Interprofessional Education and Collaborative Practice Through the Eyes of Oral Health Educators: An Interpretive Descriptive Study

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Thesis Abstract

Interprofessional collaborative practice (IPCP) is associated with improved patient outcomes, strengthened health systems, and increased practitioner satisfaction. In Aotearoa New Zealand, legislative and regulatory frameworks reinforce responsibilities to promote IPCP in ways that support equitable health outcomes. Within a context shaped by Te Tiriti o Waitangi and persistent oral health inequities, IPCP is positioned as both a professional expectation and an ethical responsibility. Despite this, interprofessional education and collaborative practice (IPECP) is not consistently embedded within undergraduate oral health therapy (OHT) programmes.

This study explored OHT educators' experiences and understandings of IPECP within undergraduate OHT programmes in Aotearoa New Zealand, with the aim of using these insights to inform future IPECP development. The research was guided by the question: *What are OHT educators' experiences and understandings of IPECP?* An Interpretive Description methodology was used to generate education and practice-relevant insights grounded in participants' accounts. Semi-structured interviews were undertaken with six OHT educators working in undergraduate OHT education, and professional practice contexts. Conventional content analysis supported the initial organisation and examination of the data, before analysis moved beyond description to interpret how participants understood and enacted IPECP within their educational and clinical contexts.

Participants described IPCP as integral to ethical, holistic, and patient-centred care, and as closely aligned with their professional values as oral health professionals and OHT educators. However, their accounts showed that IPECP was shaped by four interconnected conditions. First, participants' ethical and holistic commitments shaped IPCP as part of safe, equitable, and whole-person care. Second, the positioning of oral health outside wider health and educational systems shaped access to IPECP, with limited structural supports often requiring individual effort to create interprofessional opportunities. Third, IPECP was often enacted through relational work, with communication, trust-building, responsiveness, advocacy, and informal negotiation enabling collaboration where embedded curricular or organisational structures were limited. Fourth, limited understanding and recognition of the OHT role shaped OHT visibility, legitimacy, and participation in interprofessional spaces.

These findings highlight a tension between policy and professional expectations for collaborative practice and the everyday conditions that determine whether IPECP can be accessed, practised, and taught within undergraduate OHT programmes in Aotearoa New Zealand. By foregrounding educators' perspectives, this thesis provides practice-oriented insight into how IPECP is understood and enacted in educational and clinical environments. It shows that sustainable integration requires attention not only to curriculum design, but also to educators' ethical commitment to IPCP and the structural and relational conditions that shape its implementation. A contextually informed approach to curriculum development may strengthen alignment between policy expectations and educational practice, preparing graduates to contribute to coordinated, equitable, and holistic models of care.

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed: Melody Rosamund Martin

Date: 13/05/2026

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A summary or description of the AI-generated output. (Optional: attach output in an *appendix.)*	
Output Received:	Point 1: • Patterns were identified • Patterns became apparent • Themes were developed • Themes were constructed • Key ideas were identified • Insights were generated • Interpretations were developed • Conceptual understandings were developed Point 2: • fully integrated • routinely integrated • embedded within interprofessional activity • positioned as an integral part of care Point 3: • in a similar way • this was also evident when • this was reinforced by • this further supports

	• this strengthens the interpretation that • read alongside • taken together • reinforced this point • further noted • this illustrates • this indicates • this points to • this shows • together, these accounts indicate • read together, these accounts show • taken together • read collectively • this reinforces the interpretation
Describe how the AI output was used, edited, or transformed.	
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Chapter 1: Introduction

This thesis explores how oral health therapy (OHT) educators experience and understand interprofessional education and collaborative practice (IPECP) within undergraduate OHT programmes in Aotearoa New Zealand. The study is grounded in the recognition that OHT educators play an important role in preparing students to work collaboratively within healthcare environments. Yet little is known about how they, themselves understand, value, and navigate IPECP within educational and clinical training settings (Van Dam et al., 2025; Babin et al., 2023; Khabeer & Faridi, 2024). By focusing on educator perspectives, this research examines how IPECP is understood and taught within a profession that has historically occupied a distinctive position alongside, rather than fully within, broader health systems.

This chapter introduces the study by outlining the research focus and rationale, situating the inquiry within the context of oral health and OHT education in Aotearoa New Zealand, clarifying key terminology, presenting the research question and aims, and providing an overview of the thesis structure.

An oral health therapist's journey to this research

My interest in IPECP has been shaped by my experiences as an OHT student, clinician, and educator. Across these roles, I have come to view collaborative practice as important to safe, holistic, and person- and whānau-centred care. I have also recognised that opportunities to learn about, practise, and discuss IPECP within undergraduate OHT education are not always clear, consistent, or well supported. Throughout my education and professional career, I have become increasingly interested in how students encounter IPECP and how educators navigate its inclusion within curricula and clinical training environments.

During my undergraduate training, which began in 2010, I became aware of how visibly systemic conditions could manifest in the oral cavity. Delayed healing associated with unstable diabetes, inflammatory presentations linked to broader health conditions, and mucosal changes requiring medical referral reinforced my understanding that oral health cannot be meaningfully separated from

general health, or general health from oral health. Patients would sometimes remark that they “could not hide” aspects of their medical history during oral examinations with me. These interactions further shaped my understanding of the mouth as a gateway to overall health.

My interest was also influenced by formative undergraduate experiences during which structured exposure to interprofessional education (IPE) was limited. In this context, structured exposure refers to intentionally planned, curriculum-based learning activities that bring students from two or more health or social care disciplines together to learn with, from, and about one another. Such activities include defined learning outcomes, facilitated opportunities for interprofessional interaction, and tasks designed to develop understanding of professional roles, communication, teamwork, and collaborative care. This differs from informal or incidental exposure, such as being located near students or practitioners from other professions without an intentionally designed opportunity for shared learning.

One of the few explicit interprofessional learning (IPL) opportunities available to me was participation in the Health Care Team Challenge (HCTC). This was an interprofessional, case-based learning activity designed to simulate team-based problem-solving. Students from two or more health and social care disciplines collaborated to develop and present a patient-centred plan of care and then adapted that plan in response to new case information introduced during the event (Richardson et al., 2012; Flood et al., 2016). Participating in the HCTC highlighted for me both the potential of IPL and the limited availability of comparable, intentionally designed opportunities within my everyday OHT education. At that stage of my training, I held a strong desire to “change the healthcare world” by contributing to more connected and holistic models of care.

Following graduation in 2013, I worked in an oral health clinic alongside other OHTs, dentists, a jaw joint specialist, a mouth and facial muscle therapist, and an ear, nose and throat specialist. This environment enabled informal consultation, shared clinical reasoning, and case-based discussion to occur regularly through everyday interactions, providing opportunities for IPCP. In 2016, when I began teaching in tertiary education, I worked within a clinical training health centre where IPECP initiatives were offered, and oral health students participated in wider interprofessional programmes. These included a person-centred, wellness-based group programme for people living with long-term

conditions and a programme for people with type 2 diabetes (Auckland University of Technology, 2019; O'Brien et al., 2016). Observing and supporting oral health students' participation in these initiatives reinforced my view that oral health could make a valuable contribution within broader healthcare teams rather than sitting separately from them. Together, these experiences shaped my belief that IPCP can be professionally rewarding and can contribute to more holistic and connected care when organisational conditions actively support it.

My views were also shaped by personal experiences of supporting my mother through a prolonged illness. As she moved between practitioners and services with limited visible coordination, I often attended appointments with her, reviewed documentation, and helped to clarify information. At times, discrepancies in her records became apparent and were subsequently confirmed, suggesting to me that communication between providers had broken down. These experiences highlighted how separation between services and gaps in communication may be experienced by patients and whānau navigating complex health systems.

Over the course of my education and professional career, what began as an idealistic ambition to "change the healthcare world" developed into a more grounded commitment to understanding how IPECP is practised and taught within undergraduate OHT education. Collectively, these experiences shaped the strong belief I brought to this research regarding the value of IPECP for OHT education and practice. This belief centred on the importance of preparing graduates to work collaboratively and contribute to holistic, coordinated, person- and whānau-centred care. At the same time, my experiences led me to recognise that IPECP warranted closer examination within undergraduate OHT programmes in Aotearoa New Zealand. This study therefore explores how OHT educators experience and understand IPECP and how those understandings may inform future educational development.

Education and regulatory contexts of oral health therapy in Aotearoa New Zealand

In Aotearoa New Zealand, oral health therapy is a regulated scope of practice defined by the Dental Council of New Zealand (DCNZ). The scope involves the assessment, diagnosis, management, prevention, and treatment of diseases, disorders, and conditions affecting the orofacial complex and

associated structures, in accordance with the practitioner's approved education, training, experience, and competence (DCNZ, 2021). OHT education in Aotearoa New Zealand is currently provided through three-year undergraduate bachelor's degree programmes at the University of Otago and Auckland University of Technology (Auckland University of Technology, n.d.; University of Otago, n.d.). These two programmes represent the principal domestic pathways into the OHT profession in Aotearoa New Zealand.

In the 2023/2024 reporting year, the DCNZ registered 103 new OHTs, 99% of whom held qualifications obtained in Aotearoa New Zealand, illustrating the important contribution of the two undergraduate programmes to workforce supply. Although the DCNZ reports new registrations rather than graduate completions separately for each university, these figures indicate that the programmes collectively contributed approximately 100 newly registered OHTs to the workforce during that reporting year. As of 31 March 2024, 973 OHTs were registered in Aotearoa New Zealand, of whom 86%, or approximately 837 practitioners, held an annual practising certificate. In comparison, 3,349 dentists and dental specialists, 433 dental hygienists, and 307 dental therapists were registered during the same reporting period (DCNZ, 2024). These figures position OHT as a comparatively small profession, particularly in relation to dentistry, while also showing that it is now larger than the remaining separately registered dental hygiene and dental therapy professions. The relatively small size of the OHT workforce may have implications for professional visibility, representation, and opportunities for routine engagement with other health professions, particularly where OHTs are geographically dispersed or work in profession-specific clinical environments.

Graduates of the two undergraduate programmes are eligible to apply for registration within the OHT scope of practice with the DCNZ (DCNZ, 2021; Auckland University of Technology, n.d.; University of Otago, n.d.). Although the gazetted OHT scope of practice has no general age limit, the care an individual OHT may provide is determined by their education, training, experience, competence, and any exclusions placed on their scope. For example, many OHTs whose initial education did not include restorative treatment for adults have an adult restorative care exclusion and may not undertake this care unless they complete an approved programme and successfully apply to the DCNZ to have the exclusion removed. More broadly, areas of practice not included in an OHT's

initial training should not be undertaken without appropriate additional education and practice in accordance with the DCNZ Standards Framework (DCNZ, 2021).

OHTs in Aotearoa New Zealand work across public and private settings, including community oral health services, private general and specialist dental practices, hospital and specialist environments, educational settings, and outreach or public health contexts (DCNZ, 2021). Public-sector practice predominantly includes employment within publicly funded community oral health services administered through Health New Zealand | Te Whatu Ora. These services have traditionally focused on providing preventive and restorative oral healthcare to children and adolescents through school, community, and hospital-associated clinics. OHTs may also work in other publicly funded community, iwi, Māori, education-based, or oral health promotion services. Private practice generally refers to privately owned dental clinics, including general and specialist practices, where OHTs may be employed or self-employed and provide dental hygiene, preventive, periodontal, restorative, and other care within their individual authorised scope of practice. Some OHTs work across both public and private sectors or combine clinical practice with education, management, research, or oral health promotion.

These different settings impact OHTs' opportunities to interact with other health professionals. Some OHTs work within multidisciplinary, hospital, or community-based environments, whereas others work primarily alongside members of the dental team. The nature of the organisation, public or private, may further influence the visibility of the OHT role and the opportunities available for interprofessional collaborative practice (IPCP).

The OHT scope includes periodontal assessment and treatment across the lifespan. Oral health education, disease prevention, and oral health promotion for individuals and communities are also identified as core components of OHT practice, reflecting the position of oral health as an integral part of broader health and wellbeing (DCNZ, 2021). The profession is regulated under the Health Practitioners Competence Assurance Act 2003 (HPCAA), with the DCNZ responsible for professional regulation, competence requirements, and accreditation expectations for oral health educational programmes. Within these regulatory and professional frameworks, communication,

patient-centred care, and engagement with other health professionals are positioned as important aspects of competent, contemporary practice (DCNZ, 2021; HPCAA, 2003, 2019).

As members of a regulated profession, OHTs are expected not only to develop discipline-specific competence but also to work collaboratively within and across professional boundaries (DCNZ, 2021). This expectation is reflected across the broader health workforce, where regulatory standards position communication, coordination, and collaborative care as components of safe and competent practice (DCNZ, 2021; Medical Council of New Zealand, 2019; Nursing Council of New Zealand, 2025).

Oral health is widely recognised as both an integral component and an indicator of overall health, wellbeing, and quality of life (FDI World Dental Federation, 2016; Patel et al., 2024; World Health Organization [WHO], 2025). The WHO also positions oral health within broader noncommunicable disease, primary healthcare, and universal health coverage agendas, emphasising that oral health is closely connected to everyday functioning, including eating, speaking, and social participation (WHO, 2024, 2025). Recent scholarship similarly argues that oral diseases should not be understood as isolated clinical problems but as conditions connected to wider health, social, and policy contexts (Gallagher, 2024).

Despite this recognition, oral healthcare has often remained structurally separate from wider health systems and is frequently described as insufficiently integrated into broader health policy, primary care, and service-delivery structures (Benzian, 2024; Christian et al., 2023; WHO, 2024). Recent work examining oral health inclusion describes oral healthcare as separated from general healthcare through historical patterns of profession-specific organisation, limited inclusion within primary care structures, and weak integration across referral, information, and service-delivery pathways (Christian et al., 2023). Christian et al. (2023) argue that efforts to integrate oral health into primary care have arisen because existing arrangements remain insufficiently connected. The WHO's current global oral health strategy and action plan similarly calls for stronger integration of oral health into noncommunicable disease responses and universal health coverage benefit packages, recognising that such integration remains incomplete (WHO, 2024).

Financing arrangements also reinforce this separation. Internationally, oral healthcare is often insufficiently covered within standard health systems and remains heavily dependent on out-of-pocket payments, increasing the risk of unmet need, delayed care, and financial hardship (Proaño et al., 2024; WHO, 2025). In Aotearoa New Zealand, recent national data show that 39.8% of people aged 15 years and over had not visited a dental healthcare worker in the previous year because of cost, indicating that cost remains a major barrier to accessing dental care (Manatū Hauora, 2024). Research from Aotearoa New Zealand also links unmet oral healthcare need with poorer health outcomes, including higher rates of hospitalisation (McKenzie et al., 2024).

The implications of this structural separation extend beyond access alone. When oral health services remain only partially integrated with broader health systems, opportunities for shared care, coordinated referral, prevention, and early intervention may be reduced (Christian et al., 2023). Contemporary integration literature therefore emphasises the importance of improved documentation processes, referral pathways, operational efficiencies, and stronger integration strategies across provider groups (Christian et al., 2023). In this sense, the positioning of oral health within IPECP is not simply a curricular issue; it is also shaped by the organisation of services, policy priorities, and the extent to which oral health is recognised as part of wider healthcare (Christian et al., 2023; WHO, 2024). For oral health education, this matters because students may have fewer opportunities to observe, practise, and understand collaborative care when oral health is positioned separately from wider health services and interprofessional learning spaces (Christian et al., 2023; WHO, 2024).

Interprofessional education and collaborative practice within oral health education and practice: terminology and application

Interprofessional education and collaborative practice (IPECP) has been promoted by international health and education organisations and interprofessional education scholars as a way to address longstanding concerns within healthcare and health professional education. Before considering its relevance to oral health, it is important to distinguish the related terminology encompassed by IPECP. Although terms such as interprofessional education, interprofessional learning, interprofessional collaboration, and interprofessional collaborative practice are sometimes used

interchangeably in the literature, they have different emphases relating to learning, professional interaction, and care delivery (Barr et al., 2005; Reeves et al., 2010, 2016).

Interprofessional education (IPE) is defined as “occasions when members or students of two or more professions learn with, from, and about each other to improve collaboration and the quality of care and services” (Centre for the Advancement of Interprofessional Education, 2019, p. 1). Interprofessional learning (IPL) is used in this thesis to refer to the learning that may occur through formal or informal interprofessional experiences (Freeth et al., 2005). While IPE describes the intentionally designed educational process, IPL encompasses the learning that emerges through both planned educational activities and less formal interactions among professions.

Interprofessional collaborative practice (IPCP) refers to situations in which multiple health workers from different professional backgrounds purposefully work together with patients, whānau, carers, and communities to deliver high-quality care across settings (WHO, 2010). IPCP therefore focuses on the enactment of collaboration in practice, whereas IPE and IPL relate primarily to the educational experiences and learning processes through which collaborative capabilities may be developed.

IPCP requires ongoing relational and professional learning through which practitioners come to understand the roles, knowledge, and expectations of other professions within collaborative processes (Lingard et al., 2012; Reeves et al., 2016). This is also reflected in interprofessional competency frameworks, which identify role clarification, interprofessional communication, team functioning, and shared responsibility for patient-centred care as core capabilities for collaborative practice (Canadian Interprofessional Health Collaborative [CIHC], 2010; Interprofessional Education Collaborative [IPEC], 2023). The interdependent nature of IPE and IPCP means that education and practice cannot be meaningfully separated: educational experiences shape readiness for IPCP, while the realities of practice influence how interprofessional capabilities are developed, interpreted, and practised (D’Amour & Oandasan, 2005; Reeves et al., 2016).

Collectively, IPE and IPCP have been promoted as responses to disconnected healthcare delivery, profession-specific training models, and the need for improved communication and coordination across health professions (Barr et al., 2005; Reeves et al., 2010). International policy and scholarship

have increasingly positioned IPECP as important to patient safety, care coordination, and health-system effectiveness (WHO, 2010). However, the implementation of IPECP is shaped by organisational, relational, and professional conditions. Consequently, policy and educational expectations do not necessarily translate directly into routine educational or clinical practice.

Within oral health education, particularly undergraduate OHT programmes in Aotearoa New Zealand, how these expectations are understood, interpreted, and practised remains underexplored (Christian et al., 2023; Khabeer & Faridi, 2024; Rojo et al., 2022; Van Dam et al., 2025). This is important because the structural organisation of oral health education and practice may influence whether OHT students and practitioners have opportunities to learn with other professions and participate meaningfully in collaborative care.

Because education and practice are closely related, this thesis uses the term IPECP to refer to IPE and IPCP as a connected continuum. During analysis, it became apparent that participants did not always use interprofessional terminology consistently. Terms such as IPECP, IPCP, collaboration, and multidisciplinary practice were sometimes used interchangeably. This terminological fluidity reflects a broader challenge within interprofessional discourse and suggests that terminology requires greater attention within education and practice contexts. For consistency, this thesis uses the term IPECP when discussing the connected relationship between education and practice, while remaining attentive to the specific language participants used in their accounts.

Taken together, the background presented in this chapter establishes a clear rationale for examining IPECP within undergraduate OHT education in Aotearoa New Zealand. Although oral health is integral to overall health and OHTs are expected to work collaboratively across public, private, and community settings, oral health education and practice remain partly separated from wider health systems and interprofessional structures. The comparatively small size and geographic distribution of the OHT workforce may further influence professional visibility and opportunities for engagement with other health professions. While international policy and scholarship promote IPECP as important to safe, coordinated, and person- and whānau-centred care, limited research has examined how it is understood and experienced by the educators responsible for preparing future OHTs in Aotearoa New Zealand. This gap provides the rationale for the research question and aim guiding this study.

Research question and aim

Research question: What are oral health therapy educators' experiences and understandings of interprofessional education and collaborative practice within undergraduate oral health therapy programmes in Aotearoa New Zealand?

Aim: This study aims to explore oral health therapy educators' experiences and understandings of interprofessional education and collaborative practice within undergraduate oral health therapy programmes in Aotearoa New Zealand and to generate practice-relevant insights that may inform future interprofessional education and collaborative practice development within oral health therapy education.

Thesis overview

This thesis is organised into five chapters. Chapter One introduces the study by outlining the research focus and rationale, situating the inquiry within the context of oral health and OHT education in Aotearoa New Zealand, clarifying key terminology, and presenting the research question and aims. Chapter Two critically reviews literature relating to IPECP, with particular attention to oral health, OHT, and educator perspectives.

Chapter Three outlines the methodological approach and research design. Guided by Interpretive Description, it describes the philosophical and methodological foundations of the study, participant recruitment, data collection, analytic processes, reflexivity, rigour, and ethical considerations. Chapter Four presents the study findings, organised around the interpretive themes developed through analysis.

Chapter Five discusses these findings in relation to existing literature, the study context, and the broader implications for undergraduate OHT education and IPECP. It also concludes the thesis by summarising the study's key contributions, considering its limitations, and identifying implications for practice, education, and future research.

Chapter 2: Literature Review

This chapter critically reviews literature relating to interprofessional education and collaborative practice (IPECP) as it pertains to oral health therapy (OHT). Particular attention is given to the role of educators in preparing graduates for interprofessional collaborative practice (IPCP). Building on the contextual foundations introduced in the Introduction Chapter, this literature review examines how IPECP has been conceptualised, studied, and practiced across health and oral health education, and identifies key areas of convergence, limitation, and gaps that inform the present study.

Although interprofessional education (IPE) has been widely promoted as a strategy for preparing health professionals for IPCP, literature examining how it is put into practice within oral health remains comparatively limited (Formicola et al., 2012; Haber, 2024; Harnagea et al., 2018; Davis et al., 2018; Jiang et al., 2020). This limitation is particularly evident in relation to educator perspectives within OHT programmes in Aotearoa New Zealand, despite IPCP being embedded within professional and regulatory expectations (Davis et al., 2018; Jiang et al., 2020; Dental Council New Zealand [DCNZ], 2021; Health Practitioners Competence Assurance Act [HPCAA], 2019).

The chapter begins by drawing on broader interprofessional literature to outline the wider IPECP context. It then presents a review of oral health literature organised around five literature-derived areas: role understanding in oral health; attitudes toward interprofessional education and collaboration in oral health education; delivery of interprofessional education within oral health programmes; educator preparation and capability; and IPCP in oral health practice. The chapter concludes by synthesising the literature and identifying the gap addressed by this study.

