Developing Professional Identities in a Community of Practice: Learning in an Interprofessional Group Led by a Patient Living with Mental Illness

by

Wafa Asadian

M.A., Tarbiat Modares University, 2009

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES
(Human Development, Learning and Culture)

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

December 2019

© Wafa Asadian Falahieh, 2019
The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

**Developing Professional Identities in a Community of Practice: Learning in an Interprofessional Group Led by a Patient Living with Mental Illness**

submitted by Wafa Asadian in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Human Development, Learning and Culture

**Examinining Committee:**

Dr. Jennifer Vadeboncoeur
Supervisor

Dr. Deb Butler
Supervisory Committee Member

Dr. Richard Young
University Examiner

Dr. Laura Nimmon
University Examiner
Abstract

While patient-centred care is being encouraged in practice, patient-centred learning is not always accommodated in the education of health professionals. Based upon Lave and Wenger (1991) and Wenger’s (1998) theory of situated learning, this study examined a community of practice consisting of an interprofessional group of students (medicine, nursing, occupational therapy, and pharmacy) who learned together from a teacher with a chronic illness as part of the Patients as Teachers Program (PAT). It examined developing health professional identities in this group in order to contribute to the discussion around patient-centred learning in health professional education using a qualitative approach. This study was guided by the following research questions: 1) How can an interprofessional group involving a patient as teacher operate as a community of practice? 2) How can situated learning in the interprofessional group involving a patient as teacher inform the professional identities of the students? The qualitative inquiry followed ethnographic methods of data collection that were recordings of the group meetings, program documents including students’ reflective journals, and one-on-one interviews with the five participants. The meeting recordings and interviews were transcribed. Thematic analysis using inductive and deductive approaches was used to analyze and interpret the data. The conceptualization of the PAT group as a community of practice highlighted the unique ways of participation in the group. The findings demonstrated developing professional identities among the students as a function of institutional positioning of a patient as a teacher in the program. The study also found that developing professional identities was taking shape in a holistic learning environment that included all of cognitive, relational and social ways of learning. This process of identity formation also involved dealing with uncertainties and developing multiple perspectives in relation to them. The study found that the students were
developing health professional identities mainly in relation to their teacher and from the perspective of each of their own health professional programs. Interprofessional learning was a sequence to patient-centred learning in this context. The importance of patient-centred learning, difference of professional identities in different health professions and the role of discourses in shaping professional identities are also discussed.
Lay Summary

This research examined learning in the Patients as Teachers Program (PAT) that was offered in the curriculum of health professions. In this program, a patient with a chronic condition taught, over the course of 1.5 years, a group of four students each coming from a different health profession: medicine, nursing, occupational therapy, and pharmacy. This study was guided by the following research question: *How can situated learning in the interprofessional group involving a patient as teacher inform the professional identities of the students?* This dissertation study followed a qualitative research using ethnographic methods in collecting and analyzing the data. The PAT group was conceptualized as a community of practice. The findings of the study are discussed in terms of patient-centred learning, multiple ways of learning in the group, and the role of different discourses in developing professional identities.
Preface

This dissertation, including its design, data collection and analysis, is an original intellectual product of Wafa Asadian. This study was approved by the Behavioral Research Ethics Board at the University of British Columbia on November 14, 2014. Approval number: H14-02162.
# Table of Contents

Abstract ................................................................................................................................................. iii
Lay Summary ........................................................................................................................................... v
Preface .................................................................................................................................................. vi
Table of Contents ................................................................................................................................. vii
List of Tables ......................................................................................................................................... x
List of Figures ......................................................................................................................................... xi
Acknowledgment ................................................................................................................................. xii
Dedication ............................................................................................................................................... xvi

## Chapter 1: Introduction

1.1 Background and Significance of the Study ......................................................................................... 1
1.2 Theoretical Framework ..................................................................................................................... 3
1.3 Context ........................................................................................................................................... 3
1.4 Research Questions .......................................................................................................................... 4
1.5 Methodology .................................................................................................................................. 4
1.6 Summary .......................................................................................................................................... 5

## Chapter 2: Literature Review

2.1 Patient-centred: From Care to Learning .......................................................................................... 7
  2.1.1 Patient involvement in education ............................................................................................... 8
  2.1.2 Interprofessional education ...................................................................................................... 10
2.2 The Theory of Situated Learning ................................................................................................... 14
  2.2.1 Community of practice ........................................................................................................... 17
  2.2.2 Participation and identity ......................................................................................................... 19
2.3 Community of Practice and Identity in Health Professional Literature ......................................... 30
  2.3.1 Community of practice in health professional education ......................................................... 30
  2.3.2 Identity in literature ................................................................................................................. 34
2.4 Summary ....................................................................................................................................... 42

## Chapter 3: Methodology

3.1 Researcher’s Position ....................................................................................................................... 44
3.2 Context: Patients as Teachers Program .......................................................................................... 47
3.3 Ethics ............................................................................................................................................. 50
3.4 Epistemological Stance .................................................................................................................. 51
3.5 Design and Methodology ............................................................................................................... 52
  3.5.1 Participants and recruiting ......................................................................................................... 54
  3.5.2 Methods of data collection ....................................................................................................... 57
  3.5.3 Data analysis ............................................................................................................................ 63
3.5 Summary ....................................................................................................................................... 70

## Chapter 4: PAT Participants’ Discussions and Reflections over Time

4.1 September 2014 (Orientation Meeting): Initiation and Anticipations ...................................... 72
4.2 October 2014 (Meeting 1): Varying Perspectives ........................................................................ 73
4.3 December 2014 (Meeting 2): Journey, Disclosure, Stigma and Uncertainties ......................... 79
4.4 January 2015 (Meeting 3): Stability as the Essence of Care ...................................................... 82
4.5 February 2015 (Meeting 4): Developing Deeper Insights on Teacher’s Story ......................... 87
4.6 April 2015 (Symposium): Patients’ Experiences and Needs as Different and Unique ............. 93
4.7 September 2015 (Meeting 5): Disclosure and its Reciprocity ................................................... 96
List of Tables

Table 3.1 Table of Participants ........................................................................................................... 56
Table 3.2 Relationship Between Research Question and Data.............................................................. 57
Table 6.1 Patient-centred Care, Family-centred Care, & Client-centred Care as Defined by
Research Participants ......................................................................................................................... 143
List of Figures

Figure 3.1 Timeline and the Activities of the PAT Program ................................................. 50
Figure 3.2 Drag & Drop Operations (ATLAS.ti for Windows).............................................. 65
Figure 3.3 Drag & Drop Operations (ATLAS.ti for Windows).............................................. 65
Figure 4.1 PAT Symposium: Poster Prepared by Catherine, Dena, Emily, Nelle, and Nick ...... 94
Figure 4.2 PAT Symposium: Thoughts and Dilemma of Disclosure ....................................... 94
Figure 5.1 PAT Program as a Constellation of Practices....................................................... 122
Acknowledgments

I appreciate and acknowledge that the research for this dissertation was conducted on the unceded traditional territories of the Musqueam, Squamish, and Tsleil-Waututh First Nations.

There are many people that helped me accomplish this dissertation and my PhD program and who had a role in my life as it unfolded in these years. I would like to thank Catherine, Dena, Emily, Nelle and Nick, the research participants of the study who warmly welcomed my research devices in their intimate group meetings, and who profoundly impacted my perspective of how learning and sharing could look like. I would like to thank Jen and Deb, my supervisory committee, in guiding the direction of this dissertation, and Richard and Laura, the university examiners who with their critical perspectives helped enhance the quality of this work. I would like to thank Dr. Paula Rowland, my external examiner who gave a seal of approval to an albeit older version of my dissertation. I am thankful to the many professors in my time at UBC from whom I learned academic and professional skills: Sandra, Shawna, Amery, Yan, Shelley, Jen, Bruno, Nand, Shayna, Sharalyn, Frank, Niall, Michael, Marla, Marie-Gérald, and Juliet. I am thankful to different staff persons whose genuine and timely support kept me going: Alex, Karen, Connie, James, Penny, Lee, Jesse, Silvia, Julie, Jacqueline, Nadia, and Kristy. I am also thankful to my professors at Laval University and Montreal University: Nicolas-Christian, Micheline, Josée, Dominique, Benoit, Louise, and José.

This dissertation would not have been accomplished without participation in different projects that supported me financially. My appreciation goes to: the Centre for Teaching, Learning and Technology; Access and Diversity; scholarships from the Faculty of Education; Patricia and Martha from REACH Community Health Centre; Lynda from the Faculty of Pharmaceutical Sciences; Jay and Jill From Centre for Community Engaged Learning; Videsh,
Richard, and Jocelyn from UBC Global Health Network; Andrea from the School of Kinesiology; Estello from SocialSport; Karen from the Sustainability Scholars Initiative; Angela and Cathy from the College of Health Disciplines; and Jenna, Shelley and Shawna from the Department of Educational and Counseling Psychology and Special Education. I thank Jen, my advisor, for supporting me earlier in my PhD program including hiring me in the summers of 2014 and 2015 to provide citation for, and then to review and provide feedback to a book that she later published.

I would also like to thank many people and departments that had an important role in the opportunities that I had for professional development at the same time with my PhD program. They include: Jacqui, Rachel, Gary, Anne, Alex, Michelle, Dean, Darren, and Rachael from Graduate Pathways to Success; Jim, Rose, Gayle, Judy, Matt, and Roger from Mitacs; Charlotte, Logan, Mehdi, Jon, Jo-Anne, Danielle, Mary, and Wendy from UBC libraries; Beth, Michael, Alicia, Preetasha, Danielle, Kimberley, and Amrit from UBC Centre for Student Involvement and Careers; Patrice from the Counseling Services; Ali and Dianne from the International House; Anneke, Beth, Ling Shi, Nasrin, Autumn, Jo, Gaston from the Faculty of Education; Carolyn, Jamie, Kate and Nan from CES c2019; Carla from Mental Health Association; and Lucas, and Joseph Anthony from CTLT. Thanks to Hémilie, Aurèle, Lucie, Genevieve, Marie-Maude, Badri, and Joannie from Conseil des ministres de l'Éducation Canada, and to my colleagues at CES: Mark, Fred, Diana, Sarah, Carolyn, Michelle, Benoit, Vanessa, Frederic, Jennifer and Alisha.

Throughout my years in this PhD program, I had the pleasure to know or befriend many people who shaped my life in different ways. I am forever thankful to the loyal friendships bestowed upon me by Peter, Joanne, Deirdre, Farideh, Maryam Dehbashi, Mike & Sarah, and
My thanks go to: classmates Rose, Renia, Louai, Hitaf, Bruce, Negar, Claire, Natalia, Hadas and Maryam who impacted my life in different ways and from whom I learned lessons of life; to dear classmates and colleagues at UBC, Xiao, Susan, Reky, Sara, Chloe, Mariel, Aloy, Yue, Joanna, Minjeong, Ruijing, Mahshid, Dylan, Danjie, Lok, and Ben; to friends in Vancouver and beyond, Roger & Anne, Shwan, Mitun, Parisa, Cristina, Mina, Nil, Chiara, Jeannie, Mali, Elizabeth, Hanae, Bien, Samira, Sarah, Anahita, Roza, John, Tuba, Hanie & Shahab, Marjan, Marzieh, and Mostafa; and to my friends from Odyssey and Explore: Amal, Janine, Patience, Rushda, Robert, Missy, Veronica, Mahaa, Art, Jody, Sun, Zoe, Amanda, Jessie, Joel, April, Holly and CJ.

To Rimouski that changed my life for good and for better. My thanks go to my amazing colleagues at Cégep de Rimouski, working with them while I was grappling with finishing this dissertation: Jennifer, Darcy, Lyly, Catherine, Catherine, Eileen, Nadine, Leslie, Malcolm, Glenn, Suzie, Natasha, Andrée-Anne, Guillaume, Michel, Michel, Nicolas, Christian, Sylvain, Phillippe, Patricia, Anne, Lucie, Kathy-Éve, Maude, Tonia, Jean-Marc, Mathieu, Marie, Marina, Margot, Kathy, Jocelyn, Anoushka, Michael, Sonia and Josée. Thanks to: Katherine, Carole, Andrée, to all our frame problems and brain problems when playing badminton; and to Robin and Doris, my fitness & workout mentors. To my dearest students at Cegep de Rimouski whose curious eyes motivate me to learn more and to contribute more. Thank you to my good friends in Rimouski: Gaba, Karim, Lisan, Anja, Souad, Bernadette, Valérie, Elisabeth, Adrienne, Mahnaz & Cyrus, Eissa, Leila, Behdad, Agrin, Neda, and Monelle & Don.

To all of classmates, labmates, colleagues and friends whose names I missed to mention here, I thank you because you had an important role in my life and my accomplishments during my graduate studies.
Last, to my family for whom my appreciation can not be described in words. To Maman & Baba: Thank you for your incredible love and support in many different ways that I can imagine. You are my sources of inspiration. You are the energy that I pull my strength from. You are my strength. Thank you Baba for always being an optimistic person and for encouraging me to not give up. Thank you Maman for always seeing things and explaining things to me from a different perspective of which I would not have thought. Thank you both for your broad vision. To Yafa, Mohammad and Sami my dear, funny, and bright siblings. To Yafa for being my big sister and for being the rock in my most difficult moments. To Mohammad and Sami my joyful brothers whose presence is a source of inspiration for me. To Yafa and Mehdi for giving me their cottage when I needed a quiet space close to my family to work on my revisions. To Rana and Rafel my adorable niece and nephew: I cannot wait to see you grow into the pure souls that you are and continue to add warmth to my life. I love you all and can not imagine how my life would look like were you not there.
Dedication

To Catherine who changed my perspective about mental illness
Chapter 1: Introduction

New demands are being placed upon the Canadian health care system given an aging population and the need for chronic care. These new demands are likely to require a change in the methods of care and practice and they raise specific issues related to the preparation of health professionals and the role of patients in health care education. For example, what can patients share about their experience that is important for the developing identities of future health professionals? How does involving patients in education influence interprofessional learning? What kinds of learning are generated based on this experience? This dissertation explores learning and identity development in an interprofessional group of students learning from a patient with a chronic condition who was positioned as the teacher of this group. The theory of situated learning (Lave & Wenger, 1991) and particularly the concept of the community of practice (Wenger, 1998) inform this study.

This chapter is divided into five sections. First, an account is given regarding the state of health care and the need for incorporating patient-centred learning in health professional education. Second, the theory of situated learning is briefly described. Then this chapter briefly describes the context of the study, the research questions, and the methodology. The chapter ends with a summary and overview of the dissertation.

1.1 Background and Significance of the Study

Historically, the health care system has changed over time and often in relation to health care needs. Currently, compared to the early and mid-1900s, the needs of society have shifted from acute care to chronic care, necessitating long-term care provision (Ludmerer, 1999). A contemporary issue in the Canadian health care system is how to manage and deal with chronic illness given the increasing costs of health care and the efforts to keep patients out of hospitals.
A recent trend is to offer services in a way that patients can take ownership of their own health condition, and physicians and health professionals can help patients through this process of personal care management. This approach is usually referred to as patient-centred care (PCC). Acknowledging that there is no consensus on the precise definition of PCC, Mead and Bower (2000) summarized other studies describing PCC as an approach that regards the patient as a whole human being, focuses on experiencing of the illness, finds “common ground” in care management, advocates prevention, and enhances the relationship between the patient and the health professional (p. 51). Patient-centred care also entails holistic care, humanistic principles, patient empowerment, shared decision making, and at times, interprofessional collaboration (e.g., D’Amour & Oandasan, 2005; Ferguson, Ward, Card, Sheppard, & McMurry, 2013).

While the descriptions of PCC sound promising in terms of respecting and including patients in their own care in an interprofessional context, one concern that remains is that these principles may not translate to practical solutions for the kinds of care that patients with diverse needs have. Although PCC suggests drawing from the patient’s experience and knowledge, it is unclear how and to what extent patient-centred care is in fact practiced. In this regard, Bleakley and Bligh (2008) stated that while health professionals are expected and taught by medical educators to practice patient-centred care, “patient-centredness is then, paradoxically, not learned from patients” (pp. 91-92, emphasis in original). This requires attention to be paid to patient-centred learning (Bleakley & Bligh, 2008). One step in this direction can be the inclusion of the patients’ voices in the ways in which health professionals are educated, such as involving patients as educators in health professional curricula. In this way, the patients become “the primary locus for knowledge production” in “the student’s reading of the patient’s condition in
collaboration *with* the patient” (Bleakley & Bligh, 2008, p. 91, emphasis in original). This implies an intrinsic value to the presence and active involvement of patients in education. One such value is the assumption that a patient, by virtue of living with an illness has unique insight and expertise into the condition that they can share with health professional students.

The nascent literature on patient involvement in education has remained largely atheoretical (Bleakley & Bligh, 2008). This dissertation study addresses the need for determining the value of patient participation in the education of health professional students using a sociocultural theory in education: theory of situated learning.

### 1.2 Theoretical Framework

The theory of situated learning suggests that learning is situated in a community of practice (CoP) and in relations among people, objects and their overlapping communities of practice (Lave & Wenger, 1991). This social context situates learning and the identity of the participants through the ongoing negotiation and participation of participants in the CoP (Wenger, 1998).

Participation in a CoP includes peripheral participation, full participation, and legitimate participation. These concepts are related to one another in a complex way. The participants’ peripheral and full participation is possible if they are granted legitimacy in a CoP. Legitimacy includes recognition and validation of a person’s input in and contribution to a CoP. Lave and Wenger (1991) referred to this complex dynamic as *legitimate peripheral participation*. This concept has relevance to the developing identities of the participants in the CoP (Wenger, 1998).

### 1.3 Context

The site for this research was the Patients as Teachers (PAT) program. PAT was an interprofessional program offered as part of the curricula of different health professional
programs at the West Gardens University in the province of British Columbia, Canada. The program consisted of patients who were living with chronic conditions. Each patient was positioned as a teacher who taught, over a 16-month period, a group of students from different health professions about her/his lived experience with the chronic illness. The purpose of the program was to give health professional students the opportunity to interact with a patient as teacher and the students from other programs. It aimed at providing the students with the opportunity to learn from their teacher about the experience of living with a chronic condition and to learn interprofessionally through interaction with the students of other health professions.

The group that was the focus of this dissertation consisted of a teacher who was living with schizophrenia, a medical student, a nursing student, an occupational therapy student, and a pharmacy student.

1.4 Research Questions

The purpose of this study was to explore developing professional identities in an interprofessional group, conceptualized as a community of practice, consisting of a patient and four health professional students. This study was guided by the following research questions:
1) How can an interprofessional group involving a patient as teacher operate as a community of practice?
2) How can situated learning in the interprofessional group involving a patient as teacher inform the professional identities of the students?

1.5 Methodology

This study used qualitative research with social constructionism as its epistemological stance. Ethnographic methods were used for collecting data including audiovisual recordings of the group meetings in the PAT program, the students’ reflective journals, and one-on-one interviews with the teacher and the students. The recordings of the meetings, as well as the
interviews, were transcribed. The students’ journals, and the transcripts of meetings and interviews were used as data to be analyzed thematically.

1.6 Summary

The health-related needs of Canadian society have changed from acute care to chronic care. Patient-centred care has emerged as an approach to address the current health care needs. However, the extent to which patient-centredness is learned from patients is questionable and thus, there is a need to pay attention to patient-centred learning. This dissertation study is an effort to address the call for patient-centred learning. In doing so, it studies a group in the PAT program, an interprofessional program in which the students learn from a teacher with the lived experience of a chronic condition. This program is unique because it offers long-term interaction among a group of health professional students and their teacher. This study conceptualizes the PAT program as a community of practice to explore learning when patients are included as legitimate participants in health professional education. Specifically, this research investigates developing professional identities and learning that occurs in the PAT program using situated learning as its theoretical lens.

Chapter 2 of this dissertation reviews the literature in relation to the key concepts relevant to the theory as well as the research questions. Chapter 3 discusses the methodology used in this study. The report of the findings develops cumulatively from Chapter 4 as the first step in ethnographic reporting to chapter 7 that discusses the themes of the study. As the first step in ethnographic reporting, Chapter 4 describes the PAT group meetings and the interactions among the participants over time. Chapter 5 uses the key findings from the group meetings as well as concepts from the theory to discuss why and how the studied PAT group made a community of practice. Chapter 6 continues the ethnographic reporting of the data by identifying the key
findings from the interviews that explored learning for each of the participants. Chapter 7 builds from the discussion from the previous chapters to discuss the themes and to address the research question of about professional identities. Chapter 8 summarizes the dissertation and examines the implications of the study, its limitations, as well as suggestions for future research.
Chapter 2: Literature Review

Today’s Canadian health care system is under scrutiny to operate with best practices for patients and the public at large while being held accountable by the government that bears a high cost for health care. In the current system in Canada, there is a three-way relationship between government, health care providers, and patients. In this relationship, health care professionals provide service to patients. Patients contribute to the relationship by paying taxes to the government and engaging in relevant civil compensations. The government pays health professionals for their services to society. Therefore, there is an expectation of health care providers to deliver services in return for society’s compensation and the authority it gives to health professionals in managing its health care. This relationship is usually referred to as the social contract of health (e.g., Duffin, 2010).

This social contract, as well as the recent need for chronic care, have necessitated the participation of patients as active decision makers in their own care, thus the advancement of patient-centred care as a model for practicing care. Chapter 1 noted that attending to patient-centred care necessitates learning patient-centredness from patients themselves. One approach to achieving this goal is to include patients as active participants in the education of health professional students. In doing so, patients’ experiences need to be recognized and valued by the health professional curricula. Of equal importance to this notion is how the involvement of patients in the education of health professionals influence their developing professional identities.

This chapter reviews the literature that grounds the concepts relevant to the study. It first highlights the importance of patient-centred learning in the light of attention given to patient-centred care. Patient-centred learning aims at creating a bridge between health care and the
education of health professionals by arguing that, if we want the practice of health care to be patient-centred, we need to ensure that education of health professionals is patient-centred as well (Bleakley & Bligh, 2008). This section reviews the literature on patient involvement in education as well as the interprofessional education of the students. Second, this chapter reviews the theory of situated learning and its key concepts such as community of practice, legitimate peripheral participation and identity. Third, it discusses the health professional literature utilizing the concepts of community of practice and identity.

2.1 Patient-centred: From Care to Learning

Patient-centred care (PCC) is a term widely used in health professional literature, however a clear definition for the term has remained elusive across health professions (e.g., Dowse, 2015). Patient-centred care (PCC) is often used in nursing, pharmacy and medicine. The definition provided in these professions is often drawn from medical literature (see Appendix E) mainly the works of Nicola Mead (e.g., Mead & Bower, 2000), and Moira Stewart (e.g., Brown, Thornton, & Stewart, 2012).

Different health professions may use particular terminologies to make the concept relevant to their practice. For example, occupational therapy mainly uses the term client-centred care (CCC) and defines it as the “approach to service which embraces a philosophy of respect for, and partnership with, people receiving services” (Law, Baptiste, & Mills, 1995, p. 253) with the focus on autonomy of individuals and accessibility of health care services. The OT literature also uses person-centred care interchangeably with CCC (Walley Hammell, 2013). Nursing education has been using person-centred care (Kitson, Marshall, Basset, & Zeitz, 2013), client-centred care (Brown, McWilliam, & Ward-Griffin, 2006), and family-centred care (Registered
Nurses’ Association of Ontario, 2015) to highlight the context in which care is delivered and to emphasize the attributes related to the field of nursing. Nursing also uses patient-centred care.

The literature in nursing and pharmacy largely draws from medical literature to define patient-centred care (e.g., Flagg, 2015; Hinds, 2013; Kitson et al., 2013; Sánchez, 2011). The reason perhaps lies in the fact that publications about PCC are more proliferate in the medical literature including books that discuss in detail the concept and how to apply it in practice. According to the medical literature, patient-centred care (PCC) involves considering a patient as a whole person when providing care (Brown et al., 2012; Mead & Bower, 2000). The concept encourages health professionals to turn their attention from the disease to the illness that includes the psychological and the social impact of the disease on a person’s life. In discussing PCC, physicians are invited to share power and responsibility with their patients (Brown et al., 2012; Mead & Bower, 2000) in health care decision making (see Appendix E).

The term “patient-centred care” suggests that patient’s position is central in a health care setting, but it is unclear what an active role for the patient looks like. The descriptions of PCC call on the health professional to practice PCC, to “understand” and “listen to” patient concerns. While such emphasis on clinician practices is valuable, it does not describe how patients can be engaged in this interaction—leaving little room for patients to be actively involved in PCC. This is also evident in the guidebooks that are published about practicing PCC. Written by physicians and addressing fellow physicians, these guidebooks assume that the physicians hold both the power and the responsibility of patient-centred care (e.g., Kwong, Kwong, O’Brien, Hill, & Haswell, 2009). In these books, “patient” is a third person about whom the writer and the reader have a dialogue as to how to manage and treat different patient case scenarios.
The way that PCC is being practiced in health care settings may be rooted in the education of health professionals. This question has been raised with regard to the instructional settings in which PCC is taught by faculty, physicians, and health professionals, rather than patients who are aware of their own concerns and are likely to have significant information to share with professionals about their care (Bleakley & Bligh, 2008; Terrien & Hale, 2014; Towle & Godolphin, 2013). If health professionals are expected to truly practice patient-centred care, then the education of health professionals needs to be patient-centred as well (Bleakley & Bligh, 2008).

The terms “patient-centred learning” and “patient-centred education” are used interchangeably in the literature to refer to instances where students learn from patients (e.g., Fiddes, Brooks, & Komesaroff, 2013; Leung et al., 2002; Oswald, Czupryn, Wiseman, & Snell, 2014; Towle & Godolphin, 2013; Walters & Brooks, 2016). Others use either “patient-centred learning” (Smith, Cookson, Mckendree, & Harden, 2007) or “patient-centred education” (Bleakley & Bligh, 2008) to refer to the same experience. To add clarity, this dissertation uses the term patient-centred learning throughout (instead of education) to emphasize the process involved in learning from patients. In order to examine the literature on patient-centred learning, I studied patient involvement in education discussed in the next section.

2.1.1 Patient involvement in education

Patient involvement in education is a venue for discussing developing professional identities as it includes patients who have a voice in health professional education and curriculum and who shape the direction of learning for the health professional students. Towle et al. (2010) offered four reasons that underlie the patient participation in education. First, with the soaring costs of health care, the government is promoting self-management for people living
with chronic conditions. Second, patient-centred care is achievable mainly by involving patients in a process of informed and shared decision making. Third, unsatisfactory experiences in the past and consumerism in the present have empowered patients to take more active roles in their care and treatment. And fourth, the calls for practitioner professionalism and social accountability have prompted educational institutions to involve patients and communities in education. These calls necessitate creating opportunities for the students to have longitudinal relationships with patients and to view patient experiences in a holistic way (Irby, Cook, Bridget, & O’Brien, 2010).

