposition of primacy over a specific domain of health practice and knowledge predominantly in the clinical environment. Often, nursing's professional subjectivities help clarify roles and responsibilities both internally within nursing to nurses and externally to health professional colleagues and society at large. For some, development of professional subjectivity is reactive to the intersection of historic discourses of women and nursing, continually fueled and nurtured by historic, gender-based professional stereotypes, ontologies, and ideologies.

Often, professional subjectivity manifests as lack of value for nursing's role, capabilities, and strengths as an academic and practice discipline and may incorporate low professional self-esteem and confidence. To some degree, nursing is complicit in developing negative professional subjectivity, embodying a position as silent knower and oppressed victim, subjugating voice, knowledge, and power to the primacy of medicine (Anthony & Landeen, 2009; Henneman, 1995). While an understating of this latter subjective position can be reasoned by virtue of a history of oppression (Reverby, 1998), an inferior professional subjectivity is not an auspicious position from which to launch IPE engagement. Understandably, developing robust and positive professional subjectivity is often challenging, encumbered by historic negative discourses of women, nursing, and the relationship between nursing and medicine typified by power imbalance and hierarchies (Daiski, 2004), positional status accorded to nursing by medicine and others (MacIntosh, 2003), and lack of acknowledgement for nursing's core values (Miller et al., 2008).

As a natural consequence of the study's operational definition of nursing's IPE engagement, which featured nursing educators'/nursing faculty's IPE work, data generation centred on exploring the experiences and work of this group. Data converged to reveal specific,

shared, and seemingly context-generated positions and experiences of nurses working in academia, from which emerged the concept nurse academic. Nurse academics are subject to conventional, male-derived and dominated university structures (e.g., credentialing and the academic trinity), values, and beliefs. Moreover, nurse academics are judged against male-determined, historic university structures (e.g., workload contracts) and discourses of power and privilege while concurrently demonstrating allegiance to a practice base – the basis for membership in the academy at the outset. In developing professional subjectivity, nurse academics are caught in a ‘triple bind’: nurse academics are predominantly female in a male derived and dominated context, have roots as a practice discipline understood according to historic discourses of natural gender/biological tendency and women’s altruistic duty to care (Reverby, 1998; Jinks & Bradley, 2004), and are the newest member of academia, a position that holds tacit obligation to demonstrate worth and legitimacy. Nurse academics are challenged to dovetail the characteristics of a practice discipline with entrenched characteristics of patriarchal academic structures (Scott & Thurston, 2004), unlike the discipline of medicine that has had historic primacy that mitigates expectations of merging an academic position with commitment to a professional practice.

Nurse academics have achieved an appearance of legitimacy in academia by appropriating male ontologies (Anthony & Landeen, 2009) and acquiescing to male-determined historic power and tenure structures, including acquisition of the required doctoral degree (Jackson et al., 2011). Nurse academics’ professional identity and confidence is linked to positionality within hierarchical university structures and a relationship with academic medicine; A conflicted and uncertain professional identity mitigates professional confidence needed for engagement with colleagues on the IPE team. The nature and significance of context to nursing’s

IPE is affirmed. This impact is understood within a context of multiple intersecting realities inherent in nursing's experiences with historic discourses and stereotypes, professional and academic structures, and professional subjectivity. With consideration for the impact of context, how nursing perceives IPE capacity, capability, and necessary resources and supports is reflected in the exploration of the antecedents to nursing's IPE engagement prompted by the primary research question.

Research Question One (RQ1)

The answers to research questions two, three, and four provide a platform from which to sight answers to the primary research question that asks: What are the antecedents of nursing's IPE engagement? Walker and Avant's (2011) interpretation of antecedent pertains to "those events and incidents that must occur or be in place prior to the occurrence of the concept" (p. 167) (i.e., nursing's IPE engagement). Borrowing from Walker and Avant, the terms event and incident for this study incorporate not only their conventional, literal meanings but also a more comprehensive meaning including characteristic and an ontology. Accordingly, what is needed for nursing's IPE engagement?

Conclusively, resources and supports are needed for nursing's IPE engagement. The nature of resources and supports overlaps intra and extraprofessional etiology; data self sorted as intra-professional, or internal to nursing and extraprofessional, or external to nursing, a distinction created seemingly subconsciously, not to impart a binary or dichotomous reduction of data, but rather to convey understanding of the nature of elements perceived as resources supportive of nursing's IPE. For example, intraprofessional, or elements generated from within nursing, include adequate, dedicated nursing human resources, fiscally and administratively supported faculty development, intraprofessional collegiality rather than marginalization, and an

attitude and culture shift away from an insular professional ontology defined by territorialism, chauvinism, and exclusivity toward attitudinal and intellectual flexibility, open-mindedness and inclusivity. Extraprofessional elements refer to university infrastructure and include equitable allocation of fiscal resources and built environment across disciplines, equitable promotion and tenure structures that don't privilege one professional area over another, and value for IPE demonstrated explicitly through workload allocation. Resources and supports of intra and extraprofessional types include adequate allocation of fiscal resources at all academic levels, IPE leadership and champions at all academic levels, respect for nursing as an equitable, rightful discipline of the academy, and a non-threatening, inclusive health professional environment.

That IPE is occurring to some degree is confirmed and it is occurring despite inadequate and/or absent resources and supports. Moreover, IPE is occurring in the presence of definitional uncertainty and differential understandings. These facts together signify that the suggested resources and supports are not, by definition, antecedents to nursing's IPE engagement. However, the feature common across all Cases is nursing's willingness and commitment to engage IPE to the best of their ability and circumstance, despite competing demands of academia, suggesting that the antecedent, or what *must* occur prior to nursing's IPE engagement is nursing's willingness and commitment. This discovery prompts a more relevant question: What is needed to strengthen and augment nursing's willingness and commitment toward IPE engagement? No doubt an improvement in supports and resources from the greater university and nursing schools/faculties would not be misplaced. However, increased and improved professional identity and confidence is vital to move nursing's IPE engagement forward. Nursing does not necessarily see itself as its own valuable resource capable of embodying a professional

subjectivity rife with a rich sense of professional self-worth, solid professional confidence, and strong professional identity.

Perhaps for more than any other educational innovation to date, a strong sense of professional identity and confidence is necessary to enhance nursing's IPE engagement because of the nature of IPE, defined by relationships with health professionals. Medicine is an IPE partner that has secured a permanent position of primacy in academia. In view of historic discourses about nursing and nursing's relationship with medicine it is not inconceivable that vestiges of these discourses may be perceived as a threat not only to nursing's hard-earned autonomy, knowledge, and power but also to nursing as a legitimate discipline of the academy. Strongly constructed professional identity and confidence mitigates the negative effect of the vestiges of historic discourses against which nursing continues to struggle and creates a sturdier platform for collaboration with all health professional partners, including medicine. At the same time, leveraging strong professional identity and confidence enables nursing to become expansionary and inclusionary thinkers transporting nursing from its historic, chauvinistic ontology steeped in poor professional self-esteem to a new interprofessional academic context. When nursing embraces a new ontology, instilled with strong professional identity and confidence, it may begin to acknowledge itself equally as a member of a valued health profession and as a valued member of the IPE team, an ontology destined to enhance nursing's IPE engagement.

The answers to the research questions inherently have links to feminist poststructuralism because this theoretical framework has infused the entire study by design. The following in-depth interpretation through each FPS concept of the collective answers regarding nursing educator's/nursing faculty's IPE involvement (RQ2), and the impact of gender (RQ2) and

context (RQ3) on this involvement with discovery of the antecedents (RQ1) brings greater clarity and understanding to the case of nursing's IPE engagement.

Interpretation of Results Through FPS Concepts

Feminist poststructuralism provides an enlightening perspective from which to examine answers to research questions wherein historic gender discourses of nursing and nursing's relationships in health care and academia, hierarchical academic structures and processes, and nursing's self-ascribed subjectivity and identity have come in to play. What data or information exist objectively as interesting facts, become meaningful in light of feminist poststructuralist theory which shows why they have meaning as facts in the first place and, hence, why they have value (Dewey, 1986/1938; Poovey, 1998) in this exploration of nursing's IPE engagement. It is somewhat artificial and seemingly reductionist to separately consider FPS concepts given their inextricable link among the research findings. However, to promote textual coherence and clarity of interpretation for a dissertation document, language, subjectivity, discourse, power, and gender receive individual consideration below.

Language

The significance of language to the success of nurse educators/nursing faculty IPE engagement (RQ1) in the health education context is notable because agreement on the term used to describe IPE learning is of primary importance to educational change (Gilbert, 2005b), to collaborative health care (Sheehan et al., 2007), to future research (Gilbert; Sheehan et al.), and to allocation of fiscal resources and research funding (Gilbert; Sheehan et al.). A feminist poststructural analysis, uncovers how language use shapes (i.e., limits or promotes) not only how nursing makes sense of its discipline but also how IPE and the health professional and academic contexts, wherein nursing's IPE engagement takes place, are understood and experienced circa

21st century. The use of several terms, metaphors, and phrases warrants deconstruction in order to explore the meaning in the language of the subjectivities of nursing.

First, what is the relevance of multiple different words used to describe nursing's patchy, incoherent IPE engagement? Multiple terms, predominantly interdisciplinary, multidisciplinary and interprofessional, are used seemingly synonymously to "signal the intent of [the same] pedagogic practice" (Gilbert, 2005b, p. 89). How should the interchangeable use of these terms be interpreted? Is choice of term deliberate to convey understanding of the semantic differences between inter (between) and multi (more than one) as descriptors thereby describing an understanding of health professional interaction as among or between (i.e., inter) or additive and non-integrative (i.e., multi). Are the terms professional and disciplinary chosen deliberately to convey a vocation founded on specialized training (profession) (Soanes, 2006) or a branch of instruction or a department of knowledge (discipline) (Gilbert)? Does use of term happen by design from a place of knowing these concepts as "linguistic representations of experiential description" (Bonis, 2009, p. 1328) or does language use occur by chance? If meaning is context dependent, shifting with historical era and setting (Weedon, 1997), nursing might be transferring its historic experience of multidisciplinary practice to interprofessionalism, although Mitchell (2005) questions whether terminology matters since, in her view, team-building skills and competencies are likely to be similar. Inaccurately described IPE, at odds with the study definition, can be a barrier (Gilbert) to nursing's IPE engagement. While continued misuse of terms and misunderstandings of IPE may render nursing complicit in sustaining uncertainty surrounding IPE, minimalist IPE engagement *is* occurring. Two interpretations of this phenomenon are possible; that there is room for multiple realities, inclusive of dissimilar meanings and understandings of IPE, or the language used to define and describe IPE is not a

conscious choice but a product of unconscious, semantic use and lack of forethought due to depleted intellectual energy to fully know and be scholarly. The few faculty deeply involved with IPE exemplify the term interprofessional aligned with the study definition established by CAIPE (Barr, 2003) and promoted by Barr et al. (2005). Nevertheless, since language in its essential form is the vehicle through which sense and meaning of one's world is derived (Doering, 1992), perhaps nursing's IPE engagement would be more successful if supported by agreement on the term used to describe interprofessional learning and by greater conceptual clarity (Walker & Avant, 2010) of this term.

