"This Is How You Should Communicate": Analyzing Frames and Discourses in Interprofessional Education Guidelines

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Abstract

Communication is consistently considered as essential to interprofessional collaborative practice, especially in the educational guidelines that seek to establish norms of interprofessionality in health and social care. However, communication is also frequently undertheorized in these guidelines. Therefore, we ask how communication is framed in these guidelines, and what discourses are present. Using frame analysis, we identify six frames for communication (communication as: information exchange; joint meaning making; relational maintenance; negotiation; giving voice; and constitutive of working culture) and we discuss what each suggests about interprofessional collaborative practice. We also identify three dominant discourses in the guidelines (effective teamwork, ethics of collaboration, and institutionalization), explaining the values that they embody. We relate these findings to competing ideologies in the healthcare landscape, namely those of the managerial turn, the patient-centered care movement, and the entrenched professional hierarchy. Exploring inherent tensions between these discourses, we explain the implications for practice and make suggestions for future iterations of the guidelines.

Keywords: *interprofessional communication; interprofessional education and collaborative practice; frame analysis; discourse.*

1. Introduction

For over four decades, interprofessional education and collaborative practice has become increasingly integral to 21st century health care systems (CIHC, 2024; Hollenberg & Bourgeault, 2011; IPEC, 2011). As interprofessional education and collaborative practice have become institutionalized, various normative guidelines have actively defined the interprofessional competencies deemed necessary for collaborative success. Communication is consistently listed among these competencies (e.g.,

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CIHC, 2010, 2024; IPEC, 2011, 2016, 2023). Many studies indicate that communication is a crucial process in achieving desired collaborative results, but most do not go further in analyzing actual communicative practices (Careau *et al.*, 2014; Fox *et al.*, 2021) and fewer yet theorize communication (Mikkola & Lahti, in press).

Given both the centrality of communication to interprofessional education and collaborative practice and its under-theorization in the interprofessional literature, this study aims to examine how communication is understood in institutional guidelines regarding interprofessional collaboration. We approach this through an analysis of frames and discourses. First, using frame analysis, we seek to identify how interprofessional communication is framed – what is considered appropriate and expected with regard to interprofessional communication – in six influential institutional guidelines that outline priorities for interprofessional education and collaborative practice. Second, we aim to identify the prevalent discourses that inform and shape interprofessional education and practice norms, including but extending beyond communication.

We begin by explaining the historical context of the interprofessional education and collaborative practice "movement." Then, to contextualize how communication can be understood in interprofessional practice, we discuss three theoretical perspectives that represent the current understanding of communication processes within the field of communication studies. We then define our understanding of discourses and describe frame analysis, our conceptual and methodological approach to examining the interprofessional education and practice guidelines. These explanations are followed by a description of our methods and the presentation of our findings. We discuss these findings and offer recommendations for future iterations of interprofessional education and collaborative practice guidelines.

2. Background

The popularity of interprofessional approaches to health and social care arose in the midst of Western healthcare systems in crisis (e.g., Institute of Medicine, 1999, 2001) and a shifting institutional landscape. The last two decades of the 20th century were marked by both a managerial turn in healthcare governance and the increasing momentum of the patient-centered care movement. The managerial approach (e.g., Spagnol *et al.*, 2013) emphasizes efficiency-driven policies, practice standardization, and cost-containment strategies as responses to systemic pressures (D'Andreamatteo *et al.*, 2015; Young *et al.*, 2004). The patient-centered care movement (e.g., Stewart *et al.*, 2003) seeks to recenter health care around the people receiving care by prioritizing the needs, values, and preferences of patients and their family members in all aspects of care (e.g., Pomey *et al.*, 2015). Both the managerial turn and the patient-centered care movement challenge the professional-led model of care. This model tends to be physician-centric,

placing doctors at the top of an established professional hierarchy (Abbott, 1988; Freidson, 1970, 2001) where they act as drivers in decisions about how health care resources should be organized (Sinsky *et al.*, 2013). In contrast, the managerial approach and the patient-centered care movement prioritize values other than professional status.[1] As these three approaches emerge from different ideological stances, they can also be viewed as discourses that both manifest and shape what is valued in health care settings.

From this evolving context emerged a social movement to promote interprofessional collaboration in care (Hollenberg & Bourgeault, 2011). Its proponents claimed that interprofessional collaborative practice could serve as a remedy to health care system ailments (e.g., WHO, 2010). These include the increasing demands on finite health system resources (Leathard, 2003) as aging populations are living longer with multiple and complex conditions that require an integrated approach to their care (Davidson *et al.*, 2022; Pascucci *et al.*, 2021). They also include structural and informational challenges, such as sharing costs and information systems across agency, organizational, and professional boundaries, which can complicate the integration of care (Johnson *et al.*, 2003; Willumsen *et al.*, 2012). Proponents of interprofessional collaboration assert it can improve efficiency, effectiveness, and patient-centeredness by facilitating information sharing and relationships among providers from different professional backgrounds (Gittell *et al.*, 2013), improving access to care (White-Williams *et al.*, 2022), and encouraging patient engagement in care planning (Davidson *et al.*, 2022). Some insist on the necessity of clinical democracy, which promotes flattening the professional hierarchy and adopting a broader understanding of collaboration that includes patients and their families. This is thought to enable those with the relevant expertise regarding a given situation (including the patient) to express their views and share their knowledge freely (see Long *et al.*, 2006), while being taken seriously by their collaborators. Others propose that the professional hierarchy may be somewhat inevitable, yet that it need not impede collaboration (e.g., Noyes, 2022, 2025).

Several organizations embody the interprofessional education and collaborative practice movement, such as the Canadian Interprofessional Health Collaborative (CIHC), the Interprofessional Education Collaborative (IPEC) in the United States, the Centre for the Advancement of In-

1 These shifts in values are represented in the Triple Aim (Berwick *et al.*, 2008), which has been highly influential in shaping healthcare practice, policy, and quality improvement efforts (e.g., Kokko, 2022). The Triple Aim was intended as a guide by the Institute of Healthcare Improvement for integrative reforms to the U.S. healthcare system around three interdependent goals: to improve efficiency and patient-centeredness: improving patients' experience of care; improving measurable health outcomes; and managing costs. Bodenheimer and Sinsky's (2014) Quadruple Aim expanded these goals to include a fourth goal, provider well-being, thereby recognizing the widespread problem of clinician burnout. The more recent Quintuple Aim by Nundy *et al.* (2022) adds the goal of health equity, which the Covid-19 pandemic revealed as an urgent problem.

terprofessional Education (CAIPE) in the United Kingdom, as well as Interprofessional.Global (IP.G), a global confederation for interprofessional education and collaborative practice, and IPR.G, a global network focusing on research about interprofessional education and collaborative practice. The movement has succeeded in institutionalizing interprofessional practice in health and social care, in particular through interprofessional education initiatives during health professional training.