Rowland et al. (2019) created a timeline that shows the evolution of patient involvement till this day. According to these authors, the first call for learning from patients was made in 1904 by William Osler, a Canadian physician. In that period of time, medical education was not a field yet and education was mainly provided in settings where learners would often follow and observe a male physician as he was providing care for patients (Ludmerer, 1999). Therefore, patients were subjects about whom the students were learning from their physician mentor in care practice setting.

After 1910, medical education was standardized in North American universities (Ludmerer, 1999) to a format that more or less is practiced until today. Between 1970s and 1990s, standardized patients were brought in the education (Rowland et al., 2019). Standardized patients are defined as “healthy volunteers” (Jha, Setna, Al-Hity, Quinto, & Roberts, 2010, p. 353) who play the role of patients.

The 1990s was the beginning of the “biopsychosocial” movement in education (Towle et al., 2010) and by the 2000s, real patients were involved in education (Rowland et al., 2019). Real patients are “those that have direct lived experience with the illness and/or condition” (p. 602).
This period was characterized by the engagement of patients with varying health conditions and their caregivers conducting workshops and training for students of various disciplines (Towle et al., 2010). These conditions included AIDS, developmental disabilities, dementia, cancer, and mental illness. In addition to physical examinations, patient participation takes place in order to acquaint students with determinants of health such as social class, stigmatization associated with certain groups including people living with mental health or substance use problems, and other vulnerable groups including people with disability, children with developmental disability, elderly citizens and people with chronic illnesses (Spencer et al., 2011).

The active participation of patients in education began with institutional roles that patients have played (Spencer et al., 2011) including the role of patients as teachers. The literature on patients as teachers identify varying responsibilities for patients. Wykurz and Kelly (2002) conducted a systematic review in which they found responsibilities for patients as teachers that included giving presentations and seminars, demonstrating for groups of students, giving feedback and assessing students. The participation of patients as teachers, according to the literature, entails skills related to physical examination, diagnosis, communication, ambulatory care, mental health and whole patient experiences (Wykurz & Kelly, 2002). However, this review seems to fuse standardized patients and real patients when it comes to their involvement in education as teachers. It also seems that the role of standardized patients is highlighted more than the role of real patients (e.g., Wykurz & Kelly, 2002). Perhaps the focus on standardized patients is due to the fact that most of the reviewed studies took place in the clinical education of the students.

The literature conducted in non-clinical settings looked at the involvement of real patients in education. Fiddes et al. (2013) and Towle and Godolphin (2013) studied PCC in
interprofessional education (IPE). Fiddes et al. (2013) argued that having patients as teachers and affording direct dialogue between patients and students resulted in enhancing interprofessional education and student learning. Towle and Godolphin (2013) described a project that aimed at supporting health professional students to learn and develop PCC principles in their practice through participating in a number of workshops led by patient educators about health problems such as HIV/AIDS, arthritis, and mental illness. The third study focused on the role of patient educators in promoting PCC (Terrien & Hale, 2014). With minimal guidance from the faculty, patient educators were encouraged to share the history and story of their health condition that involved, not only their immediate experience of the health condition, but also the systemic challenges they faced in access to health care. Conducting ethnographic studies as well as qualitative research involving audio and video recordings is recommended in understanding how students “learn with, from, and about patients” (Bleakley & Bligh, 2008, p. 92) without embodying a practitioner-dominant role in relation to patients.

Patient involvement is a rewarding initiative both for patients and students (Towle et al., 2010). The outcome of involvement of patients as teachers has been documented as reducing anxiety among the students and increasing their confidence (Jha et al., 2010; Wykurz & Kelly, 2002). Content matter is an added value of patient involvement as teachers in health professional education (Henriksen & Ringsted, 2011). Furthermore, patients feel empowered as their voice is being recognized in educating future care providers (Towle et al., 2010). On the other hand, due to the reduced power imbalances in working with patients, students feel less pressured of being monitored by an authority and more comfortable in exchanging questions (Henriksen & Ringsted, 2011). Patient involvement as teachers also shows to help the students to gain deeper insights and to develop different attitudes toward patients (Wykurz & Kelly, 2002).
Despite the benefits of patient involvement in education, most of the patients’ roles include instruction, rather than institutional decision making (Spencer et al., 2011). Moreover, patient involvement in education requires considering a number of issues. First, it requires preparation in terms of training the patient instructors and setting the learning objectives (Towle et al., 2010). Second, patient participation in education requires some kind of recognition including payments, honoraria, or institutional and academic titles. Third, sustainability of patient involvement in education requires including patients’ voices in both planning and implementation of the educational programs. These issues have raised a considerable amount of debate and discussion about why and how to involve patients in education in a sustainable way.

2.1.2 Interprofessional education

The effort to discuss the literature in interprofessional education (IPE) requires a clear definition of the term. If not defined properly, using the term “interprofessional education”, in written and spoken language, may be obscure and may elicit varying thoughts. Additionally, other terms such as “interdisciplinary education” or “multiprofessional education” may be used interchangeably with IPE. The inconsistency in the terminologies used in relation to IPE has been described, understandably, as a “semantic quagmire” (Leathard, 1994, p. 5 as cited in Barr, Koppel, Reeves, Hammick, & Freeth, 2005). In this regard, Barr et al. (2005) wrote:

Prefixes (inter-, multi- and cross-) precede adjectives (professional, disciplinary and agency) which precede nouns (education, training, studies and learning) in seemingly endless permutations. Joint training and shared learning offer more prosaic alternatives, but the field is bedevilled by competing terms. Some lack definition; others are given precise but restricted definitions which lack general currency. (Barr et al., 2005, p. 31)
In this quote, the authors referred to the problem of using various terminologies or generating new terminologies, with no clear definitions, to describe, seemingly, one phenomenon. The authors chose to use interprofessional education in their book in line with the “wider movement worldwide of which it is a part” (Barr et al., 2005, p. 31). They defined interprofessional education as an educational context in which two or more students or practitioners of different professions “learn with, from, and about each other to improve collaboration and the quality of care” (CAIPE 1997, p. 19 as cited Barr et al. (2005). While this definition helps clarify the nature of the relationship between and within professions, a term that remains unclear is “professions.” The literature falls short in specifying which professions are looked at when discussing interprofessional and multiprofessional relations. Do these professions include medical and allied health professions only? Do they include other professions that may serve the same cause of care for patients? Do professions include caregivers and patients? When searching for the relevant literature, I noticed that the largest majority of the studies on IPE lacked the inclusion of patients or caregivers in the process of learning. My literature search yielded over 1000 articles on IPE involving the students, and only a handful IPE studies that actively included the patients or service-users in interprofessional education. This point is imperative given that involving patients is one of the principles of interprofessional education (CAIPE, 2001 as cited in Barr et al., 2005; PAT Handbook, 2014). Acknowledging the lack of a clear terminology, the term “interprofessional education” will be used in the rest of this dissertation. This dissertation defines IPE as a practice that involves the collaboration among all of the health professional students as well the patients and the learning that occurs as part of this collaboration.
Rutherford (2011) studied the collaboration between nursing and social work students co-learning in a homeless shelter as part of an experiential learning project in their respective faculties. The researcher conducted participant observation, interviews and the reflective journals with the students, instructors, staff members, and patients to capture the interprofessional learning process among the students. The findings showed that this process involved entering while overcoming fears at the first stage. Fear was particularly true for the patients who found working alongside academics daunting. At the second stage, engaging, participation by students, patients, staff and faculty had varying degrees of intensity. At this stage, the participants needed to revisit their own assumptions and values in working with people who do not share the same experience. The third and last was the emerging stage in which the students were concerned and interested in making a difference and to address practical issues like homelessness through their care.

Cooper and Spencer-Dawe (2006) studied the interprofessional online interactive and non-interactive workshops that brought together students from medicine, nursing, physiotherapy and social work as well as practitioners and “trained” patients. Students were divided into 22 groups with 10 students in each. The IPE program included four workshops and overall, there were three types of workshop series: 1) when the patient was present in every workshop; 2) when the patient was present at two workshops out of four, and; 3) when no patient was present at any of the workshops. One third of the 22 groups were assigned to each type of the workshop series. The evaluation of the program showed that regardless of the type of the workshop series they’d been assigned to, the students found an intrinsic value in learning from the patients in the workshops. More interestingly, only the students, who participated in the workshops that
involved patients in all the four sessions, emphasized enhancing service provision and tailoring the care toward the needs of the patients.

The key finding shared by both Rutherford (2011) and Cooper and Spencer-Dawe (2006) was that the students, after learning alongside patients developed a sense of responsibility that included adapting their practices to address the needs of the patients. Cooper and Spencer-Dawe (2006) also found that the patients who shared their experience with the students were not considered “educational ‘experts’” (p. 610) by the students and did not meet the educational standards required for the students’ learning. Nonetheless, the students emphasized the value in knowing the experiences of a variety of patients and not just one. The study emphasized the need for defining the role of the patients in education and understanding their contribution. This latter goal is the aim of the current study. While both of these studies emphasized learning from patients, they contained little discussion of IPE. IPE was mainly viewed as taking place as a result of patient-centred learning (Cooper & Spencer-Dawe, 2006). In this view, the students from different professions made sense of their interprofessional learning while being engaged in unique patient stories.

2.2 The Theory of Situated Learning

Educational institutions mostly work based on “the assumption that learning is an individualized process” (Wenger, 1998, p. 3). As a result, learners may come out of the experience viewing learning as “irrelevant” and “boring” (p. 3). An alternative view to learning is a kind of learning that is based on “the lived experience of participation in the world” (p. 3), one that is “as much a part of our human nature as eating or sleeping, that is both life-sustaining and inevitable” (p. 3). This view assumes that learning is “a fundamentally social phenomenon reflecting our own deeply social nature as human beings capable of knowing” (p. 3).
According to the theory of situated learning, learning is viewed as “an integral and inseparable aspect of social practice” (Lave & Wenger, 1991, p. 31). About situated learning, Lave and Wenger (1991) wrote:

In the concept of situated activity we were developing … the situatedness of activity appeared to be anything but a simple empirical attribute of everyday activity or a corrective to conventional pessimism about informal, experience-based learning. Instead, it took on the proportions of a general theoretical perspective, the basis of claims about the relational character of knowledge and learning, about the negotiated character of meaning, and about the concerned (engaged, dilemma-driven) nature of learning activity for the people involved. That perspective meant that there is no activity that is not situated. It implied emphasis on comprehensive understanding involving the whole person rather than “receiving” a body of factual knowledge about the world; on activity in and with the world; and on the view that agent, activity, and the world mutually constitute each other. (p. 33)

Situated learning posits that learning always occurs through situated practice. In other words, all practice is situated, and any practice involves learning, even if it is not primarily intended for learning. In situated learning, the learners are engaged as whole human beings and agents involved in activities and with the world that constitutes them. Situated learning enables transfer of knowledge (Ewertsson, Bagga-Gupta, Allvin, & Blomberg, 2017) across communities defined as “an application of knowledge from one specific situation to another” (p. 2) in which “the learner can identify similarities across tasks and contexts” (p. 2). Knowledgeability is a relevant concept highlighting that a person is knowledgeable about multiple communities and has access
to them without necessarily belonging to them as a core member of those communities (Omidvar & Kislov, 2014; Wenger-Trayner & Wenger-Trayner, 2014).

Practice “is about meaning as an experience of everyday life” (Wenger, 1998, p. 52). Inspired by the sociocultural theory (Vygotsky, 1981), the concept of practice is viewed from a historical and a social context. In other words, both historical and social contexts give meaning to practice. For example, a tool that is used in a practice has a historical sense, may have been historically created for the same or for other reasons. The same tool may cease to be used in the future in the same way that it is used today in practice. These sociohistorical meanings are always present and are assumed when one engages in practice. As such, practice “includes both the explicit and the tacit…, what is represented and what is assumed, …subtle cues,… well-tuned sensitivities, embodied understandings, underlying assumptions, and shared worldviews. Most of these may never be articulated yet they are unmistakable signs of membership in communities of practice and are crucial to the success of their enterprises” (Wenger, 1998, p. 47). This perspective renders a meaning of practice that is both practical and theoretical. The concept of “positioning” becomes relevant when discussing situatedness in a practice. Positioning is defined as identities that are “culturally and historically situated and constructed through interaction with other people within institutions and organizations” (Monrouxe, 2009, p. 42). Retaining the meaning of positioning is important as it manifests throughout this dissertation.

2.2.1 Community of practice

A key concept in the theory of situated learning is that of community of practice (CoP). CoP is a concept that situates people as part of social practices and the relations among them. A community of practice is defined as:
… a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice. A community of practice is an intrinsic condition for the existence of knowledge, not least because it provides the interpretive support necessary for making sense of its heritage. Thus, participation in the cultural practice in which any knowledge exists is an epistemological principle of learning. The social structure of this practice, its power relations, and its conditions for legitimacy define possibilities for learning (i.e., for legitimate peripheral participation).

(p. 98)

This definition posits a social context to learning that consists of the people and objects that are involved in the practice and their relations to one another and the larger social institution that contributes certain interpretations and forms of knowledge and learning over others. In other words, learning and ways of constructing knowledge are shaped by the positions, roles and relations of the participants in institutional contexts. In a CoP, newcomers are the learners who become engaged in an activity alongside the old-timers who are the master(s) in the practice. Granted legitimacy, the learners participate by moving from the periphery of the CoP toward full participation. It is this legitimacy that informs participants’ patterns of behavior in a hierarchical setting (Monrouxe, 2010). Communities of practice, through the process of engagement, reproduce social practices with “resolutions to underlying conflicts” and they produce and leave behind social historical artefacts and social structures that reconstitute over time (Lave & Wenger, 1991). Artifacts are the necessary constituents and products of learning that augment the reconstruction and transformation of not only knowledge and the object of study, but also the identities of participants (Monrouxe, 2010).
The concept of community of practice is not free from shortcomings. Fuller (2007) stated that learning is an inevitable aspect of the practice and that the theory fails to examine and account for the ways in which power relations impacted learning and participation. Furthermore, by focusing their theory on the learning that occurs for the newcomers, Lave and Wenger (1991) neglected to account for the contributions and even transformation of the old-timers (Fuller, Hodkinson, Hodkinson, & Unwin, 2005). Lave (2009) addressed this critique in a later publication by stating that the intention of the original publication was not to suggest that all newcomers were novices and all old-timers were masters. It has also been noted that the word “community” suggests harmony and common interest among the participants of a community of practice, and as such it is inadequate in accounting for the diverse motivations and intentions in joining such a community (Fuller, 2007).

Wenger (1998) tried to add clarity to the concept by stating that it does not make sense to call any pair or group activity a community of practice. On the contrary, in identifying a community of practice, we need to explore the perspective underlying the concept of practice (p. 122) and to articulate “to what degree, in which ways, and to what purpose it is (or is not) useful to view a social configuration as a community of practice” (p. 122). In brief, practice must entail aspects such as mutual engagement and a product created out of the mutual engagement before being regarded as a community of practice.

Lave and Wenger (1991) described five cases of communities of practice that contained learning as participation. First, they referred to a group of Yucatec midwives who moved “over a period of many years, from peripheral to full participation in midwifery” (p. 67). The daughters and the granddaughters of the midwives accompanied them informally when they were delivering babies. They also had other midwives help them deliver their own babies. After
decades of observing and accompanying their elders, the then daughters and granddaughters were given the legitimacy to practice midwifery (Jordan, as cited in Lave & Wenger, 1991).

Second, in the Vai and Gola tailors’ communities of practice, the child apprentices joined a community of tailors “located in commercial areas” (p. 69) and provided labor in exchange “for opportunities to learn” (p. 70). The apprentices learned at first “to make hats and drawers, informal and intimate garments for children” (p. 71) and then advanced to making “external, formal garments, ending with the Higher Heights suit” (Lave, as cited in Lave & Wenger, 1991, p. 71).

A third community of practice involved that of the navy quartermasters, and the apprentices moved from peripheral to full participation in plotting the position of the ship (Lave & Wenger, 1991). Some apprentices had received specialized training before joining the quartermasters and some but most of the learning occurred “primarily on the job” (Hutchins, as cited in Lave & Wenger, 1991, p. 73).

The fourth community of practice was a certificate program by the meat cutters union in which butcher apprentices received training on the job (Marshall, as cited in Lave & Wenger, 1991). Lave and Wenger (1991) referred to this study as a practice in which the apprentices were prevented from proper learning. This program included teaching, using a textbook, and conducting exams. Nonetheless, the material taught and tested was irrelevant to the skills needed in working in butcher stores. Additionally, in some stores, the apprentices were physically positioned in a place where they would conduct tasks other than meat cutting, and were prohibited from observing the act of cutting the meat that was a key skill in the butchery occupation. On other occasions, the apprentices were kept in the same position and given the same tasks for years before they could be replaced with newcomer apprentices.
The four communities discussed so far were focused on the practice of an occupation. Lave and Wenger (1991) described a fifth community that was focused on the reconstruction of identities: in Alcoholics Anonymous (A. A.), the participants grew from being a “drinking non-alcoholic” to a “non-drinking alcoholic” (Cain, as cited in Lave & Wenger, 1991, pp. 80-81). This reconstruction of identities signified a person who had first been a non-alcoholic in the past, who then became dependent on drinking (hence a drinking non-alcoholic), and who last chose to participate in A. A., to become sober and to become a non-drinking alcoholic. This person reconstructed her or his role by participating in storytelling sessions with other non-drinking alcoholics and by encouraging others, with a similar past, to join this community.

The CoPs described by Lave and Wenger (1991) were studied ethnographically. In examining communities of practice, Lave and Wenger (1991) dismissed formal educational contexts and their attributes as communities of practice (Fuller et al., 2005). Even when aspects of formal education existed in a CoP, such as the certificate program in butcher stores, they (textbooks and exams) were viewed as impeding learning. Investigating learning in an educational context where teaching is involved is an area that is missing from Lave and Wenger’s work and needs separate examination (Fuller et al., 2005).

Furthermore, Lave and Wenger’s (1991) book mainly drew examples from apprenticeship relationships in remote areas and it did little to explore community of practice in contemporary urban occupational institutions. Wenger (1998) addressed this by analyzing relationships in an insurance office as a community of practice. This community consisted of claims processors who, using phones and telephone conversations, followed and managed insurance claims by clients. The claims processors were ranked (from level 4 to 6), and according to their experience and seniority in the office they would move up from lower levels to
higher levels advancing their position in the community from a newcomer toward full participation. A former claims processor was even promoted to a supervisor or a manager in the office, which would allow them to join other communities such as the management team or the board of directors (Wenger, 1998).

Wenger (1998) dedicated an entire book to discuss the community of claims processors as a community of practice and the identity and the situatedness of the claims processors as they moved between levels. In spite of the exhaustive analysis provided for the claims processors’ community, it seemed that Wenger (1998) was inconsistent in keeping up with the terminology of community of practice. Earlier in his book, he wrote that any community was a community of practice (Wenger, 1998, pp. 6-7). In discussing his example of the claims processors, Wenger (1998) used the term “community of practice” to refer to other communities to which the claims processors belonged (e.g., their families, the management team) without necessarily examining those in the way he had done in examining the claims processors’ community. This was inconsistent with his later position in the book that emphasized analyzing the underlying practice before calling it a CoP.

Another shortcoming of the concept of the community of practice by Lave and Wenger (1991; 1998) is their treatment of newcomers and old-timers which seem to suggest that the former are novices and the latter are experts. The literature that has applied these concepts in pedagogy has found that those considered as newcomers are dissimilar and those considered old-timers are dissimilar in their forms of participation (Fuller & Unwin, 2004). This literature has found that newcomers at times have participated more as old-timers in certain tasks compared to those that are considered old-timers.
2.2.2 Participation and identity

Participation is “the social experience of living in the world in terms of membership in social communities and active involvement in social enterprises” (Wenger, 1998, p. 55). It is important to note that participation does not entail only passive presence such as listening or reflecting alone; rather it is “a complex process that combines doing, talking, thinking, feeling, and belonging” (Wenger, 1998, p. 56). This is consistent with an understanding of identity development that holds that identities are not to be considered as “fixed cognitive schemas” (Monrouxe, 2010, p. 44) rather as what people “do” while interacting with other people in a social context. In this way identities are transformed constantly in a non-linear and recursive manner (Monrouxe, 2009).

Active engagement using articulated language and producing concrete objects or abstract meanings are key to participation in communities of practice (Monrouxe, 2009). Also unique to participation in communities of practice is “mutual recognition” meaning that “when we engage in a conversation, we somehow recognize in each other something of ourselves, which we address” (Wenger, 1998, p. 56), and it is through the mutual recognition that our identity is shaped. The relationship among people in this mutual engagement is not necessarily equal. It may involve hierarchies and different power positions (Lave & Wenger, 1991).

A key concept in the theory of situated learning is legitimate peripheral participation, which means that the “learners inevitably participate in communities of practitioners and that the mastery of knowledge and skills requires newcomers to move toward full participation in the sociocultural practices of a community” (Lave & Wenger, 1991, p. 29). Lave and Wenger (1991) argued that legitimacy and peripherality are intricately related to the notion of power and may entail varied ways of participation that render a participant powerful or powerless in engaging
within a community and in relation with other communities of practice. A participant may have legitimate peripherality in participating in a community of practice but may, at the same time, be prevented from fully participating in a community of practice.

This point gives a rather equivocal sense to the term “peripherality.” It suggests that peripherality can be both a positive and a negative position. This equivocality does not help a researcher to articulate a clear understanding of roles in a CoP. Wenger (1998) tried to address this ambiguity by keeping peripherality as a positive notion related to varied ways of productive engagement, and instead discussing the interaction between participation and non-participation as key to legitimate participation in a community. Understanding non-participation helps us understand our participation (Wenger, 1998). When the two interact with one another, they can create identities of either peripherality or marginality. In peripherality, “some degree of non-participation is necessary to enable a kind of participation that is less than full” (p. 165). An example of peripherality is when a health professional student observes a clinical encounter between a clinician and a patient for the purpose of learning (peripheral participation). In marginality, non-participation hinders participation (for example, when the student is requested to be absent from the encounter). It is important to keep in mind the positive sense that the word “periphery” has in this context and not to assume a literal meaning to it as found in the dictionaries. This dissertation uses the meaning of periphery as enabling productive participation and learning to discuss the varying forms of participation in later chapters.

Participation entails the presence of a person, what they say and do, and how they interact while being mutually engaged in their CoP. Wenger (1998) juxtaposed the process of participation with reification as “the process of giving form to our experience by producing objects that congeal this experience into ‘thingness’” (p. 58) such as in creating a protocol, an
artefact, or a tool. This form is used as a base for negotiating meaning for the participants of the community. It may also be used and applied in other communities and in other points in time which gives a historical presence to the object or form. Wenger (1998) distinguished participation from reification by stating that in participation “we recognize ourselves in each other” and in reification “we project ourselves onto the world” (p. 58). According to him, “any community of practice produces abstractions, tools, symbols, stories, terms, and concepts that reify something of that practice in a congealed form” (p. 58). Examples of reifications can include journals that we write out of our experiences, agreements that we create and sign while collaborating with others, or an article of law that is used as a reference for resolving problems or maintaining one’s rights.

The focus on a social context has raised some critique about the meaning of participation and how it leads to learning. Edwards (2005) criticized Lave & Wenger’s (1991) explication of participation that focuses too much on the construction of knowledge in a social world and neglects acquiring, storing and applying of knowledge by the individual. Furthermore, Edwards (2005) argued that the theory does not explicate “how new knowledge is produced” or “what is learnt” (p. 57). Edwards (2005) further argued that Lave and Wenger’s conceptualization of learning deviates from the way learning was conceptualized in Vygotsky’s sociocultural theory: the interplay between the environment (social) and the mind (cognition). She wrote that understanding learning becomes only possible by analyzing cognitive information that is being exchanged in social interactions. She argued that these forms of analysis would allow a solid research on pedagogy that she defined as “the study of teaching and learning” (p. 58) as one unit.

Participation in social practices inevitably brings about developing new identities defined as “long-term, living relations between persons and their place and participation in communities
of practice. Thus identity, knowing, and social membership entail one another” (Lave & Wenger, 1991, p. 53). Membership in a community is about the competence of a person (Wenger, 1998). When a person is a member of a community, he or she has a unique position in that community. The community is a familiar territory for them, and they know how to manage their way in the community to which they belong (Wenger, 1998). They know what they are capable of doing and what they are not capable of. All these show their competency in the community in which they belong and this competency manifests itself in mutual engagement, joint enterprise and the shared repertoire of the community (Wenger, 1998). In mutual engagement a participant is viewed, respected and included in the community in their unique ways. In the joint enterprise, the person is accountable to the role that they have in relation to their community. And in the shared repertoire, they access and use the resources of the community in their own ways and within their trajectories.

Identity is entangled with learning, situatedness and peripheral participation in a practice. In other words, identity is constructed and reconstructed as a function of participation and learning in a practice and the relationships among people and their positioning in a community of practice. Identity develops via the negotiation of meaning and of self through participation and reification (Wenger, 1998). Negotiation of meaning is defined as producing meanings that “extend, redirect, dismiss, reinterpret, modify or confirm – in a word, negotiate anew – the histories of meanings of which they are part” (Wenger, 1998, pp. 52-53). The label that a person has in a CoP (such as a nursing student, or a teacher) is a reification of an identity; however, identity is much deeper and more complex (Wenger, 1998) manifested in different forms of participation and forms of membership in a social and historical sense.
Lave and Wenger’s (1991; 1998) illustrations of identity solely focused on identities as they transformed in a given practice. They did not explain what the learners brought from outside and from the past that informed their developing identities as whole persons (Fuller et al., 2005). By focusing on learning in one community of practice, they neglected the role of other communities to which the learners belonged. The personality of a person, her or his other communities, the way he or she interacts, the way he or she is known by others may show a complex and non-static identity than that of a label. In this light, identities not only are developed in relation to other people, but also are shaped by a person’s “personal, emotional and cultural stories” (Monrouxe, 2010, p. 44).

Identity is also discussed in relation to motivation on the part of the apprentice to practice “a specialized occupation” (Lave & Wenger, 1991, p. 92) and to become a master practitioner. In this view, old-timers in a CoP are “adept practitioners” (p. 110) and the newcomers are part of a “community of practitioners” (p. 110). They are on their way to take the role of the master practitioner. Change is a key concept in legitimate participation. Through the social practice, a person is “transformed into a practitioner, a newcomer becoming an old-timer, whose changing knowledge, skill, and discourse are part of a developing identity – in short, a member of a community of practice” (p. 122).

Though Lave and Wenger (1991) illustrate the transformation of identities to master practitioners by explaining several case studies, the hypothesis that the change of identity in a community of practice entails acquiring the identity of a master practitioner needs further scrutiny. By drawing the attention to the ultimate result of identity change, Lave and Wenger (1991) gave little importance to the process of transformation which may or may not result in acquiring the identity of a master practitioner. The question is left as to what happens to the
identity of the apprentices who do not become master practitioners despite participating in a craft. Does their identity stay the same as the time they entered their CoP? Does not having the identity of a master practitioner suggest that their identities never went through any transformation? Later this dissertation shows instances where reasons other than becoming a master drive the motivation of the learners.