Second, use of words taken out of or used beyond their essentialist meaning appear frequently in data about nursing's IPE engagement. For example, the noun chauvinism is used ironically to describe the bigotry of a discipline (i.e., professional chauvinism) whose hallmarks are caring and relationship development. Additionally, the noun bandwagon and the more colloquial term, buzzword, are terms bearing ostensibly negative overtones that are used to describe perceptions of IPE as the latest trendy pedagogic innovation and catchphrase. These words chosen for their fundamental meaning, convey unique meanings when placed with other discipline-specific words and in contexts outside their conventional, native origin. At the same time, several words are used for their metaphoric potential. The noun war and its cluster of related military terms (e.g., battle, order) are used metaphorically (i.e., If it's just nursing, then we are going to lose the battle; It never occurs to doctors that their orders will not be followed) to depict relationship conflict and configuration (i.e., power and dominance) between nursing and health professionals, principally medicine. The noun silo is used metaphorically in all cases to refer to the prevalent, solitary ontology of a relationally rooted discipline now in an academic context. Finally, in referring to the role of nursing, the phrase "Nursing fills in the spaces"

implies an undifferentiated and ubiquitous professional subjectivity without goal or purpose. Such an impression of amorphous professional identity does not portray a professional subjectivity infused with knowledge and power that can be harnessed to support IPE engagement.

Third, the predominant use of a masculine article to refer to physician colleagues prevails despite changes in professional demographics that demonstrate an overwhelming increase in the number of female medical graduates over the last decade (Baerlocher, Hussain, & Bradley, 2006; Darves, 2005). The use of this and other gendered parts of speech as well as gendered communication patterns imply a gendered orientation to a profession: a context that may include inequities of binary categories such as male/female, nurse/doctor, and we(nursing)/they(medicine). When professions carry a gender tag, gendered orientations to professional roles are subsumed and carry with them historic stereotypes of the nurse–physician power differential, for example. An asymmetric power differential implied by innocent, casual use of a gendered part of speech makes nursing complicit in perpetuating historically dominant discourses that diminish nursing’s professional status and undermine professional subjectivity, and is a prime example of how historic taken-for-granted aspects of language creates certain fixed meanings and legitimizes certain knowledge (Weedon, 1997) that have the potential to impact nursing’s IPE engagement. Unpredictably, the use of this type of gendered speech pattern was common across all Cases and across all participants’ generations and experience levels. Although gender-related speaking patterns may be so entrenched as to become normative, they must be examined because they may foster and perpetuate asymmetries in IPE interaction based on gender already exacerbated by an historic, socially constructed view of gender-dominated

health professions (Gilbert, 2005b); this situation has potential to mitigate collegial interprofessional interactions necessary for nursing's IPE engagement.

Ironic word use, negative metaphoric overlay, and gendered speech patterns confirm de Saussure's (1959/1916) assertion that the property of a word does not include an intrinsic meaning but that words acquire meaning because of their relationship with other words, or discursive practices. When Derrida's (1974/1967) notion of deconstruction is applied to these linguistic practices, what is uncovered is how the fluid, context-dependent (e.g., historic discourse, setting) nature of words and phrases in the study impact nursing's professional subjectivity and identity in ways that potentially hinder nursing's IPE engagement. Through language and discursive practice, as described, nursing is an active participant in reproducing an unstable "linguistic scaffold" (Sowell, 2004, p. 41), creating an inauspicious professional platform for growth of nursing's IPE engagement; The discursive field in which IPE exists affects nurses' perception of professional identity, capability, and involvement. Perhaps one of the challenges facing the growth of nursing's IPE is for nursing to find language that "offers a way to frame critique and yet maintain the recognition of all that is valued and respected in the work" (hooks, 1994, p. 49). The significance to nursing's IPE engagement of discourse in determining the meaning of language and the consequences of implanting hegemonies and ideological messages in the consciousness of people speaks to the co-dependent and mutually generative relationship between language and discourse. This relationship receives close attention in the following interpretation of the research findings through exploration of discourse.

Discourse

In chapter two, discourse is referred to as anything that carries meaning (Foucault, 1990/1976), including phenomena such as language, stories, scientific narratives, and cultural

practices (Alsop et al., 2002) which are organized and structured by the institutions and practices of the time in which they occur (Foucault, 1972/1969). Accordingly, the significance of discourse to nursing's IPE engagement is substantial because historic, dominant ideological practices and discourses have been imposed upon contemporary nursing, mapping both the discipline and shaping the profession (Holmes, Roy & Perron, 2008); this influence extends to nursing's IPE engagement. Interpretation of the answers to the research question shows how discourse indirectly and directly shapes nursing's professional subjectivity and identity, affecting IPE engagement. For example, in research question three that inquires about gender impact, the enduring effect of historic discourses of women and nursing renders an ingrained gendered professional ontology for a female dominated profession because both circumscribe female as an historically fixed identity position (Pullen & Simpson, 2009). Ironically, there exist claims that Nightingale's deduction of the characteristics of a 'good' nurse directly from the 'good' woman, contribute to the discursive process of an historic professional ideology of nursing as gendered work (Gamarnikov, 1978). Thus, nursing's professional subjectivity and identity is constructed at the intersection of historic discourses of woman and nurse where nursing is presupposed as women's work grounded in an altruistic duty to care (Reverby, 1998), rather than as an academic and practice discipline grounded in knowledge and power relationships needed for IPE engagement.

In research question four, hegemonic discourses about the academic context make suspect the legitimate membership in an historically male-derived and dominated environment of a (female-dominated) discipline thought to lack knowledge and power (Hamilton, 1994) since the hegemonic discourses in male-dominated organizations tend to be masculine discourses, ones that place higher value on men, masculinity, and power (van den Brink & Stobbe, 2009, p. 454).

The dominant masculine discourses are socially and culturally produced and constitute power by constructing objects in particular ways, playing a critical role in the interpretation (Francis, 2000) of a female-dominated profession in the academy. These hegemonic discourses in the patriarchy-specific ideological operation (van den Brink & Stobbe) of a university may be regarded as antithetical to nursing's professional ethos of caring and relationship development and to the collaborative nature of relationships needed for IPE. According to Scott and Thurston (2004), health professional programs in a social institution such as a university, are embedded in this context based on patriarchal and bureaucratic practices that do not traditionally support relational practices required for development of partnerships (p. 482) needed for IPE. Conversion of hegemonic discourses about women, nursing, and academia into the lived realities of nurse academics is not nebulous. Rather, clearly identifiable gendered practices exist (Arnold, 1996) and, as such, present an impediment to nursing's IPE engagement.

The link between subjectivity and discourse is well documented (Arnold, 1996; Holmes et al., 2008; Pullen & Simpson, 2009; St. Pierre, 2000; van den brink & Stobbe, 2009; Weedon, 1997). From research question one, the concept of professional subjectivity was uncovered and can be conceived as reactive to the intersection of historic discourses of women, nursing, and academia, continually fueled and nurtured by historic, gender-based professional stereotypes, ontologies, and ideologies. Nursing's professional subjectivity is encumbered by discourses of women, nursing, and the relationship between nursing and medicine typified by power imbalance and lack of acknowledgement for nursing's core values (Miller et al., 2008). Furthermore, when male-determined, historic university structures (e.g., academic trinity, workload contracts) and discourses of power and privilege are used as benchmarks for a relational academic and practice discipline, the development of nursing's professional subjectivity (i.e., professional autonomy,

knowledge, and power) is undervalued, underrated, and undermined, rather than valued, praised, and bolstered in support of nursing's IPE engagement.

Simultaneously, nursing's IPE engagement is impacted by historic discourses and becomes its own discourse inclusive of the language (see *Language* above) and health professional and academic cultures which define it, role knowledge and understanding generally and IPE specifically, and competing discourses pertaining to nurse and nursing's work specifically in the academy. The discourse of nursing's IPE engagement encompasses subjectivity because it is constituted not only by the ways in which nurses know and understand themselves individually and as a professional collective, but also how nursing is constituted by the dominant discourses in the academy. Consistent with an understanding of discourse in which are incorporated cultural practices organized and structured by the institutions and practices of the time in which they occur (Foucault, 1972/1969), an IPE discourse by definition includes collaborative partnerships. Although the term partnership sounds consensual and implies that everyone is being given an equal voice, the term is understood in context (Scott & Thurston, 2004) such that nursing experiences lack of equality in a partnership in a context where primacy of medicine prevails. The impact for nursing of this context is diminished professional subjectivity and identity, simultaneously exacerbated by historic hegemonic discourses of women and nursing. Paradoxically, Scott and Thurston describe the dominant emergence of a partnership strategy with a managed competition base in the current Canadian health and social care context. A context that subscribes to managed competition as a partnership strategy is antithetical to the development of the type of partnership (e.g., collaborative, non-competitive) required in IPE and is non-supportive of nursing's equality in the IPE partnership. Consequently,

nursing's IPE engagement is caught in the cross-hairs of historic, hegemonic and contemporary, emerging discourses of women and nursing, partnerships, and IPE engagement itself.

As an emerging discourse, nursing's IPE engagement is subject to an agenda in the academic context wherein historic discourses of what constitutes knowledge, who is capable of knowledge generation, and who holds power are male derived and determined. In the presence of male-dominated hegemonic discourses, nursing has evolved as a professional and academic discipline with rightful membership in the academy. Within this context, nursing's IPE engagement can be understood as a resistance strategy (Foucault, 1978) or an anti-discourse (Arnold, 1996) that sets independent, academic "nursing practice against the 19th century developed discourses of nursing and the connected embodiment of nursing and the subordinated work of women to medicine" (Arnold, p. 78). Foucault conceives power existing in resistance to something, therefore, theoretically, power lies within nurse academics work generally and nursing's IPE engagement specifically because power is constituted by resisting not only the hegemonic patriarchal discourses entrenched in the academy but also the historic discourses surrounding women and nursing.

According to Foucault (1990/1976), power is a strategy or process that is exercised within everyday situations of discourse; however, within the discourse encompassing nursing's IPE engagement disempowerment may manifest instead because of a professional subjectivity inclusive of low professional self-esteem and a professional identity lacking in confidence. Perhaps the struggles, conflicts, and negotiations that may occur between competing discourses such as between nursing in the academy and its historic male-dominated academic structures, occur through power relations among nurse academics and the institution. It is the power relations among these competing discourses that can create change (Foucault) needed to enhance

nursing's IPE engagement. Robust professional subjectivity and confident identity enables resisting or reconstructing rather than replacing male-dominated hegemonic discourses of the academy, creating an amenable context in which nursing's IPE engagement can flourish. Rehabilitating concepts of professional subjectivity and identity within a new discourse of nursing's rightful membership in the academy requires formation of a discourse *for* nurses/women rather than *about* them. In constructing a strong professional subjectivity and identity, in resistance, nursing "cannot enter the struggle as objects in order to later become subjects" (Freire cited in hooks, 1994, p. 46).

The profound influence of discourse on nursing's IPE engagement is apparent. If discourse refers to anything that carries meaning (Foucault, 1990/1976), including cultural practices (Alsop et al., 2002) organized and structured by the institutions and practices of the time in which they occur (Foucault, 1972/1969), then the emergence of a new discourse about nursing in the academy must be constructed with a robust professional subjectivity and strong professional identity in order to create cultural practices in academia that influence nursing's commitment to and willingness for IPE engagement. Subjectivity, which is inextricably linked to discourse, is the next portal for interpretation of the answers to the research questions.