This social movement for institutionalizing interprofessional education and collaborative practice surged in the 2000s, when members of CIHC and IPEC deplored what they saw as a discrepancy between an adoption of interprofessional approaches in clinical contexts and a lack of standardized training for interprofessional practice in the health professions (IPEC, 2011). In response, they brought together representatives from various professional orders to determine and promote an official interprofessional education (IPE) agenda in their respective countries and globally. These efforts culminated in the publication of several guidelines about the competencies needed for interprofessional collaborative practice (see CIHC, 2010; IPEC, 2011; WHO, 2010).

Taken together, these guidelines serve as normative frameworks for what interprofessional practice and interprofessional education should look like. Moreover, and most importantly for our purposes here, they all identify communication as a core competency for effective interprofessional collaborative practice. However, they do not appear to be informed by communication theory. If undertheorized, there may be blind spots regarding communication in the interprofessional education and collaborative practice normative guidelines. Furthermore, it is possible that they do not reflect how communication actually occurs on teams (Careau *et al.*, 2015; Caronia & Ranzani, 2025) but rather manifest the ideological stances behind the movement.

Conceptualizations of communication shape how it is taught and practiced, so such potential blind spots are consequential to how future health care professionals interact and understand the importance of their interactions. Therefore, our analysis will identify (a) through frame analysis the different views of communication that inform these interprofessional guidelines, as well as (b) the broader discourses that reflect the ideological stances behind the interprofessional movement guiding, for instance, the power relations in interprofessional encounters. But first, in the next section, we present three ways that communication is theorized to describe how they can be applied to interprofessional collaboration.

3. Conceptualizing Communication

Communication is a complex process that involves *meanings and messages;* different theoretical models of communication propose different understandings of this process. They vary regarding, for example, how mes-

sages are created, whether meanings are transmitted or negotiated, and the outcomes of the meaning-making process. Currently in communication studies, one can find the following three common theoretical perspectives: the transmission model; the transactional model; and the constitutive approach (see Fox *et al.*, 2025). While not an exhaustive exploration of theories of communication, these three perspectives provide different views of what is happening when collaborators interact. Each perspective foregrounds certain dimensions of communication that are salient for teaching about interprofessionality. However, to make theoretically informed choices in interprofessional pedagogy, it is imperative to understand the conceptual basis on which each perspective is founded, and to examine them in relation to the different discourses that inform the interprofessional movement and the ways that communication is framed.

First is the *transmission* model of communication, which is widely adopted in health care literature. Informed by cybernetic theory, it conceptualizes communication primarily as a process of information transmission from a sender to a receiver, where information is encoded in exchanged messages, implying that meaning is encoded by the sender into a message to be decoded by the receiver (Fox *et al.*, 2025). The less disturbance, or noise, during message transmission, the more successful a communication process is thought to be. Noise can be any psychological or environmental barrier that hinders or disturbs message transmission, while feedback is a message that loops back from receiver to sender and provides information about the success of the initial transmission. This model suggests communicators should strive for clear expression and polished definitions; the effectiveness of communication and collaboration is accomplished by clarifying anything ambiguous in interactions.

The transmission model presents communication as a one-way process and emphasizes its influence on outcomes (Fox *et al.*, 2025). The aim of much research on interprofessional education and collaborative practice is effective and functional interprofessional collaboration, and communication is mostly defined as an input-process-output variable, where researchers assess collaborative outcomes in terms of changed attitudes or behaviors (see Mikkola & Lahti, in press). Such studies aim to produce knowledge, such as clear definitions, that can help manage interactions and create generalizations thought to be relevant across interactional situations (see, for instance, Horila, 2025, on appropriate communication). This conceptualization is apt for describing practices such as hand-offs or SBAR (see Careau & Fox, 2025).

Second, the *transactional* model focuses on the negotiation of meanings by communicators. It purports that every communicative act has both content and relational dimensions, and that a message is not just encoded, delivered, and decoded, but that communicators co-create and negotiate meanings about each other and about the content of what they discuss (Fox *et al.*, 2025). In other words, interactions are interpreted in such a way that relational and referential meanings intertwine (e.g., Bateson,

1983). Inspired by systems thinking (e.g., Barnlund, 1970; Watzlawick *et al.*, 1967), the transactional model emphasizes the influence of *context* on communication (that is, context is a kind of container for communication, see Taylor & Van Every, 2000). It explains that the psychological, relational, social, and cultural context all influence how meanings – and the kinds of meanings – are constructed in interaction (Fox *et al.*, 2025). Moreover, communicators produce, interpret, and respond to messages simultaneously, so from this transactional perspective, communication is always a two-way process. There are not senders and receivers but rather communicators who make meanings together in a process of ongoing mutual influence and adjustment (Barnlund, 1970).

The transactional model is taught in nursing curricula (e.g., Lapum *et al.*, 2020). It is particularly useful for understanding how relationships influence and are supported by communication. It is thus well-suited for describing how collaborators achieve shared goals and mutual respect, which are considered in the interprofessional literature as key to functional and successful collaboration (see Mikkola & Lahti, in press). This model also suggests that shared goals and mutual respect are achieved when collaborators engage in joint meaning making and encourage the expression of diverse voices and perspectives.

Finally, the *constitutive approach* is currently one of the most popular approaches in our (the authors') discipline of communication (e.g., Craig, 1999).[2] There are overlaps between the transactional model and the constitutive approach in that they both emphasize the negotiation of meaning, but we argue it differs epistemologically from the previous models. First, rather than seeing communication as one process or input among many, the constitutive approach suggests that communication should be our starting point because it sees communication as the driving force of social life and relationships (Craig 1999). Thus, communication is not only a process of shared meaning making but the principal process that constitutes – or produces – the social world (Ibid.), including interprofessional collaboration and teamwork. Compared to the transactional model, which presumes that contexts exist prior to and shape communication, the constitutive approach presumes that social realities, including contexts, are also brought into being and are made meaningful in and through communication (Taylor & Van Every, 2000). For instance, rather than context being a given, a care coordinator giving a patient report during an interprofessional meeting can choose to foreground the organizational context, the ward-level context, the context of the patient's life outside of care, and so forth (see Fox & Brummans, 2019). Hence, the social world is not only established in communication, but is "constantly being constituted, negotiated, challenged, or maintained through our communicative practices in a recursive manner" (Fox *et al.* 2025, p. 14).

2 The constitutive model is similar to theories from disciplines adjacent to communication, such as Goodwin's (2017) theory of co-operative action in linguistic anthropology.

Another difference is that the constitutive approach incorporates sociomaterial elements into its view of communication. This means it recognizes the role of non-human agents in influencing, enabling, and constraining how people make meaning together (e.g., Cooren & Matte, 2010). For instance, different health professionals can share their notes asynchronously through an electronic health record, but its interface design also constrains what and how they are able to share and even who can read their notes. Moreover, the constitutive view points out that the interface design is itself the product of many rounds of previous interactions; it is also constituted in and through communication (e.g., Grosjean *et al.*, 2022). Indeed, this model would argue that interprofessional education and collaborative practice guidelines themselves participate in constituting – that is, communicating into being – the various realities of interprofessional education and collaborative practice and therefore merit our attention as such.