Interprofessional education and collaborative practice context

Interprofessional education and collaborative practice has been widely promoted across health professions as an important response to increasingly complex healthcare needs, limited coordination across services, and the need for stronger communication across professions (Patel et al., 2025; World Health Organization [WHO], 2010). Thistlethwaite (2012) similarly argues that IPE is shaped

by context, learning design, and the need to understand how interprofessional learning (IPL) contributes to professional practice. The broader literature commonly links IPECP with improved teamwork, clearer understanding of professional roles, more coordinated care, workforce preparation, service integration, and healthcare quality (WHO, 2010; Patel et al., 2025). At the same time, collaborative practice is not shaped only by professional goodwill or educational intent, with organisational structures, workplace hierarchies, service design, and workplace cultures also influencing how IPECP is understood and put into practice (WHO, 2010; Hung et al., 2025; Patel et al., 2025). This interprofessional context provides the backdrop for the present study, while also highlighting that interprofessional expectations are interpreted within specific professional and educational settings rather than applied in uniform ways across all health disciplines.

International policy and conceptual context

International policy and scholarship have played a major role in positioning IPECP as a priority for health systems and professional education globally (Reeves et al., 2016; WHO, 2010). For example, WHO's *Framework for Action on Interprofessional Education and Collaborative Practice* presents IPECP as a strategy for strengthening health systems and preparing a collaborative practice-ready workforce (WHO, 2010). WHO's *Patient Safety Curriculum Guide: Multi-professional Edition* also reflects this system-level orientation by supporting patient safety education across multiple health professions, including dentistry, medicine, midwifery, nursing, and pharmacy (WHO, 2011). Patient-safety literature similarly shifted attention from individual performance alone to the systems in which care is organised. For example, *To Err is Human* argued that patient safety problems are not simply caused by individual practitioners, but by practitioners working within systems that need to be made safer (Kohn et al., 2000). Within this context, responsibility for enabling collaborative practice extends beyond individual practitioners to include education providers, healthcare organisations, and regulatory bodies. IPECP can therefore be understood as one strategy for supporting teamwork, coordination, and quality of care across increasingly complex health environments (Patel et al., 2025; Reeves et al., 2016; WHO, 2010).

Building on this international policy and patient-safety emphasis, conceptual and competency-based literature has identified several competencies required for IPCP, including role clarification,

interprofessional communication, mutual respect, shared goals, collaborative decision-making, and patient-centred care (Canadian Interprofessional Health Collaborative [CIHC], 2010; Patel et al., 2025; WHO, 2010). These competencies are important because they show that IPCP requires more than professionals working in parallel or sharing the same care setting. It requires shared understanding of roles, communication across professional boundaries, respect for different professional contributions, and coordinated approaches to patient care. More recent literature further emphasises that these competencies are shaped by workplace structures, professional hierarchies, institutional culture, and the way different professions are recognised within teams (Hollaar et al., 2024; Hung et al., 2025). This emphasis draws attention to the complexity of IPECP by showing that collaborative practice depends not only on individual competencies, but also on the structural, relational, and organisational conditions that enable or constrain how those competencies are practiced.

While international frameworks and conceptual literature provide strong justification for IPECP, they offer less insight into how these ideas are understood and supported within particular disciplinary and educational settings. This limitation becomes important when considering oral health education, where the position of oral health within interprofessional systems is not always clearly defined and recognised (Chan et al., 2023; Hung et al., 2025).

Aotearoa New Zealand policy, legislative, and regulatory context

In Aotearoa New Zealand, collaborative practice is not only promoted through international IPECP literature but is also reflected in local legislative and regulatory expectations. The Health Practitioners Competence Assurance Act (HPCAA) 2003 establishes the regulation of health practitioners as part of protecting public safety. Following the 2019 amendment to section 118(1)(ja), responsible authorities are also required to promote collaborative practice among health practitioners to support healthcare delivery and improve health outcomes (HPCAA 2003, s 118(1)(ja)).

Within oral health, these expectations are reflected in the DCNZ competencies for OHTs, which include communication, professionalism, and collaboration as part of safe and ethical practice (DCNZ, 2021). These frameworks are significant for this study because they create an expectation that OHT graduates will be prepared to communicate and work collaboratively within wider health

and social care contexts. However, they do not explain how IPECP should be embedded within undergraduate OHT programmes or how oral health should be positioned within IPL and practice settings.

Although legislative and regulatory expectations for collaborative practice are evident, there has been limited exploration of how these expectations are interpreted and translated into educational and practice realities within undergraduate OHT education. This is particularly relevant in oral health, where professional preparation and service delivery have often developed through arrangements that are not always closely integrated with broader health education and care systems (Chan et al., 2023; Hung et al., 2025). This can be seen in the way dental therapy in Aotearoa New Zealand historically developed through the School Dental Service, which was closely linked to the development of dental nursing and later dental therapy (Moffat, 2021; Moffat et al., 2017). Dental therapy services were historically focused on children and adolescents, with the Dental Council continuing to define dental therapy services as being provided to children and adolescents up to age 18 (Dental Council New Zealand, 2021c). Later changes in oral health education and workforce development brought dental therapy and dental hygiene together within the oral health therapy scope, which came into effect on 1 November 2017 (Dental Council New Zealand, 2017). This expanded the professional role to include preventive and restorative care for children and adolescents, and periodontal care for adults (Auckland University of Technology, n.d.; Dental Council New Zealand, 2021d). Although OHT now has a broader scope, this historical separation helps contextualise why the place of oral health within IPECP may still require explicit attention.

Oral health within the wider interprofessional education and practice landscape

Although wider health literature presents IPECP as an important part of health professional education and service delivery, the place of oral health within this literature is less obvious. Across health education more broadly, the literature indicates that effective IPCP requires specific competencies and qualities, including role understanding, interprofessional communication, teamwork, collaborative readiness, mutual respect, and patient-centred care (CIHC, 2010; Interprofessional Education Collaborative [IPEC], 2016; Patel et al., 2025; WHO, 2010). Patel et al.

(2025) reinforce this by emphasising that interprofessional learning (IPL) is intended to develop collaborative capability, rather than simply expose students to other professions. These ideas have contributed to the expectation that health professional programmes should prepare graduates not only with profession-specific knowledge, but also with the capabilities needed to communicate, collaborate, and contribute to shared care.

In oral health, however, the literature more often describes interprofessional activity as limited, variable, or difficult to embed within curricula and practice settings. Studies involving dental, dental hygiene, dental therapy, and oral health learners report generally positive attitudes toward IPL, but also describe IPE activities that are short-term, programme-specific, observational, simulation-based, or dependent on local opportunities (Morison et al., 2008; Colonio Salazar et al., 2017; Davis et al., 2018; Jiang et al., 2020; Chan et al., 2023). This suggests that oral health is not absent from IPECP, but that its inclusion is not always sustained or consistently integrated.

The less consistent inclusion of oral health in IPECP may partly reflect how oral health is positioned within health systems and health professional education. Recent oral health interprofessional literature identifies ongoing challenges, including separation between dental and general healthcare, limited coordination, unclear role understanding, and barriers to shared care across services (Harnagea et al., 2018; Bissett et al., 2020; Alkhtib et al., 2023; Hung et al., 2025). Research with primary healthcare providers has also shown that knowledge, attitudes, and practices relating to oral health influence how it is understood within wider primary care contexts. For example, Alkhtib et al. (2020) found that primary healthcare providers generally held positive attitudes toward oral health promotion, but had limited knowledge of childhood oral health, with variation in practices such as examining children's teeth, discussing toothbrushing with parents, assessing fluoride intake, and referring children for dental care. These findings suggest that oral health may be viewed as relevant within primary care without being consistently embedded in everyday practice. While wider IPECP literature provides useful concepts for understanding collaborative practice, oral health and OHT education are not consistently represented within it. This does not mean that wider IPECP literature is irrelevant to OHT education, but that its concepts need to be considered alongside the specific educational, professional, and service contexts in which oral health practice occurs. It is therefore

necessary to examine oral health-specific research to understand how IPECP has been studied in relation to curricula, educator roles, professional identity, and collaborative practice contexts. The following sections focus on this literature and consider how it informs the present study.

Literature search strategy for the focused oral health review

To develop a robust understanding of the current empirical literature relevant to IPECP in oral health contexts, I undertook a structured literature review. The literature review paid particular attention to undergraduate education, educator involvement, and the positioning of oral health within wider collaborative care.

Search approach

In keeping with the purpose of this chapter and the research question, the search focused on literature relating to oral health education, OHT and closely related oral health professions, educator perspectives, and preparation for collaborative practice. Broader IPECP literature was used to define key concepts and provide context, but the structured search itself remained focused on oral health and OHT-related literature. Reference lists of key included articles were also screened for additional relevant studies not retrieved through the database search. Consistent with the methodology Interpretive Description used in this thesis, the literature review was used as a theoretical scaffold rather than as an exhaustive systematic review. In this sense, the literature helped clarify key concepts, situate the study within existing IPECP and oral health education scholarship, and provide sensitising ideas for analysis without predetermining the interpretation of participants' accounts (Thorne, 2016).

Databases and search terms

Searches were conducted using EBSCOhost databases and MEDLINE, selected for their coverage of health, education, and allied health scholarship. Search terms were organised across three main concept domains: interprofessional education/collaborative practice, oral health professions, and education/educator context. Terms within each domain were combined using OR, and the three domains were combined using AND. Truncation was used where appropriate to capture variations of relevant terms. Search settings also included related-word expanders, equivalent subject headings, English language limits, and Boolean/phrase search modes.

The core search structure was (“interprofessional collaboration” OR “interprofessional teamwork” OR “interprofessional education” OR “collaborative learning” OR multidisciplinary OR interdisciplinary OR collaborative) AND (“oral health” OR “dental hygiene” OR “dental therapist” OR “oral health therapist” OR “dental profession*” OR “oral profession*”) AND (educator OR instructor OR teacher OR supervisor OR “clinical educator” OR “clinical supervisor” OR academic* OR faculty OR lecturer* OR tutor OR “university student” OR “undergraduate student” OR “higher education student” OR “tertiary education”)

Search strings were adapted as needed for each database interface while retaining the same core concept structure.

Design and methods terms were used in supplementary searches rather than applied as mandatory terms across the main search. These included “interview*,” “focus group*,” “thematic analysis,” “content analysis,” “interpretive descripti*,” and “mixed methods.” These supplementary searches helped identify studies that explored experiences, understandings, perspectives, and programme development, while avoiding the unnecessary exclusion of relevant empirical, educational, and programme-evaluation literature.

Inclusion criteria

Inclusion criteria for the database search were limited to full-text articles published in English from January 2010 to December 2024. No restrictions were placed on study design or methodology, allowing the inclusion of survey-based, qualitative, mixed-methods, and review studies where relevant to the chapter’s focus. To be included in the review, studies needed to address interprofessional education, interprofessional learning, collaborative practice, or related collaborative activity in relation to oral health education, oral health therapy and closely related oral health professions, or oral health integration within wider healthcare contexts. One study published outside the 2010–2024 search period was retained because of its direct relevance to dental IPL and role understanding within oral health education (Morison et al., 2008).

Search outcome

The search yielded 46 records following the application of the main combined search set and inclusion criteria. These records formed the focused set of studies that informed the oral health review.

Following title, abstract, and full-text screening, 11 studies were identified as relevant to the oral health literature review. These studies are summarised in Table 1, which provides an overview of their participants, contexts, study designs, and relevance to the present review. Overall, the literature was predominantly international and focused mainly on students, programme implementation, faculty perspectives, and oral health integration within wider healthcare contexts. Across the included studies, only one study was based in Aotearoa New Zealand. Educator or faculty perspectives were directly included in three studies and indirectly included in one. One other study involved OHT input within an interprofessional training intervention, although its focus was on nursing students rather than educators. However, only one study explored oral health educators' perspectives qualitatively and in depth. This pattern shaped the themes identified in the literature review and helped clarify the gap addressed by the present study.

Overview of included studies

The search identified 11 studies relevant to IPECP in oral health contexts. Although these studies provide useful insight into student learning, programme implementation, and oral health integration, they offer limited understanding of OHT educators' experiences of IPECP within undergraduate OHT education in Aotearoa New Zealand.

Table 1. Characteristics of studies included in the oral health literature review.

Author(s), year	Country	Participants	Study design	Focus	Educator perspectives included?
Morison et al. (2008)	United Kingdom / Northern Ireland	Dental, dental hygiene, and dental nursing students	Questionnaire survey	Attitudes toward interprofessional learning and understandings of professional roles within the dental team	No
Colonio Salazar et al. (2017)	United Kingdom	Dental, dental hygiene and therapy, and dental nursing students	Questionnaire survey	Attitudes toward dental interprofessional education and	No

				perceptions of professional roles	
Davis et al. (2018)	International	Oral health educators from 29 countries	Qualitative workshops / discussion groups	Barriers, opportunities, and priorities for integrating IPE into oral health curricula	Yes
Casa-Levine (2017)	United States	Dental hygiene faculty and programme administrators	Survey	Faculty attitudes toward IPE and extent of curriculum integration	Yes
Jiang et al. (2020)	United States	Deans of dental education programmes	Survey	Barriers to IPE implementation in dental education and the quality of IPE delivery	Yes, indirectly
Tolle (2019)	United States	Dental hygiene faculty	Survey	Faculty views on IPE and barriers to stronger curriculum inclusion	Yes
Kersbergen et al. (2020)	Netherlands	Dentists and dental hygienists	Qualitative open-ended questionnaire study	Perceptions of interprofessional collaboration following collaborative educational preparation and transition into practice	No
Harnagea et al. (2018)	Canada	Primary healthcare providers and managers	Qualitative interviews	Integration of oral health into interprofessional primary care and barriers to collaboration	No
Bissett et al. (2020)	England	Medical and dental primary care staff and people with diabetes	Qualitative workshop study	Interprofessional communication and collaboration in diabetes and periodontitis care	No
Oda et al. (2023)	New Zealand	Nursing students within an oral-health-linked training intervention	Mixed methods	Oral health assessment training delivered with oral health therapist input in an interprofessional context	Limited
Alkhtib et al. (2023)	Qatar	Primary healthcare professionals	Qualitative interviews and focus groups	Barriers and enablers for oral health promotion within primary care and	No

				collaborative practice contexts	

As shown in Table 1, the literature included in the review uses a range of methods, although many studies are survey-based or programme-evaluative. Much of this literature focuses on students, curriculum implementation, or oral health integration within wider healthcare settings. A smaller number of studies include faculty, administrative, or educator perspectives, indicating that educator perspectives are present but remain limited in number, scope, and contextual relevance to undergraduate OHT programmes in Aotearoa New Zealand.

Findings from the oral health literature

The purpose of this part of the literature review was to examine and synthesise existing evidence concerning how IPECP has been understood, experienced, delivered, and supported within oral health education and practice. The review also sought to identify the factors reported as enabling or constraining IPECP and to establish what remains underexplored, particularly in relation to undergraduate OHT education and the perspectives of OHT educators in Aotearoa New Zealand. This synthesis provides the foundation for positioning the present study within the existing oral health IPECP literature.

The included studies were synthesised into five literature-derived themes: role understanding in oral health; attitudes towards IPECP in oral health education; delivery of interprofessional education within oral health programmes; educator preparation and capability; and interprofessional collaborative practice in oral health practice. These themes are not discrete categories; rather, they overlap and together demonstrate how IPECP is understood, supported, constrained, and enacted within oral health education and practice contexts.

Role understanding in oral health

Role understanding is frequently positioned within interprofessional literature as an important component of collaborative practice, because practitioners need to understand their own responsibilities as well as the contributions of others (WHO, 2010; CIHC, 2010; Reeves et al., 2010). In the oral health literature reviewed here, role understanding refers to how learners and practitioners understand their own roles and the roles of other members of the dental or wider healthcare team,

including areas of responsibility, contribution, and overlap in patient care (Morison et al., 2008; Colonio Salazar et al., 2017; Kersbergen et al., 2020). Across these studies, role understanding appears important, but it is not presented as something that develops automatically simply because learners or practitioners are brought together in interprofessional settings. Instead, it is shaped by hierarchy, professional assumptions, and the educational and practice settings in which collaboration is expected to occur (Morison et al., 2008; Colonio Salazar et al., 2017; Kersbergen et al., 2020).

Morison et al. (2008) examined attitudes toward IPL among dental, dental hygiene, and dental nursing students and found that, although attitudes were generally positive, understandings of professional roles differed across groups. Dental hygiene students appeared more likely to position themselves as partners in care rather than as simply supporting the dentist, while other student groups were more likely to attribute key responsibilities primarily to the dentist. This suggests that IPL may increase exposure to other professions without necessarily creating a shared or consistent understanding of role boundaries and contributions. In this study, role understanding remained uneven, despite opportunities for engagement in IPL.

A similar issue is evident in Colonio Salazar et al. (2017), who explored attitudes toward IPE among dental, dental hygiene and therapy, and dental nursing students training together at the University of Portsmouth Dental Academy. Although students across these groups generally valued IPL, they also showed a stronger preference for discipline-specific education and a more limited understanding of the roles of other oral health professionals. This is relevant to role understanding because it suggests that positive attitudes toward IPE do not necessarily mean that students understand how different professional roles, responsibilities, and contributions relate to one another in patient care. Shared educational experiences may support awareness of other professions, but this awareness does not automatically translate into clearer understanding of scope, responsibility, or collaborative contribution.

Kersbergen et al. (2020) provides a Netherlands-based example of how role understanding developed through interprofessional education may transfer into practice. The study examined dentists and dental hygienists who had participated in collaborative educational preparation and found that participants valued mutual recognition of each other’s roles as beneficial to

interprofessional work. However, these understandings were difficult to sustain in early professional practice, where existing workplace routines and the influence of practitioners who had not been educated through interprofessional models shaped what collaboration looked like in reality. This suggests that role understanding developed during education may be fragile when it is not reinforced by practice environments.

Together, these studies suggest that role understanding is important aspect of IPECP, but that in the oral health literature, does not develop automatically through participation in IPL activities. It may be strengthened through IPE experiences, but remains shaped by traditional hierarchies, discipline-based assumptions, and the conditions of education and practice (Morison et al., 2008; Colonio Salazar et al., 2017; Kersbergen et al., 2020). These studies show that role understanding involves more than exposure to other professions. It is also shaped by how responsibilities, authority, and professional value are understood within educational and practice settings. At the same time, this body of work provides limited insight into how OHT educators understand these issues or how they support role clarification among students within undergraduate programmes. This is important for the present study because OHT educators are positioned not only as practitioners who navigate role understanding in practice, but also as educators who may help students understand the oral health contribution within collaborative care.

Attitudes toward interprofessional education and collaborative practice in oral health education

Across the reviewed oral health literature, attitudes toward IPECP are generally favourable. Students, educators, faculty, and oral-health-related stakeholders commonly recognise the value of collaboration for patient care, professional relationships, and educational preparation (Morison et al., 2008; Colonio Salazar et al., 2017; Casa-Levine, 2017; Davis et al., 2018; Harnagea et al., 2018; Tolle, 2019). However, support for IPECP does not appear to translate easily into strong or sustained collaborative practice. Positive attitudes are often accompanied by concerns about workload, curriculum pressures, limited organisational support, and uncertainty about how interprofessional aims can be supported within existing systems (Casa-Levine, 2017; Davis et al., 2018; Harnagea et al., 2018; Jiang et al., 2020; Tolle, 2019).

Harnagea et al. (2018), in a Canadian qualitative study of primary healthcare providers and managers, identified broad support for better integration of oral health within interprofessional primary care. Participants viewed oral health as an important but underrepresented part of holistic healthcare and recognised the value of stronger collaboration across primary care settings. At the same time, they identified substantial barriers, including funding structures, service organisation, and limited institutional support. In this study, support for collaboration was clear, but participants also recognised that positive intentions alone were insufficient where organisational conditions did not support change. This shows that favourable attitudes toward collaboration can exist alongside recognition of the systemic constraints that limit how it is put into practice.

This pattern is also evident in studies focused more directly on educators and oral health programmes. Davis et al. (2018), in an international study of oral health educators, found strong recognition of the value of interprofessional education alongside considerable concern about the practicalities of embedding it within oral health curricula. Participants identified inadequate administrative support, competing curricular demands, and a lack of structured IPE opportunities as significant barriers. These findings suggest that educator attitudes are shaped not only by beliefs about the value of IPE, but also by whether institutional conditions make meaningful and sustained delivery possible. Support for IPE was evident, but so too was concern about whether it could be sustained in practice.

Casa-Levine (2017), in a United States survey of dental hygiene faculty and programme administrators, similarly reported positive attitudes toward IPE alongside relatively limited integration within undergraduate curricula. The study highlights a gap between valuing IPE and being able to embed it in ways that are coherent and sustained. Tolle (2019), also in the United States, reinforces this point through a survey of dental hygiene faculty, who wanted stronger IPE opportunities but described frustration with curricular constraints and limited support. Jiang et al. (2020), in a United States survey of dental education deans, also found that barriers to IPE implementation included curriculum crowding, uneven buy-in, and limitations in how IPE was delivered across programmes. Together, these studies suggest that positive attitudes toward IPECP within oral health education

are common, but that these attitudes are shaped and sometimes constrained by the institutional realities in which educators work.

Across the reviewed studies, support for IPECP was often evident, but this support was shaped by questions of feasibility, sustainability, and quality. The literature suggests that positive attitudes toward collaboration do not automatically translate into meaningful educational or practice experiences. Instead, the enactment of IPECP in oral health education depends on the conditions in which educators, students, and stakeholders are working, including curriculum structures, organisational priorities, leadership support, and the availability of authentic interprofessional opportunities.

Although several studies in this area include faculty, administrative, or educator participants, the literature remains limited in what it can show about educators experiences of interprofessional expectations. Existing studies tend to focus on support for IPE, barriers to implementation, or programme conditions, rather than on how educators themselves experience, understand, and support IPECP across educational and clinical teaching contexts. This leaves only a partial understanding of how OHT educators make sense of these expectations within undergraduate programmes, particularly in Aotearoa New Zealand. While the reviewed studies indicate generally favourable attitudes toward IPECP, they also raise a further question about how interprofessional learning is actually delivered within oral health programmes.

Delivery of interprofessional education within oral health programmes

Across studies, IPE is frequently described as part of oral health curricula, yet its delivery is often reported as limited, inconsistent, or weakly connected to collaborative practice (Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). This suggests that the inclusion of IPE within curriculum documents or programme descriptions does not necessarily mean that students experience sustained or meaningful interprofessional learning. What appears to matter is not simply whether IPE is present, but whether it is intentionally embedded, well connected across the programme, and supported across classroom and clinical settings (Davis et al., 2018; Jiang et al., 2020). Structured approaches such as interprofessional simulation have also been reported in

undergraduate health education, although such activities still require careful design, facilitation, and alignment with programme aims (Buckley et al., 2012).

Jiang et al. (2020) illustrates this clearly in a United States survey of dental education deans. Although many dental education programmes reported that IPE was included within their curricula, the study suggested considerable variation in how it was embedded. In many cases, IPE appeared to take the form of isolated or superficial activities rather than sustained learning experiences aligned with collaborative practice. Participants also expressed concern about graduates' preparedness for collaborative work, indicating that inconsistency in delivery may weaken the intended value of IPE. This shifts attention away from whether IPE exists in principle and toward the quality, continuity, and authenticity of what students actually experience.