Subjectivity

In the discussion of feminist poststructuralism of chapter two, subjectivity is described as embodiment of the "conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world ... which is precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak" (Weedon, 1997, p. 23). Weedon's interpretation of subjectivity has great utility for an exploration of nursing's IPE engagement, particularly when prominence is given to elements

such as sense of self (i.e., professional sense of self as nurse academic) and the social and discursive processes involved in the development of professional subjectivity and identity whose relationship with an academic world is sometimes precarious and contradictory and always in process. Due to the natural and inextricable links among FPS concepts (Davies et al., 2006; Sowell, 2004; St. Pierre, 2000; Weedon, 1997 among others), subjectivity is present naturally throughout the previous considerations of language and discourse. However, how subjectivity innately revealed itself through the answers to the research questions as an essential embodied professional attribute is considered in the following text.

According to Weedon (1997), subjectivity is constituted in part by conscious and unconscious thoughts and emotions about sense of self; nurse academics' conscious and unconscious thought did map their sense of professional self. Conscious thought about sense of professional self was evoked throughout individual and focus group interviews wherein participants shared their knowledge and understanding of nursing's role. Woven throughout descriptions of nursing's role (i.e., ubiquitous, diversified, 'fill in the spaces') were impressions of a sense of self-as-nurse and collective-as-nursing in practice and in the academy constituted by mutually informative, generative, and identifying personal and professional identity, an ontology consistent with the findings of current research (Cook et al., 2003; Sims, 2011) investigating nursing's professional identity; How nurses conceptualize what it means to act as and to be a nurse, or self perception/sense of self in the context of nursing, is a key embodied feature of nursing's professional identity (Öhlén & Segesten, 1998).

Nurse academics' descriptions of their roles and experiences in the academy impart vivid notions of individual and collective self perception/sense of self. Descriptive perceptions of professional self are co-mingled with descriptions of what sense of professional self in the

academy should be (i.e., confident, collegial, inclusive and expansionary thinkers, who have professional respect for self and others) and what it shouldn't be (i.e., whiny, oppressed, chauvinistic, marginalizing, and disenfranchised professionals who subjugate power and knowledge). For a scant few, a sense of professional self in the academy is confident, content, and collegial. For the majority, a sense of professional self in the academy is discontented, siloed, and conflicted, aligning with Bruni's (1995) poststructural exploration of nursing education in which it was revealed that nurse educators' subjectivity "was shaped ... by their sense of being constrained, and of being unable to meet the imperatives of the subject position of academic as they understood them" (p. 131). Identified in research question four, nurse academics presented a sense of professional self shaped by the challenges and constraints of merging the imperatives of professional practice education with the imperatives of an academic position (i.e., workload that privileges research over teaching [Alpers, Jarrell & Wotring, 2010]) within a context of dominant masculine, patriarchal structures and discourses (van den Brink & Stobbe, 2009) and scrutiny of nursing's place as a discipline of the academy (Andrew, Ferguson, Wilkie, Corcoran & Simpson, 2009; McNamara, 2008, 2009).

Appreciating that a sense of professional self is an embodied key feature of nursing's professional identity, significant developmental dimensions relevant to both concepts warrant further consideration. First, professional identity is integrated with personal identity (King & Ross, 2003; Öhlén and Segesten, 1998); Sense of identity is created not only from objective (i.e., others' image of nurse/nursing) and interpersonal interactive dimensions (King & Ross), but also, and most importantly, from subjective/biographical or personal feelings of self-as-nurse as the prime influence (Öhlén and Segesten). Similarly, Weedon (1997) considers emotion as a constitutive dimension of subjectivity, a truth felt in this research because descriptions of nurses'

sense of professional self and identity certainly carried affective qualities (e.g., frustration, dismay, hopelessness). Second, on a cautionary note, Sims (2011) offers an important distinguishing feature of sense of professional self: "... whilst professionals may wear the common 'badge' of their particular profession, they may have very different ideas and feelings about what it means to be a professional, linked to personal values, orientations and experiences" (p. 267). The importance of this distinguishing feature to nursing's professional subjectivity, particularly with the context of IPE, is that while robust professional subjectivity is needed for IPE engagement, in this study nursing's sense of professional self is varied (i.e., linked to personal values, orientations, and experiences) thusly impacting IPE engagement in kind.

Third, affective dimensions of nursing's sense of professional self incorporate a sense of belonging to the academic culture, a theme clearly present throughout many participants' stories. Nursing is a relatively new member of the academy whose presence has been severely scrutinized and criticized over absence and legitimacy of epistemic base (McNamara, 2008; Sims, 2011), lack of academic credentialing (Jackson et al., 2011), and probability of research productivity (Andrew & Wilkie, 2007; Kenny et al., 2004). Feelings of academic inferiority evoked by collegial scrutiny and criticism hampers development of a secure sense of professional self and identity needed for IPE engagement. Finally, nursing's sense of professional self in the academy may be conceived as evolving at the margins because its presence straddles two cultures – professional and academic (McNamara, 2009). Perhaps this evolution helps interpret nursing's professional subjectivity described in research question four, as fragmented, ambiguous, and contingent on context or current role – a phenomena noted also in Sims (2011) research on nursing's professional identity.

Schoenberger's (2001) analytic commentary on interdisciplinarity and social power provides an understanding of professional self and identity development that holds relevance for nurse academics. She explains that disciplinary culture is inextricably linked with identity questions about who we understand ourselves to be in the world and what we do there. Her logic argues that *if* disciplinary culture encompasses the material practices in which we engage (e.g., IPE), the social relations that motivate and validate our activities (i.e., relationships within the academy, especially medicine), and our ways of thinking about how we work (e.g., oppressed, chauvinistic thinking), then our sense of self is assuredly at stake in conflicts within and between disciplinary cultures (p. 370). Nursing carries two identities: one as a practice discipline and another as an academic discipline. Consequently, nurse academics' identities are challenged, or at stake, when conflicts arise within and among these two disciplinary cultures, which may account for some of the fragmentation and uncertainty within sense of professional self. An accompanying challenge for nurse academics' sense of professional self/identity lies in the conflict between the deep value held for who they are fundamentally, at the heart of their nursing sense of self (i.e., participants articulated fear of losing professional self and autonomy in IPE engagement) and who they think they need to be, or how they need to construct a sense of professional self in the academy (Arnold, 1996; Bartels, 2007; Kenny et al., 2004) (i.e., meeting the imperatives of the academic trinity).

Study participants' experience that creation of nursing's professional sense of self and identity is a developmental process that is constructed and negotiated throughout a professional career is well confirmed in the literature (Bartels, 2007; Cook et al., 2003; King & Ross, 2003; Sims, 2011). Weedon (1997), among others (King & Ross; MacIntosh, 2003; Öhlén and Segesten, 1998; Sims, 2011) regard subjectivity as developmental and generative in nature, with

discourse considered both a prominent formative feature and an outcome of subjectivity's precarious and often contradictory constitution. Because discourse gains social and political effect only in and through the actions of the individuals who become its carriers (Dickson, 1990), nurse academics take up forms of subjectivity, with meaning and values intact, then act on them and in so doing discourse is both a cause and effect of nurse academics' subjectivity (Dickson). Nurse academics' sense of professional self/identity is constructed from the intersectionality (Hancock, 2007) of socio-historic, hegemonic discourses of gender and women as nurse, (i.e., female dominated discipline in a male derived and dominated context), disciplinary practice roots, and novice position in the academy. The subjective meaning of these discourses is mutually dependent on perception of professional self, personal interpretation of the world, and prominence of other discourses, including a new discourse about IPE as the newest trend and 'buzz word' and an historic discourse about relationships between nursing and medicine (i.e., typified by power imbalance). The impact on nursing's professional sense of self/identity of this latter discourse, perceived especially within a context of interprofessional work, has been identified in this research and elsewhere (Miller et al., 2008).

The origin of the historic, tense relationship between medicine and nursing has been attributed to the struggle for scientific primacy and the advocacy for formal education in the university prompted by the iconic, ground-breaking 1910 Flexner Report (Gilbert, 2008; Henneman, 1995). At the time of the Flexner Report, a similar move to the academy for nursing was not considered and the detrimental effects for nursing of this historic arrangement have prevailed; medicine has continued to hold a position of scientific and academic primacy, while nursing science and nursing's academic status is scrutinized and censured (Andrew & Wilkie, 2007; Jackson et al., 2011; Kenny et al., 2004; McNamara, 2008; Sims, 2011). The effects of this

and other discourses are cumulative and enduring, prompting a question about how much conscious thought and emotion about professional subjectivity stems from continued unconscious acceptance of hegemonic historic, socially constructed discourses.

Several overarching interpretations of professional subjectivity inherent in the answers to the research questions need expression. First, Weedon's (1997) conception of subjectivity conveys a dynamic quality (i.e., in process, constantly being reconstituted). This reality is consistent with nurse academics' construction of professional sense of self/identity as reactive to the intersection of historic, socially constructed discourses and as mobile and multiple rather than located in a fixed position or with a fixed meaning - a phenomenon that has been well documented in the literature (Foucault, 1980; Ogle & Glass, 2006). Second, by self-report nursing is complicit in developing negative professional subjectivity and sense of professional self, embodying a position as silent knower and victim, subjugating voice, knowledge, and power. In some cases, oppressed group behaviour as a medium for development of professional subjectivity may be knowingly perpetuated for its ironic power. Third, although nursing may be subjected to criticism for embracing a paradigm in which it has become an object of its own interest (Gilbert, 2008), perhaps this stance is a necessary step on the journey to professional self-discovery and construction of professional sense of self/identity as a nurse academic in the academy. Finally, an FPS approach to subjectivity allows nursing to move beyond the limitations and structures imposed by traditional philosophies, historic socially-constructed hegemonic discourses, and complicit behaviour; Freedom from these encumbrances promotes development of robust professional subjectivity with greater potential to enhance nursing's IPE engagement. Interpreting the answers to the research questions through the lens of subjectivity brought the

concept of power in to play also. How the concept of power is evident in the answers to the research questions is interpreted in the following work.

Power

Embedded in answers to the research questions are issues of power imbalance that necessitate the need for a return to a discussion of power. From a feminist poststructural perspective, interpretation of the answers to the research questions through the concept of power focuses on power relations in hierarchical academic structures and processes, in historic and socially constructed discourses, and in health professional and educational cultures (i.e., presence of medicine) wherein nursing's IPE engagement is located. Weedon (1997) and Foucault's (1980) collective interpretation of power has been inspirational for a feminist poststructuralist understanding of matters within nursing's professional gaze (Arnold, 1996; Bruni, 1995; Dickson, 1990; Doering, 1992; Francis, 2000; Henneman, 1995). Similarly, their collective interpretation of power has utility for this research because power is conceptualized as a pervasive and complex strategic situation that can be manifest in any particular relation (i.e., nursing-medicine, nurse academic-university) rather than as a personal trait with which humans are endowed, as a position humans achieve, or as the property of an institution. Furthermore, by definition power relations are mobile, reversible, unstable, and possible only insofar as there is a certain degree of freedom and other options for both sides in the relationship (Foucault, 1997/1984).