Finally, the constitutive model is useful not only for examining how communicators create shared understanding, as suggested by the transactional model; it also allows us to see communication as a process that creates contradictions and paradoxes (Putnam *et al.* 2016) as well as the polyphony of multiple voices (e.g., Baxter 2011). This suggests that it is crucial to recognize and accept the existence of different voices and even competing accounts, and search for ways to manage tensions that may emerge from organizational and relational contradictions (Mikkola *et al.*, 2025).

These three theoretical perspectives represent current understandings of the communication process. Through frame analysis and the identification of discourses in interprofessional guidelines, we will identify how these perspectives are represented in interprofessional education and collaborative practice. We turn now to our definition of discourses.

4. Defining Discourses

We define discourses as networks of meanings that are established, maintained, and even contested in linguistic and social practices. Thus, discourses produce and include social and cultural norms. Abdulmajid (2021: 97) describes them as shared sets of "social practices and ideological assumptions incorporated into language and communication." Similarly, according to Fairhurst (2011: 32), they are systems of thought and values with their own

> linguistic tool bag, or collection of terms and metaphors for key concepts and ideas, their own categories for understanding; themes for stories, and familiar arguments to draw upon to describe, explain or justify our place in the world at any given moment.

Hence, by discourse, we mean a broader collection of meanings, with an ideological association, that discursively constructs and maintains social

reality, rather than discourse as social interaction (see Alvesson & Karreman, 2000). However, ideologically informed discourses manifest in talk, for example, in interprofessional team interactions. Discourses can serve as ideological resources for justifying the way things are or should be because they serve as shared common ground for members of a given cultural group, be it a societal, institutional, organizational, professional, or other kind of group (Fairhurst, 2011). Therefore, discourses are powerful tools for maintaining the social status quo and the relative status of different groups of people. However, discourses may also be powerful when promoting social change, such as the changes in health and social care delivery promoted by the interprofessional movement.

Yet, discourses are often so "woven into social norms that they are nearly invisible" (Slemon, 2025: 1). Therefore, a common goal of various forms of discourse analysis is to identify the discourses conveyed by texts to understand underlying the social structures or ideologies that shape them (e.g., Steinmann, *et al.*, 2020). As discourses create social realities, they also suggest what kind of role and function communication has and how it should be understood and defined. These definitions can be seen as frames through which certain dimensions of communication are amplified, and others are concealed. To put it another way, framing some part of reality, such as communication, is always aligned with prevalent discourses.

5. Frame Analysis

Frame analysis (see Bateson, 1972; Goffman, 1974) is a theoretical approach used widely in social science research to examine the interpretive influences on how people make meaning of situations and activities (Dewulf *et al.*, 2009; Entman, 1993). Given its cross-disciplinary popularity, frame analysis has been described as a "fractured paradigm" (Entman, 1993: 53) in which two broad foci can be distinguished (Dewulf *et al.*, 2009): a sociological focus that is concerned with how meanings are constructed in situated interactions, and a psychological or cognitive focus on mental models or schemata that help people to interpret the world. Putting these foci together, frames refer to the "interpretive packages" (Mendonça & Simões, 2022: 350), "entities of meaning" or "unseen structures that define social reality in the *minds* and *interactions* of individuals" (Laitinen & Valo, 2018: 13, emphasis added).

An underlying epistemological assumption of frame analysis is that meaning is created, negotiated, and contested intersubjectively (Mendonça & Simões, 2022), whether between two or more interacting communicators or between a text and a reader. In this sense, frames guide how we perceive and interpret social phenomena and social realities. Our study relies on Entman (1993), who explains that framing functions by *selecting* some aspects of a perceived reality to make them more *salient* in a text. Thus,

the analyst can pay attention to what is selected to discern how a frame proposes a particular interpretation for a perceived social reality, which we describe in further detail in the Method section.

It is imperative in frame analysis to situate the social reality being framed in its context, such as in naturally occurring interactions or in written texts. Indeed, and as Laitinen and Valo (2018) maintain, the meaning of an object – such as an organizational practice or a political controversy – must be interpreted according to how it is framed. Consequently, we propose that the normative meaning(s) of interprofessional communication can be understood through the way they are framed in institutional guidelines about interprofessional education and practice.

Frames are normative in Entman's (1993) view insofar as they evaluate and prescribe action, indicating what should be considered important and valuable, and how things ought to be. Hence, frame analysis can help us to examine how interprofessional education and practice guidelines indicate what is important with regard to communication and how collaborators ought to communicate. By extension, analyzing the ways communication is framed can also uncover the ideological discourses mobilized in these texts; by selecting certain aspects of a perceived social reality for salience, frames evoke discourses. This involves describing how frames are produced, mobilized, and interact with other frames (Mendonça & Simões, 2022) and how they can align with cultural and social discourses (Fairhurst, 2011). This does not mean, according to Fairhurst, that the relationship between frames and discourses is a one-to-one association (i.e., one frame to one discourse); rather, a given frame can be associated with more than one discourse.

Therefore, as Entman (1993) and Van Gorp (2007) suggest, frame analysis should be sensitive to framing devices (e.g., words, metaphors), as well as reasoning devices (justifications, consequences, and causes), revealing broader patterns of interpretation and social values, what we discussed earlier as discourses. Hence, we ask the following research questions:

1. How is communication framed in institutional guidelines about interprofessional education and collaborative practice?
2. What discourses appear to be associated with these communication frames?

6. Method

6.1 *Our Corpus*

To seek answers to our research questions, we examined institutional guidelines about interprofessional education. We focused on the guidelines published by the World Health Organization, the Canadian Interprofessional Health Collaborative (CIHC), and the Interprofessional Education Collaborative (IPEC) in the United States. We chose these sources for their

global influence in setting the interprofessional education agenda over the past 15 years and also because they are published in English, a language in which both authors are fluent.

The seminal document published by the World Health Organization in 2010 outlines the need for a health care workforce trained in interprofessional collaborative practice to meet the health care needs of populations around the world. Importantly, it positions interprofessional teams as a solution for fragmented health care systems. The CIHC published its interprofessional practice guidelines in that same year, and the American IPEC guidelines followed a year later. Both organizations have since published updates to their original guidelines (CIHC, 2024; IPEC, 2016, 2023), so these were also included in our analysis. Each guideline, except that of the World Health Organization (2010), is divided into sections that pertain to various dimensions of interprofessional collaborative practice, such as "Team Communication" or "Relationship Focused Care/Services" (see CIHC, 2024) and "Values and Ethics" or "Roles and Responsibilities" (see IPEC, 2023). Together, these six documents totaled 264 pages.