2.3 Community of Practice and Identity in Health Professional Literature

Having foregrounded the literature on the theory of situated learning, it is time to examine how its key concepts are used in the health professional literature. This section discusses research conducted using the concept of community of practice in the health professions practice and education. This discussion is important because it relates to the theoretical framework that this study uses.

2.3.1 Community of practice in health professional education

The concept of community of practice has undergone an evolution that consists of several iterations in application of the theory (Buckley, Steinert, Regehr, & Nimmon, 2019). This evolution began by learning as an in situ social process. While the theory was introduced in the 1990s (Lave & Wenger, 1998; Wenger, 1998), some concepts have evolved and been added to the theory over the years such as transfer and knowledgeability that was discussed earlier (Ewertsson et al., 2017; Omidvar & Kislov, 2014; Wenger-Trayner & Wenger-Trayner, 2014).

More recently and particularly in the health professional literature, community of practice has taken up an instrumental focus which concerns the ways “to develop, cultivate and sustain a community of practice for the purpose of supporting individual and collective learning and innovation” (Buckley et al., pp. 763-764). Given such an evolution, it was imperative for this
study to explore how the concept of community of practice is applied in health professional education particularly in pharmacy, occupational therapy, nursing and medicine.

A literature search for communities of practice in education in each of pharmacy, occupational therapy, nursing and medicine did not retrieve relevant results for CoPs in pharmacy education and occupational therapy education. The studies in nursing education reviewed CoPs in terms of online learning (Moule, 2006), clinical education (Thrysoe, Hounsgaard, Dohn, & Wagner, 2010), and identity construction (Woods, Cashin, & Stockhausen, 2015). This literature suggests that CoP has been applied homogenously to any group practice and that attention to the situatedness of learning was often missing from the CoP literature. It also highlights that CoP is not about a course, or a term, or a program, rather, about what occurs when people learn something together (Woods et al., 2015).

Most of the CoP studies were conducted in medical education. The CoP literature in medical education focused on students and clinical instructors as the only participants of communities of practice (Chen, Sheu, O'Sullivan, Cate, & Teherani, 2014; Dornan, Boshuizen, King, & Scherpbier, 2007; Yardley, Brosnan, Richardson, & Hays, 2012). Many of the studies discussed the need for more student-centred communities of practice and less instructor-led practices (e.g., Chen et al., 2014). In this regard, Chen et al. (2014) stated,

As newcomers to this community of practice, students start at the periphery and embark on an inbound trajectory over the course of their training during which they occupy increasingly central roles leading to full participation in the profession. The more meaningful and valued the students’ contributions to the community of practice, the greater their engagement and learning. (p. 137)
Based on this quote, being a newcomer or old-timer in a CoP affects the level of involvement from periphery to full participation. The newcomer to a CoP has less or no experience in the subject matter and begins participating at the periphery of CoP. The task of the newcomer, in this case the student, might include observation of and assistance to the more experienced participants. As they gain experience in these activities and acquire more skills, students are ready to engage in new experiences and their participation grows from peripheral toward full participation.

It seems that in the model of CoP in medical education, roles are limited to instructors and students. Medical students who enter a community of practice, gradually acquire and enhance their medical skills in participation with mentors (e.g., Zimitat, 2007). In this model, the students are the newcomers and they gain legitimacy as they take up various roles and responsibilities in the CoP. It appears that the community of practice in the medical education literature implies a linear relationship between the students and the instructors. When the former enhances their participation, the latter recedes in participation. This dynamic seems to reflect the inefficiency identified earlier in relation to the role and contribution of each of newcomers and old-timers in the theory (Fuller & Unwin, 2004). This perspective is narrow to the extent that it does not help explaining how learners evolve as they make their progress in a community of practice.

Indeed, in their systematic review of the application of the theory of situated learning in health professional literature, O’Brien and Battista (2019) found that the majority of the articles applied the theory in their studies in superficial ways “with limited acknowledgement of the purpose, stance, technical terms, and scope of the theory” (p. 19). One example of superficial dealing was to introduce the theory at the beginning and end of the article with minimal analysis.
of how the theory informed the interactions of the participants of the CoPs (O’Brien & Battista, 2019). This gap demands a different way of asking the question and examining the concept. One way to ask such a question is to examine and to understand the developing professional identities of the students (Burford, 2012).

Furthermore, the studies of CoPs in education are also narrow in the sense that they almost entirely disregard patients and their role in education. The word patient is occasionally used to refer to a person for/about whom the CoP is operating (e.g., Grealish, Bail, & Ranse, 2010; Zimitat, 2007). Even in the studies that advocate patients’ presence, patients are passive participants around whom a CoP is created. For example, patients have been referred to as the “boundary objects” (p. 119), “locus of activity where participants [clinical staff] interact” (p. 112), and as the “site” (p. 112) for student learning (Egan & Jaye, 2009).

By comparison, the CoP literature in nursing education emphasizes the social nature of learning and shared construction of knowledge. This is different from the way CoP is conceptualized in medical education taking into account only the students, instructors and the relationship between the two. This relationship is linear because it suggests that with the increasing participation of student(s), the role of the instructor decreases. A linear perspective toward a CoP is simplistic and it takes away the transformative nature of the practice by overlooking other components that constitute a CoP such as the artifacts, identities, evolving relationships, varying forms of competence and participation, and all participants including patients who are affected by educational outcomes.

Lave and Wenger’s (1991) concept of community of practice has been treated at its face value and less in-depth when studying the educational settings and where “teaching” takes place (Edwards, 2005). Specifically, an in-depth analysis of community of practice and identity is
missing from the current health professional education literature. In this realm, it is important to understand the health professional literature using the concepts of CoP and identity. Given the narrow ways in which the concept of community of practice has been adopted in health professional education, it was imperative for this dissertation to look at the original works of the theory and to build anew an analysis of a community of practice through a lens that has been missing from the literature. Such analysis encompasses an interpretive and analytical lens in understanding learning and identity, rather than a “normative and prescriptive one” (O’Brien & Battista, 2019, p. 19) found in superficial uses of the theory. Furthermore, it was important to examine the theory in an educational context given that some literature states that the original works of theory reject studying the theory in formal educational contexts (Buckley et al., 2019). Last, and an important reason for use of the original theory is that this dissertation mainly deals with the question of identity and “becoming” (Buckley et al., 2019) of the students in their community of practice which is the PAT group. An in-depth analysis is discussed in Chapter 5 of how the PAT group in this study operated as a community of practice. This analysis includes discussing the key concepts from the original theory such as negotiation of meaning, participation and reification, and peripherality.

2.3.2 Identity in literature

Identity development in health professional education is gaining ground in recent years. Due to its dynamic and transformative nature, a stable definition for identity in medical literature has shown to be elusive (Monrouxe, 2010). While some literature defines identity as how a health professional perceives himself or herself (e.g., Wilson, Cowin, Johnson, & Young, 2013), other literature extends this definition to how she sees herself and how she is seen by others (Monrouxe, 2010). Warmington and McColl (2017) used these two definitions to distinguish
between “identity” as the personal realization of the self, and “professional identity” as developing in social participation and relation to other people. Other literature differentiates “self” from the definition of professional identity by connecting it to the term “self-concept” as different from professional identity which is more connected to social factors and career trajectories (Johnson, Cowin, Wilson, & Young, 2012). It has been noted that developing professional identities “from the social relationships and organizational and institutional structures that provide context to the professional self is broadly known as socialization” (Wilson et al., 2013, p. 370). This socialization mainly occurs through group and one-on-one interaction with other people as well as support from the community.

Given these definitions, it seems that identity in the medical and health professional literature is defined differently from the way it is conceptualized in the theory of situated learning. While theory holds that identity is the interaction between the individual and the social (Wenger, 1998), the health professional literature puts it into two different categories: identity as relating to an individual’s self, and professional identity as relating to one’s social membership. However, the concept of professional identities as defined in the health professional literature is related to the theory of situated learning in such a way that professional identities entail membership in one’s current as well as previous communities. In other words, professional identity involves “importing previous identities” (Pratt, Rockmann, & Kaufmann, 2006, p. 254) that help a person make sense of their community membership and socialization in developing their professional identities.

My search through the literature resulted in studies that focused on professional identities as well as studies that focused on professionalism. Acknowledging some overlap between the two, it was imperative for this study to distinguish between the two terms. Professional identity
is defined as the way health professionals perceive themselves and are perceived by others in a social context and is achieved in the process of socialization (Monrouxe, 2010; Warmington & McColl, 2017). Professionalism involves “displaying the behavior of a professional” (Wilson et al., 2013, p. 370) that is related to the competencies that are required in health professions (Coulehan, 2005). One example is the CanMEDS framework that strives to achieve standardization in medical education in the face of diversity that it is encountering (Frost & Regehr, 2013). The concept of professionalism can in fact be narrow when concerned with understanding professional identities, because professional identity formation is a process that evolves in various phases of a person’s life (Cruess, Cruess, Boudreau, Snell & Steinert, 2014). These phases include identity of the person at birth and childhood, the various phases of a person’s education, and the culture of the environment where the students are educated (Cruess et al., 2014). Given this rationale, I made the conscious effort to explore professional identities and to avoid discussion of professionalism if it strayed from the research question of the study.

Professional identity is something that “is learned” (Barr, Bull, & Rooney, 2015, p. 333). A social constructionist approach to professional identities contends that the formation of professional identities involves individual, interactional and institutional aspects (Monrouxe, 2010) as professional identities “are contested and accepted through the synergistic internal-external process of identification that is constituted in and through language and artefacts within specific institutional sites” (p. 40). These processes enable an individual to make sense of her or his identities in diverse contexts. Areas such as career calling, hidden curriculum, communication, personality, and discourses in medicine (Clark, 2014; Frost & Regehr, 2013; Gaufberg, Batalden, Sands, & Bell, 2010; MacLeod, 2011; Manuel, Borges, Adcock, & Smith, 2018, Wilson et al., 2013) have been studied to understand professional identity and its
development in health professionals. Of particular interest to this dissertation, there is some literature around the discourses and narratives that influence the developing of professional identities.

Understanding the discourses that exist in health professional education is important in understanding professional identities, as the students rely on these discourses to understand their profession and what it means to be a professional in their health professional programs (Frost & Regehr, 2013). In this process of “sense making” (Monrouxe, 2009), the students come to observe, internalize, accept or resist the discourses that shape their developing professional identities. Discourse is defined as “a system of knowledge or representation that legitimates relations of power and that is held in place by sets of rules and practices” (MacLeod, 2011, p. 376).

Overall, the social discourses and the biomedical discourses in health professional education have been discussed and debated in health professional literature (Frost & Regehr, 2013; MacLeod, 2011; Monrouxe, 2009). Social discourses in health professional education concern the social aspects of learning that include emotions, interpersonal relationships (MacLeod, 2011), motivation (Lave & Wenger, 1991) as well as diversity such as gender, race, religion, social class, heterogeneity and individual experiences (Frost & Regehr, 2013). Professional identities such as benevolence, altruism, humbleness belong to the social discourses (MacLeod, 2011).

The biomedical discourses, also referred to as discourses of competence, concern the biomedical and clinical aspects of education (MacLeod, 2011). These discourses seek evidence, objectivity, and the “right answers” in the face of complexity that often surfaces in practice. In doing this, the health professional needs to carry a “professional demeanour” (Monrouxe, 2010,
that demonstrates confidence, capability, doubtlessness, and “self-assurance” (MacLeod, 2011, p. 380) in practice. Frost and Regehr (2013) extended this definition by referring to the discourse of standardization that is frequent in biomedical discourses and that concerns uniformity, homogeneity, and competency-based learning in education. This discourse suggests that there is a “single uniform way of being a competent professional” (p. 1572).

In biomedical discourses, confidence (self-assurance) is the “mental” state of the professional and capability (know-how, taking action) is the “active” state that they must possess in practicing their profession (MacLeod, 2011). Using the confident and capable identities, the practitioner dons “a cloak of competence” (p. 383) in which uncertainty must be avoided or disguised. The influence of such a discourse has been visible by the kinds of narratives that medical students create in research studies of identity (Branch, 2000; Ackerman, Graham, Schmidt, Stern, & Miller, 2009). One example is the narrative of certainty in medicine (Monrouxe, 2009) in which the medical professional uses medical terminology, objective descriptions and authoritative voice over social concerns.

Similar to the discourses of medicine, two dominant discourses are found to inform interprofessional collaboration: utilitarian and emancipatory (Haddara & Lingard, 2013). The former follows positivist and experimental approaches in finding the best health-care outcomes. This discourse also seeks evidence for the efficiency of interprofessional practices particularly in the involvement of patients. The emancipatory discourse, on the other hand, is concerned with addressing the power relations among the health professionals. The link between the utilitarian and emancipatory discourses is reflected in the dynamic between the biomedical and social discourses. In biomedical discourses, social issues create uncertainty and therefore need to be cured (MacLeod, 2011).
Furthermore, learning within a biomedical discourse may cultivate a hidden curriculum that influences the students’ moral reasoning (Branch, 2000). Hidden curriculum is defined as “learning that occurs by means of informal interactions among students, faculty, and others and/or learning that occurs through organizational, structural, and cultural influences intrinsic to training institutions” (Gaufberg, et al., 2010, p. 1709). In relation to patients, the biomedical discourses to medicine have shown to make the students to objectify the patients (Barr et al., 2015) and to develop adversary attitudes (Warmington & McColls, 2017) toward them. In medical education, these attitudes become particularly stronger toward the end of the medical program (Schrewe, Bates, Pratt, Ruitenberg, & McKellin, 2017). A relevant point was illustrated in a comparison study of the students who had early interactions with patients with the students who mainly learned about patients from lectures and cases (Monrouxe, Rees & Hu, 2011). It was found that the students with earlier exposure had developed a more complex and embodied realization of their developing professional identities using a variety of discourses (Monrouxe, et al., 2011).

While the biomedical discourses encourage certainty, control, and objectivity, they may in fact have an inverse effect on the students. The pressure to be capable and confident has shown to make the students to fear ambiguity (Noble, Coombes, Nissen, Shaw, & Clavarino, 2015), to feel discomfort and to lack confidence in relation to uncertainty (MacLeod, 2011). Noble et al. (2015) investigated pharmacy students’ perceptions of professional identity formation during internships where they interacted with patients. They found that while the university had focused on developing a patient-centred identity among the students, the students’ attempts in practicing PCC were not recognized neither by the patients, nor the doctors, nor through the tasks that they were assigned. The scientist identity, including knowledge of
medication, was strongest and was sought in their internships. The science focus of the identity had contributed to the students’ fear of ambiguity and uncertainty, as well as their perception of inability to deal with complexities of the workplace including unexpected patient interactions. In a study of student residents’ responses to critical incidents during clinical care, Phillips and Dalgarno (2017) found that the students developed identities related to both social and biomedical discourses. However, in decision-making, the students prioritized enacting identities related to biomedical discourses, that of the emotionally detached and scientific professional. O’Flynn and Britten (2006) reached a similar finding in relation to the primary care practitioners. They found that the practitioners used both biomedical and patient-centred approaches to care; however, they believed that practices such as clinical activities and decision making were inherent to biomedical approaches that enabled them to maintain a sense of professional identity (O’Flynn & Britten, 2006).

While some negative aspects of the dominant biomedical discourses as competing with the social discourses have been documented, there is other literature that supports the presence of both discourses as cultivating different professional identities that are unique to each profession (e.g., Clark, 2014). Such a perspective, having in mind the difference between social discourses and biomedical discourses, may explain why communities of practice were conceptualized differently in different health professions—such as the difference between nursing education CoPs and medical education CoPs discussed earlier. The literature on discourses in medicine looked cynically at the dominance of the biomedical discourse in the field of medicine (Frost & Regehr, 2013; MacLeod, 2011). It also emphasized and suggested ways to bring social discourses to education. The question remains as to what implications do the social discourses have in medicine other than fostering patient-centred values. How harmful is the biomedical
discourse really? These questions are important to address in the light of the literature that suggests that different health professions have different worldviews leading to developing different professional identities that in turn are beneficial to patient care (Clark, 2014; O'Flynn & Britten, 2006). Different discourses offer different forms of expertise and create “‘interpretive gaps’ … spaces to be filled by the different types of perspectives and contributions from other professions” (Clark, 2014, p. 37) to better serve the patients. It can be inferred from this analysis that the biomedical discourse to medicine, similar to other discourses, is a unique worldview that can offer solutions to some potential problems in health care.

The biomedical discourse of medicine may not be a problem itself, however, the problem surfaces when the paternalistic shadow of medicine overlays the perspectives of other health professions to the extent that the social discourses are regarded as feminine and unprofessional (Hoeve, Jansen, Roodbol, 2014). The biomedical discourse needs to abandon its paternalistic attributes so to allow the social discourses to persist and thrive. One way to address this issue may be to assess and reconsider the processes of belonging and membership in health professional communities at an institutional level. The institutional identity (Monrouxe, 2010), also referred to as the professional identity of suitability (MacLeod, 2011) is the manifestation of one’s professional identity using the language and demeanour learned or assumed in the profession and complying with the implicit and unofficial rules of the institution—behaviors that confirm one’s belongingness to the profession. Longitudinal research helps in understanding the multiple discourses that surface in education and how they shape the professional identities of the students over time (e.g., Monrouxe, 2009).
2.4 Summary

This chapter advocated a move from patient-centred care to patient-centred learning. While descriptions of PCC are mainly drawn from the medical literature, PCC did not seem to have a unanimous definition across disciplines (Kitson et al., 2013). This implies that PCC needs to be looked at from the perspective of other professions as well, because different health professions may focus on different aspects of PCC, and that more interprofessional research needs to be done in the area rather than a focus on PCC as practiced in one profession only (Kitson et al., 2013). This chapter argued that if patient-centred care is to be indeed practiced, it is important that patient-centredness is learned from patients (Bleakley & Bligh, 2008). Therefore, it is important to provide educational opportunities for the students that contain direct involvement of the patients in their learning. This dissertation addresses this need by studying the educational dimension of PCC and doing so in an interprofessional context with the active involvement of a patient in the education of health professional students.

The theory of situated learning (Lave & Wenger, 1991) is helpful in grounding a context in which patients can have a central role in the education of health professional students. The concept of the community of practice (Wenger, 1998) can be used as an analytical lens to examine how the participants interact with one another, negotiate meanings, use and create products by virtue of their mutual engagement. The review of the literature found that while the concept of community of practice has evolved over time, the current applications of the communities of practice are narrow and superficial. They show a linear relationship between the university instructors as the old-timers and the students as the newcomers. Patients are often missing from this encounter and the relationship among the participants are illustrated at a surface level without examining how learning takes place. Given the superficial ways in which
the concept of community of practice has been adopted in the literature, this dissertation intended to return to the original theory and examine its key concepts in studying an interprofessional group involving a patient.

The theory of situated learning is helpful in understanding how identities develop through participation in a social practice. The review of the literature found a difference between the theory that uses the concept of “identity” and the health professional literature that often uses “professional identity.” It found that the professional identities of the students are influenced by different discourses that are present in their education. Two main discourses (biomedical and social) were identified. It was discussed that while both discourses can be present at the same time, it was the biomedical discourse that was mainly encouraged as indicating the identity of a confident and capable professional.

This dissertation aims at understanding the developing professional identities of the students using the theory and the data. In doing so, it aims to address the gaps identified in the literature by studying professional identities that develop in a non-clinical setting led by a patient as teacher. The key findings from both the theory and the health professional education literature are used to explore developing professional identities in an interprofessional group of students.
Chapter 3: Methodology

This chapter describes the methodology used in conducting this dissertation study. First, it describes the researcher’s position given her past experiences and her relationship with the research context. Second, it includes a detailed description of the context of the study. Third, the procedure for obtaining the ethical approval is explained. Fourth, the epistemological stance of the research is explained. Fifth, the research design and methodology are discussed including the recruitment process, the participants, the methods of data collection, and the procedure for the analysis of data.

3.1 Researcher’s Position

When I began my PhD program in September 2010, I did so with many ambitions. Through my education, I wanted to become a better person, to serve the community, and to contribute to the bettering of our world. I wanted to increase my knowledge and understanding of the world. I took as many courses as I could in different departments at UBC and excelled in them. I took on several research and teaching projects during my time there. I published and presented in conferences as any academic does. While I learned and grew from all these experiences, I felt that I was becoming isolated from the community that I had intended to serve in the first place. That is why I also began getting involved in activism. I attended community-based initiatives and participated in causes related to social justice.

My interest in pursuing community-based research emerged from my commitment to social justice. This commitment comes from my personal and professional experiences in observing how differences among people in terms of power and social class are sometimes accentuated in institutions. I was born and raised in Iran and came to UBC as an international
student. Living in Middle East for the most part of my life and coming to Canada as a newcomer, I had a unique perspective that shaped how I positioned myself within this study.

From a personal standpoint, being an ethnic minority in my country of origin, I began realizing power and social class differences from an early age. I have always been sensitive to and cognizant of the different experiences of people with diverse background compared to those of the mainstream. This diversity reflects culture as “a dynamic process that includes language, religion, education, social class and a myriad of other factors that overlap in intricate ways in a person’s life experience” (MacLeod & Frank, 2010, p. 799). As such, diversity may also include differences in terms of sexual identity, ability, health condition, and age. All of these differences, for better and worse, socially shape the identities and experiences of people in relation to how they perceive themselves, as well as how they are perceived by others. Groups of people who are different from the mainstream may be socially marginalized and subjected to discrimination.

I also witnessed power differences in institutional contexts. One such hierarchy may exist between patients and health professionals in health professional education. In traditional medical education, patients are used as objects of study. I experienced this both being a child patient in a teaching module and as an adult when I occasionally accompanied my cousin to her medical school. I also witnessed discriminatory experiences in health providing institutions. For example, I witnessed an incident in Vancouver in which security guards dragged and pushed a woman outside of a hospital. I did not know the circumstances that led to the incident, but such observations made me wonder what makes a human being treat another human being in this way. I think that the woman deserved to be treated with dignity no matter what the circumstances were.
From a professional standpoint, this study was informed by my work experience in the community, and my education and research at university. In my first professional experience after coming to Canada, I volunteered and worked with immigrant and refugee communities. In these experiences, I learned that good health was not necessarily the direct outcome of health provision and services. Rather, health outcomes are affected by age, ability, history, place, and the socio-economic and sociocultural background of the individuals. In my work in a community health centre, I conducted an evaluation of the effectiveness of our community outreach programs on the mental health of immigrants and refugees. The results of the evaluation showed that the factors mentioned above persisted in shaping and influencing participants’ mental health, access to health care, and overall well-being.

My work with refugees was a turning point in my outlook on life. I was an adult who had grown up in favorable life conditions and had smoothly reached the status of a PhD candidate. At the same time, I was working with adults who had spent a lifetime in war and trauma that I had not experienced. As I went to a welfare agency with a refugee woman to translate and bargain to reduce the payment of an electricity bill with the welfare staff, I thought about the socioeconomic disparities. I questioned these disparities even more, as I followed the case of an 18-year-old man who had not completed any schooling in his lifetime—because the life conditions and the school in his refugee camp in the neighboring country where he lived, did not accommodate him as a child with a developmental disability. I wondered if the only thing that I shared with my refugee clients was the language that I used to speak with them. I questioned why there was such a large gap in access to life amenities between human beings who are supposed to have equal rights. I thought about the conditions that had positioned me as the expert, the educator, and the helper, and my client as the beneficiary service receiver.
In line with these values, I believe that the experiences of community members are assets that can help the health care system to respond to their health concerns. One step in utilizing these assets is to reform the way that health professionals are educated. Universities, at the present, may be elitist places in many respects. My vision is that universities will become even more inclusive and responsive places that embrace diversity and that welcome the perspectives and voices of community members and citizens regardless of their social class. I am content that through my work in this dissertation, I was able to contribute to the literature around patient-centred learning, and to add new insights on how learning occurs when students learn directly from a patient as teacher.

3.2 Context: Patients as Teachers Program

My commitment to social inclusion and advocating for the voices of those who are most marginalized, compelled me to seek a research context that encouraged inclusion. In doing so, I chose to conduct my study within an interprofessional and longitudinal educational program at university that brought together students in the health professions with a patient with a chronic condition. The goal of the program was for each group of the students to learn from a patient that led the group. Using this structure, this program pursued a number of objectives. First, by having patients as the teachers, it defied the assumed role of the patient as a passive service user. Instead, it recognized patients as “experts by lived experience” who could teach health professional students about an illness or health-related condition. Second, it sought to foster interprofessional learning and team-based collaboration among future health professionals: a competency increasingly encouraged for educating practitioners. Third, by allowing direct patient-student interaction, in the absence of academic instructors, the program offered a safe space for patients as teachers to share their experiences in their own ways and for students to ask
“stupid” questions (Terrien & Hale, 2014) or questions that may not be valued in biomedical approaches to instruction. Fourth, this program allowed the students, or future health professionals, the opportunity to have a continuous and long-term relationship with patients, a characteristic necessitated by today’s demands for chronic care management. This section describes the context where the research was conducted. Abiding by the ethical principles to protect the identities of the research participants, the specific geographical location of the research is undisclosed. Throughout this dissertation, pseudonyms are used for all of the research participants, the universities and hospitals, the neighborhoods, the cities, and the regions. The study was conducted in the province of British Columbia in Canada.

The study was based at the West Gardens University in the Sunnyside region of the province of British Columbia. The Sunnyside region included cities and neighborhoods such as Oakville, Newtown, Uptown Suburb, Lower Valley, Eastbourne, Sunhill, the Upper Valley, Downtown, the Urban Core, and the West Suburb. The health services and hospitals in this region included Central Health, the West Suburb Mental Health team, the Downtown Mental Health team, Bellevue Hospital, Edgewater Hospital, Sunnyside Hospital, and West Gardens Hospital.

The Patients as Teachers (PAT) program was embedded in the curriculum of several health professions in the West Gardens University. The participating health professional programs in the cohort of September 2014 to December 2015 included: nursing, occupational therapy, physical therapy, medicine, audiology, speech language pathology, dentistry, kinesiology, genetic counseling and pharmacy.

Each group in the PAT program consisted of four students from different health professional programs. These four students worked together with a teacher who was a carer or a
person with a chronic health condition. The program was designed so that the students learned with, from, and about their teacher in a patient-centred learning experience (Bleakley & Bligh, 2008). Typically, the teacher was recruited through referrals from community organizations or personal connections with the program. The recruitment also took into consideration the patients’ ability to communicate and have a shared mission with that of the program organizers of educating the students.