Seemingly an overarching concern for nurses in the academy are issues of power imbalance among nursing, medicine, and academic structures. When Weedon (1997) and Foucault's (1980) collective conceptualization of power is applied to nursing in the academy, nurse academics and the institution are said to be in a power relation, circumscribed by a

pervasive and complex strategic academic culture of hierarchical structures, including promotion and tenure grids and other contractual arrangements (i.e., part time faculty), disciplines that have a longer history than nursing in the academy, and primacy of academic medicine. This power relation is out of balance for nurse academics because of the monitoring and control inherent in the university's promotion and tenure structure and scrutiny by a culture created by entrenched disciplines of the academy (McNamara, 2008, 2009), including medicine. Nursing submits to the disciplinary power (Foucault, (1979/1975) inherent in these pervasive and strategic academic structures and culture because nursing experiences a sense of constantly being watched. The effect of this invisible monitoring and control is analogous to Bentham's (1995) architectural concept of panopticon wherein individuals, who are visible, self-discipline because they believe they are always under surveillance by the dominant authority (i.e., structures and culture). Visible and vulnerable nurse academics feel constantly scrutinized and submit to the invisible university structures (i.e., primacy of research over teaching [Alpers, Jarrell & Wotring, 2010]), views of the dominant health professional authority (i.e., medicine), and scrutiny of other academic disciplines even in the absence of direct and visible contact. Furthermore, nurse academics submit to the pervasive and strategic academic structures and culture by appropriating male ontologies (Anthony & Landeen, 2009) and acquiescing to male-determined historic power and tenure structures to achieve legitimacy and success in the academy.

Although construction of nursing's identity in the academy incorporates appropriation of male ontologies and adherence to male-determined historic power and tenure structures, in a reversal of a disciplinary construction of power, Freire (1998) stresses that a pre-requisite for the employment of power within an institution is the development of positive self-esteem and recognition of self-worth; If nursing wants to exercise institutional power, then developing

professional subjectivity inclusive of robust sense of professional self, identity, and confidence is advisable. Ironically, nurse academics' conceptions of power in the academic environment is opposite to that of Foucault. According to nurse academics, power *is* a trait (i.e., personal power) derived from achievement of the ultimate academic credential of doctoral status (Bartels, 2007; Jackson et al., 2011) and consequent tenure and is evidence of how male-determined historic power and tenure structures and discourses have become inured. Sadly, the power afforded by a doctoral credential is viewed also as protection from the scrutiny and monitoring of the invisible yet dominant academic and health professional culture (i.e., medicine).

Historically, power relations and processes were not explicit in the hegemonic socially constructed discourses of women and nurse. In contemporary times, power relations and processes are uncovered not only in everyday discourses and traditional practices of the prevailing patriarchal ideology of academia (Bevis, 1989) but also are in the original historic socially derived discourses that have constructed an understanding of women and nurse. For example, historic, negative socially constructed discourses imply that power is a personal trait rather than a component of nursing's ontology, and imposes on nurses a collective of stereotypes including subordinate, powerless silent knower (Belenky et al., 1986; Hamilton, 1994) bound by an altruistic duty to care based on biology. In fact, power and caring have been regarded as antithetical concepts in the development of nursing's professional ontology (Falk Rafael, 1996). The historically constructed power relations among nursing, society, and academia (i.e., predominantly medicine) are perpetuated to a certain degree because hegemonic discourses of women and nurse have served society, medicine, and academia's (i.e., dominant culture) collective purposes.

Applying Foucault's (1997/1984) perspective, there is power in resisting hegemonic discourses and the received view of nursing that silences and marginalizes women (Knights & Kerfoot, 2004), the nursing profession generally, and nurse academics specifically because nursing has the option of reconstituting its professional ontology (i.e., doing something else) with robust professional subjectivity, identity and confidence. Through unconditional resistance of assumptions and values held by privileged masculine-derived academic institutions, disciplines (i.e., medicine), and discourses, nursing and nurse academics enter into a new power relation by creating competing discourses of nursing's role and self-governance in the academy, of nurse academic's professional identity and confidence, and of nursing's equitable and rightful membership as a member of the interprofessional team. This move aligns with Foucault's (1979/1975) opinion that the nature of power is neither inherently evil nor negative and repressive but rather a productive force (Foucault, p. 194). New power relations generated from competing discourses is leveraged for positive change, including enhancement of nursing's IPE engagement. Nursing's resistance of historic discourses in society and academia makes way for the creation of newer, relevant, and collegial discourses, especially regarding interprofessional relationships where nursing's engagement in power relations should be shared and based on knowledge and expertise rather than on historic discourses, imposed stereotypes, or professional title. Above all, a mindful note raised by St. Pierre (2000) about strident, indiscriminant application of a feminist poststructural perspective to alleviation of negative and hegemonic power relations must be applied to nursing in the academy: Because of the complexity of the nursing profession and respect for multiple truths and subjective positions, some nursing colleagues might find it "impositional to define one grand vision of liberation" (p. 493) or discourse for nurse academics and nursing in the academy. Diverse reactions notwithstanding,

nursing colleagues have agreed on two immutable facts: that relations of power are complex, shifting, and contextual and that resistance requires commitment, vigilance, and perpetual practice.

Finally, two overarching power relation considerations warrant brief address. First, during the research process there were power relations between me, as the researcher, and each participant as the researched. Egalitarianism and balance of power between the researcher and the researched in these research-induced power relations lie in the nature of the research environment: participation was voluntary and participants had some control in the interview situation since they could decide whether or not to disclose information (Cotterill, 1992). Second, power relations from a gender perspective must be considered. Discourses, among other constructions, have reinforced and normalized certain knowledge and truths about women (i.e., women are incapable of rigorous scholarship or effective leadership) (St. Pierre, 2000). This view paints an incorrect contemporary picture of the power relations between nursing and society, including academia, based solely on gender. Power relations among nursing, society, and academia must be constructed with nursing's robust professional subjectivity, identity, and confidence, inclusive of respect for the profession as a knowledgeable and powerful group, rather than be constrained by gender issues or any other historic discursive view of nursing.

Gender

By definition, a feminist poststructural perspective imposes naturally a formative gender lens on this research. An interpretive summary of gender in the study findings is simultaneously formative and summative, particularly in view of this exploration of a female-dominated profession. In broad terms, gender permeates all Cases as well as language, discourse, subjectivity, and power considerations throughout chapters five and six. Gender is a common

theme for nursing particularly in view of the gender binary that exists historically within contexts of health care and academia (van den Brinke & Stobbe, 2009). Although the 21st century premise that gender is socially constructed supplants historic, essentialist constructions of gender attributed solely to biologically ascribed traits (Oakley, 1997), vestiges of old hegemonic discourses of gender binary prevail. Nursing in the academy is encumbered by a context historically grounded in gender binary stereotype as a prescriptive device for what women in the academy should be or do (van den Brink & Stobbe). Nurse academics are members of a female-dominated profession who are judged against male-determined and dominated university structures (e.g., workload contracts) and discourses of power and privilege. Arguably, the hegemonic discourses in male dominated organizations are masculine discourses (van den Brink & Stobbe) and society values all that is masculine at the expense of the feminine (David, 2000). However, in these contexts, masculinity and power are conflated such that men occupy the norm against which women's performance is measured (Knights & Kerfoot, 2004), sustaining patriarchal academic structures that privilege males over females for positions of power and authority (Evans, 1997).

The creation of environments where one gender is privileged over another has negative effects (Friere, 1998; Kenny et al., 2004) on the development of nursing's professional subjectivity, identity, and confidence. Female academics need to work to make explicit, gender binaries, implicit gender relations, and structural oppression in order to promote change for women academics, including nursing. Cotterill (1992) describes the concept of 'academic feminism' (p. 594), as a theory and method of inquiry that centres on women's understanding of women's perspectives and experiences that would provide nurses in practice and the academy with the tools to be agents of change.

Nursing in practice and in the academy has worked hard to develop a profession, recognized and trusted not because of its gender but respected for its professional knowledge and skill. Nursing, as primarily a female-dominated profession, has been in a professional hierarchy based on gendered constructions of knowledge production and professional ontology. The profession must strive to flatten such a hierarchy so that potential threats to nursing's professional subjectivity, identity, and confidence, and consequent IPE engagement, are not born of gender.

Chapter Summary

This chapter presented the cross-case analysis of the individual case reports (i.e., within-case) of nursing's IPE engagement at Sites A, B, and C university campuses of four-year baccalaureate nursing programs. This chapter, and first part of the Epilogue, opened with revisiting researcher reflexivity and theoretical framework prior to answering the research questions. Subsequently, these answers were interpreted and discussed through the concepts of feminist poststructuralism. This first part of the Epilogue sets the stage for the Epilogue conclusion of chapter seven.

Chapter Seven - Feminist Poststructuralism and Case Study Methodology Revisited, Study Conclusions, Implications, Recommendations, and Limitations

This chapter is the second and final part of the Epilogue. Here, final comments confirming the relevance of the theoretical framework and case study methodology to the research precede the study conclusions and study implications. Next, recommendations based on study findings take centre stage, followed by study limitations, brief comments about current IPE literature and definition, and chapter conclusion. The Epilogue ends with overarching comments that bring the research to a close.

Utility of Theoretical Framework

That IPE has not been studied previously from a feminist poststructural perspective is significant because there are many contributions of research findings generated from this theoretical viewpoint. First, at the outset feminist work considers gender to be an important analytic category (Keatings & Smith, 2010) so FPS as an unbounded, non-fixed-in-time transcendental theory (St. Pierre, 2000; St. Pierre & Pillow, 2000) focused on gender has uncovered temporally and socially embedded particular ways of gendered thinking about nursing. Specifically, FPS has helped uncover the pervasiveness of gendered thinking about how nursing, as a female dominated profession, negotiates its professional world in the male-derived and dominated world of academia (Bird, 2011). Second, discourse and subjectivity are concepts integral to FPS. The concept of discourse has prime importance given the context of historic and socially constructed hegemonic discourses of women, nursing, and academia (inclusive of interprofessional relationships with medicine) in which IPE engagement is located. The most significant impact of feminist poststructuralism in this research has been its attention to subjectivity and consequent construction of professional identity; The importance of subjectivity

to critical and feminist thought has been well confirmed (Ogle & Glass, 2006; McLeod, 2009; St. Pierre, 2000) and in this research has held significant importance in exposing robust professional identity and role confidence as antecedents to nursing's IPE engagement. Third, the inter-relationship among FPS concepts has promoted the exposure of relationships between and among nursing's professional subjectivity, role understanding, professional value, power, and imposition of historic, hegemonic discourses in the construction of professional identity in the academy. At the same time, feminist poststructuralism has raised awareness of the taken-for-granted historic, socially constructed identity the profession has assumed, particularly academic roles established by masculine discourses and masculine-determined structures in the academy (Bird). Ideally, this theoretical perspective conveys to nursing that there exists no obligation to assume humanly produced academic constructions because by definition they have the potential to be humanly altered (Dickson, 1990) (i.e., nurse scholar promotion and tenure rank). Furthermore, from a FPS perspective, multiple paradigms and ways of knowing are necessary for the development of nursing knowledge and nursing science. In fact, there are multiple truths (Bonis, 2009), multiple ways of knowing the truth, and multiple paradigms of inquiry (Ogle & Glass; Stajduhar, Balneaves & Thorne, 2000; St. Pierre, 2000) to find answers to problems faced by nursing. By way of example, FPS has endeavoured to denaturalize both male-derived and determined academic structures *and* that which historically and socio-culturally has been considered nursing's 'normal' professional role and place.