A similar issue is evident in Casa-Levine (2017), where dental hygiene faculty and programme administrators reported strong support for IPE alongside relatively limited curriculum integration, with implementation affected by factors such as scheduling, curriculum space, and programme-level support. Tolle (2019) reinforces this point by showing that faculty wanted more meaningful IPE opportunities yet encountered curricular constraints that limited what could be implemented. Together, these studies indicate that IPE delivery within oral health programmes is shaped not only by positive attitudes toward collaboration, but also by practical constraints such as timetable pressures, competing curriculum priorities, and the challenge of fitting interprofessional learning into already crowded programmes.

Davis et al. (2018) provides a broader international oral health education perspective through qualitative workshops and discussion groups with oral health educators from 29 countries (none being Aotearoa New Zealand). The study identified the absence of structured IPE initiatives and weak institutional support as barriers to stronger implementation. This suggests that IPE delivery is not only a curriculum design issue, but also an organisational one. Where IPL is weakly supported, it is more likely to be ad hoc, short term, or dependent on individual enthusiasm. In that sense, the literature points to delivery as a key site where institutional intentions and educational realities do not always align. Oral health programmes may value IPE, but students' opportunities to experience it in meaningful ways remain limited.

The reviewed literature also suggests that how IPE is delivered matters, not only whether it is included in the curriculum (Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). IPL appears more meaningful when it connects clearly to collaborative practice, exposes students to other professions in purposeful ways, and is reinforced across different parts of the programme rather than confined to one-off events (Davis et al., 2018; Jiang et al., 2020). Where delivery is limited to isolated activities, observational encounters, or inclusion in curriculum documents without sustained learning opportunities, the potential of IPE to support collaborative capability is reduced. This helps explain why some studies report positive attitudes toward IPE while still identifying concerns about students' preparedness for collaborative practice (Jiang et al., 2020; Tolle, 2019). Delivery, in other words, is where positive intentions either become meaningful learning experiences or remain difficult to enact in practice.

Overall, the oral health literature suggests that delivery remains a central issue in IPE. IPE may be included within oral health programmes, but its delivery is often fragmented and inconsistently embedded across educational contexts. The literature therefore points to the importance of curricular coherence, authentic interprofessional contact, and organisational support in shaping whether IPE is experienced as a meaningful preparation for collaborative practice. At the same time, existing studies provide limited insight into how OHT educators themselves experience and navigate these delivery challenges in their day-to-day teaching and clinical supervision roles. Because delivery depends not only on curriculum structures but also on those responsible for facilitating and modelling interprofessional learning, the next section considers educator preparation and capability.

Educator preparation and capability

The reviewed literature suggests that educator preparation and support are important to how IPE is interpreted, facilitated, and sustained within oral health programmes (Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). Studies involving oral health educators, dental hygiene faculty, programme administrators, and dental education leaders indicate that educator knowledge, confidence, prior experience, and institutional support can influence whether IPE is meaningfully embedded or remains limited in scope (Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). However, these studies tend to identify educator preparation and support as important,

rather than examining in depth how educators develop and use interprofessional capability in practice. Broader educator-focused literature similarly suggests that tutors and educators need support to facilitate interprofessional learning, particularly because IPL requires attention to curriculum design, facilitation, professional boundaries, and learning across disciplines (Smith & Karban, 2008; Berghout, 2021). The need for educator support, knowledge, or commitment is evident, but there is less attention to how these capacities are developed or constrained within everyday teaching and clinical education contexts (Casa-Levine, 2017; Davis et al., 2018; Tolle, 2019).

In an international study exploring oral health educators' views on integrating IPE into oral health curricula, Davis et al. (2018) found that participants identified faculty support as essential to successful IPE integration. However, participants also described significant barriers, including weak administrative support, competing curriculum demands, and limited interprofessional infrastructure. The study suggests that educator commitment alone is insufficient when broader institutional conditions do not adequately support interprofessional work. In this way, educators may value IPE, but their ability to support it is shaped by factors beyond individual willingness or belief.

A similar issue is evident in Casa-Levine (2017) and Tolle (2019). Both studies suggest that faculty support for IPE is present, yet opportunities to embed it meaningfully within oral health programmes remain constrained. These findings indicate that IPE implementation depends on more than individual educator interest. It is also shaped by the practical and organisational conditions that influence whether IPE can be integrated into curriculum and programme delivery.

Jiang et al. (2020) contributes further by showing that IPE implementation in dental education was affected by programme-level barriers, including curriculum crowding, limited faculty buy-in, and variation in the quality and delivery of IPE activities. Although the study focused on dental education programmes rather than educators lived experiences, it is relevant to educator preparation because these programme conditions shape the context in which educators are expected to facilitate IPE. Where IPE is inconsistently embedded within the curriculum, educators may have fewer clear structures, expectations, or opportunities to support students' interprofessional learning.

Kersbergen et al. (2020) adds a practice-oriented perspective by examining dentists' and dental hygienists' perceptions of interprofessional collaboration after collaborative educational preparation. The study found that participants valued role understanding and collaboration, but that these understandings were not always easy to sustain in workplaces shaped by existing routines and by more experienced colleagues who had not been prepared through the same interprofessional approach. In this context, interprofessional preparation refers to learning experiences where dental and dental hygiene students were prepared to understand each other's roles and work together in patient care. This suggests that preparing students for collaboration is important, but that this preparation needs to be reinforced in clinical practice environments where collaborative ways of working are also understood and supported.

Relatively few studies examine educator preparedness and capability in depth. Those that do are often concerned with barriers, attitudes, or implementation conditions rather than with educators' own experiences of developing and using interprofessional capability across educational and clinical teaching contexts. As a result, the literature provides limited insight into how OHT educators are prepared and supported to facilitate IPE within undergraduate programmes. This is important because educators are expected to prepare students for collaborative practice, but the literature offers limited guidance on how educators themselves are supported to undertake this role. The next section considers how oral health is positioned within IPCP.

Interprofessional collaborative practice in oral health practice

The literature reviewed in this section suggests that oral health is recognised as relevant to holistic and preventive care but is not always routinely integrated into IPCP (Harnagea et al., 2018; Bissett et al., 2020; Alkhtib et al., 2023). Rather than providing strong evidence of patient outcomes, these studies more often show the barriers that affect oral health's inclusion in collaborative care, including limited communication, poor coordination, and service separation.

Bissett et al. (2020) illustrates this clearly in a qualitative study which explored interprofessional communication and collaboration from the perspective of staff working across medical and dental primary care services in diabetes and periodontitis care. They found that interprofessional communication was recognised as important for managing complex long-term conditions, yet there

was little routine interaction between medical and dental clinicians. Participants also reported limited awareness among medical practitioners of the relationship between oral health and diabetes. The study indicates that endorsement of collaboration does not necessarily result in well-integrated interprofessional practice. Oral health may be acknowledged as relevant, but this recognition does not automatically translate into regular communication, shared responsibility, or coordinated care.

A similar pattern is evident in Alkhtib et al. (2023), who explored barriers and enablers to oral health promotion within primary healthcare settings. Participants expressed support for integrating oral health more fully into primary care and recognised its relevance to preventive and population health. At the same time, they identified time pressures, poor coordination, and policy limitations as barriers to implementation. This suggests that support for collaboration and oral health integration can coexist with service conditions that make such integration difficult to sustain in practice.

Oda et al. (2023) offers a related perspective from an educational setting. The study reported improvements in nursing students' confidence following oral-health-related training supported by an oral health therapist. This points to the potential value of bringing oral health into wider health education. However, the role of the oral health therapist in this intervention appeared more contributory than reciprocal, with oral health positioned as an input into nursing learning rather than as part of a more fully shared interprofessional exchange. This suggests that oral health may be included within interprofessional initiatives in a contributory way, without necessarily being part of a reciprocal interprofessional learning experience. Taken together, these studies suggest that oral health is increasingly recognised as relevant to interprofessional care and patient wellbeing, yet its integration into routine collaborative practice remains limited.

Overall, the oral health literature reviewed here suggests that IPCP is relevant to patient care, holistic practice, and health outcomes. However, oral health appears to remain only partially integrated within many interprofessional settings, with its inclusion shaped by professional boundaries, organisational structures, communication pathways, and role understanding (Harnagea et al., 2018; Bissett et al., 2020; Alkhtib et al., 2023; Hung et al., 2025). This creates an important gap for OHT education. Although existing studies examine oral health's inclusion in collaborative practice and interprofessional education, less is known about how OHT educators understand the place of oral

health within collaborative care. There is also limited research on how these understandings influence the way students are prepared for interprofessional practice within undergraduate OHT programmes in Aotearoa New Zealand.

Synthesis of the literature

The literature reviewed in this chapter shows both points of connection and important differences between wider IPECP scholarship and oral health-specific studies. Across both bodies of literature, IPECP is associated with role understanding, communication, teamwork, collaborative readiness, and patient-centred care. However, the oral health literature places greater emphasis on the conditions that affect whether oral health is included meaningfully within interprofessional education and practice. These include professional boundaries, limited role understanding, curriculum constraints, service separation, and organisational barriers (Chan et al., 2023; Hollaar et al., 2024; Hung et al., 2025). Therefore, wider interprofessional literature provides a useful conceptual foundation for this study, but it cannot be applied to OHT education without considering the specific educational, professional, and service contexts that shape oral health practice.

Points of alignment

In several respects, the oral health literature reflects ideas commonly reported in the wider interprofessional literature. First, both bodies of literature generally support the value of interprofessional education and collaborative practice. In wider IPECP scholarship, IPECP is associated with improved communication, clearer understanding of professional roles, collaborative readiness, and improved patient outcomes (WHO, 2010; Reeves et al., 2016; Webster et al., 2024). Similarly, the oral health studies reviewed here show broad support for IPECP, with students, educators, faculty, and other stakeholders recognising its relevance to professional preparation, role understanding, collaborative care, and patient wellbeing (Morison et al., 2008; Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). In this respect, oral health reflects many of the same collaborative goals identified in the wider interprofessional literature, although how these goals are put into practice is shaped by conditions specific to oral health education and practice.

Second, both the oral health and wider interprofessional literature suggest that positive attitudes alone are insufficient to ensure collaborative practice. In the broader literature, support for teamwork

is often complicated by organisational constraints, professional hierarchies, role boundaries, and inconsistent enactment in practice (D'Amour & Oandasan, 2005; Oandasan & Reeves, 2005; Reeves et al., 2016; Schot et al., 2020). Similar tensions are evident in oral health literature, where faculty, students, and primary care stakeholders often express support for IPECP while also identifying barriers related to time, curriculum structure, faculty support, role understanding, communication, and service organisation (Casa-Levine, 2017; Davis et al., 2018; Harnagea et al., 2018; Jiang et al., 2020; Tolle, 2019). Together, these studies suggest that collaboration depends not only on individual willingness, but also on the institutional, professional, and organisational conditions that make collaborative practice possible.

Third, both bodies of literature identify educator involvement as important to IPECP. Wider interprofessional scholarship positions educators as important in facilitating interprofessional learning, modelling collaboration, and shaping how interprofessional values are interpreted within professional preparation (WHO, 2010; Oandasan & Reeves, 2005; Reeves et al., 2016). The oral health studies reviewed here make a similar point, showing that faculty support, educator commitment, administrative support, and curriculum structures can influence whether IPE is meaningfully implemented and sustained (Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). Although the oral health literature is more limited in depth on educator experience, it still suggests that educators are important to how IPE is translated into curriculum and teaching practice.

Points of divergence

Despite these areas of alignment, the oral health literature also differs from wider interprofessional literature in important ways. One key difference concerns how oral health is included within interprofessional activity. Wider interprofessional scholarship provides a useful foundation for understanding IPECP across health professional education. However, the oral health literature reviewed here suggests that oral health is not always consistently embedded within IPECP. This does not mean that oral health is absent or unvalued. Rather, the reviewed studies show that its inclusion is often shaped by structural barriers, including limited role understanding, curriculum constraints, separation between dental and general healthcare, service organisation, and weak

coordination between oral health and wider health services (Chan et al., 2023; Hung et al., 2025; Villacorta-Siegal et al., 2024).

A second difference concerns the form that interprofessional learning takes. Wider interprofessional literature includes substantial discussion of IPE frameworks, structured curriculum models, and competency-based approaches (WHO, 2010; CIHC, 2010; Reeves et al., 2016). In contrast, the oral health literature reviewed here suggests that interprofessional activity is often less consistently embedded within oral health programmes. Many oral health studies describe IPE as inconsistently implemented, constrained by curriculum pressures, or limited to short-term or programme-specific activities rather than sustained across classroom and clinical learning (Casa-Levine, 2017; Davis et al., 2018; Jiang et al., 2020; Tolle, 2019). This suggests that, while wider interprofessional literature often considers how to strengthen IPE, the oral health literature is still frequently concerned with whether IPE is meaningfully established and sustained in the first place.

A third difference relates to role understanding and hierarchy. Wider interprofessional literature recognises that hierarchy, role boundaries, and professional status can shape collaborative practice (D'Amour & Oandasan, 2005; Oandasan & Reeves, 2005; Reeves et al., 2016; Schot et al., 2020). The oral health studies reviewed here make this issue more specific by showing how role understanding within dental and oral health contexts can be shaped by assumptions about authority, responsibility, and status within the dental team (Morison et al., 2008; Colonio Salazar et al., 2017; Kersbergen et al., 2020). This does not mean that hierarchy is unique to oral health, but it suggests that assumptions about oral health roles may create specific challenges for interprofessional education and collaborative practice.

The oral health literature also remains limited in relation to educator perspectives. Much of the reviewed research focuses on students, programme implementation, or general support for IPECP, while fewer studies examine how educators experience and support IPECP within undergraduate oral health education. This limitation matters because it affects how directly existing findings can inform undergraduate OHT programmes in Aotearoa New Zealand.

Overall, the literature shows that wider IPECP scholarship is useful for understanding the general principles of interprofessional education and collaborative practice, including communication, role understanding, teamwork, and organisational support. However, the oral health literature suggests that these principles are not always easily translated into oral health education and practice. Oral health is an important contributor to holistic, preventive, and patient-centred care, and therefore has a place within interprofessional healthcare teams. For current and future OHTs to contribute effectively to these spaces, they need to be prepared to engage in IPCP. However, the literature also indicates that this preparation may be constrained by curriculum pressures, limited role understanding, service separation, and organisational barriers (Chan et al., 2023; Hollaar et al., 2024; Hung et al., 2025). This raises an important question about how undergraduate OHT educators understand, teach, and model IPECP within undergraduate OHT programmes in Aotearoa New Zealand.

Gaps in the literature and rationale for the current study

Three gaps are particularly relevant to this study: whose perspectives are represented, the methods used to examine IPECP, and the limited Aotearoa New Zealand evidence base. First, existing oral health IPECP research has focused largely on students, programme evaluations, or practitioner attitudes, with less attention to educators' experiences and understandings. As a result, there is limited insight into how OHT educators interpret IPECP expectations, how they prepare and support undergraduate students to become interprofessional practitioners, and how they navigate the educational and practice conditions that shape this preparation. This gap is significant because understanding how OHT educators experience and understand IPECP can help explain how collaborative practice expectations are interpreted, taught, and supported within undergraduate OHT education.

Population gap

One important gap concerns who is represented in the literature. As shown in the overview of included studies, much of the oral health literature focuses on students, programme-level implementation, or broader stakeholder perspectives rather than educators as the primary participants. Although several studies do include faculty, administrators, or educator perspectives,

these remain a relatively small proportion of the evidence base overall. In addition, educator-focused studies tend to concentrate on attitudes toward IPE, perceived barriers to implementation, or broad curriculum issues rather than on educators' own experiences of IPECP and how they understand and support it across educational and clinical settings. This means that existing literature provides a limited account of how educators experience, understand, and enact IPECP, despite their central role in translating professional expectations into curriculum, teaching, and practice-based learning.

Methodological gap

A second limitation concerns methodology. The reviewed literature includes many survey-based, evaluative, and short-term designs, with fewer studies examining the relational, contextual, and experiential dimensions of IPECP in depth. This pattern is visible in the literature review, where many studies prioritise attitudes, programme inclusion, or perceived barriers, while relatively few explore how IPECP are experienced over time or across the education–practice connection. Qualitative studies are present, but they remain comparatively limited, with few focusing specifically on how educators experience IPECP within oral health education. As a result, the literature tends to show whether IPECP is valued, included, or reported, rather than how educators interpret IPECP, how they attempt to support students' preparation for collaborative practice, and how educational intentions are shaped by the clinical and organisational settings in which learning occurs.

Contextual gap

A further gap concerns context. The oral health literature identified in this review is predominantly international, with very limited research situated in Aotearoa New Zealand. Only one eligible study was explicitly located in New Zealand, meaning that most of the available evidence comes from health professional education and oral health systems with different regulatory, educational, and service contexts. This matters because the interpretation and enactment of IPECP are shaped by local professional, educational, and regulatory conditions. In Aotearoa New Zealand, IPCP is embedded within legislative and professional expectations, yet there is limited research examining how OHT educators understand and support these expectations within undergraduate OHT programmes. This leaves a substantial gap in relation to the setting of the current study.

Why these gaps matter for the current study

Educators occupy a central position in translating interprofessional expectations into educational practice. They shape how students encounter other professions, how collaboration is discussed and modelled, and how curriculum intentions are connected to clinical and practice-based learning. However, much of the reviewed literature focuses on student attitudes, curriculum implementation, or broad support for collaboration, rather than on educators' own experiences of IPECP and its implementation. This leaves limited educator-specific evidence to support the context-specific development of IPECP within undergraduate OHT programmes. This limitation is particularly important in Aotearoa New Zealand, where OHT educators work within specific professional, institutional, and regulatory conditions that may not be fully reflected in international literature.

In response to these gaps, the present study explores OHT educators' experiences and understandings of IPECP within undergraduate OHT programmes in Aotearoa New Zealand. By centring educator perspectives and adopting a qualitative, interpretive approach, the study seeks to generate insights into how IPECP is understood, enabled, constrained, and translated into educational practice. These insights may inform the future development of IPECP within undergraduate oral health programmes by clarifying what educators identify as necessary to prepare students for interprofessional collaborative practice.

The following chapter outlines the methodological approach used to address the aim of this research, including the study design, recruitment, data collection, analysis, and ethical considerations.

Chapter 3: Methodological approach and research design

This chapter outlines the methodology and methods used to explore oral health therapy (OHT) educators' experiences and understandings of interprofessional education and collaborative practice (IPECP). Guided by the research question, *what are OHT educators' experiences and understandings of IPECP?* The chapter details the design choices that shaped the generation, analysis, and interpretation of the data. As the methodological approach developed during the course of the study, the chapter begins by outlining that refinement before describing the final methodological and analytic approach adopted.

Methodological development of the study

Hermeneutic phenomenology methodology was initially selected because the research aimed to explore OHT educators' experiences and understandings of IPECP. Hermeneutic phenomenology appeared to align with the aim through its focus on lived experience and meaning-making (van Manen, 2014). However, after the interviews were conducted and early engagement with the data begun, it became clear that hermeneutic phenomenology was not the most appropriate methodological fit for either the nature of the data or the applied purpose of the study. Participants' accounts were largely reflective and practice oriented, with greater emphasis on professional reasoning, contextual influences, and implications for education and practice than on the kind of rich, in-depth exploration of lived experience typically associated with hermeneutic phenomenology (van Manen, 2014).

Following discussion with the supervisory team, the methodological approach was reconsidered through re-examination of the research question, the nature of the data, and the intended contribution of the study. Interpretive Description (ID) was assessed as a more suitable methodological framework because it aligned more closely with the study's applied focus and practice-oriented aims (Thorne, 2016). This reframed the study, and the analytic approach was revised accordingly. Conventional content analysis was used to support coding, comparison, and category development within the broader ID framework (Elo & Kyngäs, 2008; Hsieh & Shannon,

2005; Thorne, 2016). Although this methodological shift required a change in the supervisory team and delayed the progression of the study, it strengthened the alignment between the research question, the data, and the interpretive aims of the research. Regular supervisory discussion and ongoing reflexive engagement were central to this transition and supported critical examination of methodological assumptions and analytic decisions.

The sections that follow outline the study's philosophical positioning, methodology, researcher reflexivity, participant recruitment, data generation, analysis, and considerations of ethics and rigour. Together, these sections demonstrate coherence between the research question, interpretive approach, and applied purpose of the study.

Philosophical positioning

This study was positioned within a constructivist orientation, which recognises that meanings are constructed through experience, interaction, and context rather than discovered as fixed truths (Crotty, 1998). From this perspective, professional realities are understood as socially situated and shaped within particular clinical, educational, and organisational settings (Creswell & Poth, 2018). This philosophical position informed the use of ID as the methodological approach for the study (Thorne et al., 1997; Thorne, 2016).

This philosophical positioning was established during the earlier phase of the study, when hermeneutic phenomenology informed the research design. Although the methodology later shifted to ID, the broader constructivist and interpretivist orientation remained appropriate because both approaches recognise that meaning is interpreted in relation to context, experience, and the researcher's engagement with participants' accounts. Hermeneutic phenomenology emphasises interpretation and situated understanding of experience (van Manen, 2016), while ID also positions the researcher as an active interpretive agent who works with participants' accounts to develop applied, practice-relevant understandings (Thorne, 2016). The methodological shift therefore represented a change in analytic purpose, from exploring the meaning of lived experience toward developing applied insight for practice and education, rather than a change in the study's broader philosophical assumptions.

An interpretivist epistemology informed how these understandings were approached. Knowledge was generated through analytic engagement with participants' accounts and through interpretation of how they described, justified, and positioned their professional experiences (Malterud, 2016). The purpose of inquiry was to develop coherent interpretations of patterned meaning across accounts. This positioning shaped both data generation and analysis. Interviews invited participants to reflect on how they understood and enacted IPECP within their education and practice contexts, including tensions, constraints, and professional considerations. During analysis, meaning-making was understood as an interpretive process requiring reflexive judgement and close attention to the dataset (Thorne, 2016). Interpretations were developed through repeated reading, comparison, and analytic questioning of participants' accounts, with me as the researcher actively identifying patterns, examining meanings, and developing practice-relevant insights (Thorne, 2016).

Methodology

This study adopted a qualitative research design informed by ID to explore OHT educators' experiences and understandings of IPECP. Developed by Sally Thorne, ID is an applied qualitative methodology designed for health research in which the aim is to generate interpretive insights capable of informing education, policy, and clinical practice (Thorne, 2016; Thorne et al., 1997).