In this program, and throughout its meetings, the teacher shared her or his experience of living with a chronic condition or taking care of a person who had such a condition. According to the PAT Handbook, the teacher shared her or his experiences with the health care system, how the illness impacted the teacher’s life, and how the teacher perceived life under such circumstances. The impact of the disease was discussed in relation to how it influenced the family of the teacher, and/or their occupation and lifestyle. The experience with the health care system ranged from the teacher’s access to resources, information, and care facilities, their relationship with health care professionals, and the nuances that arose in these experiences such as usage of language and terminologies that tends to be different for patients and health professionals (PAT Handbook, 2014). Toward the end of the program, the teacher talked about the progress of the illness and how it was impacting their life.

The location for the meetings was decided by the group based on comfort and accessibility for all members; thus, the meetings occurred at the university, community organization sites, and patients’ homes (PAT Handbook, 2014). After each meeting, each student was required to write a reflective journal of their experience. In these journals, students wrote about the key highlights of the meeting and what they had learned in it (PAT Handbook, 2014). The students also wrote critically about their own assumptions as health professional students.
and how these assumptions were challenged and influenced after their interaction with the teacher.

The program consisted of six group meetings over 16 months. The meetings occurred approximately in October, November, January and February of the first academic year, and September and November of the second academic year. Additionally, there was a program orientation in September of the first year and a symposium in April of the first year. These two events brought together in one place all of the students and teachers, supervising faculty, and the steering committee of the program (see Figure 3.1).

![Program Timeline and Activities of the PAT Program](image)

**Figure 3.1. The Timeline and Activities of the PAT Program**

### 3.3 Ethics

An application to the research ethics board was made. The application explained the procedure of the study, provided the invitation form and the consent forms of the study, as well as questions to be used in the interviews. After two iterations of provisos, this study was given approval in November 2014 to proceed. The study procedure asked the participants’ permission
to have their meetings audio and video recorded and to access all of the reflective journals of the students. It also invited them to participate in interviews after their last meeting in the PAT program. After the participants gave consent to participate in the study, the data collection began which followed the ethical procedure outlined in the ethics board application, in the invitation letter and in the consent forms. In doing so, the researcher left the room when the recording occurred in order to encourage willing participation. This allowed the research participants to turn off the recording at any time. The participation was completely voluntary, and the participants were free to decide whether or not they wanted to participate in the study. They were also free to withdraw from the study at any time. Two post-approval amendments were requested to the ethics board: one describing the transcription procedure and one for extending the time period of data collection.

3.4 Epistemological Stance

My research is grounded in the epistemology of social constructionism. Social constructionist perspective maintains that knowledge is socially constructed through experience and interpretations. It tends to take into consideration the things that we find ordinary (Silverman, 2007). The kind of research using the eyes of a social constructionist, can be interested in and question the daily experiences that people go through. Human beings in general and research participants in particular do not come to understand the world in the same way. Their understanding of the world relies heavily on the way they experience various phenomena grounded in a social context. This understanding is not created individually; rather, it is constructed in dialectic among the people and the world and its objects (Crotty, 1998). Furthermore, knowledge in a social constructionist perspective is not fixed and absolute. Knowledge changes with experience and interpretation. In this way, an object is looked upon,
through the consciousness of the subject. It is in this dialectic that knowledge and meaning is (re)constructed. As a result, the object “cannot be adequately described apart from the subject, nor can the subject be adequately described apart from the object” (p. 79). Therefore, there is no one objective or subjective reality, nor is it to be discovered. Objectivity and subjectivity together exist in a world that is socially constructed. In so doing, each person in the world engages in a process of intentionality to be a part of this construction. This intentionality makes each of us to consciously have different and unique understandings of the world based on our approach in reaching out to its phenomena, “It is in and out of this interplay that meaning is born” (p. 45). The methods of data collection and analysis selected in this study are in line with the epistemology of social constructionism.

3.5 Design and Methodology

This study was conducted using qualitative research. About qualitative research, Denzin and Lincoln (2005) wrote,

Qualitative research is a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including fieldnotes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. (p. 3)

Qualitative research is rooted in a history of responding to scientific and objective methods of inquiry that dominated the field of research by the mid-20th century (Denzin & Lincoln, 2005). In
a qualitative approach, the researcher “looks for culturally derived and historically situated interpretations of the social life-world” (Crotty, 1998, p. 67). In this approach, the researcher intends to gain insight into the life of her/his participants by analyzing the data within the social and political milieu that surrounds the participants’ lives and the ways that participants make sense of it.

Within qualitative inquiry, there are various methodologies and methods used and suited in various research contexts and informed by the epistemological and theoretical stance of the researcher (Crotty, 1998). Given my epistemological stance, my interest in observing the interactions of the research participants and understanding the sense-making process by the research participants, I selected ethnographic methods in collecting data. In ethnographic methods, the researcher engages with the social world in order to learn about it. The extent of researcher’s social participation (or non-participation) can be variable depending on the research context (Patton, 2002). The methods that were used for collecting data for this dissertation included audiovisual recordings of the meetings (non-participating observation), interviews and accessing the reflective journals of the students.

This dissertation study used ethnographic methods because, first, the data was generated from an authentic program from a naturally occurring source. Second, the study was longitudinal, and the data was collected from the beginning to the end of a longitudinal program. Third, the researcher was a non-participating observer (Gold, 1958; Patton, 2002) as she was not present in the meetings while the conversations were being captured via a recorder. Fourth, the research findings followed ethnographic reporting that includes description of the data as the first phase and then the interpretation of data as the second phase (Patton, 2002; Reeves, Peller, Goldman, & Kitto, 2013).
3.5.1 Participants and recruiting

The number of students in the PAT program for the cohort of September 2014 was about 200. There were 52 teachers and, hence, 52 groups in this cohort of the program. The selection of the participants followed a systematic procedure using a number of criteria. The criteria for selecting the group for this study were as follows: 1) the patient as teacher had at least one year of experience teaching in the PAT program; 2) the selected group included a medical student; 3) the topic of mental health was preferred; and 4) the location of group meetings was within Sunnyside City.

The database of the cohort showed that 20 teachers out of 52 groups had one year or more than one year of experience as teachers. There were 11 groups among these 20 that had a medical student as a participant. The general condition in the groups consisted of a teacher with a movement disorder (one group), a teacher with mental health disorder (4 groups), a teacher with Cerebral Palsy and Asthma (one group), a teacher with Cerebral Palsy and Epilepsy (one group), a teacher who was a carer for a person with a Spinal Cord Injury (one group), a teacher with a transplant (one group), a teacher with HIV (one group), and a teacher who was a carer for a person with Stroke and Aphasia (one group). After applying the location criterion, the selection was narrowed down to two groups that consisted of teachers with mental health conditions. One of the teachers had requested not to be contacted for research purposes. Therefore, one group was selected to be invited to the study. This group consisted of a teacher, a medical student, a nursing student, a pharmacy student, and an occupational therapy student.

I emailed Catherine, the teacher, in November 2014 to invite her group to participate in the study. She asked to meet and talk with me before involving her students. In our conversation, she raised a concern regarding anonymity and mentioned that nobody other than her students
knew about her mental health condition. After I assured her about the procedure in place for maintaining her anonymity, she contacted her students, and as a group they agreed to participate in this study. This process included delivering an official invitation letter for the teacher and the students to participate. After they accepted my invitation, I provided consent forms for the teacher and the students and explained the purpose and procedure of the study. The participants read and signed the forms and returned them to me. Given that the ethics board approval was obtained in November 2014 and the consent was collected in December 2014, the process of data collection and recording the meetings began in January 2015; this corresponded with the third meeting of the group (see Figure 3.1).

**3.5.1.1 Catherine**

Catherine was the teacher in the PAT group. She was diagnosed with paranoid schizophrenia several years earlier. She was a professional working full-time while volunteering as a teacher in the PAT program teaching health professional students about living with schizophrenia. The five participants in the PAT were there together to share and reflect on Catherine’s experience. Due to her diagnosis with paranoid schizophrenia, Catherine had faced several disadvantages in her life.

**3.5.1.2 Nick**

Nick was a nursing student who participated in Catherine’s group. Prior to beginning nursing school, Nick had worked as an aid worker for people with HIV/AIDS. He chose to participate in PAT focusing on mental health because he stated that he hoped to specialize in mental health and to become a street nurse working in the Urban Core.
3.5.1.3 Dena

Dena was a medical student who participated in the PAT program with Catherine. Prior to medicine, she had completed an undergraduate and a master’s degree in science. Dena stated that she had decided to study medicine because her mom was a physician and because she loved being connected to people and working with people through the field.

3.5.1.4 Emily

Emily was the youngest member of the PAT group. She was studying pharmacy. She originally participated in a bachelor of science program specializing in microbiology. After two years in that program, she switched to pharmacy. Being inspired by a family member who was a pharmacist, Emily chose to study pharmaceutical sciences aiming to work in pharmacies in local communities. She stated that she had chosen to participate in the PAT program to learn about a patient’s perspective. The PAT program was an elective for pharmacy students.

3.5.1.5 Nelle

Nelle was a master’s student in occupational therapy (OT) who participated in PAT. Prior to OT, she had a bachelor’s degree in arts. Nelle stated that she had chosen to study OT because she believed that OT tended to both physical and psychological aspects of health, to which she referred as a “holistic approach.”

Table 3.1 lists the participants of the study.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine</td>
<td>The teacher</td>
</tr>
<tr>
<td>Dena</td>
<td>The medical student</td>
</tr>
<tr>
<td>Emily</td>
<td>The pharmacy student</td>
</tr>
<tr>
<td>Nelle</td>
<td>The occupational therapy student</td>
</tr>
<tr>
<td>Nick</td>
<td>The nursing student</td>
</tr>
</tbody>
</table>

Table 3.1
Table of Participants
Table 3.1 summarizes the participants of the study in terms of their names and their roles in the PAT group. Acknowledging that Catherine had a chronic condition and that she was teaching her students about her lived experiences with the chronic condition, the term “teacher” is used to refer to her throughout this dissertation. Using expressions such as “patient teacher” was avoided because it may suggest labeling her as a particular kind of a teacher or less of a teacher.

3.5.2 Methods of data collection

As mentioned earlier, the ethnographic methods for data collection included audiovisual recordings of the meetings (non-participating observation), interviews and accessing the reflective journals of the students. The data that was generated from this process and was analyzed included transcripts of the meetings, the students’ journals, and the transcripts of the interviews. The PAT Handbook and researcher notes were used as artefact that provided interpretive support to the analysis. Table 3.2 illustrates the relationship between the data and the research questions.

Table 3.2
Relationship between Research Questions and Data

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Data generated and analyzed</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How can an interprofessional group involving a patient as teacher operate as a community of practice?</td>
<td>Transcripts of the recordings of group meetings</td>
<td>Thematic analysis of the meeting transcripts, students’ reflective journals and interview transcripts.</td>
</tr>
<tr>
<td>2) How can situated learning in the interprofessional group involving a patient as teacher inform the professional identities of the students?</td>
<td>Student journals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transcripts of the interviews with participants</td>
<td></td>
</tr>
</tbody>
</table>
The first research question warranted the analysis of the PAT group interactions using the theory of situated learning and its key concepts. This analysis was important because the literature in health professional education has been using the theory and particularly the concept of the community of practice in narrow and superficial ways (O’Brien & Battista, 2019). This dissertation intended to address this shortcoming by examining how, “in which ways, and to what purpose” (Wenger, 1998, p. 122) the PAT group made a community of practice using the key concepts from the theory of situated learning (Edwards, 2005; Wenger, 1998). This analysis also discussed the relevance of the original theory to educational contexts (see Chapter 5) that has been cited as a gap of the theory (Fuller et al., 2005). The second research question of the study warranted conducting longitudinal research using ethnographic methods to explore how the professional identities of the students were influenced over time while learning in an educational setting led by a patient. The use of audiovisual and longitudinal research methods has been considered lacking and recommended in health professional education literature (Blealey & Bligh, 2008). Indeed, it was the use of these two methods that helped inform this research in the process of transcription and analysis, and the kinds of interpretations that ensued. Identity being one of the key concepts in the theory of situated learning warrants the use of this theory in addressing the second research question.

Collecting the data for this dissertation was the product of a systematic procedure in which two of the committee members were consulted in informing the steps that were needed to be taken in collecting the data. These consultations spanned several committee meetings before the procedure was approved and finalized. This consultation was important, not only for ethical reasons in relation to the research participants, but also for ensuring that a rigorous procedure was in place in collecting qualitative data. For example, the interview protocol was developed in
consultation with the main supervisor over a period of six months. This included developing seven drafts that were thought through and revised over time before the interview protocol was finalized. This process also included a pilot interview with a medical student who had participated in a previous cohort of the PAT program. After making sure that all the questions were clear and comprehensive, the interview protocol was used in interviewing the participants.

This study used triangulation (Patton, 2002), or the inclusion of a combination of data collection methods, to increase the rigor and credibility of this research. The audiovisual recordings of the group meetings made visible an evolving community over a year-long period of time. The PAT Handbook was used when transcribing the recordings. Researcher notes (memos) were useful in interpreting and making sense of the data over time. Analysis of students’ journals made visible students’ evolving thoughts over time. Interviews directly sought participants’ perspectives on topics related to the research question.

3.5.2.1 Audiovisual recording of group meetings

Given the qualitative nature of inquiry, this study endeavored to collect data naturally and with the least amount of distortion that may have been caused by direct observation. This study first used video and audio recordings of group meetings that occurred in the absence of the researcher. The video recordings were used to facilitate the transcription of spoken data given that the exchanges occurred between five different people. The recordings allowed the researcher to record and observe the immediate context, such as the actions and interactions of the participants. The researcher herself was primarily responsible to set up and turn on the video and audio recorders in the room, after which she left the room. It was at the participants’ discretion to turn off the recorder at any time. The researcher communicated with the group as to when to
collect the equipment. The recordings were transcribed using a transcription convention (see Appendix G) adapted from Schiffrin (1987).

Accessing the PAT Handbook became useful in the process of transcription, as the participants referred to it regularly in their interactions during the meeting. The PAT Handbook was used in order to ease the transcription and also to help the researcher understand the topics the participants were discussing in the meetings. In addition to transcription, watching the audiovisual recordings allowed the researcher to take notes as a non-participating observer of the research site.

Certain ethical principles need to be met while collecting visual data. These include maintaining the confidentiality of the participants in all processes of research, considering and minimizing any harm or discomfort that may occur, having a rigorous consent procedure in place, representing the data authentically, and critically questioning the findings as to whether the data represents what the participants intended (Cox et al., 2014). I made sure that these ethical considerations were followed. For example, the consent forms were given and the data collection process was explained to the participants at the beginning of the data collection. Furthermore, I reassured the participants in every meeting that the data would remain confidential and anonymous. I acted upon this promise by the steps that I took to protect the collected data. I decided to watch and listen to the videos and transcribe them myself without involving any external transcriber or transcribing software. I further anonymized the transcripts by removing proper names and giving pseudonyms to the participants. I stored the data in an encrypted and password-protected hard drive and kept it in a locked cabinet in the research lab. Last, after analyzing the data, I conducted member checking with the research participants in order to assure that my interpretations reflected their voices authentically.
The audiovisual recordings were transcribed shortly after the meetings. The process of transcribing allowed me to create and jot down new thoughts and memos that were developed as the result of listening to the interactions of the participants. While these notes were not directly used as data, they influenced how I viewed and interpreted the data. They also helped me observe my thoughts and understandings of the research as the time passed.

In the process of longitudinal research, the relationships evolve, and the roles of researcher and participants might surpass their boundaries. For example the participants in this study (i.e., teacher and students) who interacted with one another over a long period of time surpassed their initial positions. I looked at these transitions to document changes that occurred in the development and progress of the group as a community. I was positioned as a non-participating observer of the setting. The interactions in the group meetings occurred without my presence. Yet, at the same time, I was present and minimally interacting with the participants when they were exchanging emails. I also participated in an informal dinner meet-up that they had after the PAT program had ended. Throughout the process of data collection and analysis, I wrote notes and memos to be aware of my own biases and boundaries in conducting this research.

3.5.2.2 Students’ journals

All students’ journals from the first day in the program to their last meeting after 16 months were considered and analyzed to document the longitudinal changes that occurred in students’ learning and experience. Reading the students journals also allowed me to “connect the dots” and to understand better the meeting topics that were significant to the students as they appeared in their reflective journals. The students’ journals were valuable sources of data, particularly the journals from meetings one and two that gave insight about occurrences of those
meetings not recorded otherwise given the fact that video recordings began from the third meetings of each PAT groups.

3.5.2.3 Semi-structured open-ended interviewing

The study used a combination of three methods in interviewing. First, the semi-structured interview contained 40 open-ended questions (see Appendices C and D). In this type of interview, a number of questions were pre-determined and the participants were asked the same questions; it was expected that the interview process followed the same pattern and timeline (Patton, 2002). Second, this structure contained a set of questions or topics, and the interviewer drew from these topics to spontaneously ask questions and to probe (Patton, 2002). This kind of interview offered the freedom to the interviewee(s) to respond openly and for the flow of conversation to continue freely within the pre-determined topic(s) (Patton, 2002). Separate interview questions were created within the topic of the research for the teacher and students to allow probing questions pertinent to their role. Sample questions included:

- How does the PAT program fit what you are already doing in your program/profession? (general question)
- What did you learn from your teacher? (question for students)
- What do you try to deliver to your students? (question for teacher)

Third, the interview was artefact mediated. Two different sections on the interview asked questions related to patient-centred care and CanMEDS competencies. In order to ask these questions, I showed the participants documents related to these concepts. The first document showed a table (Appendix E) that contained descriptions of patient-centred care given by Mead and Bower (2000) and Brown et al. (2012). The second document showed the CanMEDS
competency framework (Appendix F). Each of these documents were used to aid the participants to view and to reflect on each of these concepts while answering the interview questions.

The use of semi-structured interviews afforded consistency of questions and answers across all interviews and it reduced the researcher bias. The guided approach to interviewing also resulted in comprehensive and situated answers (Patton, 2002). The interview protocol was chosen to be broad and to contain as many questions as possible to help inform the dissertation directly or indirectly. The interviews contained 40 questions and each interview took between 2.5 to 4 hours to complete. The interview protocol included as many questions as possible that could not only address the research questions but also help me in having a comprehensive understanding of the participants’ perspectives across various topics. Using more questions than fewer helped to offer a deeper insight to the perspective of the participants. Asking many questions in the interviews afforded an opportunity to explore research questions beyond the one addressed here. Also, it is important to note that this dissertation began its proposal with the intention of addressing four research questions that was later narrowed down to the one current question. That is why some questions in the interview protocol do not seem to immediately address the current question. Nonetheless, the analysis of answers to these questions was pivotal in understanding and interpreting participants’ perspectives with regard to the main question of the study. The interviews were transcribed using a transcription convention adapted from Schiffrin (1987). The statements of all of the interlocutors were transcribed as they mutually contributed to the construction of meaning.

3.5.3 Data analysis

In qualitative and naturalistic inquiry, it is indeed difficult to separate between data collection and analysis, as the process of collecting data itself can be an analytic process (Patton,
The act of transcribing the collected data suggests that transcription is “the researcher’s
data” and “a selective process reflecting theoretical goals and definitions” (Ochs, 1979, p. 44). In this dissertation study, transcribing the meeting recordings and the interviews was indeed the preliminary analysis of the data (Ochs, 1979). This was further enhanced by the notes and memos that the researcher wrote in the process of transcription. Before doing any further analysis, I read the transcripts and the journals to familiarize myself with the data. This process helped inform the ethnographic description of the data as the first phase of reporting the findings (Patton, 2002; Reeves et al., 2013). In this part, I describe the software that was used for analysis. I also discuss the analysis procedure that followed the transcription of the meeting and interview recordings.

The qualitative analysis software, ATLAS.ti, was used to facilitate the process of data analysis. I transferred all the data (i.e., meeting transcripts, students’ reflective journals, and interview transcripts) to the software. ATLAS.ti had a convenient platform to code the data, to look and check across different data items and to move easily from one to another. The software also contained features for adding comments and memos or highlighting significant codes. It also contained advanced features that allowed creating links among various codes, quotations, and comments. It also allowed creating network views (visual mind-maps). It had separate management sections for managing each of codes, quotations and comments. The searchable platform allowed me to easily retrieves particular codes, quotations, and comments of interest. Figures 3.2 and 3.3 show images of the software from ATLAS-ti website.

Figure 3.3. Drag & Drop operations (ATLAS.ti for Windows). From https://atlasti.com/wp-content/uploads/2014/10/Atlasti-interface-with-margin-area-Windows.jpg
Thematic analysis was used for analyzing the data. This method, that is congruent with constructionist paradigms (Braun & Clarke, 2006), is defined as “identifying, analysing and reporting patterns (themes) within data” (p. 79). Thematic analysis “interprets various aspects of the research topic” (p. 79). It contains steps including reading the data and taking preliminary notes and ideas, assigning codes, clustering codes into themes, checking the themes against the codes and the dataset, and connecting the themes to research questions (Braun & Clarke, 2006).

It is important to distinguish thematic analysis from content analysis. Content analysis searches for patterns within the dataset, but it does so with a micro-level focus using frequency counts and doing “quantitative analyses of initially qualitative data” (Braun & Clarke, 2006, p. 98). Thematic analysis on the other hand searches for patterns that convey a meaning in relation to the research questions. What is considered a theme “might be given considerable space in some data items, and little or none in others, or it might appear in relatively little of the data set” (p. 82). The key point is that a theme does not search for a proportionate representation of content in the data; rather “it captures something important in relation to the overall research question” (p. 82). Thematic analysis uses both inductive and deductive approaches in analyzing the data. In inductive analysis, the patterns and themes “emerge out of the data, through the analyst’s interactions with the data” (Patton, 2002, p. 453). In theoretical or deductive analysis, “the data are analyzed according to an existing framework” (Patton, 2002, p. 453) which may involve “a detailed analysis of some aspect of the data” (Braun & Clarke, 2006, p. 83) in relation to the theory at hand. In analyzing the data, I began with an inductive analysis working closely with the data in the early phases. Mid-way through and toward the final phases, deductive analysis was added as I checked my codes in relation to the research questions and the theory of situated learning.
I used five phases in the thematic analysis of this study. At the first phase, I read each document while coding according to the way each document was structured. Doing so, in part, helped offer the general outline and organization of each document. For example, each group meeting contained between 30-40 pages of transcripts. Coding the order in which the conversation unfolded in each meeting helped to give an overall outline of what it contained. It showed that each meeting began by the participants socializing and doing a recap of the previous meeting. Initially the PAT Handbook guided the meetings. The meetings then continued with Catherine talking about her experience with the health care system, and then to Catherine’s personal life and how the mental illness had impacted her relationship with other people and what she did to take care of herself. While Catherine was the main speaker in all the meetings, the students were engaged by listening and asking questions. The meetings often ended by participants setting up the schedule for the following meeting or talking about their personal upcoming plans. The analysis at this level was key to understanding how the participants in the group formed relationships and how they navigated their way through their shared community. The interviews followed the structure that was set by the interview questions. They began by talking about the participants’ background, followed by the learning and teaching experience in PAT, patient expertise, patient-centred care and CanMEDS competencies and ended by discussing how the experiences shared in PAT can be brought into education. The general structure of the students’ reflective journals included a summary of what they heard in the meetings and their thoughts about what was shared, as well as the interactions with other participants. This analysis was done until all the data were read and coded once amounting to 55 codes.
In choosing thematic analysis, I needed to clarify my position with regard to the approach and level of analysis. Therefore, the analysis also contained a theoretical, deductive and top-down approach given the research questions and the theory. In doing so, the analysis did not seek an in-depth analysis of the whole corpus of data; rather, those aspects of the data that reflected responses to the research questions given the theoretical framework of the study were analyzed (Braun & Clarke, 2006). The research questions and the theory of situated learning were used as sensitizing concepts (Patton, 2002) that gave lens to the reading and interpreting the data.

The second phase of the thematic analysis included rereading the data and assigning codes to different segments of the data. The analysis at this level, particularly, focused attention to the research questions of the study. This stage included navigating back and forth between the data and the research questions. At this stage codes were merged and some others were split in order to retain the unique sense that existed in the quotations that each code contained. This level also included defining each of the codes that would later prove crucial to the sense-making of the data. The merging and splitting of the codes reduced the number of codes to 51.

The third phase of analysis included grouping codes into “code families/categories” that best described them. Creating code families was helpful in managing the dataset and addressing the multi-faceted nature of the research questions. Four code families/categories were created: 1. Catherine’s life experiences (12 codes), 2. Community of practice (18 codes), 3. Patient-centred care (20 codes), and 4. CanMEDS (9 codes). Some codes were repeated in more than one family. (Please note that the CanMEDS competencies were part of one of the research questions in an earlier version of the dissertation. This question was later removed from the dissertation. Nonetheless, CanMEDS surfaced as a family of codes because of its representativeness across the data.)
The fourth phase of analysis contained a comprehensive review of the data. In separate iterations, I focused on each code family and studied it across all data. That is, the data was once reviewed for codes under Catherine’s life experiences, once reviewed for codes under community of practice, once reviewed for codes under patient-centred care, and once reviewed for codes under CanMEDS. This process was facilitated with the help of a feature in the analysis software that filters all the codes except the ones chosen under each code family. In each iteration, the codes were searched for representativeness across the three types of data. Renaming and reassigning the codes was done when needed; however, through these four iterations, the coding process reached its point of saturation. After looking across all three types of data, 25 codes were found significant and represented across all data types (i.e., meeting transcripts, students’ journals, and interview transcripts).

Toward the end of my analysis, the analysis took a recursive turn meaning that there was an interaction between the inductive and deductive phases of data analysis. The patterns identified from inductive analysis interacted with the concepts used from the research questions and the theory. The concepts used from the theory in analyzing the data included community of practice, learning, identity, participation. These concepts were merged with the codes created in earlier phases that carried meanings similar to these theoretical concepts. As they interacted, they informed, and corroborated (or even dismissed) one another. The very last phase, which was the identification of themes, was the result of a dialectic between the inductive and deductive analyses of the data. The themes that are discussed in depth in chapter 7 are: 1) Institutional positioning enabling patient-centred learning; 2) Multiple ways of learning; 3) Patient-centred learning and health professional experience.
About a year after the final interview, I contacted the participants to set up individual phone conversations to do member checking of my analysis. Catherine, Emily and Dena got back to me and I scheduled phone conversations according to their availability. The phone conversation with each participant took about 30 minutes. I talked about the process of transcription and the ways in which I had interpreted the data. In doing this, I referred to their quotations and explained how I had interpreted the quotations and that I was hoping to represent their perspective. They mainly agreed with my interpretations. Given the large time-gap between the phone conversation and the data collection, they did not always remember what they had said back in time but they liked my interpretations of their quotations. In one instance, Catherine expressed concern about being identified by her profession. I reassured her that I had removed her identifiers, including her profession, from the transcripts. I also promised her that I would not mention or use her profession at any point in my study.