Finally, from a methodological standpoint, feminist poststructuralism interfaces well with case study methodology because, by nature, FPS promotes the exploration of the impact of socio-cultural, temporal, and local (Harding, 1991) contexts on nursing's IPE engagement. FPS has highlighted and acknowledged the heterogeneity and diversity of nursing's experiences with

IPE and in the academy, while illuminating the complexities about language, discourse, subjectivity and power experiences (Ogle & Glass, 2006) .

Qualitative Case Study Methodology

The mutual importance of context to the theoretical framework *and* the study methodology is confirmed. However, it is imperative to restate that the real-life context of academia holds prime significance in the evolution of nursing's professional subjectivity as nurse academic, specifically professional identity and confidence, confirming Yin's (2009) directive about the inseparability of context and the phenomenon under investigation. Additionally, sampling of case study sites based on slight differences among case contexts, including presence or absence of collaborative nursing programs and medical programs, and designation as School or Faculty of Nursing was purposeful in order to explore the relevance of contextual difference/similarities to the study outcome. Interestingly, the presence or absence of collaborative nursing programs is not reported to impact nursing's IPE engagement specifically. Rather, the presence of collaborative nursing programs at Sites A and B is experienced in the totality of nurse academic's overwhelming workload and nursing's IPE workload is indistinguishable. Moreover, reports of the nature and magnitude of nurse academic's workload are similar across all sites despite the presence or absence of collaborative programs. Designation as Faculty (Site B) or School (Sites A & C) of Nursing seemingly does not impact nursing's IPE engagement directly, however details of this nature were not a primary focus in this exploratory case study. What *has* impacted nursing's IPE engagement, manifest via nurse academic's experience of professional subjectivity, is the presence of a medical program, satellite or indigenous. Within the academic context and interprofessional environment, it is the presence of medical colleagues that seemingly intimidates nursing and challenges nursing's professional

subjectivity, specifically professional self-esteem, and confidence. Conditioned by years of hegemonic discourses about females and nursing, nurse academics would benefit from discarding the externally induced and somewhat internally perpetuated (i.e., nursing's complicit behaviour in maintaining the status quo of oppressed group behaviour) mantle of oppression, recognizing nursing's power and knowledge, leveraging both to embrace nursing's rightful place and role on the interprofessional team in academia and practice.

A hallmark feature of case study methodology (Yin, 2009) is the use of multiple data collection methods. Indeed, the value of using multiple and varied data sources optimized the confirmability and trustworthiness of the study findings. For example, nursing program documents describing program goals and evaluation criteria corroborated participants' articulated value for IPE and intent to incorporate IPE in students' learning. At the same time, focus group interaction, together with focus group and individual interview data generated and corroborated similar themes of professional subjectivity both within and across cases. Although the compositional nature of focus groups varied minimally within and across cases with respect to number of participants per group and participants' demographics, the minimal differences in these characteristics did not impact data interpretation. In fact, in spite of minor differences among individual and focus group participant characteristics, there was overwhelming solidarity at all sites on many issues, particularly on topics related to nursing's relationship with medicine and nursing's role in the academy.

The utility of multiple data sources to the study outcome is evident. However, generation of data from some sources was not without challenge. Primarily, it was individual interviews that challenged my reflexivity as a female nurse academic researcher. On many occasions I listened to sensitive information that was not central to the research. I was committed firmly to ensuring

the moral habitability of the interview environment, subjugating my discomfort to participants' apparent need for disclosure, and balancing the needs of this research and my doctoral work with participant's painful and sensitive stories about colleagues and/or employers. As a result, I question the moral basis of setting up interviews that have the potential for painful disclosure and for research that may lead to "[h]olidaying on other people's misery" (McRobbie, 1982, p. 55). Additionally, several times participants at the same site shared the same information that was disclosed 'off-record' by one participant yet shared freely, almost gleefully by the other. Ethical issues in interviewing and data collection are discussed in the literature (Cottrell, 1992; Johnson & Clarke, 2003; Smith, 1992), however, due diligence in balancing research needs with respect for participants' privacy and confidentiality must be an active, ongoing process, not just a paper published on the matter.

Qualitative case study methodology was chosen because of its good fit with the research questions. This valid choice notwithstanding, this research should not escape the irony of feminist debates about methodology in which qualitative methodologies are privileged to the extent that they have consequently acquired a hegemonic correctness for feminist researchers (Oakley, 1998; Reinharz, 1992; Stanley & Wise, 1993). Thus, it is wise to be mindful of Lather's (2008) advice that feminist research needs to guard against its own hegemony of static routine and predictability and instead be grateful for earlier feminist research practices, yet embrace forward thinking and productivity that is iterative and open to permanent dynamism (p. 55).

Conclusions and Implications

Several conclusions are drawn from this research. First, the study purpose to explore nursing's IPE engagement was achieved; Nursing's IPE engagement is minimal, inconsistent, and diverse despite value held for and in the presence of discrepant, uncertain understandings of

the term interprofessional. That nursing's IPE engagement needs enhancement is an obvious implication of this conclusion, however, perhaps a common understanding of the term and concept of interprofessionalism is a necessary first step. Second, unexpectedly, the study findings speak principally of nursing's general experience in the academy with IPE engagement seemingly providing the vehicle to convey messages of enduring concern and tension in the role of nurse academic. Overarching themes of nursing's professional subjectivity, identity, and confidence within the academic context represented collective thought. Development of robust professional subjectivity has implications for nursing's sense of identity and professional confidence in the academy. Third, through exploration of nursing's IPE engagement, the concept of nurse academic, circa 2011, emerged as the roles and responsibilities of nursing in the academy were deconstructed. Deconstruction forced the examination of blind spots, assumptions, and illusions that undergird (Lather, 1991) the experience of a discipline with its historic practice roots now planted in the academy (Kenny et al., 2004; McNamara, 2009). In this place, perhaps nursing's professional identity is best described by Bhabha's (1994) concept of hybridity, theorized as a "liminal space in-between the designations of [practice or academic] identity ... an interstitial passage between fixed identifications ... that entertains difference without an assumed or imposed hierarchy" (p. 5). A tacit yet significant implication of this finding is that nurses must constantly negotiate their professional identities as they move between historic roots circumscribed by hegemonic discourses of women and nurse and newer discourses surrounding nursing's role in the academy. Furthermore, ensuing role conflict, confusion over allegiance to practice and/or the academy, and marginalization faced by nurse academics may be exacerbated by a single model university promotion and tenure structure.

Fourth, it may be that the advent of IPE is the impetus for nursing's examination of its

professional ontology. Since nursing curricula, including its philosophy and paradigm, influence the ontology of graduates and the way they view their practice (Bevis & Watson, 1989), it is logical that IPE may force examination of how current curricula impact the development of nursing students professional identity. The nursing literature of the middle/late 20th century (Bradby, 1990; TenBrink, 1968) held information about professional socialization in nursing education and the conformation of nursing students to a role. In more recent times, a professional identity perspective has emerged, replacing the role conformation perspective. Nursing's professional subjectivity, professional identity (Andrew et al., 2009; Cook et al., 2003; Öhlén & Segesten, 1998), and translation of self-concept into professional identity (Arthur & Randle, 2007) are current issues important to the development of the discipline's contemporary ontology. Implications for nursing education suggest that not only could IPE directly help nursing students gain competence in knowing about and appreciating the practice of health professional colleagues (MacDonald, Bally, Ferguson, Murray, Fowler-Kerry & Anonson, 2010) but also that systematic exposure to health professional student colleagues could broaden nursing students' view of their professional world (Charles et al., 2010) en route to developing a professional ontology void of professional chauvinism and permeated with robust professional identity and subjectivity.

Finally, antecedents, or the events and incidents that must occur or be in place prior to the occurrence (Walker & Avant, 2010, p. 167) of nursing's IPE engagement were explored and identified through data generated from multiple sources, analyzed within and across cases. These antecedents centre on nursing's professional identity and role confidence in the academy. At this point what is obligatory to question is whether weak and/or absent professional identity and role confidence can account for the lack of nursing's IPE engagement. Certainly robust professional

identity and confidence are fundamentally ideal for all areas of nursing's work. However, robust professional subjectivity that enables strong professional identity and role confidence is a necessary condition for nursing in the academy that must be in place prior to *and* occur during interprofessional work because of the nature of the context in which IPE occurs; a context of academic structures entrenched in masculine/male hegemonic discourses, including primacy of medicine, that is daunting for a discipline that has evolved from equally as potent historic discourses of women and nurse. It is these features of the university academic context that distinguish the need for strong professional identity and role confidence as IPE antecedents from these traits as antecedents in all areas of nursing's work. Furthermore, adoption of IPE is different from adopting other new pedagogical innovations because of the nature of the collaborative relationships in IPE that require equality of respect and value for each profession and its scope of practice. Successful IPE, and subsequent successful collaborative patient-centred care, is dependent on equitable and respectful communication among the interprofessional team in the academy and in practice. Such is the importance of responsive and responsible interprofessional communication (Suter et al., 2009) that it has been designated by CIHC (2010) as a professional competency. Implications of weak or absent professional identity and role confidence are linked to poor development of collaborative, respectful relationships with subsequent potential for compromised collaborative patient-centred care.

In light of the study conclusions and implications, a prudent next step is consideration of recommendations that could directly and indirectly support nursing's IPE engagement, development of robust professional subjectivity, and support contexts for both. Recommendations for nursing research education, and practice are addressed, beginning with nursing research.

Recommendations for Nursing Research

The recommendations for future research centre on design changes to the current study as well as suggestions for new research arising from the study. It became apparent as this study progressed across sites, that there exists a variety of understandings about IPE, specifically regarding terminology and the nature of the concept, interprofessional. The degree of IPE engagement was remarkable despite the variety of IPE knowledge and understanding and the linguistic confusion. To mitigate this confusion and to enhance understanding about the concept of IPE, first undertaking a formal concept analysis is advisable. Next, based on the linguistic and conceptual variation among faculty participants, it might be informative to develop a nursing and health professional faculty participant questionnaire regarding terminology and conceptual understanding of IPE and, once piloted, incorporate this data generation method into the case study in a mixed methods design. Transitioning this research to a mixed methods design with a quantitative focus generating data about nursing's IPE knowledge and understanding would, for example, permit regression analysis to forecast the relationship between IPE knowledge and understanding and IPE engagement.