ID is guided by several core principles. It is concerned with understanding complex experiential and practice-based phenomena in ways that are grounded in participants' accounts while extending beyond description to develop analytic understanding. It is oriented toward applied knowledge generation and maintains close connection to the clinical or professional context from which the data arise. It also allows methodological flexibility in addressing practice-based research questions (Thorne, 2016; Burdine et al., 2021). Rather than seeking formal theory development, as in grounded theory, or a phenomenological account of lived experience, ID aims to produce coherent, practice-relevant interpretations of patterned meanings across accounts (Thorne, 2016; Burdine et al., 2021).

ID was appropriate for this study because educators' experiences of IPECP were shaped by professional roles, institutional contexts, and relational interactions across clinical and educational settings. These experiences were professionally situated and context dependent, requiring an approach that could account for such complexity while remaining attentive to implications for

undergraduate OHT programmes in Aotearoa New Zealand. In this study, ID supported the development of interpretations grounded in participants' accounts and oriented toward informing oral health education and practice.

Researcher positionality and reflexivity

Within ID, the researcher's interpretive engagement with participants' accounts is understood as central to the analytic process (Thorne, 2016). In this study, my positioning was recognised as integral to the research process, particularly in ensuring that interpretations were informed by relevant professional insight while remaining analytically accountable (Malterud, 2016; Thorne, 2016).

An insider researcher is one who shares professional or experiential membership with the participant group being studied (Berger, 2015). In this research, I occupied an insider position as an OHT and lecturer exploring the experiences of OHT educators. This position provided familiarity with the professional language, educational structures, and organisational practices shaping discussions of IPECP. It enabled me to build rapport with participants during the interview process and supported them to speak openly using profession-specific language and examples without extensive contextual explanation (Berger, 2015). It also required deliberate reflexive attention to the possibility that my familiarity with oral health education could lead me to assume shared understandings about professional roles, IPCP, or organisational norms that needed instead to be critically examined.

Participants were professional colleagues working within similar educational contexts. While shared professional understanding supported depth and fluency in the interviews, it also carried analytic risk. In particular, experiences or language that appeared familiar could have been too quickly accepted as self-explanatory, rather than being examined for what they revealed about professional tensions, hierarchies, and understandings of IPECP.

My prior professional experiences and understandings of IPECP, outlined in the Introduction chapter, inevitably influenced aspects of the research process, including the way interview questions were developed and how participants' accounts were interpreted. Rather than attempting to bracket this influence, reflexivity was used to render these influences visible and open to critical examination

(Dodgson, 2019; Malterud, 2016). I kept reflexive notes throughout data collection and analysis to document assumptions, emerging interpretations, and moments where familiarity required closer scrutiny. For example, when participants used language such as “we try to integrate oral health where possible,” I initially interpreted this as *reflecting proactive engagement with IPECP.* Reflexive memoing and supervisory discussion prompted closer examination of the wider account, which revealed underlying tensions related to professional hierarchy. This led to refinement of the analytic category and reconsideration of *how educators navigated professional hierarchies within IPL environments*. This reflexive process helped ensure that interpretations remained grounded in the data rather than driven primarily by prior assumptions.

Because of my insider position, I was careful not to move too quickly to interpretation. Early interpretations were treated as provisional and repeatedly tested against the data through re-reading of transcripts and comparison across accounts. Analytic questions such as “What am I assuming here?”, “What alternative interpretation might be possible?”, and “What in the data supports this claim?” were used to unsettle initial readings and strengthen analytic grounding (Finlay, 2017). Supervisory engagement also played an important role in maintaining analytic accountability. Supervisors challenged emerging interpretations, questioned implicit assumptions, and required justification of analytic decisions. Through these processes, reflexivity functioned as an active methodological practice that supported the credibility and coherence of the interpretive account (Thorne, 2016).

Participants and recruitment

The study was conducted within the context of undergraduate OHT education in Aotearoa New Zealand. Purposive sampling was used to invite educators with direct experience of IPECP in clinical education contexts (Palinkas et al., 2015; Thorne, 2016). This approach aligns with ID’s emphasis on developing coherent, practice-informed interpretations rather than seeking demographic representation (Thorne, 2016; Varpio et al., 2017). Given the limited number of eligible educators nationally, all individuals who expressed interest and met the inclusion criteria were included in the study.

Inclusion criteria

Participants were required to:

- be current educators within an undergraduate OHT programme
- hold a professional background in oral health therapy, dental therapy, dental hygiene, dentistry, or a dental specialty
- have a minimum of five years' clinical experience

The criteria were intentionally broad to capture a range of professional perspectives and teaching roles, including academic staff, paper leaders, and clinic-only educators. The minimum clinical experience requirement was intended to ensure participants had sufficient exposure to experience and reflect meaningfully on IPCP within educational settings (Palinkas et al., 2015). Role diversity was also considered analytically significant. Including educators with varied professional backgrounds and teaching responsibilities enabled exploration of convergent and divergent interpretations of IPECP across positions within OHT education, as later reflected in the findings chapter.

Recruitment process

To minimise perceived pressure or coercion, recruitment was conducted via an intermediary. An administrator circulated a recruitment flyer and participant information sheet to all eligible educators approximately four weeks before data collection. Individuals who were interested in participating were asked to contact me directly as the researcher, supporting voluntary participation and helping to minimise potential power imbalances.

Following the initial circulation, fewer expressions of interest were received than anticipated. A second recruitment email was therefore circulated, resulting in additional participants. All individuals who expressed interest met the inclusion criteria and were invited to participate.

Sample size and recruitment context

It was anticipated that five to seven educators would be recruited for this study. This proposed range was a pragmatic planning estimate informed by the focused research question, the specificity of the participant group, the depth sought through individual interviews, and the relatively small national pool of eligible OHT educators. Qualitative research does not prescribe a universally appropriate

minimum sample size; instead, sample adequacy should be considered in relation to the study aim, methodological approach, participant specificity, quality of dialogue, and intended form of analysis (Malterud et al., 2016; Vasileiou et al., 2018). Malterud et al. (2016) describe this as *information power*, proposing that fewer participants may be required when a study has a focused aim and participants hold knowledge and experiences that are highly specific to the research question. The anticipated range of five to seven participants was therefore considered appropriate for an in-depth exploration involving a small, specialised group of educators with direct experience of undergraduate OHT education in Aotearoa New Zealand. It was not intended as a predetermined threshold for data saturation. In ID, sampling is guided by the capacity of the dataset to support meaningful interpretive engagement rather than by numerical targets alone (Thorne, 2016). In this study, all interviews were completed before formal coding and category development began. As outlined earlier in this chapter, the study was initially designed using hermeneutic phenomenology and was only later reframed as ID after data collection was complete. As a result, analysis did not proceed iteratively alongside data collection in the way often described in ID (Thorne, 2016). Instead, the full dataset was analysed retrospectively using an ID framework. During this process, iterative comparison across transcripts supported identification of patterned meanings across the dataset. While the level of detail varied across interviews, the overall depth and variation within the six interviews provided sufficient insight to address the research question and support the development of interpretive themes. No additional recruitment was undertaken.

Data collection

Data were collected using semi-structured individual interviews. Although the interviews were conducted before the study was reframed as ID, this method remained appropriate for exploring educators' experiences and understandings of IPECP. Semi-structured interviews allowed participants to articulate their experiences in their own terms while also enabling exploration of professional reasoning relevant to the research question (Brinkmann & Kvale, 2015; Kallio et al., 2016).

Within the constructivist-interpretivist orientation adopted in this study, interviews were understood not as neutral tools for data extraction but as sites of meaning-making. In this study, the interviews

functioned as dialogic encounters in which understandings of IPECP were shaped through interaction between participants and me as the researcher.

All interviews were conducted online using the Microsoft Teams video-conferencing platform at times mutually convenient for participants and the researcher. Interviews ranged from approximately 45 to 60 minutes and were audio-recorded with participants' consent. Recordings were transcribed using the Microsoft Teams transcription function as an initial transcription aid. All transcripts were then reviewed in full while listening to the original recordings, and corrections were made as required to ensure accuracy, preserve contextual meaning, and support analytic immersion prior to coding. All transcripts were anonymised using pseudonyms before analysis.

I developed an interview guide to provide a consistent structure across interviews while allowing flexibility to explore participants' individual experiences. The guide was developed following review of relevant literature and in consultation with supervisors to ensure alignment with the research aims (Thorne, 2016; Kallio et al., 2016). Indicative interview questions are provided in Appendix C. Questions were open-ended and focused on participants' experiences of IPECP within clinical education and practice contexts, their understandings of IPL, and perceived enablers and challenges within OHT education. Follow-up questions were shaped by participants' language, professional reasoning, and areas of emphasis.

As an emerging qualitative researcher, my interviewing developed across the data collection period as I became more confident in probing participants' meanings and professional reasoning. While some interviews generated richer reflective discussion than others, each contributed meaningfully to understanding participants' perspectives on IPECP. Where responses remained primarily descriptive, further probing was used where appropriate to explore reasoning, assumptions, and underlying professional judgements. For example, participants were asked questions such as, "What sorts of things did you learn from your experiences working with health professionals from other disciplines?"

Prior to commencing participant interviews, a pilot interview was conducted with a supervisor to test the clarity, relevance, and flow of the interview questions. Refinements were made to wording and

sequencing as a result, ensuring that the guide was capable of eliciting detailed and meaningful responses relevant to the research focus.

While a single interview per participant was anticipated to be sufficient, participants were informed that a follow-up interview might be requested if clarification or further exploration of particular aspects of their accounts was required. No follow-up interviews were deemed necessary.

Data analysis

Analysis was guided by core principles consistent with ID, particularly attention to patterned meaning, reflexive engagement with the data, and the development of interpretations relevant to education and practice (Thorne, 2016). In this study, the analytic process involved repeated reading of transcripts, identification and coding of data segments relevant to the research question, comparison across interviews, and development of analytic categories and interpretive themes. Initial coding drew on principles of conventional content analysis to support systematic examination and organisation of the data and identification of recurring concepts within participants' accounts (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Subsequent analysis moved beyond descriptive categorisation toward interpretive synthesis, in which codes were compared, grouped into analytic categories, and developed into interpretive themes consistent with ID (Burdine et al., 2021; Thorne, 2016; Varpio et al., 2017). This use of content analysis supported systematic organisation of the data, while the later interpretive synthesis was guided by the broader ID methodology (Burdine et al., 2021; Elo & Kyngäs, 2008; Thorne, 2016).

All interviews were completed prior to formal coding. The analytic process therefore did not occur concurrently with data collection but proceeded through retrospective engagement with the full dataset. The specific stages of this process are outlined in the sections that follow.

I conducted all stages of the data analysis. This included checking and becoming familiar with the transcripts, identifying and coding relevant data segments, maintaining the coding spreadsheet and reflexive notes, undertaking second-cycle coding, developing analytic categories, and constructing and refining the interpretive themes. My supervisors provided guidance and critical feedback at key stages of the process. This included reviewing and discussing examples of coded data, the

developing coding framework, analytic memos, emerging categories, and draft themes. Supervisory input was used to question assumptions, consider alternative interpretations, and ensure that the developing analysis remained grounded in the dataset and aligned with the research question and ID methodology. The supervisors did not independently code the complete dataset or determine the final themes; responsibility for analytic decisions and the final interpretation remained with me as the researcher.

Familiarisation and immersion

I began the analysis by repeatedly reading the interview transcripts to become immersed in the dataset. The purpose of this stage was to develop a thorough understanding of participants' accounts before engaging in more focused analytic interpretation. Within ID, familiarisation supports close engagement with the data while remaining attentive to patterns of meaning relevant to the research question and applied practice context (Burdine et al., 2021; Thorne, 2016).

Through repeated reading of the transcripts, areas of emerging significance in relation to the research question began to be identified. Early immersion in the data supported recognition of preliminary patterns, tensions, and points of convergence and divergence across participants' accounts, informing later analytic decisions about where deeper interpretation was required. In this way, aspects of IPCP and IPECP that appeared particularly significant within participants' clinical and educational contexts began to take shape.

Initial coding

Initial coding began with close engagement with the first three interview transcripts. Each transcript was read in full and then revisited to identify data segments relevant to the research question on OHT educators' experiences and understandings of IPECP. Data segments were identified when participants described a particular experience, example, or reflection relating to IPCP, IPL, or interactions with other health professionals.

These data segments were highlighted within the transcript and assigned an initial code. Codes were generated inductively and labelled using short descriptive phrases that captured the central idea conveyed in each segment. For example, when participants described how communication influenced collaboration with other health professionals, the segment was coded as *communication*

during IPCP. Other codes captured issues such as organisational barriers to IPCP or examples of facilitating IPL within teaching or clinical environments.

During this first stage, coding remained intentionally descriptive and expansive, allowing a wide range of participants' experiences to be captured without prematurely consolidating categories. To support organisation of the material, highlighted data segments and their associated codes were compiled using a macro-enabled Microsoft Excel spreadsheet, which functioned as a data management and coding support tool (Meyer & Avery, 2009; Bree & Gallagher, 2016; Silver et al., 2017). The macro extracted highlighted data segments and associated codes from the transcripts and collated them within a spreadsheet. Additional contextual information was retained, including the participant pseudonym, source transcript file, and the date each code was created. This process enabled data segments to be viewed collectively across transcripts while maintaining traceability to the original transcript and participant account.

The spreadsheet functioned solely as a data management tool to support the organisation and comparison of coded segments. Analytic interpretation, code refinement, and decisions regarding meaning remained my responsibility as the researcher. This approach supported ongoing engagement with the data while maintaining transparency in how coded segments were organised and reviewed throughout the analytic process.

After independently coding the first three transcripts, I compiled and reviewed the initial codes to identify areas of overlap, similarity, and difference. I then discussed examples of coded data and the developing coding framework with my supervisors. Their feedback prompted me to reconsider the boundaries and wording of some codes and to examine whether my interpretations were adequately supported by the participants' accounts. Following these discussions, I refined and consolidated the initial codes before applying the evolving coding framework to the remaining three transcripts. Decisions about whether to merge, retain, rename, or create codes remained my responsibility as the researcher. Through this process, a more consolidated set was developed that captured recurring aspects of participants' experiences of IPECP. These refined codes were then used to guide coding of the remaining transcripts, while remaining open to new codes where segments reflected meanings not captured within the evolving coding structure.

The remaining three transcripts were coded using this evolving coding framework. Where new concepts or experiences were identified, additional codes were created to reflect these meanings. Following completion of coding for the final transcripts, coded segments were again compiled using the macro-enabled spreadsheet to support further comparison and refinement of code names.

Throughout the coding process, I maintained reflexive notes to document emerging analytic questions, early interpretations, and points of uncertainty. In keeping with the interpretive orientation of ID, codes were understood as provisional analytic constructions developed through my engagement with the data rather than fixed categories assumed to exist independently within the transcripts (Burdine et al., 2021; Thorne, 2016). For example, an early descriptive code such as *communication during IPCP* initially captured segments in which participants discussed talking with other health professionals. With further comparison across transcripts, however, these segments were understood to reflect more than information exchange alone, highlighting communication as relational work shaped by role negotiation, hierarchy, and collaboration. This prompted later refinement of codes and contributed to the development of broader analytic categories.

Second-cycle coding and category development

Following initial coding of the first three transcripts, the remaining transcripts were coded using the evolving coding framework. Existing codes were applied where data segments reflected meanings already identified, while new codes were introduced only where segments conveyed meanings not adequately captured by the existing coding structure. This helped ensure that coding remained open to new meanings while avoiding unnecessary duplication of similar codes.

Following completion of coding across all transcripts, a second cycle of coding was undertaken using the compiled data segments within the macro-enabled spreadsheet. This enabled comparison across transcripts and examination of similarities, overlaps, and conceptual relationships between codes. Codes were then reviewed, renamed, merged, or refined to ensure that code labels captured the underlying meaning conveyed within participants' accounts rather than remaining at a purely descriptive level.

Through this analytic review, the initial pool of approximately 245 coded segments was retained, while codes representing similar or overlapping meanings were consolidated. In several instances, multiple codes conveying the same underlying concept were collapsed into a single code that more accurately represented the shared meaning across those segments. This process required interpretive judgement to determine whether codes reflected distinct meanings or variations of a shared concept (Thorne, 2016; Thorne et al., 1997).

Decisions to merge or retain codes were guided by my examination of each segment within its narrative context, including what the participant was describing, explaining, or positioning in relation to IPCP. I maintained a record of code definitions, naming changes, and decisions made during code consolidation was maintained throughout this stage of analysis. Within the spreadsheet, I created a separate tab for the second cycle of coding, where I reviewed and refined compiled data segments and their associated codes. I also developed analytic memos in separate documents to support reflexive engagement with the data. These memos involved free-writing about what participants appeared to be describing, exploring alternative interpretations of codes, and considering how different codes might relate to one another. I shared selected memos, coded examples, and developing analytic categories with my supervisors for discussion and feedback. These discussions helped me question initial assumptions and consider alternative ways of interpreting relationships within the data; however, responsibility for the analytic decisions remained with me. An example of the analytic movement from data segment to initial code, analytic category, interpretive insight, and final theme is provided later in this chapter in Table 2.

Codes demonstrating conceptual alignment were then grouped into analytic categories, with each category typically comprising three to four related codes. Fourteen categories were developed through this process. For example, several codes relating to how participants described interaction between professions were grouped within a category focused on communication and relational engagement in IPCP. These codes included *communication during IPCP, navigating professional conversations, and clarifying roles across professions*. Although these codes captured slightly different aspects of participants' experiences, together they reflected how communication shaped IPCP and enabled relational engagement between professions within educational settings.

For instance, one participant explained, “You have to actually talk with the other professions about what you’re doing, otherwise students don’t really see how it all connects.” When examined alongside similar accounts across transcripts, this data segment illustrated how participants understood communication not simply as information exchange, but as relational work necessary for making IPL visible to students. This segment was initially coded as *communication during IPCP* and, when compared with similar segments across transcripts, was grouped with related codes describing professional interaction and role clarification, contributing to the broader analytic category of communication and relational engagement in IPCP.

In another instance, codes relating to organisational and structural challenges were grouped into a category reflecting structural influences on IPCP. Codes contributing to this category included *timetabling barriers to IPL, programme silos, and limited opportunities for shared teaching across disciplines*. Grouping these codes enabled the analysis to move beyond individual examples toward identifying broader patterns in how participants experienced organisational influences on IPECP.

I developed the analytic categories by comparing codes and their associated data segments across the six transcripts and grouping codes that reflected related underlying meanings. I discussed the developing categories with my supervisors to test their coherence, boundaries, and relevance to the research question. Following these discussions, I refined the categories while retaining responsibility for decisions about their final composition and naming. These categories provided the basis for the later development of interpretive themes.

From categories to interpretive themes

Following second-cycle coding and category development, the analysis moved into a further stage of interpretive synthesis. At this point, the focus shifted from refining individual codes and categories to examining how the fourteen analytic categories related to one another and what broader meanings they generated when considered together. This stage involved reviewing the categories alongside coded data segments and analytic memos to consider how participants’ accounts spoke to the research question.

Each interpretive theme integrated multiple analytic categories and was constructed to convey a coherent account of participants' experiences and understandings of IPECP. Themes were not treated as simple summaries of categories. Rather, they were developed by examining relationships, tensions, and points of convergence across categories and considering what these patterns suggested about participants' practice contexts, professional reasoning, and understandings of IPECP.

I developed the initial interpretive themes by examining the relationships, tensions, and patterns across the fourteen analytic categories and returning repeatedly to the coded data and complete transcripts. Draft theme descriptions and the categories contributing to each theme were discussed with my supervisors at this stage. Supervisory discussions provided opportunities to test whether the proposed themes were internally coherent, sufficiently distinct from one another, appropriately interpretive, and supported by the dataset. In response to this feedback, I reconsidered the boundaries, emphasis, and wording of some themes before finalising the thematic structure. My supervisors acted as critical discussion partners throughout this process, while I retained responsibility for the final analytic interpretations and presentation of the themes.

Theme names were refined to ensure they communicated the central interpretive meaning of each theme rather than functioning as descriptive labels. This involved selecting language that captured what the grouped categories showed about participants' experiences and understandings of IPECP, while remaining grounded in participants' accounts and consistent with the applied purpose of ID (Thorne, 2016; Burdine et al., 2021).

Through this process, analytic categories were developed that captured recurring aspects of participants' experiences of IPECP. These categories provided the basis for the later development of interpretive themes.

Table 2. Example of analytic movement across stages of analysis.

Data segment (participant excerpt)	Initial code	Analytic category	Interpretive insight	Final interpretive theme
"You have to actually talk with the other	Communication during IPCP	Communication and relationship-building in IPCP	IPCP required active relational	Building and breaking

professions about what you're doing, otherwise students don't really see how it all connects."			work between professions	relational connections
"Sometimes the opportunity to work with other programmes happens if people know each other, rather than being built into the timetable."	Incidental interprofessional interaction	Structural conditions shaping collaboration	Opportunities for IPECP often depended on organisational arrangements rather than programme design	Navigating structures that shape IPECP
"We try to organise placements where students can interact with other health professionals, but coordinating that can be difficult."	Facilitating interprofessional learning opportunities	Coordination of interprofessional learning	Educators often negotiated organisational constraints to enable IPECP	Navigating structures that shape IPECP

Table 2 illustrates selected examples of the analytic movement from coded data segments to the interpretive themes. The table is not intended to show all coded data, but to demonstrate how interpretation moved beyond descriptive coding toward theme construction.

Attention was also given to instances in which participants described similar situations in different ways. For example, some participants described IPCP with other health professions as occurring informally through personal relationships, while others described actively coordinating IPL opportunities through clinical placements or shared teaching activities. Examining these contrasting accounts enabled consideration of how organisational context, educator role, and programme structures influenced participants' experiences of IPECP. Attending to these differences helped refine analytic interpretations and ensured that emerging themes reflected the range of experiences described across interviews rather than presenting IPCP as a singular or uniform experience (Thorne, 2016; Burdine et al., 2021).

The final analytic structure informed the organisation of the findings chapter. In keeping with ID, the interpretive themes are presented as interconnected dimensions of participants' accounts rather than as isolated topics, illustrating how structural conditions, relational processes, professional

identity, and ethical commitments intersected in participants' understandings of IPECP (Burdine et al., 2021; Thorne, 2016).

Ethical and cultural considerations

Ethical and cultural considerations were addressed throughout the design and conduct of the study to support participant protection, contextual sensitivity, and methodological integrity. Ethical approval for this study was obtained from the Auckland University of Technology Ethics Committee (AUTEC) prior to commencement of data collection (AUTEC Number: 21/354). All research activities were conducted in accordance with the approved ethics application and Auckland University of Technology guidelines for research involving human participants.

The informed consent process was designed to ensure participants understood the purpose of the study, what their involvement would require, and their rights as a participant. A participant information sheet outlining the study aims, procedures, and ethical considerations was provided to all potential participants before consent was sought (see Appendix D). Participation was voluntary, and participants were informed that they could withdraw from the study at any time prior to commencement of data analysis without penalty.