6.2 *Identifying How Communication Is Framed*

Selecting and coding meaning units. The documents were read several times to familiarize ourselves and to begin to get a sense of the justifications and imperatives for interprofessional education and collaborative practice. Then, we started to code the data by identifying and separating meaning units: These were stretches of text in the guidelines that referred to communication. They varied in length from a single sentence to an entire paragraph; we delineated their contours based on the meaning unit expressing a coherent idea. Through this process, we identified 239 discrete meaning units across the six documents; we did not eliminate doubles (for instance, if a meaning unit was mentioned in the introduction to the guide and developed later in the document, this was counted twice, because we were also interested in the prevalence of given frames and related inferable discourses).

In this first-order analysis, some meaning units were identified as instances where communication was mentioned explicitly, for instance, as a competency to be developed (CIHC, 2010, 2024; IPEC, 2011, 2016, 2023). We designated meaning units as "explicit" if they either used the word "communication" or other words that imply communicative action such as: discussion; interaction; listen; being heard; common language; describe; express; information sharing; articulate; give feedback; and so on. These were typically included in sections of the guidelines that explained the importance of communication to interprofessional practice. This is an example of a typical meaning unit that explicitly mentions communication:

> CC1. Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function. (IPEC, 2011: 31)

We also identified other instances that we, as communication scholars, recognized as referring to communication practice, even if words referring to communication or interaction were not explicitly mentioned. These typically occurred in sections of the guidelines *not* devoted to explaining communication, such as "Team Functioning" and "Collaborative Leadership" (i.e., CIHC 2010). As communication scholars, we consider these processes as being constituted in communicative actions, which was the reason we considered them to be implicit references to communication and included them in the analysis. We considered an implicit mention to be anything that referred to actions that necessarily require or imply interaction among communicators, such as: shared decision making or shared goal setting; facilitating team coordination; encouraging inclusion in care planning; maintaining confidentiality; practicing team reasoning; promoting common understanding; sharing leadership; building relationships; working with others; co-creating a climate or a culture; integrating knowledge and expertise; developing consensus; managing disagreements; respecting or valuing diversity; understanding roles, and so on. If a meaning unit included both an explicit and an implicit mention, it was coded as explicit.

Analyzing communication frames through second-order analysis. After the first phase of coding, we moved towards second-order analysis to identify the frames. They were inferred inductively, but also informed by communication theory (see Mendonça & Simoes, 2022; Van Gorp, 2007). First, we re-examined each coded meaning unit, following Entman's (1993) suggestion that frames select for salience "in such a way as to promote a (a) particular problem definition, (b) causal interpretation, (c) moral evaluation, and/or (d) treatment recommendation for the item described" (p. 52). Thus, this was our interpretive framework for analysis. As an illustrative example, we continued coding the meaning unit above from CIHC (2011) as follows: (a) the problem: ineffective communication; (b) causal inference: ineffective communication can be resolved by choosing the right communication tools and channels; (c) moral evaluation: effective communication is a worthy goal; (d) action recommendation: choose appropriate communication channels.

Next, we interpreted how these four elements together would describe communication, that is, how they characterize communication, and we proposed a potential name for the way communication was framed. Some names for frames inferred from the data were inspired by the theoretical perspectives described previously, such as "information exchange," "joint meaning making," and "relational maintenance" (see Fox *et al.*, 2025; Mikkola *et al.*, 2025). Others names were selected in a more *in vivo* fashion, as we discussed what we were identifying in the documents, such as "giving voice" and "negotiation." As analysis progressed, we revised these different frames, consolidating names with similar meanings until we arrived at a stable set of six frames. For example, the extract above was labelled as the "Communication as information exchange" frame.

Yet, for many meaning units in which communication was mentioned, there was insufficient information to determine a particular frame, and we therefore created the category "unspecified." Finally, some meaning units could be categorized in more than one frame, and we placed these in a category of their own: "more than one frame."

6.3 *Identifying Discourses*

Identifying discourses through second-order analysis. The discourse analysis was conducted simultaneously with frame analysis. As described above, we read through the data several times before separating the meaning units and we made notes about the different kinds of realities that were implied in the texts. As our frame analysis progressed, we shared these analytic memos to begin sketching the contours of discourses we thought might be present in the guidelines.

While conducting these two analyses simultaneously, we did not presume that a discourse – as an established network of meanings – pertained only to how communication was framed; rather, following Fairhurst (2011), we inferred broader discourses from the communication frames. Similarly, a given communication frame could be associated with a particular discourse in one section of the text, while in another textual context, it could be associated with a different discourse, depending on what was selected for salience in the framing. Discourses can serve as reasoning devices in framing (Entman, 1993; Van Gorp, 2007), implying "familiar arguments" (Fairhurst, 2011: 32) that provide justifications and imply causes and consequences.

Therefore, as we conducted our frame analysis, we tried to identify and interpret the familiar arguments, expressions, and reasoning devices that might indicate a discourse, for example, "patient-centered care", "clinical democracy", "inclusion and diversity", and "IP teams as a solution to broken health care systems". When we had coded about half of the corpus, we started to see three broad discourses emerging. To refine this analysis, we created descriptive inclusion criteria for each discourse and began to see similarities among our interpretations. We grouped these interpretations together into distinct meaning nodes for each discourse, each of which could be considered familiar arguments. This resulted in the delineation of three different discourses and their distinct characterizing meaning nodes.

7. Findings

Our findings are divided into two parts, following our research questions. First, we explain the different communication frames that we found and the framing devices that helped us identify them. This lays the foundation for our subsequent discussion of the three discourses – as multifaceted networks of meaning – that we identified in the guidelines.

7.1 *Frames of Interprofessional Communication*

Frame analysis of the meaning units in our corpus resulted in five recurrent communication frames and one communication frame occurring only once (see Table 1). As mentioned in the previous section, we identified both *explicit* and *implicit* mentions of communication. In Table 1, we indicate the prevalence of each communication frame, and how often communication was mentioned either implicitly or explicitly. By including the prevalence, we do not intend to portray a measure of objective reality, but rather we suggest that a higher prevalence indicates dominant framings, that is, framings that are more discursively available and institutionally legitimized.

Frame	Instances	Description	Explicit	Implicit
Information exchange	51	Working to ensure the right information gets to the right person at the right time; ensuring message exchange while reducing noise.	47	4
Joint meaning making	45	Communicating to establish shared meanings to guide action.	11	34
Relational maintenance	37	Communicating to promote good and collegial relationships among collaborators.	11	26
Negotiation	17	Mediating differences and navigating (potential) conflict stemming from these differences.	4	13
Giving voice	13	Actively encouraging others to express their views, especially those with less status or power in the interactional situation.	5	8
Constitutive of culture	1	The way collaborators interact constitutes and shapes the culture of the working environment.	1	0
Unspecified	57	Communication is mentioned but there is insufficient information to determine the frame.	13	44
More than one frame	18	Mention of communication that evokes more than one frame.	11	7
Total	239		103	136

Table 1: Communication Frames

7.1.1 *Communication as Information Exchange*

A prevalent frame of communication in the institutional guidelines for interprofessional education and collaborative practice was the frame of in-

formation exchange. A common framing device (i.e., words or metaphors that evoked the frame) that referred to this interpretive frame was the term "effective." This denoted a linear, message-transmission conception of communication, where the goal is minimizing misunderstanding and ensuring proper decoding to ensure the "right" interpretation of messages. For instance, in our data, successful information exchange is thought to be more likely when collaborators use common language and avoid jargon that can cause interpretive disturbance, as we can see in this example meaning unit: "All team members should use effective communication strategies, including the use of shared language and the avoidance of jargon, to ensure clear and standardized information exchange" (CIHC, 2024: 13).