Surprisingly, this research became a means to explore nursing in the academy using IPE engagement as the vehicle to explore the terrain. Several recommendations arise from this conclusion. First, although there is a growing body of international literature (Adams et al., 2006; Jackson et al., 2011; King & Ross; McNamara, 2008, 2009 among others) about professional identity of the nurse academic and nursing in the academy, Canadian research in this area is warranted because of the strategic contextual differences across university and health professional cultures geographically. Use of institutional ethnography (Smith, 2005) to explore the concept of nurse academic might be an effective methodology to investigate the linkages

among the university as nurse academics' local setting, the academic organization itself, and translocal processes (DeVault & McCoy, 2001) within academia as nurse academics enact their role. Smith's work in institutional ethnography is a suitable methodological framework from which to study nurse academics because of her sensitivity toward women's standpoint and ruling relations within institutions. An institutional ethnography of nurse academics would begin specifically with the reality or details of academic life for nurses and investigate further how the realities are embedded in social relations within the academy, both those of the ruling and those of peers (Smith, p. 31). From this standpoint, nurse academics' experiences would provide the subsequent specific direction of the research (Smith). In short, institutional ethnography would place nurse academics as a standing point within academia, providing the perspective for exploration of real issues, concerns, or problems that are situated in nursing's relationships with the institution and its structure. As well, an institutional ethnographic perspective might bring to light the differences and/or similarities in the experience between females and males in the nurse academic role as well as provide an understanding of relationships with health professional colleagues, particularly medicine. Institutional ethnography might shed a unique and valuable light on the resources and supports necessary for nursing's IPE engagement or at the very least identify university systems issues that mitigate IPE engagement for nursing.

Recommendations for Nursing Education

Recommendations for nursing education encompass the academic context in which IPE engagement is located. As a member of the academy, nursing needs to reconstruct its professional subjectivity and identity, shedding the encumbrance of the historic hegemonic discourses of women and nursing and changing the structural problems of academia. Moving toward a new ontology, inclusive of a secure, robust, and proud professional identity defined not

by others (i.e., imposed by entrenched academic structures) but by the profession itself, articulates nursing's value to the academy as both a practice and academic discipline. Nurse academics can promote this value by lobbying for construction of new promotion and tenure structures within the academy. The precedent has been set for such new structures by two Ontario universities: the first is teaching-track or teaching professor stream for rank appointments across all disciplines at McMaster University, Hamilton, Ontario (McMaster University, 2009), who devote their time predominantly to teaching and the scholarship of teaching, and the second is the provost stream for faculty in the Schulich School of Medicine and Dentistry at the University of Western Ontario, London, Ontario (The University of Western Ontario, 2002) for those whose academic workload comprises stronger clinical and academic than research mandates. University structures that perpetuate hegemonic promotion and tenure structures run the risk of creating academic mediocrity, rather than responding to changing circumstances with creativity and imagination as a forward thinking institution (Kenny et al., 2004). Female nurses academics may need to make explicit, the implicit gender relations and structural oppression in order to promote change (Kenny et al.) within the academy. At the same time, nurse academics would be wise to shift from a chauvinistic ontology to embrace the concept of communities of practice (Andrew, Ferguson, Wilkie, Corcoran & Simpson, 2009; Wenger, 1998; Wenger et al., 2002) and learning (Macdonald, 2002) formed by a group of health professionals who engage in the process of collective learning on a shared domain of human endeavour (i.e., collaborative patient-centred care), sharing a concern or a passion for something they do and learning how to do it better as they interact regularly (Wenger; Wenger et al.).

For nurse academics, development of strong professional identity and role confidence is a recommendation that nursing would be wise to consider to enable confident vocalization rather

than subjugation of its knowledge and power in deference to medicine. Miller et al. (2008) found that nursing emotion work, or the management of emotions of self and with others, must be addressed in order for nurses to engage collaboratively. Self-imposed feelings of intimidation, a vestige of the oppression from historic hegemonic discourses, renders nursing simultaneously complicit and powerless and is a mantle that nursing has worn too long and must now shed. Robust professional identity and role confidence facilitates security and comfort in interprofessional interaction and nursing's role as colleague in the academy. When this occurs, nursing can feel professionally empowered and confident rather than professionally powerless and insecure in IPE engagement. Moreover, a professional ontology created from subjective positions of worth and equality in the academy (i.e., context for nursing's IPE engagement), embraces rather than resists subject positions of prominence and leadership in the promotion of IPE. Developing virtual communities of practice and electronic listservs that link nurse academics across Canadian universities may promote collegial sharing and support for a discipline that is relatively new to the academy.

A global recommendation for nursing education pertains to the imperative for IPE in nursing curricula. What type of curriculum can include foundational IPE learning required in a collaborative patient-centred care environment, navigate societal paradoxes described as emphasis on health promotion versus demand for illness cures, public reliance on professionalism within nursing yet greater lay assertiveness, and demand for technical competence versus humanistic care-based competence (Mcilpatrick, 2004)? No one profession alone can undertake these challenges and provide competent, patient-centred holistic care (Allison, 2007; Thistlethwaite, 2008). To respond to societal paradoxes and to learn how to provide competent, patient-centred holistic care, nursing faculty are well advised to develop and

incorporate IPE into baccalaureate nursing curricula. To embed IPE in nursing curricula, many levels of leadership, supports, and resources are needed including support from schools, faculties, and senior administration, development of professional identity, comfort with collegial role (Donner & Wheeler, 2008) instead of a siloed ontology, and voice as constructed knower (Belenky et al., 1986).

Finally, and in view of nursing's historic challenges with professional subjectivity, perhaps a unique view of interprofessionalism might be considered useful for nurse academics contemplating IPE engagement because this view shifts focus away from the interprofessional ontology of individual health professionals, placing the emphasis on the interprofessional process. Interprofessionalism, as described by D'Amour and Oandasan (2005), concerns "the processes and determinants that influence interprofessional education initiatives as well as determinants and processes inherent to interprofessional collaboration" (p. 8). Embracing the conception of IPE as a process rather than as a trait of the individual may shift nursing's ontology from self-centredness to subject-centredness (Palmer, 1998) and in so doing may enhance nursing's proclivity for IPE engagement.

Recommendations for Nursing Practice

From a practice perspective, a study recommendation pertains to nursing's shortfall in articulating its role and the need to rectify this situation. If a 'filling in the spaces' perspective about nursing practice is pervasive, it is not surprising that nurses have difficulty articulating their role and developing a professional identity. Neither is it inconceivable that development of interprofessional relationships may be difficult due to self-induced intimidation arising from professional subjectivity that includes low professional self-esteem and poor confidence because of inability to articulate one's role. Role clarification is a national interprofessional CIHC

competency (CIHC, 2010). Nurses who are able to articulate their role generally and within an interprofessional practice framework specifically, a role ideally inculcated in undergraduate IPE-based curricula, are better able to embrace inter-professional practice and may increase the probability of interprofessional collaborative patient-centred holistic care.

Study Limitations

Disclosure and discussion of study limitations promotes integrity of this research. The limitations of the study include critiques about trustworthiness, researcher bias, and case study design. Throughout the study concerns about trustworthiness and researcher bias, were considered from the onset and appropriate measures were implemented to minimize their impact. For example, trustworthiness, particularly credibility, was promoted through due diligence in rigidly adhering to Yin's (2009) qualitative case study methodology in order to create evocative, authentic, and meaningful portraits of nursing's IPE engagement. Diligent adherence to a well-established qualitative case study methodology that included techniques such as using multiple sources of data, creating a case study database, and maintaining a chain of events or an audit trail were used to instill trustworthiness; not only credibility, but also dependability, confirmability, and transferability.

Researcher bias in this qualitative research was not a limitation. Rather, subjectivity, as understood from a feminist poststructural perspective applied to the researcher and the researched was a methodological strength. Furthermore, diligent efforts were made to promote reflexivity. Also consistent with the theoretical framework is the notion of multiple ways a text can be read; therefore, it was important to have experts in qualitative research consult on the coding scheme and its application to the research text. The importance of researcher subjectivity notwithstanding, some participants might have felt limited in their candidness about nursing

education and their respective schools/faculties because of my familiarity with nursing curriculum, my experience in nursing education administration, and my familiarity with some of their faculty colleagues. Additionally, many participants were fellow doctoral students and as such, may have felt compelled to be overly cooperative, offering information that they perceived I needed or that I would find helpful. To address issues of participant reactivity, I was reflexive throughout interviews, mindful of ways I could be influencing participants, and made conscious efforts to create an atmosphere of trust conducive to open and honest dialogue.

Perhaps a study limitation may be conceived as a restricted perspective arising from the predominance of female-identified participants. However, the female-dominated nature of the profession justifies the predominance of female-identified informants. Male-identified colleagues are under represented in the nursing profession, which is not to falsely assume that male colleagues cannot make important contributions to feminist research (Harding, 1987). Since “... women’s and men’s characteristic [social] experiences provide different but not equal grounds for reliable knowledge claims,” (Harding, p. 10) soliciting views on nursing’s IPE engagement from greater numbers of male-identified nursing colleagues potentially provides a comprehensive perspective beyond that which is represented herein. Furthermore, incorporating a greater male-identified collegial perspective on nursing’s IPE engagement may contribute in comprehensive and unique ways to enhance the study’s transferability.

On a related gender note, it was not possible within the scope of this study to explore specifically, male participants’ views of gender impact on IPE work from the perspective of men doing traditional female-dominated and feminized work (Pullen & Simpson, 2009). This is a ripe area for further research particularly in view of the trend toward interprofessional education and the growing nursing education opportunities open to males.

Despite evidence to the contrary (Anthony & Jack, 2009), use of case study itself might be viewed as a study limitation since the legitimacy of case study as research methodology continues to be regarded with circumspection (Daly et al., 2007; Gerring, 2007) within an entrenched discourse of a hierarchy of evidence (Denzin & Giardina, 2008; Holmes et al., 2006). Skepticism notwithstanding, a first principle of research (Creswell, 2009) was applied, therefore the research methodology most appropriate to answer the research questions was selected. A well designed methodological framework (Yin, 2009) was followed, inclusive of theoretical propositions, a formal multiple-case research design, a well-defined phenomenon of interest circumscribed by clearly defined and articulated boundaries and positioned within a specified context, and a well constructed analytic strategy. These features coupled with the multiple case research design not only mitigated study limitations related to methodology but also promoted transferability of the study findings.

IPE Literature and Definition Revisited

Since the study's initial 2003-2008 literature review, the body of IPE literature has continued to grow. Remarkably, empirical evidence of nurse educators acting as architects of interprofessional education is emerging slowly, in part due to the advent of interprofessional simulation as an adjunct to clinical learning (Grant, McKay, Rogers, Wisenthal, Cherney & Betts, 2011; Reese, Jeffries, & Engum, 2010; Williams, French & Brown, 2009; Zhang, Thompson & Miller, 2010) and, sadly, due to a variety of initiatives aimed at meeting the global mandate to enhance patient safety, including interprofessional mentoring programs, (Lait, Suter, Arthur & Deutschlander, 2011) and interprofessional collaboration and communication tutorials (Enlow, Shanks, Guhde & Perkins, 2010; Mitchell, Groves, Mitchell & Batkin, 2010; Rice, Zwarenstein, Gotlib Conn, Kenaszchuk, Russell & Reeves, 2010; Thompson & Tilden, 2009).