3.5 Summary

This chapter discussed the methodology used in this study. It discussed the researcher’s position, the Patients as Teachers program as the context of the research study, the ethical considerations of the study, and the researcher’s epistemological stance. In relation to the research design, the procedure for recruiting participants, methods of data collection and analysis were discussed.

Ethnographic methods of audiovisual recordings of the meetings (non-participating observation), interviews and program documents were particularly useful in generating the data needed to address the research questions of the study. Furthermore, thematic analysis following deductive and inductive approaches to analysis allowed examining the codes across different data types and in relation to the theory and research questions. Ethnographic methods of data
collection and thematic method of analysis are congruent with the epistemology of social constructionism.

The ethnographic methods tapped into the longitudinal process in collecting the data. It allowed exploring learning and developing professional identities over time. Use of these methods supported descriptive reporting of the data followed by analysis and interpretation. This informs the structure of the chapters to come. Chapter 4 describes the events and interactions of the five PAT group participants from the beginning of the PAT program to its end. It is followed by Chapter 5 that examines how this group made a community of practice in order to address the first research question of the study. These two chapters are then followed by chapter 6 that describes parts of the interviews with the participants that highlight learning for each of these participants that could in turn inform the developing professional identities among the students. The analysis of findings culminates in Chapter 7 that uses the findings from chapters 4, 5, and 6 to discuss the research question of professional identities under three distinct themes.

The report of the findings develops cumulatively from Chapter 4 as the first step in ethnographic reporting to chapter 7 that discusses the themes of the study. As the first step in ethnographic reporting, Chapter 4 describes the PAT group meetings and the interactions among the participants over time. Chapter 5 uses the key findings from the group meetings as well as concepts from the theory to discuss why and how the studied PAT group made a community of practice. Chapter 6 continues the ethnographic reporting of the data by identifying the key findings from the interviews that explored learning for each of the participants. Chapter 7 builds from the discussion from the previous chapters to discuss the themes and to address the research question of professional identities. Chapter 8 summarizes the dissertation and examines the implications of the study, its limitations, as well as suggestions for future research.
Chapter 4: PAT Participants’ Discussions and Reflections over Time

This chapter describes the interactions of the PAT participants from the day they met for the first time to the day they met for the last time. In doing so, an effort is made to follow ethnographic reporting in which data description is the first phase of reporting of the findings. The description consists of discussions (group meetings) and reflections (students journals) that they were having as the meetings progressed over time. Without a transcript for the orientation, the symposium, and the first and the second group meetings, I drew from the students’ journals to describe those meetings. I drew from the meeting transcripts and students’ journals to describe the interactions in the third, fourth, fifth, and sixth meetings. Please note that the transcripts of the group meetings may contain fonts such as italics and full caps. Italics were used when a person quoted a third person or expressed a thought. The full caps were used with emphasized speech (see transcript conventions in Appendix G). The quotations from students’ reflective journals are presented exactly as they appear in the journals.

Before describing the data, I would like to remind the reader of the participants of the group. Catherine was the teacher in the PAT group. Dena was the medical student, Emily was the pharmacy student, Nelle was the OT student, and Nick was the nursing student in the PAT group. I would like to note that the order in which each student’s voice is presented throughout this dissertation follows the meaning and the logical order of the topics. Also, in making this decision, an effort was made not to give power to any particular person by presenting their voice first in every place.

Title for each section reflects the development of events that occurred in the PAT group meetings and students’ journals over time. The sections are titled: 1) September 2014 (orientation meeting): initiation and anticipations; 2) October 2014 (meeting 1): varying

4.1 September 2014 (Orientation Meeting): Initiation and Anticipations

Dena, Nelle, Nick, Emily, and Catherine encountered one another for the first time in the orientation of the PAT program in September 2014. According to students’ journals (J1), Catherine introduced herself to the students and told them that she was going to be their teacher for the next year and a half. The PAT Handbook had instructed the students to write, in their first reflective journal, about what they found surprising in the orientation and what challenges or concerns they anticipated of participation in the PAT program. The students each wrote about the appeal of the PAT program in terms of including a teacher who was a patient living with a chronic condition, and in providing exposure to students from other health programs. The students also wrote about their anticipation of the PAT program and the challenges that they expected to be facing.

Nick wrote, in his first journal, about his previous experience working as an HIV/AIDS outreach worker and a community-based program assistant. Having had that experience, Nick chose to participate in the PAT program to learn more about a person’s lived experience with a chronic condition. Regarding challenges, Nick wrote that he anticipated the program to be “emotionally tough” (L17). He referred to Catherine’s experiences as “an open book” (L18) that he believed would help him learn and prepare as a “future clinician” (L19). He wrote, “The PAT program will help me learn more about this highly stigmatized mental condition, and how will I
be able to support individuals living with chronic conditions when I finish the nursing program” (L20-22). He also wrote that, through participating in the PAT program, he would be able to “work in a multidisciplinary team and learn what other disciplines can do to support people living with chronic illnesses” (L22-23).

About the way she became involved in the PAT program, Dena wrote, “This course is not mandatory for our program but when I heard about the program I knew it was too valuable of an opportunity to pass up” (L7-9). Dena also wrote about her thrill in meeting her group members, “Now that I have met them I feel like I am even more excited than I was before” (L11-12). Dena wrote (J1) that she had never met a person who had schizophrenia and that her teacher was different than what she might have expected, “She [Catherine] has had many encounters with the health care system, both good and bad, and is eager and willing to share them with us” (L15-16). Dena wrote that she was happy to participate in the PAT program early in her career. She reasoned, “so I hopefully will never forget the lessons I learn and I will be able to apply them throughout my practice” (L30-31). About challenges, Dena wrote, “sometimes it may be difficult to know how to respond to the stories that our teacher shares with us, and also to know whether a question is appropriate or not to ask her” (L22-23).

Nelle wrote, in her first journal, how privileged she felt about learning from Catherine. She wrote that she intended to apply what she learned from her teacher in her practice of occupational therapy (OT) “to hypothetical (and one day, real) clients that will become a part of my training and practice” (L13-14). She also wrote about the anticipated learning outcomes in participating in the PAT group, “personal pursuit, available resources, and methods of treatment with respect to my teacher’s past, present, and future will all be fundamental learning outcomes of our time spent together” (L10-12). She also wrote that she looked forward to learning from
“an interdisciplinary team” (L32) that helped her “throughout future interprofessional situations as well as future challenges posed when advocating for clients in mental health” (L32-33). About her anticipated challenges, Nelle wrote that instances may happen when she would listen to her teacher but she may not “truly” (L20) hear her, “While I don’t expect my level of skill to cause problems, I do anticipate that communication will become easier as I gain more experience” (L23-24). She wrote that the PAT experience would shape her “into a well-versed, approachable, and mature individual” (L30-31). She also wrote that learning about the health system can become a challenge for her, “Solutions to her issues may seem obvious to me, yet prove to be unrealistic as I learn about loop-holes of the system and societal expectations engrained into our practice” (L26-28).

In her first journal, Emily wrote about her interest in learning how, in her role as a pharmacist, she could help her patients and collaborate with other health professionals. She also wrote that she was excited to learn about schizophrenia, a condition with which she was unfamiliar. She also wanted to learn about Catherine’s experience in the “medical system” (L5). She wrote that the “inside perspective” (L7) that she would learn from Catherine would be different from what she “would read in a textbook” (L7-8). She also wrote about her anticipation of collaborating with and learning from the other health professional students in her group. She was particularly interested to learn about the OT, a profession of which she did not have “the best grasp” (L11).

**4.2 October 2014 (Meeting 1): Varying Perspectives**

The first PAT group meeting occurred in October 2014. The topic of the session was the use of words. The PAT Handbook suggested that the participants have a structured discussion
about words such as “health, disease, illness, disability,” “patient, client, consumer, service user, survivor,” and “normality, recovery, coping, self-management.”

The meeting began by discussing what words different health professionals used to refer to the person(s) for whom they cared. According the students’ journals (J2), in the first meeting, Catherine talked to the students about her experience in the health care system and that she felt powerless when she was referred to as a “patient” (Nick, Nelle, Emily, Dena, J2). The students wrote that they talked in that meeting about the meanings of words such as “client” and “patient.” They discussed that “client” was often used by “dieticians and occupational health care workers” (Dena, J2, L9-10). “Patient,” on the other hand, was used by physicians and pharmacists. Students wrote (J2) that Catherine told the students that she did not identify with any of these terms and that she wanted to be treated as the whole person that she was.

The students also wrote that they learned that they had differing perspectives about the definition of “health.” They wrote that Catherine did not see herself as a healthy person because she was living with schizophrenia. From the conversations of Catherine with her students, it was becoming apparent that the stigma associated with schizophrenia and the fear of disclosure affected how Catherine perceived herself.

Emily wrote in her second journal, “I learned that health, illness and other words mean different things to different people and this is something I should be aware of when working in a pharmacy and in everyday life” (L3-5). She also wrote about her teacher’s experience of stigma with her mental illness and that she could “lose everything” (L34) if she disclosed. Emily wrote, “I was sad to hear this but felt my teacher [had] a very good point and [I] understood her reasoning” (L34-36).
Nick wrote, in his second journal, on Catherine’s perspective of herself as not being a healthy person, “She feels afraid that her life will change if someone knows about her condition. She feels like she will never be able to be ‘normal’ or however society describes the word ‘normal’” (L18-20). Nick wrote that he learned from Catherine that the word “patient” implied “helplessness and being dependent on the health care system” (L7-8). Nick wrote about the implications of what he had learned from Catherine’s story in that day. He wrote that he learned about the importance of language that is used in a conversation and reflected that referring to the patients by their name may result in “positive outcomes” (L23) for people for whom he cared. He also wrote, “Something that I want to take from this meeting and apply it to my future career as a nurse is to listen to my patients” (L33-34). He wanted to listen to his patients because he learned from Catherine that, in the hospital, she “is always asked how she feels and how she is doing but she never truly feels heard” (L35-36).

He also wrote about the specific lessons that he learned from his teacher about schizophrenia. He wrote that “the most interesting” (L10) lesson he learned from Catherine in that meeting, was “her physical, emotional and psychological changes that occur before a psychotic episode resulting in hospital admission” (L11-12) and how “her senses became overstimulated” (L12-13). He added an example about Catherine’s sense of touch, “she reported that the rubbing between her skin and a piece of clothing hurts. She mentioned that other senses deteriorate, such as her vision begins to decline. Reading becomes near impossible and her peripheral vision diminishes” (L13-16). It seems that Nick did not know (or had not read or heard) about the physiological changes that a person with schizophrenia may have during psychosis, and he gained this insight from Catherine’s experience.
Nelle reflected, in her second journal, on the discussion the group had around the use of words and wrote about the implications of what they discussed that day in her own practice. She wrote that she understood from the group discussion that “a ‘patient’ description is often not desirable because of the vulnerability attached to it but that a ‘client’ description can be equally unwelcome as it causes an individual to be labelled in requiring services with an implied power imbalance” (L36-39). She also noted that the “discussions were useful but also difficult because I know it will be challenging to provide positive service for individuals who have such an awareness about the uncertainty of tomorrow” (L40-42). She wrote that she was “unsure about how to effectively level the power differential that is so common between clients and health care providers” (L42-43). She wrote that she was hoping that the placements will help her with this uncertainty and “how to manage such delicate subjects” (L45).

Dena wrote, in her second journal, that the group met in a meeting room in the Faculty of Medicine and that she “made chocolate chip cookies which were a huge hit and were quickly devoured during the meeting” (L4-5). Making and bringing cookies to the meeting may have helped socializing among the participants. In spite of that, Dena wrote that the PAT participants were yet new to the group, and that they did not know what to say at the beginning. She wrote, “I found that the beginning of the meeting was a little bit awkward and because we don’t really know each other we didn’t really know what to say” (L6-7). Toward the end of the same journal entry, Dena wrote, “although the conversation may have started out a little awkward with us not knowing how to begin the conversation quickly gained a mind of its own and Catherine told us about many of her memories and experiences, her lifestyle, and we asked her many questions that we had as well” (L32-35). It appeared to Dena that, as Catherine shared her experiences, the students asked questions and engaged more in the conversation.
4.3 December 2014 (Meeting 2): Journey, Disclosure, Stigma and Uncertainties

The topic of the second group meeting was living with and management of the chronic disease. The PAT Handbook instructed the participants to talk about the life story and the journey of the teacher with the chronic condition and to create a timeline of the teacher’s journey including the key events. The Handbook noted, “unlike other sessions, this one will probably be less of a discussion and more about listening to the teacher and learning from his / her experiences, but nevertheless we hope that you will make it as interactive as possible” (PAT Handbook, p. 13). Given that the topic of the session was about Catherine’s life journey, the students referred, in their third journal entries, to diverse points about Catherine’s journey including her personal and professional life.

According to the students’ journals (J3), Catherine narrated her experiences of living with schizophrenia from the time she was diagnosed with the condition. Nick wrote that it was one Christmas Eve in the 1990s, the night before Catherine was about to fly home, when she had her first episode. She was taken to the West Gardens Hospital and was then diagnosed with paranoid schizophrenia. After that she began losing friends and colleagues once they knew about her condition. She could not work for a few years and was living in group homes for people with mental illness.

Nick described seeing and serving people like Catherine as a “privilege” (L31) and value that he held dear. Hearing the experiences of Catherine created questions in Nick’s mind about the support systems that were available for people with mental illness and whether there were other people like Catherine who successfully re-established their lives after being diagnosed with a mental illness. He also tried to relate these questions to his own profession of nursing. Nick was determined to help people like Catherine and to link them to the available resources “to end
this vicious cycle of mental health and poverty” (L32-33). He also wrote about the importance of having a “strong therapeutic relationship” (L34), and “good communication and trust” (L35) with patients and clients.

In her third journal, Emily wrote that she respected and admired Catherine for how “independent” (L2) she was. She wrote that she was concerned that Catherine’s independence may skew her perspective on other people who lived with mental illness and that she may have high expectations of them in the future. In another part of her reflection Emily wrote about Nelle, “The OT student appeared very interested in welfare and disability programs and had a lot of questions regarding this” (L21-22). She reasoned, “I guess this is because [it] is more relevant to her practice and would contribute to our teacher’s and other client’s quality of life on a broader level” (L22-23). As she indicated in her first journal entry, Emily was curious to learn about occupational therapy.

Nelle wrote that Catherine described to the students how the stigma associated with schizophrenia had impacted her professional life (J3). For example, she explained to them that she felt vulnerable in her workplace given that the governing body of her workplace was trying to add a clause to its professional association membership about the disclosure of mental illness. The clause demanded that the staff who wanted to be members of the professional association needed to disclose whether they had a mental illness. Catherine was uncomfortable disclosing her mental illness to the professional association given the negative experiences she had in the past after disclosing her mental illness. At the same time, she did not want to lie about it either. This situation had created conflict for Catherine as she did not know what course of action to take if the professional association indeed approved and added the clause to its membership mandates. Nelle reacted to her teacher’s situation, in her third journal, stating, “What my teacher
may be legally subjected to disclose at work is despicable” (L7). She elaborated, “This situation takes hard-earned control away from my teacher. She has proven herself to be dependable time and time again, yet this application could put an abrupt halt on her path to [Catherine’s profession]” (L29-31). Nelle troubled the fact that she could not help Catherine in her problem of the possibility of disclosure in the workplace. Then, she tried to connect this problem to her own profession of occupational therapy and asked herself what she could do in helping her clients in similar situations, “I feel like today’s journal entry is particularly bothersome because the matter is out of my hands. As a future Occupational Therapist, I do not understand how I will be able to help in situations like these...” (L39-41). It appeared overall, that Nelle was interested in Catherine’s wellbeing and in the way the mental illness impacted other aspects of Catherine’s life. Nelle also had concerns for her future clients.

In her third journal, Dena recounted Catherine’s dilemma of disclosure in relation to the professional association membership. She also wrote about the story of how she first got diagnosed with schizophrenia, her experience in the hospital and her reactions and thoughts in relation the treatment she received. Dena wrote, “I have the impression that during her time on the street and in group homes that she did not abuse drugs or alcohol and was relatively compliant with her behaviour and medications” (L38-40). She wrote that Catherine was compliant “because she realized that it was the only way that she was going to be able to cope with her illness and get her life back on track” (L44-45). Dena also wrote that she was uncomfortable at the beginning to ask Catherine personal questions that may be related to her mental illness. Dena anticipated asking the questions in following meetings once they became more comfortable in the group.
4.4 January 2015 (Meeting 3): Stability as the Essence of Care

Dena brought in pies and tarts for the third group meeting. Also she was the one person who always booked the rooms for the meetings. The rooms she booked were the same as the ones she attended for the group learning sessions in her medical program. The topic of the day was the “health care team.” The PAT Handbook instructed that first each student describe their profession and its role in the health care team. It also asked that the participants illustrate the teacher’s health care team.

Addressing the first objective for the meeting, Emily volunteered to begin introducing herself. She described her role as a pharmacist to be a person who had knowledge about medication and who could advise patients of the benefits and the side effects of different medications. She mentioned that she was inspired to choose pharmacy by her pharmacist uncle. She said that her uncle had lots of knowledge and that he was the person to whom everyone in the family went for help.

Dena continued by introducing herself. She mentioned that there was “huge diversity in the roles” (L97) in medicine and that doctors, in general, were “taking all the information like the lab tests and clinical symptoms and try to put it together in a story in order to try help the person both treat the illness and the disease” (L100-101). Dena referred to her physician mother and said that she did not know until recently that she wanted to become a doctor. She said that she had thought about following various paths in life from becoming a ballet dancer to a research scientist. She studied psychology in her undergraduate program and neuroscience in her master’s program. She said that she also worked for some time in a science lab doing research and from that experience, she realized that she preferred to work with human beings than the “lab mice” (L120). So, she chose to apply for the medical program.
In introducing his profession, Nick said that the roles of nurses were diverse from elderly care and care for people with comorbidities to acute care. He explained that, following his family members, he studied engineering first, but soon learned that he did not like engineering. He said that after working in the health care system as an outreach worker, he learned about the work that nurses did and became interested in the profession. Working alongside nurses inspired Nick to “want to be them” (L141-142).

Nelle introduced her profession of occupational therapy as assisting people in living their daily life and that included self-care, leisure, and productivity. She mentioned that OTs needed to be creative to tend to the unique needs of each and every individual. She also mentioned what a privilege she had in entering people’s private space to help them with what they needed. In choosing her profession, she referred to the strict way in which she learned belly dancing and the time that she had spent with physiotherapists. She said that having had those experiences, she desired to follow a profession that had a holistic approach to care and health. She found what she was looking for in OT.

After each student introduced herself/himself, the participants talked about the fact that a person is usually inspired, by people close to them, to pursue a profession. The group then returned to the PAT Handbook that offered them instruction as to what to discuss next, “The group should try to map out as a diagram who is involved in the teacher’s care, indicating who is working as a team and who may not know of each other’s existence” (PAT Handbook, p. 15). In addressing the instruction, Catherine mentioned that in fact her psychiatrist was the only health care team that she had. She also mentioned that her psychiatrist was about to retire and that she was concerned about not finding a new psychiatrist because the practicing psychiatrists took severely sick patients under their care and refused to accept high functioning patients like
herself. She said that her only choice would be to go to a family physician to refill her medication. Catherine also talked about mental health services being withdrawn and added, “the issue of the care team that’s out there for people with mental illness is CARING for them and not RECOVERY, and recovery means moving out of the system and recovering into your own independent life” (L236-238).

Nick asked Catherine if she was part of the health care team in the neighborhood where she was living. Catherine replied:

I was with West Suburb mental health team, and I was with THEM until they kicked me out, well, or I left! Or I think it both happened at the same time (giggling) meaning they kicked me out because I was so high functioning, and they said they had to get rid of all the people that are high functioning and I also said I’m not gonna come back, you guys don’t support me to go back to school, so I’m not gonna come back! (L258-265)

She added that the health care system routinely prioritized people who were extremely sick.

The conversation in the meeting then focused on health professionals to whom Catherine needed access. For example, Catherine talked about her need to access a family doctor. According to her, her then family doctor would not listen to her and would rush her in the appointments. In her efforts to find a new family doctor, she faced some road blocks such as privatized services or services that were dedicated to particular groups of patients (e.g., pre-natal care). She also talked about accessing walk-in clinics and, at times, was happy with some of the doctors that she met there. So, it became a norm for Catherine to access walk-in clinics, and if she found a doctor there who met her needs, to visit them again.

About Catherine’s difficulty in finding a family doctor, Dena asked, “What’s the reason, I guess I should be answering this question myself (laughing) did they give you a reasoning”
It seemed that Dena was somehow feeling responsible about the issue given that she was the medical student in the group. The participants continued talking about other reasons such as mis-matched schedules, some doctors choosing to work part-time, and some doctors opting to practice in different locations. Each of the students weighed in with regard to their own experience of accessing family doctors.

The conversation about having a stable care team and an ongoing relationship with one doctor led Catherine to mention how important stability was for her mental “equilibrium” (L498). She talked about how small incidents in her life impacted her equilibrium and the effort she needed to make in order to feel well. She stated:

the holistic approach to things, that I feel and I see it more and more and more that my health care is MULTIFACETED that a mental health specialist is not providing ME with the care that I need and the mental health field is not providing me with the care that I need, that I need all kinds of other stabilities and other issues in place or other areas in place that are supporting me in my health and so it’s not necessarily one-sided, or just go to the mental health profession, no no no, it’s just many other things. (L475-480)

Nick asked Catherine what she did in order to keep her mental equilibrium. Catherine replied by talking about her menopause and taking iron pills, eating organically, and taking control of her diet. She also talked about having an “executive coach,” who helped her “streamline” her life goals and set an agenda and stay on track. She stated, “They give you feedback and they give you ideas but they don’t tell you how to get to the answer. They ask questions and then you have to come to your own answers and your own solutions” (L583-585).

This conversation led Nick to think and talk about the relation between the executive coach and similar services in the health care system. He pointed out case managers who are part
of the health care team and may consist of nurses, social workers, and psychologists. He told the group that the executive coach’s role could be fulfilled by a case manager. Catherine responded that she preferred to stay with an executive coach because to her, it appeared that the case managers made clinical decisions for a person. She preferred the former because the executive coach was separated from the medical world and because she could develop a long-term and trusting relationship with her.

Catherine mentioned that having stability was not just about relationships with health professionals, but also with friends and coworkers. Catherine talked in detail about friendships, how she had to screen people before becoming friends with them, and that she screened people before disclosing her mental illness to them. She said that as she grew older, she realized that time was precious and that she needed to be selective in her friendships. Similarly, she talked about being selective in living the kind of life that she needed. For example, she chose not to listen to the news or to the music so to keep her mind clear as much as she could. She also needed to follow a daily routine that gave stability to her life. Toward the end, the students asked Catherine about exercise, meditation, and spirituality. The meeting ended by the group talking about their schedules and their availability for the following meeting.

The students wrote their journals related to this meeting in their own ways. For Dena, the conversation in the third meeting was “introspective” and helped her “reevaluate many things” in her life. She wrote that she was “getting a lot out of these meetings” and enjoyed learning about Catherine’s “trials and tribulations.” She wrote about “warming up to the group” and looked forward to continuing the conversation with them.

For Emily, the fact that Catherine was “so independent” and that she consulted health professionals only when needed, reminded her that “not all people want help or advice from
health care professionals and that that is their own prerogative.” She wrote that her teacher was “happy and healthy,” so she did not “see anything wrong with this.” She also wrote about the OT student and what new points she learned from her, “When discussing our different professions the Occupational Therapist student mentioned how her profession focuses on a holistic view of someone's health, not just their physical well being and this really struck a cord with our health teacher.”

Nelle wrote in her fourth journal, that she learned from Catherine about “the importance of active listening and creative approaches for care.” She wrote that “client will have different expectations and goals, it will be vital to develop what Catherine referred to as ‘soft skills’: empathy, an open-mind, intuition, and rapport building.” In writing this reflection, Nelle tried to relate what she had learned from Catherine’s story to the skills that she needed to develop in her program. She asked herself, “How often will I actually be able to build a solid, client-centred relationship with clients in a system that is grossly under-funded and focused on acute care rather than preventative measures?” She wrote that she felt “anxious and curious to learn more” about how to adjust her practice “not only to treat but also to understand and implement what prevention looks like for each and every client.”

4.5 February 2015 (Meeting 4): Developing Deeper Insights on Teacher’s Story

The fourth meeting was the last group meeting before Catherine, Dena, Nick, Nelle and Emily met the other PAT groups in the symposium. Catherine started the meeting by reading out a survey that she had distributed in the symposium of the previous cohort. The survey had asked several questions to the symposium attendees about their opinion of people who lived with schizophrenia as well as the issue of disclosure. The survey asked, for example, whether a person with mental illness could be in a leadership position, or if he/she could become a pilot or a
doctor. The survey also asked who had the right to know about a person’s diagnosis with schizophrenia. Catherine was planning to distribute the same survey to the participants of that year’s symposium.

Next, Catherine reached to the PAT Handbook and read out the instructions for the meeting. The Handbook asked the group to recap from the previous meeting, what each participant had learned and the key ideas that they wanted to share. The Handbook also instructed the participants to talk about patient-centred care.

The conversation followed from what they talked about at the end of the third meeting about the need for stability in relationships with other people, friends and health professionals alike. Dena mentioned that the executive coach had stood out for her from the previous meeting. She echoed the importance of having a long-term relationship with a service provider. Catherine said that it was like “preventative medicine” (L157) to build and maintain a relationship with a health professional.

The group continued the conversation about the executive coach, psychologists, psychiatrists and family doctors. Catherine updated the students about her latest efforts in seeing doctors and finding another “really good” (L239) doctor in the walk-in clinic. Catherine commented on her family doctor’s personality, “The only thing she is worried about is my medication … She doesn’t care about lots of other things” (L235-236). From there, the group talked about the reasons why general practitioners behaved differently. They talked about the younger doctors and the more experienced doctors, the personality of different physicians, and whether the doctors’ education and generation had something to do with their perspective today. This topic was of particular interest to Dena because medicine was her anticipated profession. She said that she had similar experiences in her interactions with the physicians in the medical
school. Dena asked other students if this was the case with other health professions. Nick answered that, in his experience interacting with nurses, “99 percent behaving extremely friendly” (L313). He added, however, that he had classmates who were working under nurses who were “rolling their eyes” (L319) when the student asked them questions. Nelle shared her perspective in interacting with the occupational therapists. She mentioned how passionate one of her preceptors was in passing her knowledge to the students.

Next, the discussion took a new direction. Catherine told the students that she had recently been laid off from her job. She then shared her reflections on the job loss. She said that she was not satisfied in that position in the first place and that she saw the layoff coming eventually. Catherine described her experience of losing her job as ending a relationship that was not working. She was sorry that she lost all the benefits that came with having a job, but in her heart, the job was not a good fit for her.