Interested participants contacted the researcher directly following receipt of the recruitment email circulated by an administrator. Eligible participants were then provided with a consent form, which they were asked to read, sign, and return prior to participation. Participants were offered the opportunity to discuss the study and ask questions before providing consent. No participants sought further clarification. Consent was also reconfirmed verbally prior to commencement of each interview.

Participant confidentiality was maintained throughout all stages of the research process. Identifying information was removed from interview transcripts, and pseudonyms were used in all records and reporting to protect participants' identities. Given the relatively small professional community of OHT educators in Aotearoa New Zealand, particular care was taken to avoid including contextual details that could indirectly identify participants. This included removing or generalising references to specific institutions, colleagues, or roles where disclosure could risk identification.

Identifiable data were accessible only to the researcher and supervisory team. When selecting quotations for inclusion in the findings chapter, care was taken to ensure that excerpts illustrated analytic points without revealing identifying information. Decisions were also made about what contextual details not to report in order to preserve participant confidentiality while retaining the interpretive meaning of participants' accounts.

Audio recordings and digital transcripts were stored on password-protected university systems. In accordance with AUTEC requirements, all research data will be securely stored for a minimum of six years following completion of the study, after which digital files will be permanently deleted and any hard-copy materials securely destroyed. Although data were stored across more than one secure digital location during the research process, all procedures remained consistent with AUTEC requirements regarding confidentiality, security, and restricted access.

Managing potential ethical risks

Several ethical considerations were addressed during the design and conduct of the study. As the researcher worked within the OHT education context, particular attention was given to the potential ethical implications of insider positioning and collegial relationships. In a relatively small professional and educational community, participants may have been concerned about how their views could be interpreted or whether participation might affect existing professional relationships.

To minimise any perception of coercion or obligation to participate, recruitment was facilitated through an intermediary, and participants were required to initiate contact directly with the researcher if they wished to take part in the study. These measures supported voluntary participation and helped reduce potential power imbalances. Participants were also informed that participation was voluntary, that they could decline to answer any question, and that they could withdraw from the study prior to commencement of data analysis without penalty. Together, these measures were intended to reduce ethical risk and support participants' autonomy throughout the research process.

Cultural considerations: Vision Mātauranga and Te Tiriti o Waitangi

This research was conducted within the context of Aotearoa New Zealand, where health and education research is undertaken within broader expectations of cultural responsiveness, equity, and accountability, including those reflected in Vision Mātauranga and Te Tiriti o Waitangi (Ministry

of Business, Innovation and Employment, 2019). In preparing the study, attention was given to the social and cultural sensitivity requirements of the AUTEC process. The ethics application recorded consultation with supervisors, the Faculty of Health and Environmental Sciences Interprofessional Research Cluster, and members of the Oral Health Department during the initial development of the project. This consultation did not result in changes to the research design.

The study recruited from a defined group of eligible OHT educators within the educational context of this research. Recruitment was based on professional role and eligibility criteria rather than ethnicity. None of the participants identified as Māori. As a result, the study does not claim to represent Māori perspectives on IPECP, and the findings are limited to the accounts of those who participated. This is an important limitation and should be considered when interpreting the scope of the findings. This limitation should also be considered in the wider workforce context. In 2022, Māori comprised 10.1% of practising OHTs in Aotearoa New Zealand, which remained below the estimated Māori proportion of the national population at 17.4% (DCNZ, 2023). Given the absence of Māori participants, the relevance of Vision Mātauranga and Te Tiriti o Waitangi within this study was limited. However, as the study was conducted within Aotearoa New Zealand, these frameworks remained relevant to the ethical and cultural positioning of the research. Their relevance lay in acknowledging the cultural context of the study, recognising the under-representation of Māori within the participant group, and making clear that the findings do not represent Māori perspectives on IPECP.

Rigour

Rigour in ID is understood as the development of credible and defensible interpretive insights through transparent analytic engagement rather than adherence to procedural checklists (Thorne, 2016). Thorne (2016) identifies four key principles supporting rigour in ID: epistemological integrity, representative credibility, analytic logic, and interpretive authority. These principles guided both the conduct and evaluation of the study.

Epistemological integrity refers to coherence between the philosophical positioning of the study, the research question, the methods used, and the resulting interpretations (Thorne, 2016). In this study, methodological decisions were guided by the aim of understanding how OHT educators experienced and understood IPECP. Semi-structured interviews supported exploration of educators' professional

reasoning and contextual experiences, while the analytic process remained interpretive and practice oriented, consistent with the applied intent of ID.

Representative credibility concerns the extent to which interpretations adequately reflect the range and depth of participants' accounts (Thorne, 2016). This was supported through repeated engagement with the full dataset during analysis, including comparison of coded data segments across interviews and attention to instances in which participants described similar situations differently. This helped ensure that the analytic account remained responsive to the dataset as a whole rather than privileging especially vivid or early interview accounts. For example, some participant's' described IPCP as occurring informally through personal relationships, whereas others described actively coordinating IPL opportunities within structured teaching or clinical contexts. Attending to these differences helped ensure that themes reflected the diversity of participants' experiences rather than privileging a single narrative of collaboration.

Analytic logic refers to the transparency of the analytic pathway linking data to interpretation (Thorne, 2016). In this study, analytic reasoning was documented through coding records, category development notes, and reflexive analytic memos. The use of a macro-enabled spreadsheet allowed coded data segments to be compiled and reviewed across transcripts, enabling systematic comparison of codes and supporting development of analytic categories. Together, these materials provided a clear record of how interpretations developed from coded segments through categories to interpretive themes.

Interpretive authority relates to the researcher's capacity to generate defensible interpretations grounded in both the data and relevant contextual knowledge. As a researcher working within the oral health education context, reflexive awareness of professional positioning was maintained throughout the research process. I used reflexive notes to examine my assumptions and analytic decisions. Regular supervisory discussions also provided opportunities to question interpretations and check that analytic claims remained grounded in participants' accounts. Through this process, interpretations were refined to remain proportionate to the dataset and aligned with the applied aims of the study.

Participants were not invited to review their interview transcripts, and formal member checking of developing interpretations or final themes was not undertaken. This was consistent with the interpretive nature of the study, in which findings were developed through comparison and interpretation across the complete dataset rather than treated as direct reproductions of individual participants' accounts. Participants were therefore not asked to approve the final themes, as these represented an interpretive synthesis of patterns, variations, and relationships identified across all six accounts. Instead, analytic credibility was supported through repeated engagement with the interview recordings and transcripts, iterative comparison across participants' accounts, reflexive consideration of my assumptions and positioning, maintenance of coding records and analytic memos, and discussion of developing interpretations with the supervisory team (Thorne, 2016).

Together, these practices supported rigour by demonstrating coherence between the study's methodological orientation, analytic process, and interpretive conclusions. Rather than relying on procedural validation techniques, rigour in this study was achieved through transparent analytic reasoning, reflexive engagement with the data, and careful consideration of the scope and limits of interpretation (Thorne, 2016).

Summary

This chapter has outlined the methodological approach and methods used to explore OHT educators' experiences and understandings of IPECP. In its final methodological form, the study was grounded in ID and designed to generate education- and practice-relevant insights grounded in professional context and applied educational concerns.

The chapter described the philosophical positioning of the research, my reflexive stance as the researcher, participant recruitment, and data collection through semi-structured interviews. It also detailed the analytic process, in which data segments were initially coded using principles of conventional content analysis and then examined and compared across transcripts to develop analytic categories and interpretive themes.

Ethical, cultural, and rigour considerations were addressed to support transparency, reflexivity, and methodological coherence throughout the research process. Together, these methodological

decisions provide a coherent basis for interpreting participants' accounts of IPECP within oral health education. The following chapter presents the study findings, organised into interpretive themes that represent patterned meanings across participants' accounts and provide the basis for considering implications for interprofessional education within undergraduate OHT programmes in Aotearoa New Zealand.

Chapter 4: Findings

This chapter presents an interpretive account of oral health therapy (OHT) educators' experiences and understandings of interprofessional education and collaborative practice (IPECP). Grounded in the methodological principles of Interpretive Description (ID), the findings are presented as interpretive understandings developed from patterns across participants' accounts, rather than as isolated categories or purely descriptive summaries (Thorne, 2016; Thorne et al., 1997). Consistent with ID, the analysis considers how participants made sense of IPECP in teaching and practice contexts, while retaining attention to the clinical and educational relevance of their experiences (Thorne, 2016).

The chapter begins with a brief overview of the participants and the professional contexts from which their accounts were drawn. Four interconnected themes are then presented, each representing an interpretive pattern developed from the data (Thorne, 2016; Thorne et al., 1997). These themes examine how educators understood IPCP as connected to ethical and holistic care, how structural conditions shaped access to IPECP, how relational work influenced whether collaboration could be enacted, and how educators navigated the visibility and recognition of oral health within interprofessional spaces. Together, the findings offer a practice-informed interpretation of how IPECP was understood, enacted, constrained, and sustained across oral health education and practice contexts. The chapter concludes with a synthesis of how the themes interrelate, providing the foundation for the Discussion Chapter, where the findings are situated in relation to relevant literature.

Participant context

Six educators participated in this study. They came from professional backgrounds in dentistry, oral health therapy, and dental therapy, and all were involved in teaching or supervising within an undergraduate OHT programme in Aotearoa New Zealand. Participants ranged in age from 25 to 55 years and had between five and more than 20 years of oral health clinical experience across public and private settings.

Although all participants held educator roles, their professional and clinical backgrounds varied. Some continued to work concurrently in clinical practice, while others were primarily based in tertiary education and drew on previous clinical experience. Their accounts drew on experiences across university clinics, public health services, and private practices. This variation is important because participants did not all describe the same kinds of IPECP experiences. Some drew more readily on clinical examples, while others described limited or less visible opportunities within tertiary educational contexts.

All participants were assigned pseudonyms, and specific institutional and clinical details have been removed to protect anonymity.

Table 3. Participant demographic overview

Pseudonym	Profession	Age	Years' experience	Clinical experience
William	Dentist	45–55	20+	Private
Harley	Oral Health Therapist	25–35	0–5	Public
Eden	Dental Therapist	45–55	20+	Private
Alex	Oral Health Therapist	35–45	11–20	Private
Max	Oral Health Therapist	35–45	5–10	Private
Asher	Dentist	45–55	20+	Private

Note. *Primary clinical practice context* refers to the principal sector in which each participant's clinical experience relevant to this study was situated. *Public* refers to practice within publicly funded oral health services, including community oral health services administered through Health New Zealand | Te Whatu Ora. *Private* refers to practice within privately owned general or specialist dental clinics. These classifications identify participants' primary practice contexts and do not necessarily represent the full range of settings in which they may have worked during their careers.

Five participants' primary clinical experience was situated within private dental practice, while one participant, Harley, represented the public oral health sector. This distinction is important when interpreting the findings because public and private settings differ in their service structures, patient populations, organisational arrangements, and opportunities for engagement with other health professionals. Harley's accounts therefore provide insight into the public-sector context; however, as Harley was the only participant classified within this setting, these accounts should not be interpreted as representative of all public-sector OHT experiences in Aotearoa New Zealand.

Overview of findings

The analysis generated four interconnected themes. These are: (1) Interprofessional collaboration as a requirement for ethical and holistic care; (2) Navigating structures that shape interprofessional

education and collaborative practice; (3) Relational practice shaped whether interprofessional collaborative practice could be enacted; and (4) Impact of role understanding on interprofessional collaboration. Together, these themes show how participants experienced IPECP as shaped by ethical and holistic commitments, structural positioning, relational conditions, and the visibility and recognition of oral health within interprofessional spaces.

Theme 1: Interprofessional collaboration as a requirement for ethical and holistic care

This theme captures how educators described IPCP as grounded not only in professional expectations, but also in values about how care should be delivered. Across participants' accounts, collaboration was described as closely tied to holistic and person-centred care, ethical responsibility, and commitment to patient wellbeing. Rather than being treated as an optional addition to practice, IPCP was often described as part of responding appropriately to patients whose needs extended beyond the scope of any one discipline.

Holistic and person-centred approach

Participants described holistic care as an important reason for engaging in collaboration. Participants described seeing patients as shaped by interconnected oral, systemic, social, and their whānau context. This prompted participants to work beyond disciplinary boundaries and involve other professionals where needed.

Asher, a Dentist with over 20 years clinical experience in the private sector, described IPCP as an approach in which different health professionals "gather together to support a patient in a multifaceted way." For him, the purpose of IPCP was "not to look at a patient from a specific health professional perspective, but to look at a patient as a whole and improve that person's overall wellbeing". Suggesting that collaboration was understood as a way of widening care beyond a single professional focus so that the patient's broader health needs could be recognised and supported. He went on to recall an experience of working collaboratively with a GP and described how it supported more individualised care, "It gave me the opportunity to provide a service that was quite customised to that person, not a one-size-fits-all kind of treatment." His account suggests that collaboration was valued because it allowed care to be more responsive to the particular circumstances of the patient.

Alex, an OHT drawing on his experience in the private sector, also emphasised the need to look beyond isolated oral conditions and work with other health professions, “There’s a lot of benefits when working with everyone. Because we can’t treat it as gums only. We have to treat the whole body to get the right answers.” Max similarly described holistic care as recognising the connections between oral health and the wider body:

> When I say holistic, I mean the mouth is connected to the oesophagus, to the stomach, it’s actually a person you’re working with, not just teeth, and not just a spine, and not just veins and blood tests. It’s all together. That’s a whole person.

Together, these accounts show that participants understood collaboration as a way of responding to patients as whole people, rather than treating oral health as separate from wider bodily and social contexts. Further, collaboration across disciplines was described as an important part of providing holistic care. Rather than being framed only as a preferred approach, collaboration was understood as a way of recognising and responding to patient needs that extended beyond a single professional perspective.

Max, an OHT also described holistic care as requiring conscious attention to the person beyond the mouth. She explained,

> I value looking at patients holistically, as their mouth is connected to the rest of their body. As cliché as it sounds, we do focus on just the teeth when we’re working in the mouth, and it takes a lot of conscious effort to think, ‘Okay, hold on, there’s the rest of the body on the chair there’.

Max went on to explain that interprofessional work should not be viewed as an optional extra “It should not be something that is an extra that we do, or an extra service that we provide. It should be something that is just a given, that we always work interprofessionally to support someone’s wellbeing.” Max’s account of holistic care suggests the need for a deliberate shift away from a single-focused practice toward care that recognises the patient as a whole person. For Max, IPCP was not an additional activity, but integral to patient wellbeing which should be routinely undertaken.

Asher described a situation in which discussion with another practitioner supported a provisional diagnosis for a patient with a severe periodontal (gum) condition:

> I said, 'think this is kind of bordering on necrotizing gingivitis' and she said to me, 'I was thinking the exact same thing, but I just needed to know your thoughts on it,' and so we both came to the provisional diagnosis. She said she can work on the patient's medical condition, and I can help her oral condition.

Ashers account illustrates collaboration as a process of shared clinical reasoning, rather than simply referral between practitioners. The other practitioner sought Asher's oral health perspective, while Asher also valued her role in addressing the patient's wider medical condition. In this example, holistic care was enacted through shared judgement and coordinated attention to both oral and wider health needs.

Eden a dental therapist with over 20 years' experience working in private practice, also described collaboration as helping practitioners move beyond a narrow disciplinary view. She explained that, in collaborative care:

> You need to take a minute and think, OK, so how can I approach this as a whole rather than just as a mouth or just as a foot. When everyone contributes, rather than having a small picture, you've got this really big picture.

This account strengthens the interpretation that holistic care was not only about recognising oral-systemic links, but also about widening understandings of the person's needs through other professional perspectives.

Taken together, these accounts suggest that participants viewed IPCP as important for supporting a holistic and person-whānau centred approach. Collaboration was described as a way of widening the clinical view beyond the mouth and responding to the wider oral, systemic, social, and whānau contexts shaping patients' lives.

Ethical responsibility and commitment to patient wellbeing

Alongside the idea that IPCP was important for achieving holistic care, participants also described collaboration as part of their ethical responsibility as practitioners and educators. In these accounts,

IPCP contributed to safe and appropriate care by supporting practitioners to recognise the limits of their own scope, draw on the expertise of others, and respond when patients' needs extended beyond oral health alone.

Alex described this when reflecting on an experience related to systemic health and periodontal care, where collaboration with GPs helped support medication decisions: "When we see systemic health relating to periodontal [gum] disease, we work with GPs for antibiotics or medications with fewer side effects. That's part of our ethical obligation to those patients." Max similarly positioned referral and interprofessional involvement as part of putting patients first, explaining:

> When you know something is not necessarily out of your scope, but not your expertise area, and you refer that patient on, you're putting them first, putting their needs first. As an ethical obligation, we have to give those patients that kind of experience.

Alex and Max's accounts above suggest that ethical practice involved recognising when patient needs required input beyond one practitioner's expertise.

Asher's account extends this point by showing how collaboration could support safe care when oral health needs were closely connected to wider medical conditions. He described caring for an older patient whose medications and medical conditions were affecting her oral health. Asher explained:

> I contacted the GP as well as her specialist cardiologist, because these two teams [were] working together to help stabilise her medical conditions. I contacted them both in order to develop a plan where they can work with her medical conditions and her medications that are also contributing to side effects in her oral health.

He added that, after speaking with the GP again, they were "formulating a plan" in which the GP would review "her blood test and the medications" and consider changing some medications to "help me to improve her oral health," particularly as "her number one issue is her xerostomia [dry mouth condition] and she's also bordering on a [pre-cancerous gum condition] lichen planus situation." This account shows ethical and holistic care as involving coordinated attention to both oral and wider health needs, rather than treating oral health in isolation.

Harley's public-sector account also showed how commitment to patient wellbeing shaped responses to constrained systems. He described needing to use practitioners' "own personal time" to facilitate interprofessional care and support "the best care or the best outcome for the patient." His account suggests that ethical commitment could require additional effort when interprofessional care was not fully built into routine service expectations.

Max and Harley also connected ethical responsibility and holistic care with cultural responsiveness. Reflecting on her own development, Max stated, "If I could do anything differently, I'd focus more on cultural aspects and look more holistically rather than just focusing on their teeth and gums." Harley similarly reflected that, if he could do anything differently, "of course I'll be focusing a bit more on cultural aspects of it" and taking a "more holistic perspective, rather than just focusing on their oral health." Suggesting that participants understood ethical practice as extending beyond clinical care to include cultural and social dimensions of practice. In these accounts, culturally responsive practice was positioned as part of holistic and person-centred care, rather than as separate from clinical decision-making.

William's account further extended this ethical framing into the educator context. Reflecting on tertiary education contexts where organisational change was slow and formal support for IPE was limited, William explained:

> You can try and complain about things and want things to improve, and interprofessional education and practice to get better, but by the time the structural and systemic changes happen, you just can't wait for that. You have to do whatever you possibly can on your own, we have the ability to change ourselves easier than the organisation.

His account suggests that, where organisational change was slow, educators sometimes took responsibility for creating or sustaining IPECP within the limits of their own practice. This connects with Harley's account of working within constrained public-sector conditions, where interprofessional care required additional effort to support the best outcome for patients and whānau. Together, these accounts suggest that ethical commitment did not remove structural barriers but shaped how participants worked within those barriers to support patients and students.

Across these accounts, collaboration was described not only as a professional requirement, but as something sustained by commitments to patient-centred and holistic care. Ethical obligation helped frame collaboration as professionally legitimate, while participants' values shaped how they sought to enact it in practice, particularly when patient needs extended beyond one practitioner's expertise or when formal structures did not fully support IPECP.

Overall, participants described IPCP as integral to ethical and holistic care. Collaboration was framed as important when patients' needs extended beyond oral health alone, and as part of acting responsibly within professional practice. Participants' accounts suggested that holistic care was strengthened when practitioners worked beyond a single discipline, because patients' needs were shaped by oral, systemic, social, cultural, and whānau contexts. Collaboration was therefore positioned as closely connected to holistic care, rather than an optional addition to practice. Even when opportunities for interprofessional work were limited, some participants described seeking collaborative responses because of their commitment to patient wellbeing.

Theme 2: Navigating structures that shape interprofessional education and collaborative practice

This theme captures how educators experienced and described the structural conditions that shaped access to IPECP. Across participants' accounts, opportunities for IPECP were influenced by how services and programmes were organised, the time available for interprofessional work, and whether collaboration was built into routine practice. These conditions shaped whether IPCP occurred as a usual part of clinical and educational activity, or whether it depended on educators and practitioners actively creating opportunities across separated systems.

Structural silos

Participants described physical location, service arrangements, and limited connection between services and programmes as important influences on whether interprofessional collaboration could occur routinely or required deliberate effort. While co-location could create opportunities for connection, it did not in itself ensure that collaboration occurred. Across participants' accounts, IPECP was often described as something that had to be actively created, rather than something routinely built into educational or practice structures.

Harley, an OHT, drew on his experience in the public sector to describe how separation from other services limited routine interprofessional contact: “We’re so separate from other services that unless you make the effort, you’ll never cross paths.” Eden described a similar pattern of disconnection, explaining, “We’ve got different systems, different pathways, different everything so unless someone goes out of their way, nothing connects.” Together, these accounts suggest that separation was experienced not only as physical distance, but as a wider structural issue involving different systems, pathways, and service arrangements. In these conditions, interprofessional contact was unlikely to occur routinely unless individuals actively worked across boundaries.

Harley’s account also illustrated how the absence of formal structures shaped the enactment of integrated care. Reflecting on his experience in the public sector, he explained:

> There is no protocol or guideline for the integrated care. In the public sectors, when I started was more like, give it a go and try to find out what actually works and see what I can achieve as well. So, I learned how to initiate that kind of care.

This account extends the earlier point by showing that the issue was not only separation between services, but also the lack of clear protocols or established pathways to guide integrated care. Instead, Harley had to learn through trial, initiative, and experience, reinforcing the finding that IPECP often depended on individual effort rather than embedded organisational systems.

This sense of separation was not confined to public-sector practice. Harley also described limited integration within the university clinic context, explaining, “I feel like we are quite isolated from other disciplines as well, the only integration that I can think of would be the diabetic programme. Apart from that, it’s just referring to the different departments.” Harley’s account distinguishes between meaningful integration and referral-based contact. Although referral to other departments created a pathway between services, it was not described as sustained interprofessional engagement. Instead, collaboration appeared limited when contact between disciplines was reduced to directing patients or information elsewhere, rather than working together through shared care processes.