Some initiatives report federal (Bilodeau et al., 2010; Wood, Flavell, Vanstolk, Bainbridge & Nasmith, 2009) and provincial (Cragg, Hirsh, Jelley & Barnes, 2010) funding, confirming the importance to IPE development of political and administrative level support. Other initiatives (Sommerfeldt, Barton, Stayko, Patterson & Pimlott, 2011; Jinks, Armitage & Pitt, 2009) reflect Reeves and Freeth's (2002) early assertion about the importance of clinically-based interprofessional learning opportunities. Literature reporting direct and formal integration of IPE into baccalaureate nursing education (e.g., Enlow Shanks, Guhde & Perkins, 2010), while relatively minimal, describes educational initiatives for achievement of key IPE competencies (CIHC, 2010; Suter et al, 2009), including knowing the professional role of others (MacDonald, Bally, Ferguson, Murray, Fowler-Kerry & Anonson, 2010). Evaluation research of IPE initiatives in nursing is appearing steadily (Chan, Mei, Ching & Lam, 2010; Derbyshire & Machin, 2011, Jinks et al.).

The IPE definition adopted for this study originates with the work of CAIPE and Barr et al., (2005). Although other definitions of IPE exist (WHO, 1988), the IPE definition provided by Barr et al. holds utmost appeal for health professional practitioners and scholars as evidenced by the extensive use of this particular definition in the body of literature explored and used for this research. Examination of this accepted IPE definition has begun (Bainbridge, 2008) and is likely to continue as IPE becomes mainstream and its accompanying body of IPE literature grows.

Chapter Conclusion

Presented first in this chapter have been final considerations regarding the relationship between the theoretical framework and the study findings, and comments on the relevance of case study methodology. Next, the study conclusions, based on the cross-case analysis, and corresponding implications preceded recommendations for nursing research, education and

practice. Consideration of the limitations of the study and overarching comments regarding trustworthiness of the research have been shared prior to the following brief summary of the research that sets the stage for the final overarching comments about the study.

Concluding Comments

Several overarching comments bring closure to this research. First, at the outset, this study contributes generally to the development of nursing's knowledge and specifically to the growing body of IPE knowledge, with relevance for other female-dominated health professions in the academy. Second, the role of the nurse academic is not well articulated. When appropriate supports and resources are not present for nurse academics, retrenchment and regression to antiquated modes of behaving and thinking may cause intra and interprofessional tension – not an auspicious platform for IPE. Nursing cannot and should not continue to 'fill in the spaces.' Instead, nursing needs to forge ahead, transform and change so that as practice professionals, academic scholars, and critical thinkers we are able to cross boundaries and shatter the barriers erected by gender (hooks, 1994), historic socially-constructed hegemonic discourses of women and nursing, historic male derived and determined structures of academia, and intra-professional complicit behaviour, among others. Third, as a profession generally, and within the realm of IPE specifically, we would do well to remember and acknowledge that we are our own valuable resource and support. Developing professional subjectivity, inclusive of robust professional identity and confidence, will enable us to be proactive in determining our own future path in IPE and in the academy. Nursing can move in this direction from a platform of strong professional confidence, value for own role/identity, and appreciation of its professional knowledge base with recognition of the power inherent in all three.

Toward this end, nursing needs to appreciate difference (i.e., from medicine) not as a dichotomy (i.e., bad/good) but as complimentary, constructing and embodying a new ontology circa 2011 for nurse academics. As a result, nursing's IPE engagement may be enabled so as to mainstream IPE in baccalaureate programs, supporting development of theory-based IPE "that can be understood intellectually, challenged empirically, and then argued for politically" (Gilbert, 2005b, p.102) in order to become a basic structure for future practice. Furthermore, in contemporary times no one profession alone can undertake the challenges of the current context of health and health care (Allison, 2007; Thistlethwaite, 2008). To respond to societal needs and to learn how to provide competent, collaborative patient-centred holistic nursing care, nursing is well advised to engage in IPE.

Finally, nursing and nursing education are in evolution (Andrew et al., 2009; Bartels, 2007; McNamara, 2008, 2009; Newman, Smith, Pharris & Jones, 2008; Sims, 2011). Historically the brand of nursing was strong (Harmer, 2010); despite historic hegemonic discourses of nursing, it was clear intraprofessionally and extraprofessionally who a nurse was and what a nurse did (McNamara, 2008). Today, nursing is more complex and varied, imbued with fears of identity loss attributed to blurred professional boundaries (Harmer) among educational and political mandates for interprofessionalism requiring professional boundary shifts (Jones, 2007; Masterson, 2002; Sims, 2011). In the process, some believe nursing might lose its hard won professional autonomy. It remains to be determined for nursing in the academy whether this 'Kuhnianesque' evolution (1970) in health professional education is simultaneously a painful yet vital process of normalization. Nonetheless, nursing needs to develop individual and collective robust professional identity and confidence through renewed appreciation for its own history (McAllister, John & Gray, 2009; Roberts, 2000) and attributes (i.e., knowledge and power), by

taking control of its own destiny rather than *being* controlled, and by ridding itself of internalized beliefs about its inferiority (Roberts). In this place, nursing's IPE engagement can be enhanced, promoting collaborative patient-centred care infused with exceptional communication, seamless coordination, and utmost respect among the interprofessional team so that, no more, will ailing clerics or any patient needlessly experience iatrogenic crises at the hands of the health care team entrusted with their care. Critically exploring how past practices inform the present can help determine to what extent they should shape its future.

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Appendix A

A Case Study of the Antecedents of Nursing's Engagement in Interprofessional Education

PARTICIPATION INFORMATION LETTER: INTERVIEW

DATE

Dear School of Nursing Faculty Member

You are being asked to participate in a research study about nursing and interprofessional education. I am a student in the Doctor of Philosophy program at McMaster University, Hamilton, Ontario. My supervisor is Dr. Janet Landeen. The Research Ethics Board of McMaster University has given permission for this research study to take place.

What are the Study Purpose and Benefits?

The purpose of the study is to explore the events and incidents that are necessary for nurse educators to participate in interprofessional education (IPE). Interprofessional education is defined as opportunities where students in the health professions learn together in the classroom and in clinical practice. It is not clear where IPE is in nursing education or how nurse educators are involved in IPE. The study results will provide an understanding of nursing faculty members' needs for developing and including IPE in nursing education. This research is important to nursing because it is believed that IPE may lead to improved communication and teamwork among the health care team and improved health services.

What Would My Participation Involve?

I am asking you to participate in an interview to share your thoughts about IPE. The interview will last approximately 30 minutes and will occur at a time and place that are best for you. The conversation will be tape-recorded. You will be asked to complete a brief general data survey.

What are the Potential Risks and Discomforts?

The potential risks may include embarrassment or regret about disclosure of opinions that are not aligned with the university's IPE strategic direction, or unintentional personal or professional disclosures in the presence of colleagues. Risks to the university and School/Faculty of Nursing are low, but may include inadvertent disclosure of confidential academic information or material.

How are my Privacy and Confidentiality Protected?

All identifying information will be removed from the data. All data will be seen only by my supervisor, Dr. Landeen, my supervisory committee members Dr. Catherine Tompkins and Dr. Patty Solomon, and me. All data will be kept in password protected electronic files and locked filing cabinet in my office. The study results will be written as a report and will not contain specific individual information. Private university information that is mistakenly shared will be altered and will not be part of the case report. You will have the right to review the interview audiotapes. The tapes will be destroyed when I successfully complete my PhD studies.

Will the Data be Used After the Study is Completed?

There is a chance that the data in the case report will be used in future research or in a general report on IPE in baccalaureate nursing education.

If so, do you give consent for the subsequent use of data from the case report? yes no

Must I Participate and Could I Withdraw My Participation?

Your participation in the study is voluntary. You may withdraw from the study at any time without penalty, negative impact, or consequences to your current faculty standing or for the school and the university. You will receive a copy of the signed consent statement.

If you have any questions or concerns about this research, or would like any additional information, please contact Sue Anthony at 519-661-2111, extension 86562 or at anthonse@univmail.cis.mcmaster.ca, or Dr. Janet Landeen at landeen@mcmaster.ca

If you have any questions regarding your rights as a research participant you may contact the Office of the Chair of the Hamilton Health Sciences/Faculty of Health Sciences Research Ethics Board at 905-521-2100, extension 42013.

Thank you for considering participation in this research.

Yours Sincerely

Sue Anthony RN MScN
519-661-2111, ext: 86562
anthonse@univmail.cis.mcmaster.ca

A Case Study of the Antecedents of Nursing's Engagement in Interprofessional Education**INTERVIEW PARTICIPANT CONSENT STATEMENT*****Signature of Research Participant:***

I have read the Participant Information Letter thoroughly. I have had the opportunity to discuss the study with Sue Anthony. My questions have been answered to my satisfaction. I understand that I will receive a signed copy of this form. I consent to participate in the study.

Participant Name (Printed)

Participant Signature

Date***Consent form administered and explained in person by:***

Name and title

Signature

Date***Signature of Witness to Participant's Consent:***

My signature as witness certifies that I witnessed the participant voluntarily sign this consent form.

Witness

Date***Signature of Investigator:***

In my judgment, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

Signature of Investigator

Date

A Case Study of the Antecedents of Nursing's Engagement in Interprofessional Education

PARTICIPATION INFORMATION LETTER: FOCUS GROUP

DATE

Dear School of Nursing Faculty Member

You are being asked to participate in a research study about nursing and interprofessional education. I am a student in the Doctor of Philosophy program at McMaster University, Hamilton, Ontario. My supervisor is Dr. Janet Landeen. The Research Ethics Board of McMaster University has given permission for this research study to take place.

What are the Study Purpose and Benefits?

The purpose of the study is to explore the events and incidents that are necessary for nurse educators to participate in interprofessional education (IPE). Interprofessional education is defined as opportunities where students in the health professions learn together in the classroom and in clinical practice. It is not clear where IPE is in nursing education or how nurse educators are involved in IPE. The study results will provide an understanding of nursing faculty members' needs for developing and including IPE in nursing education. This research is important to nursing because it is believed that IPE may lead to improved communication and teamwork among the health care team and improved health services.

What Would My Participation Involve?

I am asking you to participate in a focus group to share your thoughts about IPE. There will be six to eight faculty members in the group. The session will last 45-60 minutes and will occur at a time and place that are best for you. The conversation will be tape-recorded. You will be asked to complete a brief general data survey.

What are the Potential Risks and Discomforts?

The potential risks may include embarrassment or regret about sharing opinions that are not similar to the university's IPE plans, or mistakenly sharing personal or professional information in front of co-workers. The risks to the university and nursing school are low, but may include mistaken sharing of private university or educational information.

How are my Privacy and Confidentiality Protected?

All identifying information will be removed from the data. All data will be seen only by my supervisor, Dr. Landeen, my supervisory committee members Dr. Catherine Tompkins and Dr. Patty Solomon, and me. All data will be kept in password protected electronic files and locked filing cabinet in my office. The study results will be written as a report and will not contain specific individual information. Private university information that is mistakenly shared will be altered and will not be part of the case report. You will have the right to review the interview audiotapes. The tapes will be destroyed when I successfully complete my PhD studies.

Will the Data be Used After the Study is Completed?

There is a chance that the data in the research report will be used in future research or in a general report on IPE in undergraduate nursing education.

If so, do you give consent for the subsequent use of data from the case report? yes no

Must I Participate and Could I Withdraw My Participation?