Dena asked Catherine how the job loss impacted her mental health. She answered Dena’s question by comparing the incident with a difficult experience she had a few years earlier. It was the suicide of her boyfriend that was an “emotional roller coaster and really hard” (Catherine, L355). She stayed on high dose until a month after the funeral and went back to her regular dose. She said that she did not change her dose for the job loss because it did not have that big of an impact on her. She also said that she made her own choice with regard to the dose of her medication. She said that her psychiatrist used to tell her what doses to take. However, she later took charge of her own doses and only reported that to her psychiatrist. She stated, “He knows if he says that [what dose to take], I still do what I want… Long time ago he stopped telling me what to do! For anything” (L534-536).
In her reflection about the job loss (J5) Dena wrote about the insight she gained about the complexity of Catherine’s experience losing her job while living with schizophrenia, not only “for the obvious reasons” (L62-63) but also:

for less obvious things such as how there are so many more things there are to consider and evaluate when you are going through a life changing event other than just the life changing event itself [emphasis added]. For example Catherine had to consider her health, whether she was going to have another episode, what she could do to precipitate an episode before it occurred such as taking an increased dose of medications, losing her health benefits and thus having to pay for expensive medications out of her own pocket... and these are just examples of things she would need to consider specifically because of her condition. (L64-70)

She referred to the “less obvious reasons” that made a life with schizophrenia difficult including events that may trigger psychosis, as well as losing a job and its benefits and how it impacted her access to services that were usually paid. Dena added, “As a budding physician it makes me appreciate how important it is to get a patient’s full persona, social, and family history in addition to their medical history when they present to you with a problem” (L76-78). Dena added:

When deciding to disclose Catherine has so many different things that she has to consider before going through with it: (1) how close she is with the person (2) whether the person will change their opinion of her because of her condition (3) whether this person is trustworthy and will keep the information confidential (4) whether the person will treat her differently once they know. (L89-93)
The reflection and observation of the complexity involved in having mental illness was a unique insight that Dena and other students were developing over the course of the PAT program.

Nick wrote, in his fifth journal, on what Catherine shared that day, in terms of losing her job and the “sense of community” that came with it, as well as her problem of the disclosure. He wrote that, from Catherine’s experience in losing her job, he learned that the nurses and health professionals needed to take a holistic approach to care and “to pay attention to the patient’s social wellbeing.” He noted, “As HCP we need to make sure to support out patients to fulfill all their needs: physical, mental and social needs.” In her journal, Emily wrote that she needed to question the assumptions that she may have about people with mental illness, to listen and to understand that each patient has a different story (J5).

The conversation in the fourth group meeting also included the topic of friendships. Catherine talked about her dilemma of disclosure and that she had just found a friend from childhood to whom she wanted to disclose. She was contemplating how she was planning to confide to him without risking the friendship. In her contemplation, she talked about herself as having the sense of being “a damaged good” (L564) because she had this mental illness that she was carrying with herself in every aspect of her life. Nick asked her if Catherine felt that schizophrenia defined her. Catherine answered that she was trying to not let her illness define her, but it was impacting her in every decision in her life. She explained that her personal and professional life, her relationship with friends and colleagues were all impacted by the illness. For example, she had kept the illness a secret from her colleagues. One time, her colleagues at work were having a conversation about people on welfare. Catherine expressed how hard it was for her to keep quiet and not share her opinion with her colleagues. She was afraid that if she
spoke in support of the people who were on welfare, her colleagues would find out that she was once on welfare and that, it may be disclosed to the colleagues that she had a mental illness.

This point surfaced in the students’ reflective journals in interesting ways. Dena wrote about the conflict that Catherine lived: not wanting to identify with schizophrenia but schizophrenia impacted every aspect of her life. She wrote that Catherine really wanted to disclose to other people to have an open and sincere relationship with them, yet, “in the same breath Catherine would also tell you that disclosing is one of the hardest things for her to do” (L88-89). About Catherine’s dilemma of disclosure, Nelle wrote in her journal (J5) that people with visible disabilities did not have a choice in disclosing the condition, but for the people with mental illness, “daily decisions must be made about whether or not they will disclose. They are constantly weighing the pros and cons about keeping their true identity a secret. What a dreadfully exhausting scenario!” (L22-24). Such reflections by Dena and Nelle gave light into a nuanced way in which they had begun thinking about the dilemma of disclosure for Catherine.

Nelle added in her journal: to disclose or not to disclose was a dilemma that a person with mental illness had to address. She added that “a deeper understanding of these questions” (L30) would help her in her OT practice, “I hope that I will be better equipped to help those facing stigma to make confident decisions about disclosure and that I will be a solid source of support when these decisions are causing pain or difficulty” (L30-33).

The group spent the rest of the fourth meeting talking about preparations for the symposium, the materials they needed, and what they wanted to share with other groups about the lessons that they had learned. The fourth meeting ended by scheduling the follow-up meeting, the one in which they were going to prepare their board material and twitter content for the symposium.
4.6 April 2015 (Symposium): Patients’ Experiences and Needs as Different and Unique

The PAT Handbook instructed the PAT participants to have a prep meeting for the symposium and together decide “one key piece of learning” (p. 17) and “other information they want to display on their poster board at the symposium … this could be in the form of photos, drawings, writing, cartoons, newspaper clippings etc” (p. 17). The PAT Handbook described the structure of the symposium as having a closed session for all the groups participating in the PAT program to view and discuss each other’s boards, and then an open house for the public including other students who did not participate in the PAT program.

Catherine, Nick, Nelle, Dena and Emily had dedicated their board to the theme of stigma and disclosure. They also distributed the survey about people’s perspectives on schizophrenia. Nick, Nelle, Dena, and Emily walked around to look at board made by other groups. Catherine chose to stay next to their own board.

Images below show the board that the group had created. It reflected the survey that was distributed to the symposium attendees (see Figure 4.1). It also displayed content regarding disclosure of mental illness (see Figure 4.2). The drawing in the centre of the poster was a general image created by the students, and bears no resemblance to any actual person.
Figure 4.1. PAT Symposium: Poster Prepared by Catherine, Dena, Emily, Nelle and Nick

Figure 4.2. PAT Symposium: Thoughts and Dilemma of Disclosure
The students wrote, in their reflective journals, on the learning that occurred in the PAT symposium alongside other groups that participated in the PAT program. Dena wrote, in her journal (J6), that her group’s board was “stark” (L5) and “barren” (L7) compared to the creativity that she observed in the other boards. She wrote, however, that the topic of her group was “serious” (L6), so the format that they used was appropriate. She wrote that she “learned a lot” (L9) from the other groups about various chronic conditions of which she had never heard. She wrote, “Overall the symposium taught me that there is so much about chronic illness from a patient’s perspective that we are never taught and do not discuss in school” (L19-20). To Dena, learning about a patient’s perspective was something to which she had access only in the PAT program. This kind of learning was otherwise not available in her medical program.

Nelle wrote in her journal (J6) that she was intrigued by the insights and the knowledge that she encountered in the PAT symposium. She wrote, “From mental health conditions to debilitating conditions caused by chemotherapy, there was a wealth of knowledge to be shared and I know I did not grasp the messages from all groups and members” (L3-5). She added that some groups had an interactive component in their presentation that engaged her and helped with her learning. She reflected on her own group’s presentation. She wrote that if she was to re-design her presentation, she would provide a more confidential space for participants to fill the survey.

Nick wrote, in his sixth journal, that in the groups he visited, the teachers had been living a successful life despite their chronic condition. He wrote how insightful it was for him to observe that the teachers had adapted to their life with the chronic condition. Emily dedicated most of her sixth journal discussing the theme that her group had chosen to present in the symposium. Emily wrote that disclosure was the main theme that surfaced throughout the
meetings and conversations with her teacher, as such, it was important to be shared with other
groups. She also referred to seeing other teachers who were living with different chronic
conditions. She wrote that each teacher being “an expert in their own illness” (L22-23) was the
key point that stood out for her.

4.7 September 2015 (Meeting 5): Disclosure and its Reciprocity

The PAT group had their fifth meeting about five months after the PAT symposium.
Dena requested if the group could start the meeting with a debrief from what everybody had
done over the summer. Nick began by telling that he had travelled to his home country for the
summer vacation. Catherine asked him what he had learned in his vacation. He answered that he
learned a lot about kids, and that his experience helped him think whether he wanted to have
children of his own. Nelle and Dena explained that they had each spent their summer vacations
with family and friends in some of the BC islands. Emily had spent her summer doing rotations
and working in pharmacies in the Upper Valley and in the Sunhill City. Catherine talked about
her long summer vacation going on a road trip across some of the American states, as well as an
island in BC.

Once everyone shared their summer updates, the group talked about the symposium. Nick
brought to the meeting the survey responses that he had analyzed earlier. Catherine read over the
survey questions and people’s answers to it. These questions included,

Do you closely know someone with schizophrenia? Do you think someone with
schizophrenia should be in a leadership position? Would you think differently of hiring
someone if you knew they had schizophrenia? Would you think differently about
someone if you knew that they had schizophrenia? Who …has the right to know that
someone they interact with has schizophrenia? Should people with schizophrenia have
guardian? Would you stay with your health care professional if you knew they had schizophrenia? Would you stay in a romantic relationship with someone if you find they had schizophrenia? Do you think it is safe for someone with schizophrenia to be the pilot of a commercial airplane? (L158-205)

The group was surprised that many of responses to these questions were supportive of people with schizophrenia. They reasoned that perhaps the positive responses had something to do with the fact that the respondents did not have a space to put in their responses confidentially, therefore their responses were not completely anonymous. In this regard, Nelle said that it “would be really nice to set up so that there is a little blockades and a couple of different desks so that people can go in and fill up a survey in a more confidential way” (L244-245). She added that she would not be comfortable to be the “one in a crowd of whoever many people were there that filled out the opposite answer for a specific group and especially if I was in the eyesight from someone else who may or may not judge my answer” (L247-249). Other participants agreed with the point.

Then the group talked a bit about their experience of the symposium. Catherine talked about one of the teachers that she knew from her professional network and who she tried to avoid in the symposium, so that this person would not find out about her mental illness. Catherine also mentioned that in talking with some people in the symposium, she felt that she was “OPENING UP too much, revealing TOO MUCH” (L237-238)! She added, “But, I got over it, I just moved on and I was like, whatever. So for me too that I’m more comfortable talking about it and care less about what people think, so yeah, was good” (L238-240).
After discussing the symposium, Catherine read out the instructions from the PAT Handbook. The topic for the fifth meeting was: finding, accessing, managing and sharing health information sources.

In discussing this topic, Catherine mentioned her childhood friend to whom she had disclosed her mental illness recently. According to Catherine, once her friend heard about her illness, he became concerned. Catherine said that disclosing her illness had “set up a whole WHACK of anxiety in him” (L364)! She added that her friend was “shaped by his environment, by his own thoughts, by whatever the media whatever he picked up along the way! And probably what he is gonna read on the Internet, but I feel also the responsibility of educating him right” (L397-400)? Nick addressed Catherine’s comment saying that such reactions often had to do with “ignorance, lack of information, not knowing what schizophrenia is” (L667-668). He also said, “I don’t think that’s your responsibility to do that…something you can do is … I’m not gonna educate you all with schizophrenia but I can provide you information and resources that you can read if you want to” (L668-672). Catherine replied, “Yeah, BUT I don’t trust those information, because that info was probably written by somebody in the health care profession that has only OBSERVED but hasn’t have LIVED with schizophrenia themselves” (L672-674)!

She said that she would instead refer them “to information where the person with schizophrenia talks about themselves and what it’s like” (L674-675).

Catherine also talked about the complexity that was inherent in choosing to disclose and not to disclose the mental illness and how that impacted the person who heard it:

I just wanted to share … about my story and about my EVOLUTION about coming forward and out, kind of really selecting people that I want to talk about my mental illness with, but also taking more risks about, *Oh let’s just talk about it to just ANYbody*
that wants to listen and then, … I have to be prepared about what hooh’s come back! It can be negative, it can be positive, but it can also be something that is IRREVERSIBLE and I don’t know if such a word exists but I can’t influence the other person. That person now worries and probably will always worry about anything right now because he has that additional piece of information about me and which he doesn’t know what to do with and how to digest it but it’s just interesting to me how powerful and influential that information is that I hold inside that I have and that I can actually set off an avalanche of all kinds of emotion in other people when you share something with them. It’s very, very tricky to have this responsibility to kind of figuring out when are you sharing and whether it’s better to just be quiet and because I’M more feeling I wanna get more and closer to people around me so I have to share, but if I don’t share, then I’m never allowed to see who I am because of mental illness and all the stuff that happened has shaped my outlook, and so for them to understand you, they gotta know. (L369-384)

Catherine talked about how intricate it was, the line between not disclosing and disclosing. She wanted to disclose to people so that she could be closer to them. At the same time, she was aware that once she disclosed her mental illness, she did not have any control over people’s reaction, and that she could not take back that secret anymore.

Catherine also said that after disclosing her mental illness to her friend, he also disclosed something personal to her from his life. Nelle wrote about this point in her reflective journal (J7). She described disclosure as the “education” (L23) that Catherine provided “to a friend with no past experience – a pivotal step in normalizing this stigmatized topic” (Nelle, J7, L24-25). She added, “Simultaneously, a friendship was deepened when the act of disclosing was reciprocated by the friend” (L25-26). Nelle also wrote in her journal,
Fear → secrecy → courage → disclosure = uncontrolled response.

This is a repeating cycle that my health teacher faces throughout daily life. Her mental health condition frequently barricades the chain of events at “fear”, but her desire to be honest with loved ones occasionally carries her all the way to “disclosure”. Through disclosing, my teacher has extended a vulnerable hand to the receiver, and with the disclosed information, she faces an uncontrolled response. (L1-6)

In her journal, Nelle had developed a deep insight: that Catherine’s ordeal with schizophrenia began with her fear of disclosure to other people, so she kept it as a secret. Catherine then gained the courage to disclose, however, once she disclosed her illness, she did not have any control of how people reacted to it. Nelle also noted, “Without lived experience it’s hard to imagine how the confines of secrecy could possibly outweigh the freedom of disclosure” (L10-11).

In the meeting, the participants continued the conversation of how the internet could be a bad source for accessing information. In one example, Nick described a situation in which he was trying to locate information about reasons his tongue had changed color. Reading the symptoms and descriptions on the internet he found, “I had like jaundice and I had tongue cancer, and I don’t know how many medical conditions, I was like I think I’m gonna die! (laughter)” (L692-693). Later his doctor had told him that the changed color had something to do with the medication he was taking. Emily weighed in and said that the medication (Pepto Bismol) had side effects and that it changes the color of the tongue to black. This story lead to discussing about validity of sources of information and the need for better knowledge about medication before making conclusions about the symptoms.

The group continued the discussion talking about health professionals as sources of information. This conversation led itself to the discussion of the extent to which a health
professional had a say in making decisions for patients and what personal choices patients had. Catherine mentioned that she felt uncomfortable disclosing her mental illness and her medication to health professionals. She recounted an experience with a dentist who asked her why she took that medication and if she was afraid of needles. She mentioned that in her experience, health professionals wanted to readily access her private information, information that she had to “dig deep to disclose” (L34). She stated that she had a hard time disclosing to health professionals because they were “right in there jumping to conclusions and not really valuating how much that took me to say something … how tricky it is to even say something PERIOD, never mind to health care professionals that I haven’t saw before” (L535-538).

About this point, Emily wrote in her journal, “It reminds me that despite a good education and well researched advice patients make choices for themselves and their autonomy has to be respected” (L17-18). She also wrote, “This made me think about most people’s relationships with Health Care Providers and how they’re always making themselves vulnerable and telling us about themselves but it’s never returned [emphasis added]” (L34-36). Her reflection suggested that Emily learned from Catherine, that sharing personal health information with the health professionals was a private matter; that the patients made themselves “vulnerable” by sharing private information that was “never returned” by health professionals.

This sixth group meeting ended by the group scheduling their next meeting.

4.8 October 2015 (Meeting 6): Strengthening Ties and Separating Trajectories

The PAT group had its last meeting in the October of 2015. The group had decided to have the last meeting in October instead of November as indicated in the PAT Handbook, the reasons for which being that Catherine was going to be out of town for the month of November,
and that Nelle was about to leave to another province to begin a new practicum. The topic of the sixth meeting was “partnerships, collaboration, shared decision making and the future.”

As usual, the group started their conversation with a recap from the participants. Catherine updated the students about her job hunt and recent interviews. She also said that she was invited by the PAT program to interview some of the new teacher candidates for joining the program for the new academic year. She said that she accepted the invite and participated in interviewing the new candidates. She also said that, at the same time, she was not invited back as a teacher in the PAT program, and she expressed how disappointed she was in that decision. The students empathized with Catherine. Dena told her that they can “put a good word” (L23) if that helped with the decision. In her reflective journal after the meeting (J8), she wrote how sad she felt that Catherine was not being invited back to participate as a teacher in the PAT program, and that “another group will not be able to learn from Catherine this year” (L13-14).

Other updates included Dena talking about her school and her extracurricular activities. Nick told the group that he was excited because he had just become a Canadian citizen and that he could vote in 2015 federal election. Nelle talked about her school, work and her partner’s dog that she needed to walk every day. Nelle’s partner was a medical graduate who was having his residency in another province. The group spent a few minutes talking about his practice in internal medicine and rheumatology.

After the recap, Catherine told her students that she finally found a family doctor who was a great fit for her needs. According to Catherine, her new family doctor was “SO knowledgeable and SO down to earth” (L250), and had an interest in mental health. In describing her new family doctor, Catherine said, “she took her time” (L255) and “she asked me all the questions about schizophrenia and stuff” (L255-256), and “she was really interested. We just
talked about mental health because, I could go for long long long time, and she was really curious and asked questions and she wanted to get as much detail” (L339-340). Catherine said that with her former doctor, she felt rushed and not listened to, but her new family doctor listened. Catherine felt that the new family doctor was showing genuine interest in her. In sharing her positive experiences with health professionals, Catherine may have given the students an idea as to what their patients may expect from them as future health professionals.

The group continued talking about possible reasons why family doctors had different approaches in interacting with patients. They discussed and reasoned that the differences were due to different personalities, overbooked schedules, the generation gap and different theories and approaches to education that different generations received. The students discussed, from their experiences, that the health professionals who received their education several decades ago, learned about science and practicing it, rather than ways to relate to patients. Dena said that the system needed to change “from the bottom up” (L391). She said, “you are not gonna be able to come in and change somebody who has been in practice for 20 years … but then you start at school level and say this needs to change, you should start as you enter” (L391-194). Emily said, “you wait for them to retire” (L396). Dena added, “Then the system gradually changes like that” (L397). For the students, it seemed as if many of the experiences that Catherine shared with them were systematic in nature, and resolving the problem had something to do with changing the system.

While the group was discussing their experiences with the health professionals and why health professionals treated patients differently, Nick kept referring to the point that “decisions should be taken together… That it’s a collaboration between patient and health professional to
make decisions together… That should be team oriented, all the decisions” (L373-378). For him collaboration was a key theme in successful patient-health professional relationship.

The group also talked about health and relationship with other people. Catherine talked about her neighbor who was diagnosed with pancreatic cancer. She said that she did not know about the illness and did not know how to interact with her neighbor about that. Dena and Emily filled in and said, “They are normally detected pretty late in the course. It’s one of those you don’t see very early because there is not, all the symptoms [Emily: Typically it’s not … you need your pancreas] it’s dangerous” (L459-461). It seemed that Dena and Emily’s science-based background was helpful in the co-construction of knowledge in this group.

As part of their discussion agenda, the students in the group talked about what was next for them. Nick said that he wanted to become a street nurse “working in Urban Core with homeless people… finding people in Urban Core, to care, the care they need on site! Whatever they need” (L559-560). The group spent some time talking about the street nurses and how they worked. Describing it as a “detective job” (L600), Nick said:

we need to start looking Ok are they covered with MSP? So we need to go online. When was the last time that they went to hospital? So go to the system, so John was in the hospital last week, they are still covered with MSP/

… Find them wherever they are, like could be in the hospital, could be on the street, could be at the bar, could be jail, could be like anywhere. So it’s like really lots of fun. I like that job. So I was doing that but not as a nurse, but as a health care worker, so now I am planning to go at the same job plus the nursing scope. Fingers crossed! (L601-608)
The work of a street nurse sounded new for the group. The other students did not know that such a role existed for nurses. The role seemed so interesting to the students that Dena asked Nick if she could shadow him one day and Nick agreed.

After talking for a while about what street nurses did, the other students talked about their plans. Emily and Dena were going to be in school still. Nelle was graduating in the summer. She was going to do “out of province placements to network there as much as possible” (L629). She was planning to specialize in mental health and eating disorders.

Catherine commented on the unique contributions that each person can make. She also talked about her own contribution. She said, “I supported the PAT program so much because they are letting us have a voice, letting us talk” (L672-673)! She then said that the participation in the PAT program was “just on a small setting but having more of those opportunities to be able to speak to others is really good!” (L673-675). Nick replied to her saying:

whatever you have done in a group of future health professionals. You have changed a lot in the way we think, in the way we collaborate with the patients, so if there is someone like you, putting a little bit of something in four students, then us we are gonna do our part in working with people, whoever, we will be working with like other doctors, other pharmacists or OTs or whatever the profession is. This is what I learned, this is what I want, so this is how I feel, and this is what I think you should be and then we can change other people after what you just put in our heads! Like, for example something that has been in my head a lot, when you said when you were in the hospital, you never felt cared.

When I did my mental health rotation, I asked them How do you feel? What do you want? What do you expect from me? (L678-688)
Nick was moved by Catherine’s comment that perhaps she did not have a big impact by having four students. His answer was accompanied by a passionate voice as to how he disagreed and that the impact of Catherine’s teachings was beyond what she thought.

Related to this point, in her journal after the meeting (J8), Nelle likened her experience in the PAT program to a cycle that patients went through every time they accessed the health care system. She wrote that her teacher “taught and proved to us just how much she has to share about the provision of great care” (L16-17). According to Nelle, the skills and experiences that she learned from Catherine could not be taught “in a book or online” (L21) and that what the students learned from Catherine helped them understand how their future practices looked like. She also wrote, “From within our unique clinical perspectives, we discovered how this may look in our future practices. Collectively, we agree that without this experience we’d be walking into our future professions not knowing how much MORE there is to know” (L17-19).

In her journal, Emily wrote, “I thought in our group our personalities matched our disciplines surprisingly well.” She described Nick as “very talkative and outgoing always encouraging and empowering our teacher,” Nelle as having a “really holistic view of health and wellness,” and Dena as “really interested in the condition itself and took a lot of initiative with asking questions.” She also noted that it was helpful to know what the other disciplines were “learning about and doing” and to hear “the questions they had” for their teacher.

During the meeting and after addressing the objectives of the session, the conversation became more personal. Dena suggested to the group that they meet up again casually for dinner after the PAT program and to stay in touch. Catherine was excited and surprised with her students’ interest to stay in touch with her. Continuity in the relationships with her students was important for Catherine. At the end of the meeting, the students gave Catherine a thank you card.
that they had prepared. Catherine thanked the students back and told them that she would send out a doodle for the restaurant meetup.

In her journal, Dena wrote about Catherine’s reaction to her invite for an informal meetup (J8). She wrote that she wanted to stay in touch with Catherine over time. She wrote that it would be difficult for her to stay in touch with the other people in the group “because we really don't know a lot about each other, we were always there to learn about Catherine.”

The informal dinner meetup occurred in January 2016. Catherine, her four students, and I all attended the meet-up. There, they shared updates on their personal and professional lives, as well as their studies. No recordings were done in the informal meetup. A point that became interesting to me was my interactions with the students in that meet-up that reminded me of my researcher role in relation to them. I realized that I interacted with the students from a place of knowing: I knew the students very well. I knew where they came from, why they were there, what they had done, and what they were going to do next. I gained all this information by observing their group interactions over time, by reading their journals and by interviewing them. This knowing made me feel very close to the students. When I saw them in the dinner meet-up, I was warm and affectionate toward them, but then I noticed that the students were taken aback by that and they did not reciprocate my feelings. It seemed that they did not know what questions to ask me or about what topics to talk to me. It seemed that my warmth only intensified this attitude. It took me some time to realize that “Oh, the students do not know me! That is why they are bewildered how to responds to my warm and affectionate approach in the interactions!” I remembered and realized that they did not know anything about me except that I was a doctoral candidate doing my dissertation research with their group. My feelings and my observations
from that day made me realize and experience first-hand that this dynamic was the result of my position in this research context: a non-participating observer of the group.

4.9 Summary

The progress of events in the PAT program seemed to highlight the importance of time and how people and perspectives evolved over time. The first reflective journal of the students revealed the questions, curiosities, and the emotions they had for a program of which they did not know much. Their reflections were filled with uncertainties and open-ended questions for which they were seeking answers.

The first group meeting about the use of words, generated a discussion that gave light into each health profession. This discussion also gave insight into some of the power dynamics that existed not only between a patient and the health professionals, but also, a similar dynamic among the health professions. The students began to learn about the dilemma of disclosure in Catherine’s life and the uncertainties they had in helping her in that regard. They also learned about physiological reactions to psychotic episodes. In the first meeting, the students had just begun to know each other and had felt uncomfortable about it. Dena’s bringing cookies might have helped to bring the group together.

The group discussions and the students’ journals revealed that the PAT program was indeed patient-centred. While the reflective journals of the students were clearly showing that the discussions in the meeting were centred on Catherine’s experiences, the PAT Handbook extended this emphasis in the second meeting by asking the students to talk less but listen more to their teacher. This showed the emphasis that the PAT program had on patient-centred learning (Bleakley & Blight, 2008). It was in the second meeting also, that the students began to warm up to one another, and to show interest in learning from one another’s health professions. More
importantly, each student continued to engage with Catherine’s stories as a future health professional. They questioned how they could help Catherine in her dilemma of disclosure. They questioned how they could help people like Catherine to navigate their way through the health care system. These reflections also showed that the students were beginning to get emotionally engaged in their teacher’s life story and the problems that she had. The students had begun also to show ways of thinking that seemed to be particular to their own health professions. For example, while Nelle and Nick were concerned about the health care system for people with mental illness, Dena wrote about Catherine’s experience in the hospital and her compliance with medication.

The health professions of the students became even more clear in the third group meeting. Emily talked about her role in telling the patients about advantages and side effects of different medication. Dena described her role as giving clinical information to the patients and help them choose a treatment. Nick, acknowledging the diversity of roles in nursing, talked about his own interest in becoming a street nurse helping people with mental illness. Nelle described her profession as having a holistic approach to care that tended to self-care, leisure and productivity the clients. According to what Catherine shared in that meeting, it seemed that accessing a family physician was more important to her than having a health care team. This was not because she did not want a team. It was more because according to her, the services for people with mental illness were being withdrawn more and more: that after her psychiatrist retired, she would not be referred to a new one because she was high functioning.