This distinction between referral and collaboration was also evident in William’s account. Reflecting on the traditions of dentistry, William stated, “Traditionally, dentistry has been fairly isolated, solo

practices were the norm and only dentists could have dental practices." He went on to explain that traditional referral processes were often "more of a hand over where another practitioner completed a specialised procedure and then hopefully the patient returned. It is more of a checking process rather than working collaboratively." William's account suggests that the siloing described by participants was connected not only to present-day organisational arrangements, but also to longer-standing professional traditions within dentistry. These traditions shaped how oral health had been positioned and practised, with referral operating as a form of contact that did not necessarily involve shared decision-making, mutual learning, or ongoing collaborative care.

Max described a similar lack of crossover within the university setting, noting, "I don't know much about the Physio Department, or the Psychology Department, and I'm not sure that they know much about us either." She added that she did not feel the departments were "communicating very well," with an expectation that educators "should make an effort to do this among themselves." Max's account extends this pattern into the educational environment, where collaboration was not described as a routine or supported part of organisational practice, but as something educators were expected to initiate themselves.

Although participants described structural separation as limiting routine IPECP, they also gave examples of interprofessional activity being created through individual initiative. William described working beyond usual oral health boundaries to develop an interprofessional project: "I've been spending a lot of time trying to work interprofessionally, I'll be working with communications and engineering students to make a dental app. That's through my own initiative." This account shows that interprofessional activity was possible but often depended on educators actively creating opportunities outside established structures. Rather than being routinely embedded within programme or service design, IPECP could rely on individual motivation, personal networks, and additional effort. Taken together, participants' accounts suggest that structural silos shaped the conditions for IPECP by limiting routine contact, reducing opportunities for shared work, and positioning collaboration as something educators had to actively negotiate rather than something embedded within everyday educational and practice systems.

Limited opportunities for interprofessional education and collaborative practice in education

When asked about IPECP in education, participants did not describe it as a routine or clearly embedded part of their programmes. Instead, educational opportunities appeared to be limited, unevenly available, or dependent on specific placements, initiatives, or individual educators. Harley described IPE opportunities for both educators and students as limited, explaining, “I felt the opportunity was quite limited, there were limited opportunities for myself and for students as well.” He also reflected that, although there were other disciplines across the school, meaningful engagement with them was limited, “I don’t think I’ve had that proper engagement with them.” Harley further described student participation in a university-wide interprofessional programme as something that required active selection rather than routine inclusion. He explained, “We had to select all the students last year for the programme, and even that wasn’t easy because it wasn’t well promoted for our students.” His account suggests that although oral health students could participate in some interprofessional initiatives, these opportunities were not always clearly embedded, promoted, or routinely accessible within the programme. William similarly described few opportunities for educators to come together, stating that there were “very rare and few opportunities for us outside of what we routinely do to come together, and very few opportunities to meet people from other disciplines.”

Asher shared that he only had one opportunity to be part of a collaborative experience as an educator. Even though “I've always opened that avenue for interprofessional opportunities. It was just, I think for me a little bit sad because we were not as supervisors heavily involved, I felt”. Eden’s account similarly pointed to the limited presence of interprofessional engagement within her educational work. When asked whether she could recall experiences of working collaboratively with other disciplines, she did not describe shared teaching, joint clinical activity, or structured IPL. Instead, she replied “No, other than smiling to them as you walk past in the hall. That’s kind of it.” This brief response suggests that interprofessional proximity did not necessarily translate into collaborative engagement. For Eden, contact with other disciplines appeared to occur in passing rather than through structured opportunities to learn, teach, or practise collaboratively.

Alex could recall one example where students from another department came into the clinic as part of an IPL opportunity. However, his account suggested that the activity was largely observational and lacked clear structure, guidance, or intended outcomes:

> There is one session where students are supposed to be doing interprofessional things in clinic, where students from another department come into the clinic. But they stood in the corner and tried to hear what we were saying, it was just observing. They did not ask any questions, and there was no guideline as to what the requirement was for that session, or whether we were supposed to give them any information about anything. It was more like observation with no outcomes. Anyone could stand at the bus station and look at the buses go past, but no one knows how to drive it. There is no outcome, nothing that comes out of it. There is no correlation with the department organising it. I think it is just being done superficially.

Alex's comparison to watching buses go past illustrates how mere exposure to another professional setting was not experienced as meaningful IPECP. For Alex, the issue was not that interprofessional opportunities were entirely absent, but that they lacked the structure, interaction, and learning outcomes needed to help students understand how collaborative practice actually works.

Harley made a similar point when reflecting on students' learning needs. He suggested that it would be useful for "final-year students to participate in [IPECP at least once, so they could learn about integrated care not just by the book, but by actually participating." Read alongside Alex's account, Harley's reflection suggests that students' exposure to IPECP needed to involve active participation rather than passive observation or theoretical discussion alone. His account also indicates that such opportunities were not consistently built into the programme as routine learning experiences.

Max described the potential value of IPECP for students' future practice, while noting that these opportunities could feel secondary within a tertiary education student-led clinic. She explained that students were often focused on what they needed "to achieve to graduate," while educators were focused on providing "an abundance of experience and opportunities [for students] to learn," meaning interprofessional opportunities could feel "like they're an accessory, they're not a focus."

However, Max also saw these experiences as important for students' future professional development, explaining that they would contribute toward graduates who were "more collaborative, more holistic, more understanding of the whole person."

Harley similarly described the value of IPECP for student learning after participating in an interprofessional case discussion. He recalled that it was "really useful" and that he could see "the students learnt heaps," particularly because students understood "the importance of actually discussing the case with the other disciplines." Harley also noted that students recognised how combined care could reduce repeated information for patients, with critical information given "at one time and repeated when it's necessary." Read alongside Max's account, this suggests that participants viewed IPECP as important for preparing students to think beyond discipline-specific requirements and understand collaborative care as part of future practice.

At the same time, both accounts suggest that the educational value of IPECP was not always matched by its position within the programme. For Max, IPECP could feel like an "accessory" rather than a focus, while Harley described useful IPL as something that would be beneficial if it could be facilitated more often for final-year students. Together, these accounts suggest that IPECP was recognised as valuable for developing future OHT practice but was not always positioned as a central or consistently embedded part of clinical education.

Time, workload, and service pressures constraining collaboration

Participants also described time, workload, and service pressures as constraints on meaningful IPCP across both clinical and teaching contexts. Even where collaboration was valued, it was difficult to prioritise when workloads, productivity expectations, and teaching demands limited the time available for interprofessional engagement.

Drawing on his public-sector experience, Harley described how service targets reduced the time available for collaboration. He explained:

> that there was a lack of resources in terms of time and pressure to meet daily or weekly targets, meaning patients had to be seen [within the maximum time for more extensive treatment] being 40 to 45 minutes max. To facilitate any interdisciplinary care approach,

practitioners had to use their own personal time to support the best care or the best outcome for the patient.

His account suggests that IPCP was valued, throughput expectations reduced the space available for interprofessional interactions. Rather than being built into the working day, IPCP required additional effort beyond routine clinical expectations.

William described similar pressures in private practice, where referral and communication processes required additional coordination, “It’s not just the money. It’s the time sending information, sending photos, sending their history, organising for the patient to go somewhere else. It’s time and time is money. The process is complicated and energy consuming as well.” Collaboration was often experienced as an additional layer of work rather than as an embedded part of care.

Harley also described similar pressures in teaching contexts, where limited time constrained deeper interprofessional engagement, “It felt that there’s not enough time for proper discussion to occur, it was quite fast-paced discussion, I felt we could have actually engaged in deeper discussion and shared knowledge and learn from each other.” In Harley’s account, scheduling pressures compressed interprofessional engagement and learning into brief exchanges, limiting opportunities for deeper discussion and IPL.

Across participants’ accounts, time and service pressures shaped both whether collaboration occurred and the depth of engagement. Collaboration was often described as valuable, but difficult to sustain when it had to compete with productivity demands.

Overall, participants described structures as shaping the conditions under which IPECP became possible, difficult, or dependent on individual effort. Across clinical and educational contexts, collaboration was influenced by how services and programmes were organised, the time available for interprofessional work, and whether referral pathways supported shared care or only enabled points of contact. Where interprofessional activity was not embedded into routine structures, it relied heavily on the willingness, initiative, and effort of individual practitioners and educators. This finding provides an important link to the next theme, which explores how participants enacted IPECP through relational work, including communication, trust, responsiveness, and relationship-building.

Theme 3: Relational practice shaped whether interprofessional collaborative practice could be enacted

This theme captures how participants described relationships as central to IPECP. While structural conditions influenced whether opportunities for collaboration were available, participants' accounts suggested that open communication, interpersonal safety, trust, and responsive follow-up shaped whether collaboration was taken up and sustained in everyday practice. Across clinical and teaching settings, these relational conditions were not consistently present. When these conditions were present, IPECP was more likely to occur; when they were limited by uncertainty, lack of confidence, restricted contact, or disconnection, collaboration became more tentative and difficult to sustain.

Communication and interpersonal safety enabled collaboration

Participants described communication and interpersonal safety as key relational conditions through which IPCP and IPECP were enacted. While Theme 2 showed that interprofessional opportunities were not always embedded into routine structures, participants' accounts also showed that collaboration could become possible through everyday interactions, including informal conversations, questions, and shared observations. These exchanges depended on people being approachable, responsive, and willing to share knowledge across professional or departmental boundaries.

Alex described an interaction with a lecturer from a different department who supported him with organising and presenting a lecture on Māori health to OHT students. He explained that he initiated the interaction:

> I approached her and told her what the lecture I was doing, and she was able to help me out. She was very welcoming and gave me ideas for the lecture. I had a really good interaction with her. She was open for me to approach her again and then to speak so she could explain things more.

This account shows how collaboration was enabled through approachability, responsiveness, and openness. Although the interaction depended on Alex initiating contact, the lecturer's response created a relational condition in which interprofessional teaching support became possible.

Harley similarly described an IPE opportunity that became possible through informal conversation with a staff member from another discipline, explaining, “I was having a chat, just an informal chat with someone from another discipline, [who was] the facilitator, and then I got to support students.” In this account, communication functioned as an accessible starting point for interprofessional engagement, rather than something requiring a formalised structure.

While Alex and Harley described informal communication in educational contexts, Alex also described brief exchanges as important in clinical practice. Alex explained, “Sometimes it’s just about asking, ‘What did you do with this patient?’ or ‘What do you think about this?’ And suddenly the whole treatment plan makes more sense.” This account aligns with wider participant accounts in which collaboration developed through everyday questions, informal conversations, and direct exchanges rather than formal processes alone. Read alongside Harley’s account, Alex’s example suggests that informal communication could operate as a practical mechanism through which collaboration was initiated and made clinically or educationally meaningful.

Participants also suggested that communication depended on whether they felt safe to speak openly. William explained that if people expected judgement, they were less likely to voice concerns or question practice. Reflecting on situations where he let concerns go, he explained that colleagues might “take it personally or take offence, particularly in front of students. If you think the person is going to judge you, you probably won’t open up to them or share your concerns.” This suggests that communication was not simply about exchanging information, but about whether the relational environment felt safe enough for honest discussion.

Max similarly reflected on feeling intimidated in an interprofessional teaching session where she was expected to support students while also working outside the familiar routines of her own discipline, “It did feel intimidating because, for example, I did not know how to unclip things on a wheelchair and being an educator and you should know things. In a room full of students.” Her account suggests that IPL could involve uncertainty as well as opportunity, particularly when participants were expected to support students while also learning alongside other disciplines. Across these accounts, feeling able to speak with others, ask questions, and learn from them appeared closely tied to whether collaboration felt possible and safe.

Trust, responsive follow-up, and mutual learning through relationships

Participants described trust, responsive follow-up, professional recognition, and supportive relationships as relational processes through which interprofessional collaboration developed over time. These processes helped strengthen confidence and made collaborative engagement more sustainable.

Harley described how a supportive environment enabled care to be organised around patient and family needs. He explained:

> They helped, in terms of interdisciplinary support and care. The environment was quite supportive in terms of getting the patients in, providing the care holistically and designing the treatment plan to support easier access for the family or for the children.

This account suggests that supportive relationships helped translate interprofessional contact into coordinated care. In this example, collaboration was not only about communication between professionals, but about creating conditions that made care more accessible, holistic, and responsive to patients and families.

Asher described ongoing communication with a referring clinician:

> He called me straight after that and said to me that he's really thankful that I refer these patients, and every time he saw improvements he would give me either a message or give me a call and explain what was going on.

In this account, feedback was not presented as formal evaluation, but as an ongoing relational process that reinforced collaboration and kept both practitioners informed.

Eden also described trust as something that developed through repeated exposure to how others worked, reflecting, "The more you get exposed to how people work they trusted my work and I trusted their work, and that led to the relationship we had." She described positive collaboration with dentists where opinions were exchanged both ways, explaining, "If there's something I'm looking at and I'm confused about or I'm not sure how to tackle, I will work with them and ask their opinion and they did the same." She added that it was "nice to be seen, not as just the [dental] therapist, but as a professional colleague." This account shows that relational trust was connected to professional

recognition. Collaboration felt stronger when oral health input was treated as legitimate and reciprocal, rather than subordinate.

Eden also described how relational connection could support patient engagement. She recalled working with a social worker to support a young person who had difficulty engaging with care. The social worker selected practitioners the young person could "click with so they would commit to care," and together they could "tag team the child's care." This account suggests that collaboration was not only a matter of coordinating clinical input. It also depended on identifying relationships that made care more accessible and acceptable for the young person. In this example, the social worker's knowledge of the young person helped shape how collaborative care was organised, showing how relational understanding could support IPCP in practice.

Max also described mutual learning as emerging through informal conversations with others from different disciplines. Reflecting on orthodontic care, she explained that through "getting into a conversation" with an osteopath, she learned that "when you're trying to move teeth within the bone, the fascia that's between the muscle and the bone gets tugged." Max described how, when orthodontic treatment was not progressing as expected, seeing an osteopath to "release that fascia and support alignment meant that their movements and their treatment plan went a lot faster." She also explained that these conversations helped her understand "what she could offer in terms of us referring to her and her referring to us as well." This account suggests that collaboration developed through relational familiarity and dialogue, rather than through formal referral pathways alone. It also shows how interprofessional conversations expanded Max's clinical reasoning by helping her recognise connections between mouth and other health factors impacting patient outcomes.

Alex linked professional affirmation from another practitioner with growing confidence in clinical judgement: "When another professional agrees with your diagnosis it helps you grow confident in your own judgement and be encouraged by any new learning." This suggests that collaborative relationships could support professional confidence as well as patient care.

Eden also described trust as grounded in respect and reliability: "You trust the people you know will follow through, who respect what you do, and who don't make you feel like you're stepping out of

line for asking for help." Eden's account suggests that trust developed through repeated evidence that others were reliable, respectful, and open to collaborative discussion. In this sense, relational confidence was built through seeing how others worked, whether they followed through, and whether they treated oral health input as legitimate.

Across these accounts, trust was built through supportive relationships, responsive follow-up, reciprocal recognition, learning together, and evidence that others would follow through. These relational processes supported more than relationship quality alone. They strengthened confidence in collaborative reasoning and helped make interprofessional engagement feel more purposeful and sustainable over time.

Limited contact and indirect communication constrained collaboration

Although relationships could support collaboration, participants also described relational conditions that limited their ability to participate confidently or meaningfully. Limited direct contact, restricted opportunities for engagement, and communication through indirect channels could weaken the sense of working as part of a collaborative team.

Participants described disconnection and limited engagement across teaching and clinical contexts. William described limited interaction beyond a small group of familiar educators and students: "I have interactions with the same students, and the same educators, but I have not had any interactions with the majority of the staff." Harley also described limited engagement with colleagues from other disciplines, stating, "I don't think I've had proper engagement with them." Max described this lack of connection in emotional terms when reflecting on days where she felt professionally isolated within the teaching environment: "There are days where you just feel like you're on an island."

Harley also noted that educators needed "more opportunities to learn and facilitate those interdisciplinary cares" so they could "actually teach our students as well." William reinforced this point when he observed that there were "not that many opportunities to even work with other staff members, there's not much cross fertilisation," suggesting that interprofessional exchange was less likely to become routine where recurring contact was sparse.

Asher described the limitations of indirect communication in collaborative work. Reflecting on a situation where information had to pass through others rather than being shared directly within the team, he stated:

> I just thought we weren't working as a team because I would obviously have to hear it from a second source instead of hearing from the first source. It would have just been a better, easier way of communication if we just all got involved.

This account shows that indirect communication could make collaboration feel disconnected, even when information was technically being shared. For participants, meaningful IPCP required direct communication and a sense of working together, not simply passing information through separate channels. The quality of collaboration was shaped not only by whether contact occurred, but by how directly and cohesively communication was organised.

These accounts suggest that relational practice depended on more than proximity, shared settings, or being located within the same organisation. Direct engagement, repeated contact, trust, and interpersonal safety shaped whether collaborative relationships could develop and continue over time. Where these relational conditions were present, collaboration was more likely to occur and feel meaningful; where uncertainty, limited contact, or indirect communication dominated, participation became more hesitant and restricted. Overall, relational practice appeared to function as the medium through which structural opportunities were either translated into collaboration or remained unused.

Theme 4: Impact of role understanding on interprofessional collaboration

This theme captures how educators described oral health as not always well understood or consistently recognised within interprofessional spaces. Across clinical and teaching settings, participants described needing to explain the contribution of oral health and navigate situations where their expertise was misunderstood, minimised, or overlooked. In these accounts, limited role understanding by others shaped whether oral health was recognised as relevant to interprofessional care.

Role understanding and visibility

Participants described oral health as not always visible or understood as relevant within interprofessional spaces. This was particularly evident in accounts where other professionals did not appear to see oral health as part of wider patient care. Asher stated, “Depending on who you talk to, oral health is either respected or invisible.” His account suggests that oral health was not always part of how other professionals thought about everyday healthcare. As a result, oral health practitioners could feel invisible within interprofessional spaces, which may reflect limited understanding of the oral health role by other professions. Max described furthers this when she reflected on moments where others appeared to reduce the oral health contribution to teeth alone, “You get those moments where they look at you like, ‘you’re just teeth.’ That’s when you really feel the hierarchy.” Together, these accounts suggest a lack of visibility within interprofessional spaces with oral health not consistently acknowledge or valued within these contexts. This shaped how participants experienced their place within interprofessional spaces and whether their contribution was understood as relevant to wider care.

Alex similarly described oral health as occupying an unclear position within the wider health system. Although oral health was connected to health, he felt it was not always treated as an integrated part of broader care: “We’re part of health, but also not part of it. We’re like this side unit that no one quite knows where to place.” His account suggests that oral health could be positioned as relevant to health in principle but still treated as separate from wider care in practice. This unclear positioning shaped whether oral health was understood as part of interprofessional care or as something sitting outside it.

William also questioned how care was coordinated when multiple practitioners were involved. He explained, “We do our bit and the other health care professionals do their bit, but there’s no team leader; it’s kind of up to the patient to manage themselves.” His account suggests that limited role clarity affected how oral health was connected to wider care. Rather than each profession’s contribution being understood as part of a shared interprofessional process, care was described as separated into individual professional responsibilities. In this context, oral health was not necessarily excluded, but it was not clearly integrated into a coordinated model of care. As a result, responsibility for connecting different parts of care could fall back onto the patient.

In response to this limited role understanding, participants described actively working to make oral health visible and credible within interprofessional spaces. This included explaining oral health's relevance, advocating for its place in collaborative care, adjusting communication, and building relationships that helped others better understand the contribution oral health could make.

Alex described how professional hierarchy shaped whether oral health perspectives were taken seriously within collaborative spaces: "If you're not placed in the right hierarchy people can disregard what you say." Asher's account further illustrated dismissive attitudes towards oral health, stating, "They are just an oral health therapist, what has that got to do with a foot or their backache?" William described a related experience in which oral health's place within collaboration was not assumed, explaining, "It's part of our job description to network and collaborate, but I think oral health is still not seen as integral to that. You have to justify why you're there." Together, these accounts suggest that participants were working in contexts where the contribution of oral health could be minimised, dismissed, or treated as needing justification before it was accepted as relevant.

Participants also described modifying how they communicated in response to these conditions. Alex described changing the wording of referral letters to reduce the likelihood that oral health concerns would be dismissed, explaining:

> Most GPs are not open; it is sad to say that. But the way I have done it [avoided being dismissed] is just wording the referral letter in a more basic form rather than an aggressive form of writing, and it has helped them listen to your advice.

Max also described being cautious about raising holistic or broader health concerns with other practitioners, explaining, "I would have reservations as to who I approached to talk about these things because I'm not sure how they'll respond to me." These accounts suggest that making oral health visible within interprofessional care sometimes required careful communication rather than straightforward participation. In this way, limited role understanding shaped not only whether oral health concerns were noticed, but also how participants felt they needed to present those concerns, so they were more likely to be accepted.

Max's concern appeared to relate not only to whether others would respond positively, but to whether her meaning would be understood in the way she intended. She explained that she had "reservations about who I approach because I am unsure how others would respond to me blabbing on about holistic care." She clarified that, for her, holistic care was "not the hocus pocus kind of thing, you know burning sage." This account suggests that making oral health visible involved more than explaining clinical relevance. It also required educators to manage how their language, professional judgement, and credibility might be received by others. In this way, limited shared understanding constrained not only collaboration itself, but also educators' confidence to initiate interprofessional conversations.

Participants also described visibility work as part of their educator role, particularly where interprofessional opportunities were not already embedded. Rather than only seeking recognition from other professions, educators described helping students understand how oral health contributes to broader collaborative care. This shows that making oral health visible was both an outward-facing process, directed toward other professionals, and an educational process, directed toward students' developing understanding of IPCP.

Participants also described creating opportunities for collaboration when these were not already embedded. Asher described supporting students to work across disciplines, explaining, "I supported Xena working alongside the podiatry student to help the patient. That's where collaboration happens, it's through those moments we create interprofessional opportunities ourselves." Alex's account reinforced this point, describing collaboration as sometimes beginning through educator initiative: "Sometimes it's just about sitting down with another educator and saying, 'let's do this together.'" These accounts suggest that educators did not only experience limited visibility passively. They also worked to create spaces where oral health could be seen, understood, and connected to wider care. However, because these opportunities depended on individual initiative, oral health visibility remained dependent on educators actively creating spaces for interprofessional learning and connection.

Max also suggested that visibility could be strengthened through more deliberate exposure to other professional perspectives in OHT teaching. She suggested that the programme could "involve a lot

more departments in our teaching, including guest lecturers from other health areas who could help students understand what other providers could be providing for patients." Max linked this to educators' responsibility to help students think beyond routine clinical tasks, explaining that students and clinicians can become focused on "just achieving what we need to achieve or doing what you need to do day in and day out, rather than asking, what else can I do for this person that's in my chair?" This account suggests that visibility work was not only about explaining oral health to other professions, but also about deliberately exposing OHT students to the wider healthcare contributions that could support patient care.