Your participation in the study is voluntary. You may withdraw from the study at any time without penalty, negative impact, or consequences to your current faculty standing or for the school and the university. You will receive a copy of the signed consent statement.

If you have any questions or concerns about this research, or would like any additional information, please contact Sue Anthony at 519-661-2111, extension 86562 or at anthonse@univmail.cis.mcmaster.ca, or Dr. Janet Landeen at landeen@mcmaster.ca

If you have any questions regarding your rights as a research participant you may contact the Office of the Chair of the Hamilton Health Sciences/Faculty of Health Sciences Research Ethics Board at 905-521-2100, extension 42013.

Thank you for considering participation in this research.

Yours Sincerely

Sue Anthony RN MScN
519-661-2111, ext: 86562
anthonse@univmail.cis.mcmaster.ca

A Case Study of the Antecedents of Nursing’s Engagement in Interprofessional Education

FOCUS GROUP PARTICIPANT CONSENT STATEMENT

Signature of Research Participant:

I have read the Participant Information Letter thoroughly. I have had the opportunity to discuss the study with Sue Anthony. My questions have been answered to my satisfaction. I understand that I will receive a signed copy of this form. I consent to participate in the study.

Participant Name (Printed)

Participant Signature

Date

Consent form administered and explained in person by:

Name and title

Signature

Date

Signature of Witness to Participant’s Consent:

My signature as witness certifies that I witnessed the participant voluntarily sign this consent form.

Witness

Date

Signature of Investigator:

In my judgment, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

Signature of Investigator

Date

Appendix B

A Case Study of the Antecedents of Nursing's Engagement in Interprofessional Education

Demographic Questionnaire

Please mark your chosen response with an X.

1. What is your age?

- 25 or under 26 - 35 46 - 55
 36 - 45 56 - 66 66 or older

2. What is your sex?

- Female Male

3. How many years have you been in nursing/chosen profession?

Please specify: _____

4. How many years have you been teaching in nursing/chosen profession?

Please specify: _____

5. How many years have you been teaching nursing/chosen profession at this university?

Please specify: _____

6. What is your highest degree in nursing?

- Bachelor's degree
 Master's degree
 Doctoral degree
 Other Please specify: _____

6. What is your highest degree if not in nursing?

Bachelor's degree

Master's degree

Doctoral degree

Other Please specify: _____

Appendix C

Individual and Focus Group Interview Question Guide

1. What is your understanding of interprofessional education?
2. What is/How do you view nursing's role in IPE?
3. Please describe IPE at NAME OF UNIVERSITY?
4. How are nursing faculty involved in interprofessional curriculum development and implementation?
6. Why nursing is/is not engaging in IPE?
7. How do nursing faculty perceive/feel about your involvement/lack of involvement in IPE?
8. What do you think is needed for nursing to be proactive and engaged in IPE?
- 9(a). How does gender affect nursing's involvement in IPE?
- 9(b). How does gender impact nursing's involvement in IPE development and implementation?
10. How do nursing faculty engage in interprofessional educational collaboration with faculty from other profession disciplines?
11. Describe the academic context for nursing and health professional students?
What is the academic culture within which nursing IPE engagement occurs?

Appendix D

Document Review Question Guide

1. What is the document and who are its authors?
2. How are nursing and gender represented?
3. What language is used in writing the text?
4. What indications of power and power relations are present?
5. How is nursing's IPE knowledge and participation present in curriculum and course documents?
6. Do documents corroborate participants' experiences? (i.e., Is there a hidden IPE curriculum or agenda?)
7. What is the relationship between written representations of nursing's IPE, gender, language and power and data derived from the same question asked of other data sources.
8. How is the educational culture and context evident in the text?

Appendix E

Participant Demographic Data

B – Baccalaureate M – Master’s D – Doctorate O - Other

Site	Age						Sex		Years (range, average) in discipline		Years teaching (range, average)		Years at this univ	Highest nsg degree				Highest non-nursing degree			
	≤25	26-35	36-45	46-55	56-65	66≥	M	F	Nsg	other	Nsg	Other		B	M	D	O	B	M	D	O
A	0	1	2	4	5	0	1	11	11-40 (26.3)	30	9-32 (18.2)	23	5-32 (16.5)	3	3	5	1	1	4	4	0
B	0	0	3	5	3	0	1	10	10-41 (21.1)	5-40 (25.0)	4-35 (13.6)	4-40 (22.0)	3-35 (9.2)	2	2	3	2	1	5	2	0
C	0	1	1	3	3	0	0	9	4-40 (27.2)	16-30 (24.6)	3-25 (14.4)	4-12 (10.0)	3-20 (7.2)	2	1	3	0	3	3	1	1

Appendix F

Cross Case Analysis Word Table

	Case A	Case B	Case C
IPE knowledge/ understanding (data for RQ1 RQ4, FPS tenet - language)	<p>Mixture of specific IPE knowledge and understanding;</p> <p>Terms interprofessional, multidisciplinary, interdisciplinary used interchangeably;</p> <p>Old concept with new label;</p> <p>Absence of viewing IPE as an add-on – rival explanation is that this Site is well on its way to embracing IPE;</p> <p>No mention of uni or intra/interprofessional dichotomy; uni and interprofessionalism are not articulated as mutually exclusive or complementary;</p> <p>Newest educational bandwagon/buzzword;</p> <p>PARADOX- cynicism and value for IPE</p>	<p>Knowledge/understanding straddles perception and reality;</p> <p>Terms interprofessional, multidisciplinary, and interdisciplinary used synonymously;</p> <p>IPE conceived as a long-standing pedagogy;</p> <p>A curriculum add-on;</p> <p>Competition for/may subvert uniprofessional education;</p> <p>PARADOX - IPE championed in spite of lack of IPE knowledge/presence of IPE misunderstanding</p>	<p>Diverse range of IPE knowledge and understanding;</p> <p>Terms multidisciplinary, interdisciplinary and interprofessional are used interchangeably;</p> <p>Addition to an already overflowing <i>and</i> a replacement rather than an add on;</p> <p>Uni and interprofessionalism are understood as complementary;</p> <p>Warm fuzzy stuff, the newest buzzword, and the flavour of the month;</p> <p>PARADOX - IPE may not be understood but it is valued</p>

Appendix G

Study Recruitment Poster

Where is Nursing in Interprofessional Education?

**Would you be interested
in participating in a
focus group to discuss
Nursing
and
Interprofessional
Education?**

For more information
please contact Sue Anthony RN MScN
at anthonse@univmail.cis.mcmaster.ca

**Refreshments provided and
parking reimbursed as required**

Appendix H

Summary of Women's Ways of Knowing (Belenky et al., 1986, p.15; Bevis, 1989b, p. 179)

Way of knowing	Description
Silent	A position in which women experience themselves as mindless and voiceless and subject to the whims of external authority.
Received	Women conceive of themselves as capable of receiving, even reproducing knowledge from external authorities, but not capable of creating knowledge on their own.
Subjective	A perspective from which truth and knowledge are conceived of as personal, private, and subjectively known or intuited; truth resides with the person and is more powerful than the answers the outside world offers. Subjective knowing is an important growth step for women. It is an adaptive move that leads to strength, optimism, and self-valuing on one hand and to stubborn rejection of other forms of knowing that can isolate women and make them impatient and dismissive of other persons' ideas.
Procedural	Women are invested in learning and apply objective procedures for obtaining and communicating knowledge. It is having thorough knowledge of standard procedures that allows one to create unique combinations and even new ways to inquire into the nature of things. It is in this category that women are invested in learning and applying objective procedures for obtaining and communicating knowledge. It tends to be a masculine modality. Procedural knowledge is about "knowing how" and is very attractive because the knowledge yielded by procedures provides a person more control and makes the world more orderly and manageable. The problem comes not in the kind of knowledge that procedural knowledge is itself, but in its 'dogmatization' in education. It is a valuable part of knowing but becomes a liability when dogmatized.
Constructed	Women view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing. It is in this position that women integrate all ways of knowing. Compared to other positions, there is a capacity at the position of constructed knowing to attend to another person and to feel related to that person in spite of what might appear to be enormous differences. Constructivist knowing brings all ways of knowing together to bear on a problem.

Appendix I

Falk Rafael's Ordered, Assimilated, and Empowered Caring Framework

Dialectic is a generic process of reasoning to obtain truth and knowledge and is a useful method to rationalize thoughts about two apparently contradictory concepts (Blackburn, 1996; Moccia, 1986). To analyze the evolution of nursing's professional ontology, Falk Rafael (1996) uses a Hegelian perspective in which "dialectic is a logical progression of thought that exposes and examines contradictions and reconciles them through a process of thesis, antithesis, and synthesis" (p. 4).

Ordered Caring

The first layer of the dialectic represents ordered caring in which the relationship between power and caring in nursing exists within a pervasive patriarchal ideology; power and caring are polar opposites where power is aligned with the dominant masculine perspective and caring is aligned with the docile feminine perspective (Falk Rafael, 1996). Power is conceptualized as 'power over' nursing by the dominant male, medical culture, and caring is conceptualized as natural women's work rather than an expert practice based on a specific knowledge base (Falk Rafael, 1998); by virtue of sex, women were "ordered to care ..." (Reverby, 1998, p. 1). Within a context of ordered caring, there is no recognition that caring involves knowledge and power. Nurses are viewed as powerless and are not only limited in access to knowledge, but also are perceived as devoid of intellectual capacity (Falk Rafael, 1996). From a Foucauldian perspective (1980), in which power is exercised at a cost, power in ordered caring is gained at the expense of "devaluation of that which has been labeled feminine in both men and women" (Falk Rafael, p. 8).

Assimilated caring. At the second layer of the dialectic, the relationship between power and caring changes as nurses gain a measure of power through assimilating dominant male and medical values. Dominant conceptualizations of power are similar to ordered caring, however, assimilated caring allows access to power through appropriation of traditionally male power sources and assimilation of male characteristics, practices, and values (Falk Rafael, 1996). In contrast to ordered caring that is devoid of knowledge and power, assimilated caring is now based on knowledge gained in hospital schools of nursing. Male privilege in defining what counts as knowledge is unchallenged, although liberal feminism emerges to champion women's equal access to male power (Falk Rafael, 1996). From a Foucauldian perspective, in which power is not only restrictive but also productive (Doering, 1992), change is made possible within the context of assimilated caring because of resistance to the dominant discourse on power and caring.

Empowered caring. In the third layer of the dialectic, "power and caring are intertwined, rather than present as conflicting concepts" (Falk Rafael, 1996, p.13). Power and caring are symbiotic, not dualistic as in ordered caring, or aligned with the dominant male discourse, as in assimilated caring. Power is recreated to recognize nurses' expertise as a source of power (Benner, 1984). Caring is recreated as an ontology, epistemology, and praxis (Falk Rafael, p. 15). An empowered caring ontology is not consistent with deference to the dominant male and medical authority. Rather, opportunities are created for equal and mutual relationships. As praxis, empowered caring is informed by various forms of knowledge and in this sense is an epistemology (Falk Rafael). From a Foucauldian perspective (1980), empowered caring encompasses mutual generativity between power and knowledge-based caring.

AUTHOR'S NOTE: To promote textual comprehension, this material has been excerpted as background material from my unpublished comprehensive exam paper of June 15, 2007.