In the fourth group meeting, the importance of accessing a family physician and having stability in care was again brought into attention. The group then talked about Catherine’s job loss as well as the problem of disclosure. What was interesting about this meeting, which was
mid-way through the PAT program, was the fact that the students had begun to engage intellectually in Catherine’s problems, offering solutions to the uncertainties. In earlier meetings, the students’ reactions to Catherine’s problems were more emotional, whereas in this meeting they had begun to reflect more at an intellectual level and they seemed to be more confident giving insight and showing a nuanced form of reasoning that had developed over time.

The symposium was the one session that allowed the PAT group to interact with other groups in the PAT program. It was also the one session in which the use of artefact influenced students’ learning. The students wrote about the survey and the board that they had created and how it helped their group to interact with the attendees in the symposium. The students also wrote about their own interactions with other groups, how they had learned about other health conditions by engaging with other posters and by interacting with other teachers.

The students’ participation in group meetings and their reflective journals after the fifth and the sixth group meetings showed three interesting points. First, they continued to develop a nuanced form of reasoning over time in relation to the stories that Catherine had shared with them and how as health professionals they could react to them. The longitudinal reflections over time, showed that the students were engaging in various narratives (Monrouxe, 2009) in relation to their roles in their own professions. This process was non-linear and recursive which in turn gave insights into their developing professional identities. Second, the students continued to bring in unique perspectives form their own health professions building on the knowledge that was being constructed in the group. Third, one year after they had met for the first time, the group had created a bond. This was evident in the way they talked about their own personal life trajectories in addition to what they were already learning as part of the PAT program’s mandate. Social interactions such as having snacks together or sharing stories from different aspects of
one’s life seemed to be one way in which this PAT group created a bond together. Sharing a personal story, such as how a person spent their vacation helped the group members to get closer to one another and to learn from one another. It seemed that participation in such conversations over a long period of time influenced and augmented the way the participants interacted with one another and the way each person was contributing to discussions in the meetings. The next chapter interprets the occurrences in Chapter 4 to demonstrate how this PAT group made a community of practice.
Chapter 5: PAT Group as a Community of Practice

This chapter is written to address the first research question of the study: *How can an interprofessional group involving a patient as teacher operate as a community of practice?* Grounded in a social constructionist epistemology (Wenger, 1998), the theory of situated learning worked as the analytical lens in this study to conceptualize the PAT group as a community of practice (CoP). Such analysis can begin by deriving from the Alcoholics Anonymous (A. A.) program (Lave & Wenger, 1991). Storytelling was the central practice through which the A. A. CoP was constituted. Through the practice of storytelling, participants were supported and enabled to reconstruct their identities: moving from drinking non-alcoholics to non-drinking alcoholics. Indeed, the participants in the A. A. community were not there to develop an occupation of a master practitioner, per se, but to participate in storytelling as a method of shifting and building their identities anew. This process required both coming to see themselves and being seen as non-drinking alcoholics.

The PAT group was similar to the A. A. community of practice in two ways. First, the practice of storytelling in the PAT group was facilitated by Catherine and was focused on her experiences and her responses to questions. Guided by the PAT Handbook, the interaction between all the participants led to further discussion, reflection, and exchange among the PAT participants. Second, the PAT students were not apprentices to Catherine’s occupation, nor was their goal to become a person who lived with schizophrenia. Instead, Catherine’s experiences living with this illness were central to learning patient-centred care within their professions and interprofessionally. As such, participation in the PAT community of practice contributed to their developing professional identities. This point is explored in chapter 7.
According to Wenger (1998), community alone and practice alone do not make a community of practice. In this view, a practice needs to have special characteristics to be considered a *community of practice*. Such practice involves negotiation of meaning through participation and reification, and community coherence that work together to constitute learning over time (Wenger, 1998). This chapter substantiates the characterization of the PAT group as a community of practice using the theoretical lens provided by Wenger (1998) and Lave and Wenger (1991).

5.1 What Made the PAT Group Community, a Community of Practice?

Community can stand separate from practice. Wenger (1998) wrote that a “community of practice” has certain characteristics that distinguish it from just any community or any practice. By using the term “community of practice,” we establish a connection between the community and the practice, and we consider the CoP as one unit.

An essential dimension of practice in a community of practice is mutual engagement where the participants of a CoP interact with one another, use artefacts, do something together, and negotiate meanings with one another in their practice (Lave & Wenger, 1991; Wenger, 1998). To be a member in a community of practice, participants “sustain dense relations of mutual engagement organized around what they are there to do” (Wenger, 1998, p. 74). In the PAT group, the participants had come together in a group mainly to learn from the teacher, but also to learn from peers about different health professions. In their group, not only did Catherine, Dena, Emily, Nelle, and Nick mutually engage in the practice related to the objectives of the PAT program, but also they helped each other out and answered each other’s questions, and when needed, filled in information related to each person’s profession and background.
This mutual engagement also entailed all the other practices that took place as a virtue of being in a community of practice. The membership and mutual engagement of the PAT participants was enabled by what they did to make their collaborative practice inclusive of one another. This included choosing a meeting place that was convenient for everyone, offering rides to the place when needed, and chatting about personal lives and concerns. Even the pastry that Dena was bringing to the meetings brought participants closer together in their mutually engaged practice. Another example of this interconnection was the scheduling of the last meeting that had to be done earlier because Nelle was moving to another city. In their joint enterprise, the PAT participants willingly adjusted their practice to accommodate the circumstances of their group members.

While a community of practice such as the PAT group was originally shaped for the purpose of the PAT program, the PAT participants, through their mutual engagement, shaped their own ways of running and maintaining their community as their joint enterprise (Wenger, 1998) and that was indigenous and unique to this community of practice. They created their own particular ways of conducting the PAT practices such as maintaining a friendly and collaborative space where they worked together. In doing so, they had their own in-group rules and responsibilities. For example, Nick was responsible for collecting and analyzing the survey data from the symposium participants. Dena was responsible for booking rooms for each meeting. Emily and Nelle maintained communication with the PAT organizers.

In their participation, the PAT participants created, what Wegner (1998) called, a shared repertoire that included “resources for negotiating meaning” (p. 82), such as “routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions, or concepts that the community has produced or adopted in the course of its existence” (p. 83). The shared repertoire
in the PAT group was present in unique ways of communicating, deciding what to ask and what not to ask, what to say and what to imply. It also showed itself in the process of creating the material for the symposium. The PAT participants discussed their values and interpretations of their practice when they created the board. Similarly, concepts such as disclosure and stigma were among the shared repertoire of this group that found their way to the poster and the survey that the group used in the symposium. The survey that the group created about disclosure of mental illness was a shared repertoire that the group co-created and was likely to stay on had Catherine had another chance to be in the PAT program and to use with other cohorts, just as she had done with the previous one.

5.1.1 Negotiation of meaning by the PAT participants

People’s daily activities such as interacting with colleagues or eating with them are situations that involve negotiation of meaning. In these situations, although we repeat a same act many times again, every time that we engage in the act, we produce new meanings (Wenger, 1998). In each PAT meeting, Catherine, Dena, Emily, Nelle, and Nick shared the same space and talked about Catherine’s experiences living with paranoid schizophrenia. Yet, in each and every meeting, they negotiated new topics generating new meanings (Wenger, 1998). In each meeting, they brought in new experiences, memories, and perspectives that shaped the construction of knowledge in this group.

The students further extended their negotiations of meaning every time they wrote a reflective journal. Each time that each student wrote a journal, they re-examined their learning from the past, they made new connections to their current understandings, and they created new directions that they were taking in their learning. These processes included confirming, questioning, re-adjusting, or dismissing assumptions that they had earlier and recreating new
ways of thinking (Wenger, 1998). Nelle wrote in her reflection (J2) that she learned a lot from her teacher through the open discussion that they had, and this way of learning was very different from a rigid structure she had expected to follow before attending the PAT meetings. In the same way, the students wrote that, after spending time with Catherine and hearing her stories, they had come to revisit their assumptions about schizophrenia. The process of the negotiation of meaning was ongoing for the students as they wrote their reflective journals after the meetings.

The new meanings generated by the group sometimes confirmed and at times dismissed meanings created before (Wenger, 1998). This was the case with ‘disclosure’ that was a subject to much negotiation. Catherine, through her earlier conversations with students, was adamant that she wanted to protect her identity by not disclosing her mental illness to others. Over time and throughout the conversations, this meaning was modified when she entertained the possibility of disclosure by discussing with students ways that helped her open up about her illness. Later in the PAT program, she dismissed the idea of concealing her condition having had disclosed it to some people.

Related to the concept of practice, negotiation of meaning is situated historically and socially, and that involves implicit and explicit understandings among the interlocutors. It also has “a flavor of continuous interaction, of gradual achievement, and of give and take” (Wenger, 1998, p. 53). In this view, assumptions and values develop historically and experientially, have a role in negotiation of meaning. For the PAT participants, the first time that they met was the time that they got introduced and that they got to learn about one another’s roles. In that meeting, while they did not know one another yet, they were aware of their roles in the program: that Catherine was the teacher who lived with schizophrenia, and that Dena, Emily, Nelle, and Nick each belonged to the professions of medicine, nursing, pharmacy and OT. This awareness
enabled them to make sense of their roles through historical assumptions underlying the role: how to interact as a student in relation to their teacher and vice versa; or how to interact with peers based on the assumptions that the students had for each health profession. The more they interacted with their group members throughout the PAT program, the more they modified their assumptions about each role, created new values and immersed in the process of negotiation of meaning. Their negotiation of meaning was “both historical and dynamic, contextual and unique” (Wenger, 1998, p. 54).

5.1.2 Participation and reification in the PAT community

In the PAT group, participation and reification surfaced in various ways. The students created reflective journals that were the reifications of their experiences in the PAT group. At the same time, these students and their teacher used the PAT Handbook, a reification that was created by the PAT organizers, to enable them to negotiate new meanings. Using this product as a point of reference that gave them direction and instruction, they uniquely shaped their own interactions and negotiated and created their own meanings in this process.

In the PAT group, participation and reification had a fundamentally dual relationship (Wenger, 1998). Duality suggests that the two form a unity informing and transforming one another, and neither replaces the other, as such they are not dichotomous; they have unity in their duality, and “to enable one, it is necessary to enable the other. They come about through each other, but they cannot replace each other. It is through their various combinations that they give rise to a variety of experiences of meaning” (p.62). A journal entry written by a PAT student as a reification did not exist separate from participation in a social context such as the PAT group. Neither did participation stand as an abstract concept: it always led to creation of new forms,
symbols, and tools such as language, conversations, and promises, such as the poster that the PAT group created for the symposium.

Participation and reification are a duality that “converge and diverge” (Wenger, 1998, p. 87) over time. Having this longitude in mind, participation and reification connect at times through negotiation of meaning. For example, each of the PAT students wrote a journal entry while reflecting on their PAT group meeting. In that process, participation (reflecting) and reification (writing the journal) were connected and directly informing one another as the students were negotiating the meaning of their experience. At other times, reification and participation may not seem to be directly connected to one another, but because of their connection certain forms and meanings persist and are utilized in other contexts. This was the case when the students used the survey from the previous cohort, modified its questions and reused it in the symposium for their own cohort.

Looked at from the perspective of time, participation and reification interact and inform one another in a practice at one point in time. In another point in time, they diffuse (Wenger, 1998). At times, a reification created as the result of participation in a practice, becomes useful in other practices in other points in time. For example, the students took notes in the meetings as reifications of their group meetings. Then they wrote their reflective journals according to their notes and what they remembered from the group meetings. While these reflective journals were reifications of the group meetings, they were used at other points in time in different ways. The supervisors of the students used these journals to grade the students as part of the requirements for gaining the credits for participation in PAT. The PAT administrators (having had taken consent from the students in the orientation) used the journals to evaluate the quality of the PAT program.
Similarly, when the PAT participants got together in the meetings and talked with one another, I had set audiovisual recorders to capture their interaction. The recordings, as reifications of participants’ interactions in the meetings were used later by me for transcribing and analyzing and interpreting. By transcribing, interpreting and writing researcher notes, I created new meanings for what the participants had said in an earlier point in time. And every time I returned to the data and to the transcripts, I made yet newer meanings and interpretations.

As illustrated from the data, the PAT group and its participants were involved in processes of participation and reification. These processes were further solidified through the dual relationship that was present between the two.

5.1.3 PAT ways of diverging from and connecting to other communities

The journals that each of the students wrote as well as the poster that they created for the symposium took the form of objects that created boundaries for this particular PAT group and distinguished it from other groups, or other communities to which each of the participants belonged. These boundary objects are forms of reification that contribute to the creation of boundaries that make a community of practice to stand out and be distinguished from other communities (Wenger, 1998).

While boundary objects render a CoP distinct from other communities, they also work as objects that connect a CoP to other communities, thus maintaining their reificative functions (Wenger, 1998). The students’ journal entries worked as boundary objects that connected the experiences of each student to their professional domain. These journals also served as objects that connected these students to their faculty supervisor each time they read and graded these journals. Last, the journals as boundary objects were used by me as data for this dissertation. These journals connected the students with me as the researcher trying to gain insight into their
reflections as well as their developing professional identities. In the same way, the poster and the survey created by the PAT group worked as objects that connected the PAT group with the wider PAT community including other teachers and other students. It also connected the group with the public that attended the open house after the symposium.

Each participant in the PAT group belonged to other communities, and at times connected their practice in the PAT group to their other practices via brokering that involves providing connections “by people who can introduce elements of one practice into another” (Wenger, 1998, p. 105). For example, when Dena was describing pancreatic cancer to the group, she connected information from her medical program community and used it in the PAT group. In the same way, Emily brought in her pharmaceutical knowledge when she described to Nick the side effects of taking Pepto Bismol in one of the meetings.

Brokering can be related to the concept of peripherality. As discussed in chapter 2, periphery is a productive position. In a community there is no designated place for the periphery; instead periphery is viewed as “multiple, varied, more- or less-engaged and -inclusive ways of being located in the fields of participation” (Lave & Wenger, 1991, p. 36). It was through their peripherality that the PAT students could bring to and use in the PAT concepts from their other communities and vice versa.

People can engage at the periphery of a community of practice for a long or a short time. Indeed, there are people who may participate at the periphery for a short time and not intending to stay long (Wenger, 1998). For example, the PAT symposium allowed the public to engage with the PAT group albeit for a short time. On the other hand, there are people who stay on the periphery for a long time. For example, in conducting my research, I engaged in the periphery of this PAT group for a longer time than the group itself.
5.1.4 PAT program: Constellation of PAT practices

As discussed in the previous parts, the PAT group entailed what is characterized in the theory of situated learning (Lave & Wenger, 1991; Wenger, 1998) as key processes involved in a community of practice. These processes included negotiation of meaning, participation and reification, boundaries, brokering and peripherality. According to the discussion so far, the PAT group possessed the features and characteristics of what makes a community of practice. I can further corroborate this finding when investigating these characteristics in the PAT group in relation to the PAT program.

First, it is important to refer back to a point made at the beginning of the chapter: community alone and practice alone do not make a community of practice. And that practice requires to have certain characteristics to make a community of practice. The PAT group was a community of practice because it contained long-term mutual engagement among its participants, coming together for a shared purpose, exchanging information, creating a joint enterprise that was unique to this group, creating artefact that belonged to this group, yet at the same time worked as boundary objects that signified the group as a community of practice and also connected them to communities and people outside their group. In this joint enterprise, each participant had a clear role and place within the community and he/she exchanged information and knowledge from his/her position.

The PAT program, on the other hand, was the larger structure within which the PAT group, among other PAT groups, was placed and functioned. In the PAT program, the PAT groups did not interact with one another regularly. They did not engage in an enterprise together; the groups did not create artefacts for one another, nor did they engage with one another in a practice that showed signs of negotiation of meaning, participation and reification amongst them.
One way to illustrate the relationship among the PAT groups in the PAT program can be illustrated in Figure 5.1.

![Figure 5.1. PAT Program as a Constellation of Practices](image)

Having been created by an educational institution and having several stakeholders who had a vested interest in the program, gave a sense of sustainability and continuity to the PAT program. Nonetheless, the PAT program, while it is indeed a community bringing cohorts of students and teachers together, it may not be considered a community of practice. The reason is that the participants in the PAT program, that is, the 52 teachers and 200 students, that were nested in groups of 4 or 5, did not have a sustaining relationship with other groups and participants in the PAT program. The members of each group were chosen and arranged by the PAT program administrators. In the orientation, the students and teachers were placed around tables that belonged to their own group. The participants mainly interacted within their own
group rather than across groups. From my own observations when attending the orientation in September 2014, the different PAT groups had minimal or no interaction with one another, and after that, they were set to go their own ways scheduling their own group meetings and encounters. The only time that the PAT groups and participants may have interacted was in the symposium of the PAT program where each group showcased their poster and collaborative work to other groups. If interactions occurred, they were only on the periphery of these communities without any long-lasting engagement, creation and legacy. From this viewpoint, the PAT program can be described a “constellation” (Wenger, 1998, p. 127) that brought together the 52 PAT groups and related them under the rubric of the PAT program for serving its intended objectives. This point can be supported by the literature that suggests that it is possible that the evolution and continuity of a community of practice (in this case the PAT group) can be put into place by external forces (Fuller et al., 2005) which is the PAT program and the curriculum in this case. From this perspective, membership and belonging to the PAT community from the boarder perspective is essential in considering the PAT group as a community of practice. This argument is consistent with other literature that maintains that communities of practice must be viewed from both broad and narrow perspectives (Hodkinson & Hodkinson, as cited in Fuller, 2007). The broad perspective entails membership, and the narrow perspective entails learning and participation in a community of practice which is often a smaller group.

In the PAT group, due to the direct interaction and involvement of Catherine, Dena, Emily, Nelle and Nick with one another, a different product was created: one that resembled the communities of practice described by Lave and Wenger (1991) and Wenger (1998). The various ways in which these participants learned, bonded together and grew over time indicate the making of this community of practice. In light of the literature around health professional CoPs
discussed in chapter 2, using the ways discussed so far in conceptualizing the PAT group as a CoP was a step above the simplistic ways in which CoPs have been conceptualized in medical literature.

5.2 Questioning the PAT Group as a CoP

The previous section discussed the different reasons why the PAT group was a community of practice. These were substantiated according to the key characteristics and processes that the concept of community of practice entails (Wenger, 1998). This section discusses two issues that can be raised to question the PAT group as a CoP. While raising the two issues, I discuss resolutions to them. I discuss how, regardless of these issues, the PAT group remained a community of practice.

The first issue can be raised in relation to the difference between the PAT CoP and those described by Wenger (1998) and Lave & Wenger (1991) in terms of the incoming and outgoing participants of the CoP. In the PAT group, the participants entered and exited the community at the same time. In the CoPs described by Jean Lave and Etienne Wenger (Lave & Wenger, 1991; Wenger, 1998), new participants came while other participants were still making their progress toward fuller participation in the community. In the case of PAT, the four students would change every year. Even Catherine herself stayed for four cohorts only and then was removed, and potentially changed by another teacher.

In the examples of Alinsu, Yucatec midwives and other CoPs given (Lave & Wenger, 1991; Wenger, 1998), the community was constructed in such a way that newcomers joined into an existing CoP while other participants were still making their progress by getting promoted to higher ranks. While some participants advanced in their participation, some may have left the CoP. The surge of newcomers while the old-timers and other participants were making their way
up to the next phase-whatever that phase be- ensured the longevity and sustainability of the community (Wenger, 1998).

The PAT group did not contain this flow. However, it is important to keep in mind that its constellation, the PAT program, contained such a flow. The way the PAT program was designed ensured that new cohorts of students kept coming every year in a journey in which each group would meet for the duration of 1.5 years. When one PAT group was in the 12th month of their journey, new groups were being created. As such, the end of this particular PAT group did not disrupt the continuity of the PAT program.

It is important to note that the PAT program was designed and structured by forces much larger than itself. In the PAT program, there was the university that was providing funding and accreditation for a program like PAT to be and to continue. At the same time, the PAT program met the interest of several stakeholders. That included the health professional programs that wanted their students to learn about patient-centred care and to have interprofessional exposure. It met the interest of community organizations and members that pursued the mission of patient-centred learning and patient voices in education. At the same time, it met the interest of the students that may have not had experiences with some chronic conditions and to which the PAT program gave them access. Therefore the fact that newcomers and old-timers of the PAT CoP were changing in every cohort, left a reproductive cycle, and it did not disrupt the continuation of the program or the shared repertoire that each group created under the rubrics of the PAT program.

One of the shortcomings of Lave and Wenger’s (1991) theory is noted to be a focus on “continuity and reproduction rather than discontinuity and transformation” (Fuller, 2007, p. 22). The PAT group contained the latter (discontinuity and transformation). It did not have the kind
of generational continuity that was exemplified in Wenger (1998) and Lave and Wenger (1991). However, it did lead to productions and reproductions that suggested transformation among its participants. This was evidenced in the products of their mutual engagement that they left behind, and their meaningful interactions that showed to be transforming over time throughout their engagement in their practice. The PAT group had a cycle of generating health professional students who valued patient-centred learning and care enabled by their participation in the PAT program and their exposure to a patient with a chronic condition that enabled them to view this patient as a whole human being, and her condition as a part that constituted her identity. Thus, generational continuity existed in the PAT program in a form that new cohorts of students came in. These new cohorts of groups with the same or new teachers were created to sustain the flow of the developing of professional identities toward patient-centred values.

The second issue in questioning the PAT group as a CoP can be raised in relation to the amount of time the PAT group participants spent together. Wenger (1998) noted that the practice in which the participants engaged must be *significant* involving shared histories of mutual engagement. This mutual engagement showed itself in a long-term generation-after-generation passing of a craft (Lave & Wenger, 1991). It may also be short-lived but “intense” (Wenger, 1998, p. 86) such as when a disaster brought people together. The examples provided by both Wenger (1998) and Lave and Wenger (1991), included participants that spent substantial amount of their daily lives engaged in the practice that they were doing—be it the Yucatec midwives, Vai and Gola tailors or Alinsu claims processors. Even in the Alcoholics Anonymous program, though not precisely described by Lave and Wenger (1991), the participants need to go to the meetings every day for 90 days as the minimum time required to transform their identities (Harvard Health Publishing, 2007; Recovery First, n.d.). In the case of the PAT group, the
meetings and interactions of the participants was less significant in terms of amount of time spent together. They met once every two or three months. This gap was even longer when there was no school over the summer. The duration of the group meetings was about two hours, and it was longer on the days of orientation and symposium.

In comparing the PAT group with the CoPs described by Jean Lave and Etienne Wenger, the PAT participants were not immersed in the PAT practice. In fact, each of the participants was immersed in different professional practices. Catherine, the teacher of the group was already immersed in her own specialty and profession which was very different from her PAT role. The students were immersed in their studies. In addition to PAT, they were taking other courses related to their health professions. Some were doing clinical rotations or out-of-town practicums at the same time that they were attending the PAT program. It is more correct to say that the students were immersed in their own health professional studies: studies that consisted of the PAT program, theory courses, specialization courses, and clinical rotations (studies of which PAT program was a part).

In comparing the PAT group with the CoPs described by Jean Lave and Etienne Wenger, the PAT group spent much less significant amount of time together. Does this difference suggest that the PAT practice was not significant enough to be considered a community of practice? In order to answer this question, it is important to reflect back to the product of a CoP for individuals, and that was learning as participation and the changing and constructing of identities. The analysis of data suggested that participation in the PAT program showed to have impacted the professional identities of its participants. This finding is discussed in a separate chapter (Chapter 7). It discusses how the professional identities of the PAT students grew as part
of their participation in the PAT program which demonstrates the significance of participation in this program.

5.3 Summary

This chapter substantiated the premise that the PAT group was a community of practice. The participants in the PAT group engaged in negotiation of meanings during the meetings and in their reflective journals. The meanings that the participants created showed to be transforming over time in relation to self and other people in the group. In this process, they corroborated, dismissed or redirected the meanings that they were negotiating out of their experiences. In their joint enterprise, each participant had a role to play and was accountable to the product of their engagement with one another. Their participation led to the creation and use of reifications that worked as objects that created a boundary for their community and at the same time connected them to the other people and other communities. Negotiation of meaning, participation and reification in this PAT group indicated a reproductive cycle that was taking place over the 1.5 years that they were together and supported by the PAT program which constituted a constellation of practices.

The chapter ended with two critical points that may be used to question the conceptualization of the PAT group as one community of practice. One of the points questioned the significance of the time that the PAT participants spent together. In order to address this critical point, it is important to pay attention to the product of their engagement in terms of developing professional identities. Acknowledging that professional identity “is learned” (Barr et al., 2015, p. 333), it is crucial to explore learning among the PAT participants. The following two chapters serve this purpose. Chapter 6 describes those parts of the interviews with the PAT participants that informed their learning. Chapter 7 creates a connection between learning and
developing professional identities. It substantiates the ways in which the professional identities of the students transformed as a result of their participation in the PAT group regardless of the amount of time spent together.
Chapter 6: Perspectives Few Months after the PAT Program

Having discussed the occurrences in the PAT group meetings and how the PAT group made a community of practice, this chapter moves on to the topic of learning and roles in the PAT group. Understanding learning among the PAT participants helps understanding how their developing identities was growing. This chapter describes the interviews to illustrate how the PAT participants learned, how they perceived their roles. It also describes their perspectives on patient-centred care and the future of health professional education.

I conducted one-on-one semi-structured interviews with the research participants a few months after the PAT program had ended. This chapter reflects parts of the exchanges that occurred in the interviews. First, it describes the reasons that the students stated for joining the PAT program. It also describes their perspectives on the extent to which the PAT program addressed the objectives in their health professional curricula. Second, it describes the participants’ perspectives on what they learned in the PAT program and how they made sense of that learning. Third, it describes the participants’ perspectives on their roles in the PAT program. Fourth, it describes patient-centred care from the perspective of the participants. Fifth, it describes participants’ perspectives on how health professional education could be improved. Exploring each of these topics, as they surfaced in the interviews, was important mainly because it informed the particularities of each of the four health professions from the perspective of the students who were in those programs. Exploring these topics specifically informed how learning was taking place for each of the students that shaped their developing professional identities (Barr et al., 2015).
6.1 Patient-centred Learning and Interprofessional Learning as Key Reasons for Participation

The students said in the interviews that they had chosen to participate in the PAT program to learn from a patient and to learn about other health professions by engaging in group discussions with students from other health professions.

One of the courses at the nursing school at WGU asked the students to choose between two options for either doing research with patients or learning from a patient. Nick had chosen the latter. In the interview, he noted that he chose the PAT program because he wanted to interact with patients, as well as other health professionals.

About why she decided to participate in the PAT program, Dena said she found the idea of interacting and learning with a patient over a long period of time appealing. She applied without noting any preference for the chronic condition. She said in the interview, “I am very happy with the group that I was placed in, I could be remembering that” (L274-275).