Taken together, these accounts suggest that limited role understanding shaped whether oral health was seen as relevant to interprofessional care. Participants described oral health as overlooked, minimised, or requiring explanation in some contexts. As a result, educators often had to make oral health visible through careful communication, advocacy, relationship-building, and the creation of learning opportunities for students.

Cross-theme synthesis

IPECP was experienced differently depending on the conditions in which educators worked and taught. Although participants valued IPECP, their accounts showed that access to, and engagement with, IPECP varied across contexts. The four themes show that IPECP was experienced as a situated practice shaped by the interaction of ethical and holistic commitments, structures, relationships, and role understanding. None of these dimensions operated in isolation. Participants' ethical and holistic commitments gave collaboration meaning, but these commitments could only be enacted when structural conditions, relational opportunities, and recognition of oral health's contribution supported collaboration. Differences were also apparent between participants' public- and private-sector practice contexts. Harley's public-sector account highlighted how collaboration was shaped by the organisational structures, communication pathways, and referral processes of a publicly funded oral health service. In contrast, participants whose experience was situated primarily in private practice more often described collaboration in relation to the immediate dental team and the professional relationships available within or around an individual practice. Across both contexts, opportunities for collaboration depended on whether OHTs had access to other professions and

whether organisational and relational conditions supported meaningful interaction. As Harley was the only participant representing the public sector, these differences should be interpreted as contextual insights within this dataset rather than as conclusions about all public- and private-sector OHT practice in Aotearoa New Zealand.

This cross-theme pattern is important because it suggests that the challenge was not simply whether educators valued collaboration or understood its importance. Rather, IPECP depended on whether oral health was structurally included, supported through relational conditions such as communication and trust, and recognised as a meaningful contributor to wider collaborative care. Where these conditions were limited, IPECP became harder to access and put into practice.

Summary

This chapter has presented an interpretive account of OHT educators' experiences and understandings of IPECP. Four interconnected themes were constructed from the analysis: ethical and holistic commitments shaped understandings and practice of IPCP; being positioned outside wider systems limited access to IPECP; relational conditions influenced whether IPCP could be enacted; and limited visibility of oral health shaped how OHT educators and students were recognised within interprofessional spaces. Together, these themes show that IPECP was influenced by the interaction of values, structures, relationships, and recognition.

The findings suggest that collaboration in OHT education cannot be understood only as a competency or activity. It is influenced by whether oral health is included within interprofessional structures, supported through communication, trust, and opportunities for interprofessional contact, and recognised as a meaningful contributor to interprofessional care. The following chapter situates these findings in relation to existing literature and considers how this study supports, extends, and challenges current understandings of IPECP within oral health education and practice.

Chapter 5: Discussion

This chapter discusses the findings of this study in the context of current evidence and in relation to the research question: *What are oral health therapy (OHT) educators' experiences and understandings of interprofessional education and collaborative practice (IPECP) within undergraduate OHT programmes in Aotearoa New Zealand?* The study aimed to explore these experiences and understandings and to consider how they may inform future approaches to IPECP in undergraduate OHT education, including curriculum design, clinical learning, educator support, and preparation for interprofessional collaborative practice (IPCP).

The central point developed in this chapter is that within the Aotearoa New Zealand undergraduate OHT context examined in this study, IPECP involving oral health was shaped by the educational and practice contexts in which collaboration was expected to occur. Participants' accounts suggested that collaboration depended on more than individual willingness. It was shaped by the position of oral health within wider health and education systems, the quality of everyday interprofessional relationships, and the extent to which the OHT role was understood and embedded within interprofessional spaces. These findings suggest that future IPECP development within undergraduate OHT education requires attention to the structural inclusion of oral health, the relational conditions that enable collaboration, and the visibility and recognition of the OHT role within interprofessional spaces.

The chapter is organised around three key discussion points: how structural siloing of oral health shapes collaborative practice; how relational conditions mediate the enactment of IPECP; and how participants' experiences indicated that limited understanding of the OHT role within Aotearoa New Zealand IPECP settings constrained participation, visibility, and recognition. The chapter concludes by considering the implications of these findings for future IPECP development within undergraduate OHT programmes in Aotearoa New Zealand. The discussion begins with structural siloing because participants' accounts suggested that the wider positioning of oral health shaped the conditions through which relational and role-based issues were experienced.

1. The structural siloing of oral health shapes collaborative practice

Oral health therapy educators' experiences and understandings of IPECP were shaped by the siloed positioning of oral health across educational and practice contexts. In this discussion, siloing refers to the way oral health was organised separately from wider health services, curriculum structures, placement arrangements, and everyday systems of communication. This is distinct from interpersonal barriers because it refers to the organisational and structural conditions that shape whether professions have routine opportunities to learn with, from, and about each other. Participants' accounts suggested that IPCP involving oral health was shaped by the marginal positioning of oral health within wider health and education systems. Rather than being consistently integrated into interprofessional structures, oral health often appeared on outsides of IPECP opportunities. This affected how easily educators and students could access interprofessional opportunities, communicate with other professions, participate in interprofessional learning, and make the OHT contribution visible. Existing literature has identified ongoing challenges related to the separation of oral health from wider health systems and tertiary education contexts (Jatrana et al., 2009; Moffat et al., 2009; World Health Organization [WHO], 2024). This study adds to that knowledge by showing how OHT educators experienced this separation in everyday educational and practice settings, particularly through limited integration with wider health services, fragmented communication and referral processes, and uneven access to interprofessional learning (IPL) opportunities. The following discussion develops these points by considering how the marginal positioning of oral health, fragmented infrastructures, and historical and organisational separation shaped what forms of IPECP were possible within undergraduate OHT education.

The findings also suggest that separation operated not only between oral health and wider health systems, but also through the organisation of oral health practice itself. In some settings, participants described limited routine contact with other professionals, meaning collaboration had to be actively created through individual effort rather than being supported through established systems or shared processes. This is consistent with literature showing that oral health integration is often limited by separate service arrangements, fragmented referral and communication pathways, and insufficient

organisational mechanisms for routine interprofessional engagement (Jatrana et al., 2009; Harnagea et al., 2018; WHO, 2024).

This separation can also be understood in relation to broader patterns of professional specialisation in healthcare. As patient care has become more complex, health professions have developed increasingly specialised roles and service pathways. D'Amour and Oandasan (2005) argue that complex health needs create greater interdependence among professionals, while also requiring deliberate attention to the processes that enable collaboration across professional boundaries. In this sense, interdependence alone is insufficient. Interprofessional literature suggests that collaboration is not produced by the presence of multiple professions alone, but depends on organisational arrangements, communication processes, role clarity, and opportunities for routine interaction (Reeves et al., 2017; Rawlinson et al., 2021). While specialisation can strengthen profession-specific expertise, separate service pathways and limited shared systems can make collaborative practice more difficult when professions have infrequent contact, unclear roles, and few routine mechanisms for communication (D'Amour & Oandasan, 2005; Rawlinson et al., 2021; Reeves et al., 2017). The combination of professional specialisation, separate service pathways, and limited shared systems helps explain why participants in the present study could value IPECP while also describing few routine opportunities to interact with other disciplines or to embed oral health within wider collaborative care.

This study adds to the oral health and broader interprofessional literature by showing how structural separation was experienced within undergraduate OHT education in Aotearoa New Zealand. Existing literature identifies fragmented service arrangements, limited communication pathways, and insufficient organisational mechanisms as barriers to collaboration (Jatrana et al., 2009; Harnagea et al., 2018; WHO, 2024). The present study extends this by showing how similar structural conditions affected OHT educators' ability to access, model, and teach IPECP, rather than only shaping service delivery.

As briefly mentioned earlier in the Literature Review Chapter, in Aotearoa New Zealand, the historical development of dental therapy and oral health therapy provides a local example of how oral health roles have been organised through distinct professional and service pathways. Dental therapy was

initially positioned within the School Dental Service, where dental therapists provided care for children in school-based dental clinics rather than working alongside dentists or other health professionals in general healthcare settings (Moffat et al., 2009; Moffat et al., 2017). Over time, changes to professional education, regulation, and scope of practice contributed to the development of oral health therapy, with OHTs practising across broader child, adolescent, and adult oral health contexts. These developments, together with later community-based service models, help contextualise how dental therapy and oral health roles were organised through distinct pathways that shaped their relationship with other parts of the health system (Moffat & Ahmadi, 2021; Moffat et al., 2017).

This thesis adds to this literature by showing how participants experienced these organisational arrangements as shaping everyday possibilities for IPECP. Participants' accounts suggested that the organisation of oral health practice influenced whether they had routine contact with other professionals, access to interprofessional spaces, shared communication pathways, and practical opportunities to model collaborative practice for students. Under these organisational arrangements, collaboration could be valued in principle while remaining difficult to operationalise in practice. This helps interpret participants' experiences not as exceptional or purely local, but as reflective of a wider systemic pattern in which oral health is expected to contribute to collaborative care without always being structurally positioned to do so.

The World Health Organization's (WHO) *Global strategy and action plan on oral health 2023–2030* is relevant here because it challenges the continued separation of oral health from wider health systems. By positioning oral health as integral to general health and wellbeing, and by calling for stronger integration of oral health into primary healthcare systems, the strategy supports the need to move beyond siloed service arrangements (WHO, 2024). However, despite this growing policy recognition, recent literature suggests that oral health remains only partially integrated into wider healthcare teams and systems (Hung et al., 2025; WHO, 2024). This gap between policy recognition and service integration is important for the present study because participants' accounts showed a similar tension: although oral health was understood as relevant to holistic care, it remained difficult to embed within routine IPECP opportunities. Although related to the Australian context, Veginadu

and Haddock's (2024) policy brief reinforces the significance of structural factors identified in this study by highlighting similar barriers to integration, including separation between dental and general healthcare systems, weak coordination mechanisms, and limited information sharing across services. Together, this literature positions participants' accounts within a broader implementation gap between the aspiration for integrated healthcare and the organisational arrangements needed to support it.

A second aspect of structural siloing was that organisational systems and processes shaped whether IPCP was part of routine practice. In participants' accounts, collaboration was possible, but it was not always supported through shared communication pathways or regular opportunities for interprofessional contact. As a result, IPECP often had to be actively created by educators rather than being embedded in everyday organisational practice. This finding aligns with broader IPECP literature, which emphasises that collaborative practice is difficult to sustain without organisational support, shared communication processes, and structures that allow professionals to work together routinely rather than in ad hoc ways (Reeves et al., 2010; Reeves et al., 2016; Schot et al., 2020). The finding that oral health remained difficult to embed within wider collaborative systems also aligns with oral health-specific literature, which identifies fragmented service arrangements and limited coordination between dental and general healthcare systems as barriers to embedding oral health within wider care (Harnagea et al., 2018; WHO, 2024). This study builds on existing literature by illustrating how OHT educators experienced organisational conditions as shaping the everyday practical work required to initiate, coordinate, and sustain IPECP. These structural arrangements also had implications for the visibility of oral health within interprofessional spaces, a point developed later in relation to role understanding and recognition.

The finding that oral health was not routinely embedded within IPL and practice aligns with literature suggesting that oral health is increasingly recognised within IPECP but remains unevenly included in how such activities are designed and enacted. For example, de Mendonça et al. (2024) found that dentistry is included in undergraduate interprofessional education (IPE) internationally, but that the form, timing, and depth of this inclusion vary considerably across programmes. This uneven inclusion is significant in the Aotearoa New Zealand context because the DCNZ competencies position

communication, collaboration, and culturally responsive practice as core aspects of OHT capability, rather than optional additions to practice (DCNZ, 2021). Taken together, the reviewed literature suggests that although oral health is increasingly recognised within interprofessional and integrated-care discourse, this recognition has not yet translated consistently into routine inclusion within IPECP. Further structural and educational design is therefore needed to support oral health's meaningful participation in interprofessional learning and collaborative practice.

However, the findings indicate that structural conditions did not determine collaboration in a simple or complete way. Even within constrained systems, participants described moments where collaborative practice became possible when everyday relationships supported communication, trust, reciprocity, and mutual responsiveness. This reflects Sangaleti et al (2017) systematic review of teamwork and IPCP in primary healthcare, which identified relational and organisational features such as trust, frequent contact, shared workspaces, communication, and knowledge of professional roles as important to collaborative practice. Broader IPECP literature similarly suggests that collaboration is not produced by formal structures alone, but is negotiated through everyday interactions, communication practices, role understanding, and responsive work across professional boundaries (Reeves et al., 2010; Reeves et al., 2016; Schot et al., 2020). This study supports this literature by showing how, within oral health, relational work became particularly important where formal structures for IPECP were limited or unevenly embedded. These relational conditions are discussed further in the next section, but they are introduced here because they show that structural constraints shaped, rather than fully determined, the possibilities for IPECP. In this sense, structural conditions shaped what collaboration was possible, while relational conditions shaped whether and how collaboration was enacted in everyday practice.

2. Relational conditions mediate whether collaboration can be enacted

The second discussion point is that OHT educators' experiences and understandings of IPECP were shaped by the relational nature of IPCP. In this discussion, relational refers to the everyday interactions, communication practices, trust, respect, reciprocity, and responsiveness through which practitioners come to understand one another and work together in practice. Interprofessional

literature has long argued that collaboration is not created by formal structures or co-location alone, but is negotiated through relationships, communication, shared understandings, and the everyday work of coordinating care across professional boundaries (D'Amour & Oandasan, 2005; Reeves et al., 2010; Schot et al., 2020). Looking at Flood's work here foregrounds the human and relational qualities of interprofessional practice, including getting to know others, genuine dialogue, trust, and respect (Flood et al., 2019; Flood, 2022). In the present study, these relational conditions shaped whether IPECP could be enacted, sustained, and made meaningful within OHT education and practice. Professional cultures can act as barriers to teamwork when different professions bring distinct assumptions, communication patterns, and expectations into collaborative spaces (Hall, 2005). Participants' accounts suggested that collaboration did not automatically occur just because professionals shared the same workplace. This supports Sargeant et al.'s (2008) argument that contact alone is insufficient to build effective interprofessional teams. Rather, collaboration depended on the quality of everyday interactions and whether these interactions supported openness, trust, and a sense of interpersonal safety.

This interpretation aligns with literature that understands IPCP as an active and relational process rather than a fixed outcome of organisational design. Schot et al.'s (2020) systematic review shows that IPCP is built through everyday practices that help professionals work across boundaries, clarify roles, and organise shared care. Hovey and Craig (2011) also emphasise that learning with, from, and about others depends on the relational practices underpinning professional interactions and communication. Within this study, communication was central to how collaboration was built. Where communication was open and responsive, participants appeared more willing to contribute their oral health perspective and develop shared understanding with other professionals. Trust and reciprocity were also important because they developed through repeated contact, responsiveness, and opportunities to know how others worked, rather than through formal role arrangements alone. This aligns with wider relational IPECP literature, which positions communication, trust, and responsiveness as central to how collaboration is enacted in practice (Hovey & Craig, 2011; McAllum et al., 2025; Schot et al., 2020). This study extends this literature by showing how, for OHT educators,

communication, trust, and responsiveness operated as practical mechanisms through which IPECP became possible in everyday educational and practice settings.

The findings also link with literature on psychological safety, although this concept is applied cautiously because participants did not explicitly use this term. Psychological safety is generally understood as a shared belief that a team or workplace context allows interpersonal risk-taking, such as asking for help, acknowledging uncertainty, raising concerns, and contributing ideas (Edmondson, 1999; Edmondson & Lei, 2014; Ito et al., 2022). These elements were reflected in participants' accounts when they described collaboration as easier in contexts where communication felt open, responses from others were constructive, and they felt able to contribute an oral health perspective without feeling judged or dismissed. Psychological safety literature is also useful because it shows that these forms of participation are shaped by relational and organisational conditions. O'Donovan et al.'s (2020) review identifies psychological safety as influenced by factors such as leadership, peer support, familiarity, and learning-oriented environments. In this study, this literature helps explain why open communication, trust, and constructive responses from others appeared to shape whether OHT educators could initiate and sustain interprofessional collaboration.

The findings also suggest that collaboration became more fragile where relational connection was limited. When participants had fewer opportunities for direct engagement and responsive communication, collaboration appeared less likely to develop into sustained IPCP. This aligns with relational IPCP literature showing that collaboration depends on everyday interaction, dialogue, trust, and willingness to learn from others, rather than formal expectations alone (Flood et al., 2022; Hovey & Craig, 2011; Schot et al., 2020). In this study, relational difficulties also interacted with structural siloing. Where routine collaboration was not supported through established communication processes or regular opportunities for interprofessional contact, participants' accounts suggested that the relationships needed for IPECP were harder to build and sustain.

In the Aotearoa New Zealand context, this discussion of relational IPCP is relevant to current expectations for OHT practice. The DCNZ competencies position communication, professionalism, and collaboration as core aspects of safe and effective OHT practice (DCNZ, 2021). The significance of these competencies for this discussion is that they frame collaboration as a practice capability,

not simply as an expectation that OHTs work with others. This aligns with wider IPCP competency frameworks, which emphasise interprofessional communication, role understanding, values and ethics, teamwork, and collaborative practice as necessary capabilities for working effectively across professional boundaries. Read this way, the DCNZ competencies support the point that IPCP requires relational capability: the ability to communicate openly, respond constructively, build trust, understand others' roles, and work respectfully with other professionals. Interprofessional literature suggests that these capabilities are supported by repeated interaction, opportunities for dialogue, familiarity with other professionals, trust, respect, and learning environments where practitioners feel able to ask questions and contribute their perspectives (Flood, 2022; Hovey & Craig, 2011; O'Donovan et al., 2020; Sargeant et al., 2008). This helps interpret participants' accounts by showing why collaboration was easier to initiate where direct communication and trusting relationships were present, and harder to sustain where contact was limited or communication was indirect.

3. Impact of role understanding on interprofessional collaboration

The third discussion point considers how limited role understanding shaped participation, positioning, and recognition within IPECP. In interprofessional literature, role understanding is often discussed as role clarification, which refers to practitioners understanding their own role as well as the roles, responsibilities, and contributions of others to support collaborative care (Canadian Interprofessional Health Collaborative [CIHC], 2010). In this study, role clarification is used to consider how oral health and the OHT role were understood, recognised, and positioned as relevant within IPL and practice contexts. Participants' accounts suggested that role understanding was limited in reciprocal ways. Other professionals did not always understand the OHT role or scope of practice, while OHT educators also described uncertainty about the roles, responsibilities, and contributions of other professions. This affected more than general awareness of professional roles. It shaped whether the OHT contribution to interprofessional care was understood as relevant and credible, or whether it first needed to be explained, clarified, or justified. It also shaped whether OHT educators and students could participate in IPECP as recognised contributors to collaborative care.

These findings align with wider IPECP literature showing that role understanding and role clarification are central to effective IPL and IPCP (Brewer & Jones, 2013; CIHC, 2010; IPEC, 2016; Reeves et

al., 2010). They also connect with professional identity formation, as students' understandings of their own profession and other professions begin developing early in health professional education and can shape how they position themselves in relation to collaborative practice (Adams et al., 2006). Learning with, from, and about other professions is intended to support not only knowledge of professional roles but also respect for the contributions of different professions and improved collaboration (CAIPE, 2019; WHO, 2010). Role understanding is also central within interprofessional competency and capability frameworks, where understanding one's own role, recognising the roles and expertise of others, communicating across professional boundaries, and contributing to team-based care are positioned as core aspects of collaborative practice (Brewer & Jones, 2013; CIHC, 2010; IPEC, 2016; McLaney et al., 2022). In this study, participants described needing to explain how oral health could contribute to patient care, clarify the OHT scope, and advocate for oral health to be included in interprofessional discussions. This suggests that limited role understanding affected participation because OHT educators could not always enter interprofessional spaces with their contribution already recognised. Instead, they often had to make the OHT role and oral health contribution visible before meaningful participation in IPECP could occur.

In this study, role understanding influenced whether oral health was regarded as relevant to collaborative care and whether OHTs were included and recognised as credible contributors within interprofessional settings. Where oral health was not well understood, participants' accounts suggested that its contribution to wider health, wellbeing, and holistic care could be overlooked. Although oral health is increasingly recognised as connected to overall health and wellbeing (Hung et al., 2025; WHO, 2024), this recognition does not necessarily mean that oral health expertise is routinely included in collaborative decision-making or IPL. Existing oral health IPECP literature similarly indicates that IPL can enhance understanding of professional roles, however, meaningful inclusion of oral health depends on how oral health expertise is positioned within the activity, rather than on the mere presence of oral health students or practitioners (de Mendonça et al., 2024; Van Dam et al., 2025). This distinction helps interpret participants' accounts, where OHT participants described needing to explain the OHT scope, clarify how oral health contributes to patient care, and advocate for oral health to be included in interprofessional discussions. This suggests that role

understanding is not only an educational outcome of IPECP, but also a condition that shapes whether oral health can participate meaningfully in IPECP in the first place.

This literature also suggests that oral health IPECP is more likely to support role understanding when learning is intentionally designed, facilitated, and connected to authentic patient or case-based care (de Mendonça et al., 2024; Van Dam et al., 2025). However, implementation remains variable and context-dependent, with limited evidence about how oral health IPECP influences longer-term collaborative practice. This reinforces the need to consider not only whether IPECP is present in undergraduate OHT education, but how it is designed, supported, and connected to practice. In the present study, this was important because participants' accounts suggested that the OHT contribution was not always understood by other health professionals or students from other disciplines through shared placement, co-location, or interprofessional contact alone. Where understanding was limited, OHT educators described doing additional explanatory work in their own interprofessional practice to make oral health visible as part of collaborative care. This was less evident in relation to students, who participants suggested had fewer sustained opportunities to enact this work directly.

This explanatory work can be understood as role clarification work. Participants described clarifying the OHT scope, explaining links between oral and general health, and advocating for oral health as part of holistic care. This reflects interprofessional literature showing that unclear professional roles can limit collaboration and that role clarification is necessary for effective IPCP (CIHC, 2010; Reeves et al., 2010). It also aligns with interprofessional competency and capability frameworks, where understanding one's own role, recognising the roles and expertise of others, communicating across professional boundaries, and contributing to team-based care are positioned as core aspects of collaborative practice (Brewer & Jones, 2013; CIHC, 2010; IPEC, 2016; McLaney et al., 2022).

In the Aotearoa New Zealand context, limited understanding of the OHT role is relevant because OHTs are expected to communicate, work collaboratively, and provide culturally responsive care (DCNZ, 2021). However, these expectations focus on the capabilities OHTs are required to develop; they do not, on their own, ensure that the OHT role will be understood or recognised by others in interprofessional settings. This study suggests that meaningful participation in IPECP also depends

on whether other professionals and students understand the OHT scope and recognise the oral health contribution to wider health and wellbeing. This aligns with wider IPECP literature that identifies role clarification, communication, and understanding of professional responsibilities as central to collaborative practice (CIHC, 2010; IPEC, 2023; WHO, 2010). Where role understanding was limited, OHT educators and students had to do additional explanatory work before oral health could be recognised as relevant to IPCP. Where the OHT role was better understood, participation in IPECP appeared more achievable.