This frame suggests that there is a right communication channel (e.g., information system or communication technology) in which information exchange can be standardized, and structured communication techniques can be adopted as necessary, such as during handoffs. Thus, communication is a process that can be improved by enhancing the work environment by building and organizing it to facilitate the flow of information and effective communication. Likewise, clearly communicating one's role (i.e., transmitting role information) can result in shared understandings and expectations. In the documents we analyzed, this frame most often appeared when explicitly referencing communication, especially in the sections of the guidelines devoted to explaining the importance of communication to interprofessional practice.

7.1.2 *Communication as Joint Meaning Making*

The frame "communication as joint meaning making" was the second most common communication frame in the documents, but it appeared mostly implicitly, in sections of the guidelines that describe dimensions of interprofessional practice other than communication. An important framing device that we identified for joint meaning making was any mention of "shared." Through this frame, communication is the collective creation of meaning in which collaborators interpret circumstances (e.g., the patient's situation or the collaborative situation), information, and relationships together. Therefore, joint meaning making is recognized when collaborators collectively set goals, create treatment plans, and share decision making and/or accountability in their discussions, as is described in IPEC (2023), where guidelines instruct learners and practitioners to "practice team reasoning, problem-solving, and decision-making" (50).

7.1.3 *Communication as Relational Maintenance*

The third most common communication frame was "relational maintenance." Through this frame, communication is given the meaning of being mindful when interacting with others and fostering positive or collegial relationships. Thus, communication is a process of facilitating team performance, but at the same time, fostering good relationships is also considered as a worthy end in itself, independent of team performance. A relevant

framing device was the term "respect," and it referred to expressing respect for others' diversity, dignity, or privacy and for the confidentiality of their information. For instance: "Work with individuals of other professions to maintain a climate of mutual respect and shared values" (IPEC, 2016: 11). In our corpus, respectful interactions and supportive communication were associated with fostering trust and openness among collaborators. This communication frame also suggested that communication involves allowing the other to save face in interactions and acknowledging collaborators as persons rather than as their professional categories (e.g., "nurse"). Overall, what is considered appropriate, according to this frame, is to foster trust and openness among collaborators so as to create a psychologically safe environment for interacting. Once again, this communication frame appeared more often implicitly in the guidelines, in sections not devoted to explaining communication.

7.1.4 *Communication as Negotiation*

This communication frame defines communication as joint meaning making in situations that are potentially emotionally charged and require extra effort to navigate, such as in conflicts or potential conflicts. Framing devices include "conflict" and "disagreement." According to this framing of communication, in such interactions, collaborators are expected to mediate between opposing opinions and to navigate potential conflicts. This frame was proposed in the guidelines when referring to difficult conversations where emotional navigation and negotiation is required, such as the disclosure of error or at the end of life. The following is an example: "Apply interprofessional conflict management methods, including identifying conflict cause and addressing divergent perspectives" (IPEC, 2023: 19). Again, the negotiation frame appeared primarily when communication was referenced implicitly.

7.1.5 *Communication as Giving Voice*

From this communication frame, communication involves actively and mindfully encouraging others to express their views. Voice is associated especially with those who hold less status in an interactional situation, such as lower-status professionals as well as patients and their families as compared to, say, physicians. It was also most frequently associated with implicit mentions of communication, especially in sections of the guidelines addressing patient-centered or relationship-centered care. Framing devices included words such as "engage," "draw out," "seek the input of," "active listening," "advocate," and "help to express." A typical meaning unit for this communication frame is the following: "All members should support person(s) participating in and receiving care/services and their care partner(s) as full members of the team, helping them to express and clarify their role accordingly" (CIHC, 2024: 14). While this frame was not the most frequent communication frame, the moral imperative to give voice to others was quite strong, often appearing as an injunction. For instance,

we find in CIHC (2024: 13): "All team members should listen actively and respectfully, and value all, with emphasis on inclusivity, equity, and diversity." This meaning is echoed in IPEC (2011: 23): "Listen actively, and encourage ideas and opinions of other team members."

7.1.6 *Communication as Constitutive of Working Culture*

Finally, the communication frame that saw communication as constitutive of working culture appeared only once, in the WHO (2010: 22) document:

> By shifting the way health workers think about and interact with one another, the culture of the working environment and attitudes of the workforce will change, improving the working experience of staff and benefiting the community as a whole.

Although it appeared only once, we considered it significant enough to include here. Indisputably, according to this frame, communication is the process in which the work environment and culture are constituted and manifested.

Having outlined the different ways that communication is framed in these documents, we turn now to an explanation of the discourses we identified in the corpus, and how the communication frames relate to them.

7.2 *Prevalent Discourses in the Guidelines*

Our analysis identified three prevalent discourses in the interprofessional guidelines: *effective teamwork*; *ethics of collaboration*; and *institutionalization*. The first two represent strong, normative imperatives for how interprofessional education and collaborative practice should occur. The third represents the broader project of the interprofessional movement, which is precisely to institutionalize interprofessional collaborative practice as an approach to health and social care. We present each of the discourses, which we understand as networks of meanings. Therefore, we also present the distinct meaning nodes we identified that characterize the meanings in each discourse. We also present the communication frames linked to each discourse (see Tables 2, 3, and 4), although, as Fairhurst (2011) notes, this was not a one-to-one correlation.

7.2.1 *Effective Teamwork*

"Effective teamwork" emerged as a dominant discourse in the guidelines. Strongly managerial, it portrays interprofessional teamwork as an orchestrated choreography whose ideal performance aims to improve patient outcomes and to promote a learner use of resources. This discourse normatively describes how to "do" teamwork right. Words such as *clarity*, *fidelity*, and *right time, right person* recur, casting communication primarily as the effective transmission of information in a relay system. The overarching idea is that adding or specifying information

is the best way to ensure team effectiveness, which presumes that information can be unambiguously interpreted because it is not polysemic. For this discourse, we arranged the meanings associated with it into four meaning nodes (see Table 2).