This has implications for both OHT students and students from other health disciplines. If the OHT role is not clearly understood within interprofessional learning environments, OHT students may have fewer opportunities to see their future contribution recognised within collaborative care. At the same time, students from other disciplines may have limited opportunities to understand how oral health relates to their own future practice. While competency frameworks identify role understanding as a core element of collaborative capability, this study shows that such capability depends on whether oral health roles are made visible and recognised within interprofessional spaces. For OHT educators, the challenge was therefore not only to prepare students for IPCP, but also to navigate education and practice settings where oral health still needed to be positioned as relevant to shared care.

IPECP literature often positions education as an important mechanism for preparing a collaborative practice-ready workforce (WHO, 2010). However, the findings of this study suggest that the limited embedding of IPECP in undergraduate OHT education cannot be understood as a curriculum issue alone. Taken together, the three discussion points show that IPECP was shaped by the interaction of wider structural, relational, and role-based conditions: oral health has been positioned separately from wider health systems, the OHT role is not always well understood or recognised, and collaboration often depends on individual relationships rather than routine systems. This interpretation aligns with implementation literature showing that IPE requires more than curriculum content, because its success also depends on organisational support, facilitation, faculty capability, logistics, and the relationship between education and practice settings (Bogossian et al., 2022; Oandasan & Reeves, 2005; Reeves et al., 2007). Within these conditions, students may have limited

opportunities to see IPCP modelled, practised, and normalised. This is important because, without deliberate educational and organisational support, existing siloed ways of working may continue to shape how future OHT practitioners understand and enact collaborative practice.

Implications for future interprofessional education and collaborative practice development in undergraduate oral health therapy programmes in Aotearoa New Zealand

This study aimed to explore OHT educators' experiences and understandings of IPECP and to use these insights to inform future IPECP development. The findings indicate that IPECP within undergraduate OHT programmes in Aotearoa New Zealand needs to be designed and developed with attention to the structural, relational, and role-based conditions that make collaboration possible. Structurally, this means positioning oral health as an integral part of IPCP, rather than treating it as separate from wider health practice. Relationally, it means creating opportunities for current and future OHTs to develop the communication, trust, responsiveness, and shared understanding needed to engage in the relational work of collaborative practice. In relation to role understanding, it means creating opportunities for others to learn not only about the OHT role, but also about the contribution of oral health to wider health, wellbeing, and holistic care. Therefore, the implication is not simply that OHT students and practitioners need more opportunities to be present in interprofessional spaces, but that IPECP needs to be deliberately designed so that oral health is visible, relational engagement is supported, and the OHT role is understood.

Existing IPECP literature shows that interprofessional learning and practice depend on more than bringing professions into contact with one another. Role understanding, communication, trust, facilitation, authentic learning opportunities, and organisational support all shape whether IPECP can be meaningfully practiced (Sargeant et al., 2008; Schot et al., 2020; WHO, 2010). Oral health IPE literature similarly suggests that interprofessional activities can support students' role understanding and collaborative capability, but that implementation is often variable, short-term, dependent on individual champions, or limited by weak evaluation of longer-term practice outcomes (de Mendonça et al., 2024; Van Dam et al., 2025). The findings of this study add to this knowledge by showing that, within undergraduate OHT programmes in Aotearoa New Zealand, IPECP design

needs to respond to the structural separation of oral health, limited recognition of the OHT role, and the relational work required to build communication, trust, and professional relationships.

The first implication is that future IPECP development should make the oral health contribution explicit within undergraduate OHT education. The findings suggest that oral health cannot be assumed to be recognised as a usual or necessary part of IPCP. Therefore, IPL activities and practice-based learning experiences need to be designed so that the relevance of oral health to shared care is clear from the outset. This may include integrating oral health into case discussions, care planning activities, role clarification exercises, and placement-based conversations about collaborative care. The purpose is not only to increase exposure to oral health, but to support students from other disciplines and health professionals involved in student learning to understand how OHT knowledge contributes to whole-person care.

Oral health IPE literature supports this implication by showing that IPECP is more likely to be meaningful when it is intentionally designed, facilitated, and connected to authentic patient or case-based learning (de Mendonça et al., 2024; Van Dam et al., 2025). However, this literature also cautions against assuming that the presence of oral health students or practitioners in interprofessional activities will automatically produce meaningful collaborative learning. The findings of this study add to that evidence by showing why IPECP activities within undergraduate OHT education need to do more than bring students together. They need to make the oral health contribution explicit, create opportunities for facilitated interaction, and support students to practise explaining and negotiating the OHT role within shared care contexts.

The second implication is that IPECP development should support the relational work through which collaboration is enacted. The study findings suggest that collaboration was more likely to become meaningful where participants experienced open communication, trust, responsiveness, and opportunities for direct engagement. In undergraduate OHT education, this means that IPECP should not depend only on students being placed near other professions or attending isolated IPL events. Rather, learning opportunities need to be designed so that students can practise the relational aspects of collaborative practice, including communicating their oral health perspective, listening to other professional perspectives, asking questions, and developing shared understanding.

This aligns with interprofessional literature showing that contact alone is insufficient for effective IPL, and that collaboration is developed through purposeful interaction, role understanding, communication, and everyday practices of working across professional boundaries (Sargeant et al., 2008; Schot et al., 2020; Van Dam et al., 2025). This implication is important because relational capability is not only an individual attribute; it is developed through learning environments that make relational engagement possible.

A third implication is that IPECP should be supported at programme and organisational levels. The findings suggest that IPECP was less sustainable when it depended on individual educators' relationships, informal coordination, or capacity to create opportunities. Future development therefore requires structures that make IPECP easier to plan, enact, and sustain. In undergraduate OHT programmes, this may include clearer planning between oral health and other health programmes, agreed expectations with placement settings, and intentional opportunities for OHT students to engage with other professions during clinical or community-based learning. These supports would help shift IPECP from being an occasional or person-dependent activity toward a more embedded part of OHT education.

The literature also helps explain why IPECP may be difficult to embed when these supports are absent. Recent oral health integration literature identifies barriers such as fragmented service systems, limited coordination between dental and general healthcare, unclear understanding of professional roles, and insufficient interprofessional training as key constraints on integrating oral health professionals into wider healthcare teams (Harnagea et al., 2018; WHO, 2024). These barriers closely reflect the structural, relational, and role-recognition challenges identified in this study, where collaboration was often dependent on individual effort, relationships, and explanation of the OHT role rather than supported through routine organisational systems. Therefore, the issue is not only whether OHT educators and students value collaboration, but whether programmes and practice settings provide the shared structures, communication pathways, role clarity, and repeated opportunities needed for collaboration to become routine.

These implications are particularly relevant in Aotearoa New Zealand because current professional and health strategy directions position communication, collaboration, and person-centred care as

important to health practice (DCNZ, 2021; Manatū Hauora, 2023). However, the findings of this study suggest that these expectations cannot be achieved through competency statements or policy aspirations alone. Undergraduate OHT programmes, placement providers, and other health programmes need to translate these expectations into the everyday design and organisation of learning. This aligns with the WHO (2010) framework for interprofessional education, which argues that students who learn with, from, and about each other are better prepared for collaborative practice. Therefore, undergraduate OHT programmes need to provide learning conditions that allow students to experience, practise, and reflect on collaboration in ways that make the oral health contribution visible and meaningful.

Strengths, limitations, and recommendations for future research

Several strengths of this study should be noted. First, the use of ID was well suited to examining OHT educators' experiences and understandings of IPECP in a way that remained attentive to both contextual complexity and practice relevance (Thorne et al., 2004; Thorne, 2016). Rather than limiting the analysis to a descriptive account of barriers and facilitators, this approach enabled insights into the structural, relational, and role-based conditions that shaped participants' accounts of IPECP.

Second, focusing on OHT educators provided a useful perspective because educators occupy a position at the intersection of curriculum, clinical supervision, professional socialisation, and practice. Their accounts therefore offered insight not only into how IPECP is experienced, but also into how collaboration is understood, modelled, and made possible within undergraduate OHT education and practice settings. This perspective was particularly relevant to the aims of the study because the research sought to inform future IPECP development within undergraduate OHT programmes in Aotearoa New Zealand. It also responds to a gap in the oral health IPECP literature, where research has more often examined student experiences, programme evaluations, or specific IPE activities than the perspectives of educators involved in shaping and supporting IPECP (de Mendonça et al., 2024; Van Dam et al., 2025).

A further strength was the study's specific focus on IPECP within undergraduate OHT programmes in Aotearoa New Zealand. While IPECP is widely discussed in health professional education, limited

research has examined how OHT educators experience and understand IPECP in this specific educational and professional context. The study therefore provides context-specific insight into how oral health is positioned within interprofessional learning and practice, how relational work supports collaboration, and how understanding of the OHT role shapes participation and recognition.

Several limitations should also be acknowledged. First, the study was based on interviews with six OHT educators. This was appropriate for the qualitative and interpretive aims of the study, where the purpose was to generate an in-depth, practice-relevant understanding of participants' experiences rather than statistically generalisable findings (Creswell & Poth, 2018; Thorne, 2016). Second, the study did not include the perspectives of OHT students, other health professional students, practitioners from other disciplines, service leaders, or patients. These perspectives may have generated different or additional understandings of how IPECP is experienced, supported, or constrained.

Third, the study relied on self-reported interview data collected at one point in time. While this enabled participants to reflect on their experiences and understandings in depth, it did not directly observe how IPCP or IPL were upkept in practice or education settings. Observational or longitudinal approaches may have provided further insight into how collaboration is initiated, sustained, or disrupted over time. Finally, my position as an OHT educator shaped the research process. This insider position provided contextual understanding of OHT education and practice, but also required ongoing reflexive attention to assumptions, familiarity, and interpretation.

Future research could extend this study in several ways. Research involving OHT students, other health professional students, educators from other disciplines, practitioners, and patients would help examine how oral health and the OHT role are understood across interprofessional learning and practice contexts. This would be useful for exploring whether the role-understanding issues identified in this study are experienced similarly by others, or whether different professions understand the oral health contribution in different ways. This aligns with interprofessional literature and competency frameworks that identify role understanding, communication, and recognition of others' contributions as central to collaborative practice (CIHC, 2010; IPEC, 2016; Reeves et al., 2016).

Further research could also examine how specific IPECP approaches are designed, implemented, and evaluated within undergraduate OHT programmes. This may include research into case-based IPL, practice-based learning, shared placement experiences, or interprofessional activities that explicitly position oral health as part of wider health, wellbeing, and holistic care. This is important because IPECP literature highlights the need for intentional design, facilitation, and authentic learning opportunities rather than assuming that interprofessional learning occurs through proximity alone (Sargeant et al., 2008; Van Dam et al., 2025; WHO, 2010). Longitudinal research would also be valuable to examine whether IPECP experiences during undergraduate education influence graduates' confidence, role understanding, and participation in collaborative practice after entering the workforce.

Finally, future research could examine how IPECP involving oral health can be developed in ways that support Te Tiriti o Waitangi responsibilities, equity, and whānau-centred approaches to care in Aotearoa New Zealand. This would extend the present study by engaging more directly with Indigenous health priorities, structural inequities, and culturally grounded approaches to collaborative oral healthcare (Durie, 1999; Manatū Hauora, 2015; Pae Tū, 2023).

Conclusion

Overall, this study suggests that future IPECP development within undergraduate OHT programmes in Aotearoa New Zealand needs to be deliberate, supported, and clearly connected to the OHT role. The contribution of this thesis is that it provides insight from OHT educators' experiences across practice and education settings, which may inform how future IPECP is shaped for oral health students and practitioners. Meaningful IPECP requires more than including oral health students and practitioners in interprofessional spaces, and more than relying on positive attitudes toward collaborative practice. It requires educational and practice-based opportunities where oral health is understood, relationships are supported, and organisational conditions make collaboration possible in practice. Strengthening IPECP involving OHT will therefore require structural, educational, and professional support that positions oral health as integral to holistic care and supports IPCP as an expected, resourced, and legitimate part of practice (DCNZ, 2021; Manatū Hauora, 2023; WHO, 2024).

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Glossary

DCNZ - Dental Council of New Zealand

ID – Interpretive Descriptive

IPE - Interprofessional education

IPECP - Interprofessional Education and Collaborative Practice

IPCP - Interprofessional collaborative practice

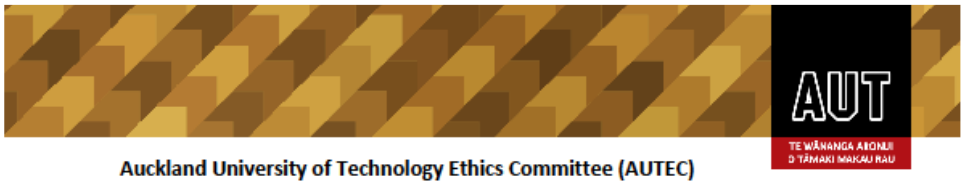
IPL – Interprofessional learning

OHT - Oral health therapy

WHO – World Health Organization

Appendices

Appendix A: Auckland University of Technology Ethics Committee approval letter



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

16 November 2022

Brenda Flood
Faculty of Health and Environmental Sciences

Dear Brenda

Ethics Application: **21/354 Interprofessional education and practice through the eyes of oral health therapy educators: A hermeneutic phenomenological study.**

At their meeting of 7 November 2022, the Auckland University of Technology Ethics Committee (AUTEC) received the report on your ethics application. AUTEC noted your report and asked us to thank you.

On behalf of AUTEC, we congratulate the researchers on the project and look forward to reading more about it in future reports.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6038.

(This is a computer-generated letter for which no signature is required)
The AUTEC Secretariat
Auckland University of Technology Ethics Committee
Cc: Melody.martin@aut.ac.nz; Zac Morse

Appendix B: Auckland University of Technology Ethics Committee amendment approval letter



Auckland University of Technology Ethics Committee (AUTEC)

31 October 2024

Brenda Flood
Faculty of Health and Environmental Sciences

Dear Brenda

Re: Ethics Application: **21/354 Interprofessional education and practice through the eyes of oral health therapy educators: An interpretive descriptive study**

Thank you for your request for approval of amendments to your ethics application.

The change to the title and to the methodology has been noted.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact the Secretariat at ethics@aut.ac.nz

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Melody.martin@aut.ac.nz; Zac Morse

Auckland University of Technology, Private Bag 92006, Auckland 1142, New Zealand
ethics@aut.ac.nz; www.aut.ac.nz/researchethics

Appendix C: Indicative questions for semi-structured interviews

Possible questions:

1. What does interprofessional practice mean to you?
2. Tell me about a time when you were working closely (in clinical practice) with one or more health professionals from another discipline.
    a. Describe an occasion/moment/event that went well?
    b. How did you feel at the time?
    c. Could you tell me about the impact/outcomes that resulted from working with other disciplines, for yourself, the patient/client, and the organisation?
3. What sorts of things did you learn from your experiences working with health professionals from other disciplines?
4. What does interprofessional education mean to you?
5. What do you think about IPE?
6. Tell me about your experience of IPE as an OHT educator
7. How might you see IPECP be better in the future within the education sector?

Possible prompt questions:

a. What do you remember?
b. What was this like?
c. What were the positive aspects of this interaction?
d. What did this involve?
e. What did you think about it?

Appendix D: Participant Information Sheet



Participant Information Sheet

Date Information Sheet Produced:

16 September 2021

Project Title

Interprofessional education and practice through the eyes of oral health therapy educators: A hermeneutic phenomenological study.

An Invitation

Tēnā koe,

I am Melody Martin, an oral health clinical educator at AUT and the primary researcher for this research. This research will contribute towards a Master of Philosophy qualification and is focused on interprofessional education (IPE) in oral health. Interprofessional education is when two or more professionals learn from, with, and about one another and results in interprofessional collaboration (IPC), when multiple health workers come together to provide optimal, high-quality, person and whanau centred healthcare. You are warmly invited to participate in this study, which will explore your experiences, perspectives, and associated understandings of IPE and IPC. This study is being carried out by myself, with the supervision of Dr Brenda Flood and Prof. Zac Morse, who are based in the School of Clinical Sciences at AUT.

This information sheet will explain the research study. I appreciate your time reading this material. Your participation in this study is entirely voluntary (your choice).

What is the purpose of this research?

This research aims to explore participants' experiences, perspectives, and understandings of IPE and IPC. Interprofessional collaborative practice has been shown to improve health outcomes, improve health systems and contribute to health worker job satisfaction. Interprofessional education is an area that is not well developed or embedded into oral health therapy programmes despite clear international and national recommendations for interprofessional education and practice change. The participants' experiences will provide insights that may inform future action in relation to the development of interprofessional education [redacted].

The findings of this research may be used for academic publications and presentations. These include a thesis and summary of findings which will be disseminated to the broader oral health community.

How was I identified and why am I being invited to participate in this research?

You have been identified as a potential participant for this research as you are an [redacted] oral health educator. We will be recruiting a cross-section of participants from each of the following areas: academic, course leaders, and clinical staff, who volunteer first. We believe your experiences and understandings of IPE and IPC will help to inform the future development of [redacted] oral health programme.

How do I agree to participate in this research?

If you would like to participate in this study, please contact me directly via email, phone, or text message. Once your involvement in the research is confirmed and

before the interview commences, you will be asked to complete a consent form that I will send to you in advance.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Please indicate your willingness to take part in this research by emailing me, the primary researcher.

What will happen in this research?

If you consent to take part in the research, you will be invited to an individual interview with myself. Interviews will take 45 minutes to 1 hour and be held at a time that is suitable for you. The interview could include making use of technologies such as AUT Microsoft Teams, Zoom or Skype or be in person. The venue will be at AUT North Shore campus in a quiet, private room if in person. Scheduling of the interviews can be either in or out of work hours. The questions will focus on your experiences, perspectives, and/or understandings of interprofessional education and collaborative practice during the interview. It is anticipated that there would be only one interview; however, a short (30 minutes max) second interview may be necessary to clarify any details, to ask for more specific details, or you may remember important information you would like to share.

The information you have supplied during the interview will be transcribed verbatim. Following this, various narratives will be selected, drawn, and edited from the transcripts to make the experience or perspective stand out clearly. The researcher will then send the recrafted narrative to you to review to ensure your meaning has not changed. It is anticipated this could take approximately 30 minutes of your time.

What are the discomforts and risks?

There should not be any risk to you from this study. You can choose not to answer any questions you do not feel comfortable answering and can choose to cease your involvement in the interview at any time. If at any time, you wish to withdraw from the research, you can do so without an adverse consequence of any kind. This will be possible up to the completion of data collection via an email to the primary supervisor stating you wish to withdraw.

What are the benefits?

The research findings will serve to inform the development of interprofessional education within the Oral Health Department at AUT. In addition, this research provides participants with the opportunity to tell their stories of experiences of IPECP; these contributions will be utilised to assist in the development for the inclusion of IPL for AUT oral health students. Finally, the primary researcher seeks to gain a Master of Philosophy through undertaking this study.

How will my privacy be protected?

As there is a small number of oral health educators [redacted] every attempt to maintain confidentiality and privacy will be taken throughout the research. All identifiable features will be removed from the data and analysis. Any identifiable information will be removed from transcripts and all names replaced with pseudonyms. Computer files will be password protected.

Recordings will be stored on a confidential, password-protected USB. Original transcripts will be assigned a code and held in a secure location.

What are the costs of participating in this research?

1.5 to 2 hours of your time will be required in total. It is not envisioned that you will incur any cost due to participating in this research; however, your time is appreciated, so all endeavours will be made to keep to time.

What opportunity do I have to consider this invitation?

If you are interested in participating in this study, I would ask that you contact me within 14 days of receiving this information. In addition, if you would like further information about the research, please feel free to contact us. Contact details are listed below.

Will I receive feedback on the results of this research?

Yes, you will receive feedback on the results of this research. A one-to-two-page summary of the findings report will be sent to you upon completion of the thesis.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Brenda Flood, Brenda.flood@aut.ac.nz, 09 921 9999 ext 9008.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

AUTEC approval details:

Approved by the Auckland University of Technology Ethics Committee on 21 10 2021.

AUTEC Reference number 21/354

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Primary researcher: Melody Martin, melody.martin@aut.ac.nz, 02102925914, 09 921 9999 ext 5051

RESEARCHER CONTACT DETAILS:

Primary researcher: Melody Martin, melody.martin@aut.ac.nz, 02102925914, 09 921 9999 ext 5051

PROJECT SUPERVISOR CONTACT DETAILS:

Primary project supervisor: Dr Brenda Flood, brenda.flood@aut.ac.nz, 09 921 9008

Secondary project supervisor: Prof Zac Morse, zac.morse@aut.ac.nz, 09 921 9999 ext 7524

Appendix D: Consent form



Consent Form

For use when interviews are involved.

Project title: ***Interprofessional education and practice through the eyes of oral health therapy educators: A hermeneutic phenomenological study.***

Project Supervisor: ***Dr Brenda Flood***

Researcher: ***Melody Martin***

- O I have read and understood the information provided about this research project in the Information Sheet dated 16 September 2021.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one): YesO NoO

Participants signature : .....

Participants name : .....

Participants Contact Details (email and/or phone number) :

.....

.....

.....

.....

Date : .....

Approved by the Auckland University of Technology Ethics Committee on 21 October 2021 AUTEC Reference number 21/354

Note: The Participant should retain a copy of this form.

Appendix E: Sample of coding

Asher
There was, I mean, the were situations where I had advised patients who like for example, their diabetes was pretty bad and you know they were not regular with their visits to the GP or doing their regular blood sugar levels. And I did actually kind of had to communicate with the GPS to kind of like, really kind of hone in on these patients and kind of like make sure that they call them back and like, just follow them up. Umm, but that's as far as it went. I did speak to a cardiologist once when Maven was there, and she did refer me a patient, and I had to work alongside Maven as well as this cardiologist to treat this patient I can't remember what the heart condition was. Umm, but I did actually speak to the cardiologist at that time, and we did kind of collaborate in terms of sorting it out from my perspective, and what Maven could do to actually help with as well as the cardiologist.

Melody
And how did you get involved with the cardiologist?

Asher
Maven told me to do it. So that's how I kind of started off. I mean it wasn't like super satisfactory because my first kind of thing that I that I remember I did at that point just because the cardiologist just was hardly ever available. Whenever I tried to get some sort of information, it will always be via maven, who had already spoken to the cardiologist.

Melody
So did it feel like it was becoming like whispers, it was too many people involved.

Asher
Umm, I just thought we weren't working as a team because I would obviously have to hear it from a second source instead of hearing from the first source and you know, like she will have to then email him and talk to him and then she'll come and talk to me. And you could have just been better. Easier way of communication if we just all got involved. We just one situation kind of thing.