Meaning Nodes	Meanings	Descriptions	Communication Frames
Effective information flow	Effective communication (n=17)	How to effectively and smoothly exchange information.	Dominant: Information exchange Present: Relational maintenance (minimally)
	Role understanding (n=16)	Understanding and communicating one's role and those of others to better coordinate and plan care.	
	Avoiding misunderstandings (n=13)	Working to ensure common understanding and avoid misunderstanding.	
Relational calibration	Conflict management (n=6)	Pertains to how team members should handle conflict or potential conflict.	Dominant: Joint meaning making; Negotiation Present: Relational maintenance
	Effective leadership (n=4)	Being able to read the situation to know how to lead appropriately.	
	Understanding team dynamics (n=16)	Defining the processes and dynamics of effective IP teams.	
Collective reflexivity	Mindfulness for performance (n=15)	Being aware of the collaborative situation and one's own way of interacting to ensure better team effectiveness and performance.	Co-dominant: Information exchange + joint meaning making Present: Relational maintenance
Aligned purpose	Sharing goals and responsibilities (n=9)	Pertains to the importance of setting collective goals and sharing responsibilities, including how to best do so.	Dominant: Joint meaning making Present: Relational maintenance; Negotiation; Giving voice

Table 2. Effective teamwork discourses (appearing in 103 meaning units)

An important meaning node in this discourse defines teamwork as *effective information flow,* which consists of effective communication, role understanding, and avoiding misunderstandings. Teamwork is a structured process aimed at optimizing performance and patient outcomes. It is achieved through role and task coordination among collaborators, including patients and their families. It stipulates that everyone should know and clearly communicate their own and others' roles. Effective teamwork requires successful message transmission. Similarly, mutual understanding can be ensured by avoiding professional jargon, using common language and structured communication protocols, such as check-backs, and communicating clearly and with confidence. Moreover, collaborators should communicate in ways deemed technically appropriate: "All team members should effectively use information and communication technologies to improve collaborative relationship-focused care/services, ensuring that all convey the right message along the channel(s) to the right person(s) at the right time" (CIHC, 2024, p. 13). Overall, human interaction is portrayed as instrumentally valuable: a means to prevent error and optimize outcomes.

Another meaning node of this discourse was *relational calibration*, which can be achieved through effective leadership, conflict management, and understanding team dynamics. These meanings define teamwork as a relational and adaptive practice, involving careful coordination among team members. Again, human interaction is considered instrumental to team performance and collaborative outcomes. Leaders must read the care situation to know how to lead effectively, involving the right collaborators at the right time, fostering their participation, and keeping people on task. IP learners and practitioners should establish and follow conflict management guidelines so that collaborative action is not derailed by conflicts. Everyone should learn about the team dynamics and processes that characterize effective teamwork, so they know how to act in every team situation: "To support collaborative leadership, all are able to: advance interdependent working relationships among all participants; facilitate effective team processes for shared decision-making and to re-evaluate as needed" (CIHC, 2024:17).

As *collective reflexivity,* another meaning node, effective teamwork calls on learners and collaborators to reflect on practice, both individually and collectively, to improve performance. This includes being mindful of all aspects of team communication that affect performance, including relational dimensions. It can involve collectively discussing how to improve team processes for better effectiveness, as we see in this example: "Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others" (IPEC, 2016:13)

Effective teamwork also means having *an aligned purpose*, the fourth meaning node which suggests that effective teamwork is about knowing who is responsible for what and when in order to improve team effectiveness and shared problem solving. It involves setting shared goals and

care plans, collaboratively making decisions, using constructive feedback to coordinate care actions, connecting with others and aligning team goals. For instance: "Use constructive feedback to connect, align, and accomplish team goals" (IPEC, 2023:18).

7.2.2 *Ethics of Collaboration*

We identified "ethics of collaboration" as the second most dominant discourse in the guidelines. This discourse defines how we should treat others, emphasizing the intrinsic ethical imperative of respectful, inclusive collaboration. Unlike the performance-focused "effective teamwork" discourse, this discourse foregrounds values of dignity, equity, and civility as ends in themselves. It constructs communication as a way to recognize dignity, create inclusive and respectful relationships, and navigate difference with mutual respect; communication is seen as essential to maintaining humanity and civility in care. We identified two meaning nodes in this discourse (see Table 3).

Meaning Nodes	Meanings	Descriptions	Communication Frames
Inclusion as ethical imperative	Inclusion and diversity (n=23)	Imperatives about accepting and valuing diversity and differences.	Dominant: Giving voice Present: Joint meaning making; Relational maintenance; Negotiation
	Clinical democracy (n=14)	Refers to equality and democratic participation among collaborators in shared problem solving and decision making.	
	Patient partnership (n=7)	How to treat and include the patient as an equal team member.	
Relational climate of respect and reflection	Reflective practice and respectful climate (n=27)	How to work together respectfully despite differences.	Dominant: Relational maintenance Present: Negotiation; Joint meaning making; Communication as constitutive of culture
	Patient-centered practice (n=8)	How professional members of IP teams talk about patients when they are not present.	
	Healthcare worker wellbeing (n=14)	Good collaboration can promote health care worker wellbeing.	

Table 3 Ethics of collaboration discourse (appearing in 83 meaning units)

A central meaning node of this discourse sees *inclusion as an ethical imperative* and comprises the meanings of inclusion and diversity, clinical democracy, and patient partnership. From this group of meanings, inclusion is seen not as

instrumental but as morally necessary for just collaboration. This ideological and moral imperative has to do with who gets to participate in collaborative care and how they can participate. It positions inclusion, diversity, and equality as foundational ethical commitments in collaborative practice, emphasizing the need to respect and value all voices – whether professional, patient, or family and regardless of collaborators' relative status – in shared care planning and decision making. This can be seen in the following extract:

> All members should support person(s) participating in and receiving care/services and their care partner(s) as full members of the team, helping them to express and clarify their role accordingly. (CIHC, 2024:14)

This discourse is manifested in those frames that define communication as a process of recognizing difference, supporting voice and agency, and promoting egalitarian participation. Collaborators should interact respectfully and in a manner that is psychologically and culturally safe, where culture refers both to professional culture and the cultures of patients and families.

From the lens of this discourse, collaborators must nurture a *relational climate of respect and reflection*, which is this discourse's second meaning node, including the meanings of reflective practice and respectful climate, patient-centered practice, and healthcare worker wellbeing. This meaning node portrays the interpersonal and organizational conditions that sustain ethical and inclusive collaboration over time. It urges practitioners, individually and collectively, to be reflective about their practice. Their reflection should include establishing how to practice ethically (e.g., "Develop consensus on the ethical principles to guide all aspects of patient care and teamwork," IPEC 2011:25) and working to constructively manage conflicts and disagreements about values and goals (e.g., "All members of a team actively engage constructively in addressing disagreements," CIHC, 2024:16). Ethical collaboration should continue behind-the-scenes, when patients are not present, as professionals ought to "respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care" (IPEC, 2016, p. 11). Hence, communication is central to sustaining relationships and navigating differences. By being mindful of their relative status and by listening respectfully in interactions, collaborators create a respectful climate and a just culture, so everyone feels safe to work together to find consensus and navigate difficult conversations, despite their differences.

7.2.3 Institutionalization

"Institutionalization" was the third discourse we identified in the guidelines. It constructs the interprofessional movement as a transformative social project aimed at embedding interprofessional approaches into the structures, standards, and routines of health and social care systems. It also reflects the momentum of this movement itself, articulating a vision of systemic change led by the uptake of interprofessional competency frameworks, guidelines,

and policy across organizations and professions. The meaning units in this discourse cluster around three meaning nodes (see Table 4). It is interesting to note that the meanings aligned with this discourse often refer to the contents of the documents themselves, as we can see here:

> The hope then, which is still apt today, was that other professional education organizations and a broader group of stakeholders in the quality of health professions education would see the value of these competencies and adopt the recommendations in their own work. The competencies were intentionally general enough in nature to allow flexibility within the professions and at the institutional level. This would allow faculty and administrators to develop a program of study for their profession or institution that is aligned with the general interprofessional competency statements but in a context appropriate to particular professional, clinical, practitioner, or institutional circumstances. This would broaden the scope and increase the momentum of the transformation of interprofessional education of health professionals. (IPEC 2016: 3)

Likewise, meaining units that refer to communication often reference the efforts of the interprofessional education and collaborative practice proponents themselves in creating the guidelines.

Meaning Node	Meanings	Descriptions	Communication Frames
Institutionalization as systemic solution	IPECP as solution to systemic problems (n=14)	Improving health care outcomes and systemic challenges through the implementation of interprofessional education and collaborative practice (IPECP).	Dominant: Information exchange; joint meaning making Present: many instances of unspecified frames
Norm-setting and structural embedding	Establishing standards for IP practice (n=21)	Establishing policies, concepts, and standards for IP practice.	Dominant: Joint meaning making Present: many instances of unspecified frame
Narrating progress and legitimacy	Success story (n=14)	Sharing reports that establish the historical evolution and success in institutionalizing an interprofessional approach to care.	No dominant frame Present: many instances of unspecified frame

Table 4. Institutionalization Discourse (appeared in 43 meaning units)

This discourse includes a meaning node that sees the *institutionalization of interprofessionalism as a systemic solution*. It speaks to the rationale behind the interprofessional movement: solving structural problems in healthcare through interprofessionalism. Moreover, it positions interprofessional education as a response to system-level problems in healthcare. This discourse is aligned with the frames of information exchange and joint meaning making. Thus, communication is framed explicitly and instrumentally as a lever for transforming care delivery and improving outcomes through better coordination and shared goals. For instance, IPEC (2011: 11) claims: "The goal of this interprofessional learning is to prepare all health professions students for deliberatively working together with the common goal of building a safer and better patient-centered and community/population oriented U.S. health care system."

Meanings associated with this discourse also clustered around the node of *norm-setting and structural embedding,* which emphasizes the institutional and governance mechanisms needed to embed interprofessionalism. In other words, it focuses on how institutionalization happens: through standards, definitions, and formal processes. Communication is central to defining collaboration and structuring how it is taught and enacted, often described as synergy-building and creating shared understanding across professional boundaries. For example, the WHO (2010: 36) offers the following definition of collaboration:

> Collaboration, however, is not only about agreement and communication, but about creation and synergy. Collaboration occurs when two or more individuals from different backgrounds with complementary skills interact to create a shared understanding that none had previously possessed or could have come to on their own. When health workers collaborate together, something is there that was not there before.

Finally, meanings also clustered around the meaning node we called *narrating progress and legitimacy,* which showcases the success of the movement. In this way, the institutionalization discourse is distinct from the others as it uses narrative – success stories of interprofessional education and collaborative practice initiatives – to affirm legitimacy and historicize the institutional entrenchment of the interprofessional movement. Communication plays an implicit role in demonstrating how interprofessional values are taken up, enacted, and celebrated. In this way, we can think of this discourse as strengthening the communicative constitution of interprofessional collaboration in teaching, learning, and practicing health and social care.

Discussion

Interprofessional collaboration is widely recognized as dependent on communication, a point that is underscored in the guidelines we analyzed.

However, the field lacks clarity on what communication is, how it works, and what it does. The dual aim of this study was therefore (a) to examine how communication is normatively framed and (b) to identify prevalent discourses in six institutional guidelines that outline priorities and values for interprofessional education and collaborative practice. In what follows, we discuss the communication frames we identified in relation with the three theoretical perspectives of communication presented earlier (transmission, transactional, and constitutive views). Then, we examine the discourses we identified in our corpus in the light of the ideologically informed discourses behind the managerial turn, the rise of patient-centered care, and the persistence of professional hierarchies. Throughout this discussion, we also interpret the significance of our results for organizational and interprofessional practice.

8.1 *Mapping Communication Frames onto Theory and Practice*

We identified six communication frames: information exchange; joint meaning making; relational maintenance; negotiation; giving voice; and constitutive of culture. They appeared throughout the corpus, but their appearance was fragmented and uneven, which suggests that communication remains undertheorized in interprofessional education and collaboration practices documents. The frames reflect a mix of the transmission, transactional, and constitutive perspectives.

Our results showed that information exchange was the most prevalent – and explicitly mentioned – frame in the sections of the guidelines dedicated to explaining communication. Its prevalence suggest that the *transmission* model of communication is the dominant communication perspective. It emphasizes effectiveness in teamwork. This suggests that, in interprofessional education and collaboration practices, communication is primarily understood instrumentally, as a coordination tool to achieve care goals and improved health and organizational outcomes. By extension, it also suggests a rationalized and instrumental view of interprofessional collaborative practice.

The dominance of this frame may have implications for how resources are understood and allocated in interprofessional contexts. For instance, care might be organized around standardized procedures that can be clearly communicated and carried out; communication is seen to facilitate coordination and compliance with protocols. Importantly, professional time is probably allocated based on efficiency and clarity of tasks, and communication is expected to be targeted, brief, and task-oriented because time spent on reflection and negotiation may be seen as inefficient. Furthermore, financial investments might favor technological systems or communication tools that streamline information flow.

"Joint meaning making," or the collective creation of shared meanings, was the second most prevalent frames in the documents. "Relational maintenance," which focuses on communication as the means for maintaining

positive relationships, was the third. They both can be seen representing the *transactional* view of communication, as can the "negotiation" frame, which focuses on joint meaning making in emotionally laden situations. These frames emphasize communication as fostering mutual recognition, inclusion, and civility, and there is a focus on relational dynamics, shared understandings, and adaptive coordination built on trust. Together, the prevalence of these communication frames suggest that the transactional model of communication is actually quite prevalent in the interprofessional guidelines. We can recall that this theoretical perspective considers communication as a dynamic and reciprocal process where meaning is co-created in interaction. Yet, as these communication frames appeared in sections of the guidelines not devoted to discussing communication explicitly, it is difficult to say whether the role of communication is understood in the social phenomena they portray. If not, important possibilities for contributions from communication theory to understanding of interprofessionality are overlooked. Furthermore, this perspective might only be used in a fragmented fashion when planning how to organize resources.

However, there can be value in relying on this view of communication to guide decisions about collaborative practice and organizational resources. For instance, care routines could be designed to be more flexible and negotiated in context, because time and space are allocated to allow team members (including patients) to check understanding and adapt plans. Indeed, this requires that decision makers consider it necessary and legitimate to plan for and compensate professional time devoted to interactive work, including communication practices such as interprofessional meetings, huddles, and shared care planning. Physical and digital environments can be designed to support interaction, not just documentation. Funding might be allocated for interprofessional training in interpersonal and conflict-resolution skills.

The communication frames of "giving voice" and "communication as constitutive of working culture" appeared the least frequently in the documents, the latter appearing only once. We claim that these frames represent the *constitutive* perspective of communication, which posits that communication constitutes interprofessional relationships, identities, norms, and power structures – who is heard and whose knowledge counts (see Ashcraft *et al.*, 2009; Craig, 1999; Fox *et al.*, 2025). What's more, the constitutive perspective suggests a particular role for the interprofessional guidelines themselves: Because they inform teaching activities and guide policy decisions, they contribute to stabilizing and normalizing the interprofessional agenda, turning aspirational discussions into practical realities. In fact, each iteration of a guideline emerges from many cycles of communication among interprofessional planners, educators, and clinicians who build on the previous version to reflect current norms, standards, understandings, and expectations about interprofessional education and collaborative practice. In this recursive fashion, these guidelines contribute to constituting interprofessional collaborative practice.

This constitutive perspective can also have implications for how clinical and organizational resources are allocated. For instance, according to this perspective, care routines are seen as discursively constructed and negotiated; therefore, time should be allocated to co-create such routines, so that they reflect diverse professional and patient perspectives. Meaning making is seen as the very essence of interprofessional collaborative practice, so decision makers pay special attention to *how* collaborators communicate, understanding that communication practices constitute (re-create or resist) power relations.

Finally, an interesting observation was that there were so many meaning units for which a communication frame could not be specified. We suggest that this confirms our hunch that communication is undertheorized in the interprofessional education and collaborative practice literature and normative guidelines, which we have discussed elsewhere (Fox *et al.,* 2025).

8.2 *Discursive Resonances: Distinct Logics, Divergent Ends*

We identified three discourses in these guidelines: effective teamwork; ethics of collaboration; and institutionalization. They appeared throughout the different sections of the guidelines.

"Effective teamwork" was the most dominant discourse, concerned with coordination processes, team performance, and patient outcomes, resonating with the ideology of the managerial turn described in the Background (e.g., Spagnol *et al.*, 2013). Human interaction is instrumental to performance through the efficient transmission of messages. However, whereas the managerial ideology is often preoccupied with reducing costs, as can be inferred by "lean" initiatives (e.g., D'Andreamatteo *et al.*, 2015), the meanings associated with the effective teamwork discourse did not pertain to financial costs.

The "ethics of collaboration" was another powerful discourse, one that prescribes how collaborators ought to treat one another in order to ensure just collaboration. It resists the entrenched clinical hierarchy (Abbott, 1988; Freidson, 1970, 2001) through its emphasis on the importance of equitable participation in meaning and decision making, namely clinical democracy (Long *et al.*, 2006; Noyes, 2022, 2025). It also strongly resonates with the ideology of the patient-centered care movement (e.g., Stewart *et al.*, 2003), especially with regard to giving patients and their loved ones agency in collaboration and teamwork as well as respecting their wishes and confidentiality. This includes recognizing the importance of respecting the dignity of *all* team members for both individual and collective wellbeing. Respectful human interaction is how equity and inclusion are collectively achieved.

The third discourse, "institutionalization," encapsulates the force and success of the interprofessional education and collaborative practice movement itself. It does not propose what communication "does" in relation to collaboration so much as it harnesses the constitutive power of communication as a means to legitimize and embed interprofessionalism in health care institutions.

One could claim that, together, the discourses of "effective teamwork" and "ethics of collaboration" constitute the ideology of the interprofessional education and collaborative practice movement, manifesting both how its proponents understand social reality in health and social care contexts as well as their shared core values. We argue there is a fundamental tension inherent to this double-sided ideology, which is evident in how each discourse privileges a different function of communication: "Effective teamwork" sees communication as a collaborative tool whereas "ethics of collaboration" views communication as ethical practice.

Hence, these discourses can be seen as contradictory, even struggling (Baxter 2011). While the discourse of effective teamwork manifests the ideology of efficiency and effectiveness, suggesting that resources, including time, must be budgeted and controlled through practice standardization, the ethics of collaboration discourse suggests that the resources of time and space are precisely what it takes to develop the inclusivity and respect needed to create a supportive collaborative climate. In other words, the necessary conditions of one discourse are the potential target for elimination of the other.

Yet these discourses exist simultaneously in the interprofessional guidelines we examined. Managing the tension between them requires a dialogic understanding of communication (see Baxter, 2011), one that recognizes the co-construction of meaning as the site of an ongoing, inherent, and dialectical struggle between multiple, competing discourses. From this perspective, contradictions and tensions between discourses are a natural part of communication, and there is no reason nor possibility to "resolve" them. Rather, becoming aware of contradictions is the starting point for managing these dialectical tensions.

Once identified, there are different strategies for managing such tension. An "either/or" strategy refers to the kind of communication in which one discourse dominates, and the other is bypassed (Putnam *et al. 2016*). However, a "both-and" approach offers a better option (Putnam *et al. 2016*), namely by broadening the scope: for instance, by considering that effective teamwork *requires* mutual understanding – produced through ethical collaboration – of what is effective, whose needs are prioritized, and what kinds of practices and communicative actions are defined as effective. Thus, effectiveness is not pursued by setting some standard measures of effectiveness but by jointly creating situated understanding of effectiveness and seeing the creation of shared meanings *as* effectiveness.

Overall, we hope this study's contribution is that it stimulates a deeper appreciation by interprofessional educators, clinicians, students, and policy makers of the power of communication theory. We are suggesting that it can serve as a discussion point for future iterations of the interprofessional education and collaborative practice guidelines. Our study was limited by our examination of primarily North American documents; future analysis could broaden this scope to include interprofessional education and collaborative practice guidelines from other regions and countries.

Conclusion

We conclude by emphasizing that the framing of interprofessional communication shapes, in a normative sense, how educators and curriculum developers in the health professions teach interprofessional collaborative practice. In turn, this influences practical learning activities and evaluations. Our findings suggest that the authors of these normative guidelines might hold a somewhat narrow view of communication, one that does not account for the complexity of communication as a multifaceted process. It is as if the more dialogic and negotiated aspects of communication are designated as "soft skills" that are left out of what is explicitly taught about communication. Therefore, we think future versions of these guidelines should aim to more deeply theorize how communication is framed in sections where it is mentioned only implicitly. Such theorization should acknowledge and embrace a dialogic understanding of communication (see Baxter, 2011), one that sees it as situated, negotiated, and as the primordial site of – and yes, a primary tool for – intersubjective meaning making.

In sum, we celebrate the fact that communication is given such a central place in these guidelines, and we look forward to seeing future developments and hope that communication theory is woven throughout.

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