Emily said that she had heard about the PAT program from a professor and other students who had participated in the program and then decided to participate herself. The PAT program was offered as one of several electives in the pharmacy program. Nelle, in the OT program, was the only student who had to take the PAT program as requisite. The PAT program was an elective for the other three students.

I asked the students of the PAT group about the extent to which the PAT program met the objectives of their health professional program. Emily referred to the “patient-centred learning” (L213) that was being encouraged in her program, “a huge thing is patient-centred care, and getting to know your patients and what their needs are and what they’re like, along with, like just sort of being more integrated with other fields” (L216-218).
Nick referred to patient-centred care and family-centred care encouraged in his program. He talked about learning from and listening to patients as the skills that were more important than providing care for patients. About the other students in nursing who did not take the PAT program, he said, “I think that they didn’t have the exposure to, in a long-term base, to a patient” (L202-204). The PAT program gave Nick the opportunity to build a long-term relationship with a patient and to learn about a chronic condition—a position that was not readily available to the other students who had not taken the PAT program.

About patient-centred learning in the group, Nelle said that the PAT students were not participating as much as Catherine in the meetings, because according to her, they were there to listen to their teacher and to be “attuned to” (I, L477) her. She said that their participation evolved later in the symposium and in the process of making the board because all the team members were actively taking responsibilities. Nelle said that, in the symposium, they would “delegate” (L471) tasks and that there was “less emphasis on us coming together to learn from someone who has a lived experience, hm, and more emphasis on us working all at the same level on a team” (Nelle, I, L472-474).

6.2 Learning in the PAT

This section is divided into five separate parts to describe what the participants stated about what they had learned in the PAT program.

6.2.1 Learning for Nick

Nick talked about the difference between the PAT program and other instructional approaches in his nursing program. He said, “in lectures it’s very theoretical, and also in my rotations that I had in hospitals it’s very clinical, and in PAT it’s very personal …, and also very human” (L216-218). He explained that, for example in the hospital, usually there was not enough
time for him to build a relationship with his patients and that the clinical practice focused more on the skills such as patient assessment, injections and administering drugs. For Nick, clinical rotations were more “skill-oriented” (L252) whereas the PAT program was “patient-oriented” (L252). Nick described learning from his patients in the hospital and from Catherine:

I learned from patients in terms of, even when they’re sleeping they’re still my patients no matter if they’re unconscious or under anesthetics they’re still my patients, so it’s not because they’re sleeping, that they don’t know. I know that they’re, they’re my patients.

(I, L162-165).

Nick also said that “I mean Catherine was not my patient but she was a patient! So I think that we learned so much” (L203-204).

When I asked Nick, what particular lessons he had learned from Catherine, he said that he learned from Catherine’s experience that he needed to listen to his patients. He also said that he learned that care should be a collaboration between the patient and the health professional. He said that he learned how resilient Catherine could be in the face of the adversity. He also said, “I learned from her that you need to be mindful that some people may see themselves like a condition, that the condition is part of who they are” (L311-313). He was referring to the conversation in which Catherine described herself as a “damaged good.” Nick argued that he perceived Catherine to be healthy (due to her resilience and independence), but it did not mean that Catherine saw herself the same way as Nick did.

6.2.2 Learning for Emily

On learning in the PAT program, Emily said, “I wouldn’t be able to say I learned this this and this but I feel like just the experience in itself was kind of helpful and gave me a lot of insight into like care and in terms of mental health and other health profession roles” (L276-278).
It seemed that, for Emily, participating in the PAT program had a holistic educational value to it and it could not be compartmentalized into discrete learning objectives.

Emily said that she was “really happy” (L615) that she experienced the PAT program. She compared her position with the other pharmacy students who did not participate in PAT and said, “it’s helpful to gain a better idea of other people’s roles and if you had preconceived ideas of certain professions or students, maybe being more involved with them would help change that” (L616-618).

I asked Emily how she thought about having a professor directly involved in the PAT group meetings. She replied:

I don’t think I would’ve learned more, but I think I maybe would’ve learned different things. I think in a way maybe I would’ve, if anything I might’ve learned a bit less, because the session would’ve been like so restrictive and we would’ve been very task-oriented so any sort of side stories would’ve been maybe cut short, or would have been cut off because we would’ve been more on a schedule or like. (L1100-1104)

Emily said, if there was a professor present in the meetings, what she would learn would probably be “different” or “less.” She said, in such scenario, Catherine’s stories would probably be “cut short” or “cut off” because they would need to follow a certain schedule.

She said that the program “reinforced” (L284) listening instead of “reading in the textbook and thinking You know what’s best” (L285). She added:

listen and chat with a patient especially in mental health because I think a lot of time and we’re just starting to learn more about like all these conditions now but it’s interesting to hear to be like Oh we don’t really know the mechanism of, like This drug we don’t really know how it works but it does or it kind of does, or it half does so really listening to her,
kind of reinforced that *Oh maybe there should be a really strongly patient-directed field* as opposed to you thinking you know what’s best and kind of thinking *Well in this type of situation we always skip this type of medication and that’s how it is,* and for certain fields I guess like cardiology and stuff it’s more cut and dry, like giving this person this drug at this dose has been shown to reduce mortality by this percent and it’s pretty like black and white in that respect and I think that listening to her kind of gave me more insight and it’s not really that black and white and like to be really reinforced like *Listen to the patient because you don’t really know the patients full story and they may have a better idea of their condition than you.* (L286-298)

It appeared from this quote that Emily had begun to think in a nuanced way: that some of the problems that patients have are more intricate than clear or “black and white.”

Emily also mentioned that she learned in the PAT program that different patients perceived health professionals differently. While she thought “very optimistically” (L307) about the health care system in terms of doctors listening to the patients and treating them well, she realized that “that’s not always the case … we think we’re treating the patients well but that might not be how they’re perceiving us” (L309-311). She also added that this realization made her understand that “certain therapies are not going to be clear as to what you should use to help this patient” (L312-313), and that it gave her “more insight into *Oh the patient’s pretty self-aware and has a good idea themselves on how to like handle their situation* because they’ve been living with their condition for however many years” (L313-315).

### 6.2.3 Learning for Dena

Dena said that she learned in the PAT program about “the resources for people with mental illness” (L324). She added, “while may have been touched on in the curriculum, you
remember it much more when there is somebody that you know that’s using those resources or needs those resources” (L326-328). She said that she also learned about “the struggles” (L328) that Catherine faced in her life such as the “power of disclosure” (L330) and the “challenge it was to feel comfortable telling somebody about their illness, especially because it’s mental illness, especially because it’s schizophrenia because of I guess stigma associated with it” (L330-332).

At the time of the interview and for a week, Dena’s medical program was teaching them about schizophrenia. Dena told me that having had the prior experience of being in the PAT program made the understanding of schizophrenia “a lot more real … than just saying Oh, this patient has hallucinations and delusions and all these set of symptoms that schizophrenic patients generally have” (L111-112). Having that perspective, Dena guided her learning in a different way than other students. She was also able to share that unique perspective with her peers who had not had a similar experience.

Dena mentioned that, in addition to learning from Catherine about her chronic condition, she found value in the interprofessional exposure that she experienced in the PAT program. She said that her medical school in the first and second year did not include much interprofessional practice. Here is an exchange Dena and I had about this topic:

W: Do you have electives that involve interdisciplinary interaction?
D: For sure, I mean next year, in third year and fourth year we will be working a lot with other disciplines in the health care setting, but, and I could be forgetting right now, so I’m not saying no, so I don’t recall there being specific instances in which we work closely with other students from other faculties.
W: So it’s only in the PAT program so far?
D: I’m recalling one in particular. There was like an interdisciplinary program. It was like scavenger type of thing, I don’t know last year anyways we got into different groups with med students and different … occupations I guess, students but again that was once and I can’t remember the details about it so from a continual and significant basis, yes, that was the only one. (L293-320)

Overall, it did not seem that Dena’s medical program was offering much interprofessional learning for the students, at least not in the first two years.

About the other students in her group, Dena said, “It was more observing how different people interacted or what kinds of questions they would ask and how the profession they were training for came through in the questions that they were asking, in how they were interacting” (L614-617). She said that she found the nursing student to be “very interesting” (L573) in terms of his career goals and the intensive two-year program that he was completing. She also talked about Nelle, the OT student in her group as having a “very patient-based perspective of things, especially closer to the end of the program” (L601-602). Dena said that Nelle “would often ask Catherine questions about how different things had affected her and you could see that that also has to do with their studies and what they have to do in their jobs” (L602-604). Learning about other professions from the questions they asked, gave Dena a unique insight that she may not have had if she did not have long-term interaction with the students in her group.

6.2.4 Learning for Nelle

Nelle found that the learning through group discussion and hearing Catherine’s experiences was in-depth and profound—a way of learning from which she grew in wisdom.

According to Nelle, participating in a small group helped knowing the other people in the group,
building rapport, and becoming comfortable sharing experiences that a person would not share otherwise.

About what she had learned in the PAT program, Nelle said how insightful it was for her to know that disclosure of mental illness was a big issue with which a person may be dealing because disclosure impacted many aspects of a person’s life. Participating in the PAT program helped her combat her own stereotypes about mental illness, “I have been able to reduce any socially constructed stigmas I might have had before coming in about mental illness” (L527-529).

6.2.5 Learning for Catherine

From the conversations with her students, Catherine learned more about her feelings and emotions. In her interview, Catherine mentioned that she learned to manage her anger regarding her unpleasant experiences in the health care system. The questions that the students asked her, helped Catherine reflect on the different incidents in her life and to analyze them in alternative ways. This helped her to gradually be at ease with disclosure and taking steps toward talking with some people about her illness. It seemed that Catherine, in her role as a teacher, was deliberate in drawing a lesson from the points that surfaced in the conversations.

6.3 Participants’ Roles in the PAT Group

This section discusses the roles of the participants in the PAT group from their own perspectives. Their input is discussed in two parts: role of Catherine and the role of the students in the PAT group.

6.3.1 Role of Catherine in the PAT group

About her role in the PAT program, Catherine described herself as a “storyteller” (L338). About the experiences that she shared with her students, Catherine said, “the majority of the
things I talk about are the things that would never appear in a textbook. Because I feel they can learn a lot” (L226-227). She also said that “I’m not an expert on textbook talk. I don’t read the medical journals, I don’t read the medical diagnosis, books and all of that. They can all learn that wherever they get the information from” (L227-229). She elaborated saying, “For me it’s important to put a human face and feelings to the experiences instead of making it a clinical case” (L229-230). She said that she did not want to “generalize things” (L231), “my own feelings and experiences … are stronger than just some cases you hear about or something you can read up on or generalize schizophrenia off of a textbook” (L231-233). She added, “I put my experiences in it and I feel that’s important for you to know” (L233-234). She added, “I decided many times what stories to share. I get questions from students a lot and then I decide how am I gonna answer that to make it more effective” (L234-236). I probed more about what she chose to share. Catherine replied:  

I always think about that many times and maybe I don’t want to share one or two stories at the beginning of the encounters with the students but at the end of the year and half I had no hesitation of sharing anything they wanted to know about. And it’s the same with each group. I test them at the beginning and see where they are at and then ok, I figure out how far I can go with you guys. You are gonna hear the stories! (L351-356)

Catherine stated that she saw the students in her cohorts growing over time. I asked her to elaborate on how she saw students growing. She said:

I always ask at the initial stages of the meeting Who of you chose the topic of mental illness when you signed up. So out of the four, they are usually maximum there are two people who chose mental illness … some of the students just said Oh I should go into the
program but I don’t know what to expect and then at the end they are pleasantly surprised of what they have got out of it! (L312-320)

Through the questions that she received from her students, Catherine evaluated how they were learning. Similarly, by taking part in the discussion, the students conveyed their depth of learning to their teacher.

6.3.2 Role of the students in the PAT group

One of the questions that the students were asked was about the role that they perceived that they had in the PAT group and in relation to their teacher and their peers. Nick said about his role in the PAT group, “I tried to talk as much as I could, as much as possible, trying to bring what I learned in school and what I learned in my personal experience to the group and I always try to share as much as I was able to” (L449-451). He also mentioned that he wanted “not to represent nursing but to talk about nursing” (L453), what he had learned in school, and “the role of nurses in the health care setting and in the multidisciplinary team” (L454-455). Nick said, “I try to talk and make sure that nurses are not only people who administer medication, that nurses can do so much more and that we’re not only in hospitals” (L455-457). He said that he communicated to his group that he wanted to become a street nurse, “so talking about those things to let my team know that nurses can be anywhere, that nurses are in community, could be in politics, could be in hospital” (L458-460). Sharing learning in the PAT group was important to Nick. Also of importance to him was that he wanted to make sure that Catherine and the students in the group knew that roles in nursing were diverse.

Nick said that his role in relation to Catherine was to listen to her experiences, “I think that listening to her experience, personal experience, medial experience, or life experience, if you wanna call it, that way we learned a lot and our role was to be the student learning from her not
teaching her” (L471-474)! Nick suggested that it was his responsibility to learn from his teacher and not to teach her, because, after all, Catherine was the teacher and he was the student.

Nick said that he tried his best to learn about other professions in the PAT program because he perceived that “education is lacking” (L478) learning in “multidisciplinary settings” (L479), “to learn more from other health care professionals, where their scope of practice is, and what can they do, what they cannot do in terms of the scope of practice” (Nick, I, L479-481).

About her role in the PAT program, Emily said, “to represent my field and kind of show where my knowledge lies in health care” (L447-448). She mentioned “chatting” (L448) with her teacher otherwise. About roles, she also said, “each person kind of has questions … or insight related to their own field and I guess that was my role to bring insight that maybe others haven’t thought of just based like my learning and my field and stuff” (L449-451). For the students, part of representing their field had to do with the kinds of questions that they asked. About learning from the other students, Emily said:

I didn’t really have a good idea of like occupational therapy, was kind of a bit of a foreign thing to me and I always tried to look it up and be like What do occupational therapists do. (461-465)

Emily said that she was more familiar with doctors’ and nurses’ roles because she had interacted with them throughout her life. She said that what she learned from Nick and Dena, “reinforced” (L471) what she already knew about these professions. Emily also said that overall she did not have a good perception of doctors but the medical student in her PAT group was different.

About her role in the PAT program, Nelle said that she felt that she was the “good guy” (L513) among the other professions in her group. She said that she felt lucky that in her profession, there was not “much of power imbalance” (L508) between OTs and their clients. She
added, “I get to be the support, I get to listen, and I get to work through challenges to get to a place where a person wants to go” (L514-515). Nelle compared her profession of OT with other professions saying, “I think other people have to have more, maybe authority or … use their title to do things that a patient or client might not be as excited about” (L515-517). Nelle also said that people did not know much about OT as a profession and the kind of practices that OTs did.

About what she was sharing in the group and whether she was representing her field of medicine in the PAT group, Dena said:

we did discuss about the medical profession and how it should be different … I think that’s changed a lot in medical program both at WGU but also across Canada recently and so when our teacher was talking about those experiences, it was easy to see the difference based on how those people were trained then and then how you become after years of practice versus like what you’re taught in the curriculum and how it’s patient-centred. I did share a bit about that and how it was different and I think like newer generations are treating the problems and patients differently than the old generation (L639-648)

It seemed that Dena, somehow, perceived her role (or saw it as her responsibility) to explain the position of doctors particularly in relation to Catherine’s negative experiences with physicians. About her role in relation to her teacher, Dena said “I think Catherine and I had a very good relationship, we got along well” (L525). About her role in the group, she said, “I think at first I was a more active participant in the group at the beginning than maybe some of the other students” (L528-529).
6.4 Patient-Centred Care

In the interviews, each participant provided her or his own definition of Patient-centred Care (see Table 6.1).

Table 6.1
Patient-centred Care, Family-centred Care, & Client-centred Care as Defined by Research Participants

| Nick  | *Patient-centred care* basically focuses the attention on the individual, who I’m providing care but hmm I really believe that *family-centred care* is much bigger because many times this patient whose let’s say like is in the hospital is going to go back home, so in order to prepare this person to go back to where they belong, we need to make sure how everything else works in their environment and with family-centred care, I may not refer to mom and dad and brother and sister, is like the social support this person may have in his or her own community and supports like other health care professionals hmm neighbors, friends, roommates, like who this person lives with, who this person is interacting with on a daily basis that may impact their health, and potential relapse or readmission or something, so like in order to make sure that my patient is ready and healthy, I need to see their environment where this person is living so like assessing the entire family and again by family I refer the people that live or interact on a daily basis with my patient, it’s important. (L546-558) |
| Emily | *[patient-centred care]* care that is very individualized and specialized to a particular patient and one that’s sort of takes into account their needs and their goals and desired outcomes with therapy along with just sort of explaining the options to the patient and sort of pretty much at that point they get to choose where they would like to go with therapy. (L632-635) |
| Dena  | *[patient-centred care]* I would say focusing on the patient as opposed to the illness, so that means taking the time to describe the condition to the patient and make sure that they understand it. That means giving choices to the patient in terms of their medical and non-medical care and focusing on what’s best for them and what’s best for you as a health care professional. (L652-656) |
| Nelle | *[client-centred care and patient-centred care]* I think they are different. I think that both terms are used to identify that the health professional using that term is interested in knowing the patients or clients wants, needs, values, and beliefs to hm, help guide what medical decisions they are making, but I think that patient is, for the lack of a better word describing it, is more like, maybe a little bit more at the mercy of people who are providing the services, where a client is more, there is less of a *I need you to help me right now! Because I’m not able to help myself right now.* Hm, so I think there is a difference that way. (L661-667) |
| Catherine | I don’t have a definition of *client-centred care*. Because it is idea with words that is not translated into practical experiences meaning client-centred care sounds great on paper, sounds great on concepts, sounds great on discussions. It sounds great for certain illnesses but for me in my experiences, client-centred care is never practiced until the last week when I was released from the hospital. Before that client-centred care was thrown out of the window because they are not listening to anything I say, because I am certified and the people around me have power over me on EVERYthing I do, so it’s not client-centred, so that’s why I’m saying it’s a great new model that’s out there but you gotta change the Mental Health Act to even impose a client-centred care in the mental health act. I don’t see it happening. W: Is client-centred care the same as *patient-centred care* or is it different? |
C: Oh I don’t know who defines that term and what it is. 
W: In your mind how do you see that? 
C: … I don’t like the term patient or client. For me both of them is something that I don’t identify with. Whether you use this or the other one it doesn’t matter. It’s not modeled to the need of an individual, so it doesn’t matter for me these words are interchangeable. Patient is the old word, client is new word but they still refer to the same person. 
(L439-455)

When I asked the participants about the meaning of patient-centred care (PCC), I noticed that Nick and Nelle provided or used other terms in addition to the PCC. When asked to define patient-centred care, Emily and Dena provided their definitions. Nick and Nelle, however, replaced it with family-centred care (FCC) and client-centred care (CCC).

In general, the students defined PCC as individualized care that was geared to each patient, that paid attention to patient’s needs, goals, values, and that tended to both medical and non-medical need of the patient. Nelle defined CCC as being similar to PCC in terms of respecting the needs, wants, and values of the patients, but different from PCC because the patient in CCC was less “at the mercy of people who are providing the services” (L665). Nick defined FCC as focusing on the social support surrounding the patients including their family, friends, neighbors, and roommates, and preparing the patient to return home or to their community. It seemed that Nick and Nelle had more holistic perspectives in relation to the patients. Nick was concerned about the familial and societal issues surrounding his patients. Nelle regarded her patients as clients whom she helped toward living a better life as a whole. Whereas Dena viewed PCC as a relationship with the patient in which the health professional communicates with the patient about the illness, “make[s] sure that they understand it” (L653-654) and gives choices. Emily also mentioned “explaining the options” (L634) and having the patients “choose where they would like to go with therapy” (L635) taking into account “their needs … and desired outcomes” (L633).
The definitions that each of the participants provided was distinct and different. At the same time, it reflected their unique positioning in each health profession. Nick, the nursing student, was concerned about the life of the patients beyond the hospital bed, so he emphasized the role of family in providing care. Nelle emphasized client-centred care because in their practice as OTs, they work with clients not patients. Emily, the pharmacy student, emphasized giving options to the patients as to which therapies would work and then have the patients choose their own care. Dena focused on the information-sharing aspect of the relationship with patients as well as the difference between the illness and the disease, something that had been “hammered in” her head in medical school.

Catherine declined to provide a definition for PCC asserting that it did not exist and was not being practiced. She drew from her experience as a patient with mental illness. She was critical of the terms insisting that creating terms like CCC or PCC did not guarantee their implementation in the health care system.

About a term such as client- or patient-centred care, Catherine said that it “needs refinement to include people with mental illness or people with schizophrenia, because it includes a lot of people around them, their family, their friends” (L422-424). She explained that “just because there is a new buzz word around and everybody is doing it, it doesn’t mean it’s a solution for everybody” (L425-426), that “there are some outliers” (L432) and “some unique patients out there that require some different care or they wanna be treated or handled differently than you are used to, so be open-minded and start a conversation” (L432-434). She added, “every example I strongly pushed this forward taking the individual and not impose a model on everybody that walks to the door” (L436-437)
I asked Catherine, if PCC or CCC were not the right model to follow, then what the right model was. She replied:

Unique Human Care! First of all every person is unique! They have different needs! They have different experiences they walk in to you office and second, they are all human beings! And defining that one person has rights and the other person has no rights taking their humanness away and confine them into rooms and straitjackets and all that into an unhuman condition is not for me pleasant. It is something that still exists. I don’t have answer for an alternative but it takes the humanness out of care. So when you just say patient or client for me that client has a lot of rights but I had little rights when I was in hospital so we need more human care than client care, because that care only certain people would get it that are clients but for me EVERYBODY needs certain standards and if you have your rights taken away you need to come back to human level first before becoming a client. You are not a client! You’re automatically a human being but as a human being there are different levels. Those that have a right and those that don’t have a right and if they’re not having a right, they’re down-sized in level of humanness. (L457-470)

According to Catherine, the solution for improving the health care system was to provide *Unique Human Care*, a form of care that tended to individuality and humanness of each patient, a care that did away with power differences among patients and health professionals, and a care in which patients had their rights respected.

**6.5 Future of Health Professions Education**

I asked the participants in the interviews, that from their experiences in the PAT program, how they thought the health professional education could be improved. Catherine said
that it was important for patient educators “to have more exposure to a larger crowd” (L1427-1428) in addition to the programs that already exist. In this regard, she said, “You’d better meet two hundred than ten” (L1441). She said nonetheless, that the problem of disclosure was something that prevented her from wanting to do it to a larger crowd herself.

Emily talked about having “more realistic patient cases” (L1064-1065) or “more actual patient interaction” (L1065) in the pharmacy program. In terms of patient involvement in education, she said that it would be good to have a “balance” (L1109) between course that involved longer term interaction with the patients and the courses that were directed by professors and focusing on specific educational objectives. She wished that the PAT program was a “required course” (L1121) in pharmacy. She also said that it was important that the education encouraged collaboration, not just among health professions but also with patients and “getting people more involved in care” (L1145-1146). About the other students in her PAT group, Emily said, “I feel like at that point we were kind of all friends but once we leave, we kind of are very much just doing our own lives and our own things” (L442-443). It did not seem that relationship with her interprofessional group was much of relevance to Emily, as much as it was the case with her teacher.

Nick said that it was important that the curriculum brought in experiences of different people. He talked about an occasion in which a person with schizophrenia spoke in one of his nursing classes, “If I compare Catherine with this gentleman, it’s day and night! It’s important to first of all see the people with certain conditions or whatever it is, but also not everybody will have the same course of their illness” (L1059-1061). Nick said that the PAT program was “phenomenal” (L1036) but he did not think that every student could have similar experiences that take two years. He suggested, instead, “creating … shorter versions of PAT” (L1042) and “a
short topic like a shorter goal” (L1043). He said that the PAT program was “BIG on learning about health, about background about hmm resources, it was so big in topics, to break it into smaller topics so more people can have the chance to be a part of that” (L1044-1046). He also talked about integrating the overlapping content in health professions, “if we integrated certain courses that they’re like applicable to every single discipline and bringing disciplines together, would really help with a better collaboration in the future as a health professional team” (L1038-1040).

Dena said that “something like that [the PAT program] should be in place for everybody to learn, not just as an optional thing, but maybe more embedded within the curriculum” (L976). She said that the PAT program “both helped in developing our own CanMEDS roles but also seeing the CanMEDS roles that they bring to the table as a patient expert, rather than necessarily medical expert” (L971-973). Dena also talked about interprofessional learning, ”Everybody is health professional, so we all have to learn some common aspects, so maybe if there is some overlaps in our curriculum, maybe we can be learning the same things, sort of together … as we did in the PAT” (L993-996). When I asked Dena, what specifically she had learned from her peers she said, “we touch based with each other but the majority of the time was speaking with Catherine… most of our conversations were based on hers and asking her, so learning specifically from each other it was more indirectly and I don’t know if I can pick one” (L611-614). She also told me that she would have liked to stay in touch with her teacher after the PAT program. She was not feeling the same way about the students in her group.

Nelle said that it would be good if the curricula allowed the students to interview clients in “their home or their place of work” (L1036) and “in a meaningful setting … to practice some of the theoretical stuff that they are learning about but to do it on someone that’s not just a case
study on a paper” (L1037-1039). She also said, “it would be really great to have some classes like maybe the class on Neoliberalism that is with all health care professions that were in my group” (L1043-1044) where “we could all be in the same room and learning together things like that, then it would help us understand our scope of practice as well” (L1046-1047). She said this kind of learning needs to take place before the students go to the workforce because “we have been through some similar things and we can work as a team really well” (L1051-1052). She also said topics such as “ideology” (L1052) be taught in the interprofessional education, “so that we are learning the same, for some of it, the same basic foundation, that would be really helpful” (L1053-1054).

In the light of their experiences in the PAT program, the students suggested that the health professional education could be improved if they had more exposure to patients early in their program. They also highlighted the importance of interprofessional learning and the possibility of bringing the students together in interprofessional groups in the overlapping areas of their education.

6.6 Summary

The interviews occurring a few months after the end of the PAT program allowed the students to have a retrospective reflection on their participation in the program. They talked about their objectives for attending the program including how they had learned from their teacher as well as the other students in the group. The students particularly noted the different ways in which they had learned from Catherine. They had learned to respect, to listen to and to collaborate with their patients. They had begun to apply in other contexts what they had learned from Catherine. It seemed that this way of learning was made possible because Catherine was the teacher in that group leading the discussions that were centred on her experiences. This was
evident when the students expressed that learning was different because it was not from a textbook, rather it involved interacting with Catherine.

The students compared the PAT program with other courses in their health professional programs. While the courses in their programs were led by professors and had specific objectives, the PAT program offered the “big picture” drawing from Catherine’s experiences. This made the students begin to learn and appreciate this form of learning. Even in learning clinical information, the students began to see the situations in a more holistic way, and not as “black and white.”

Interacting in a small group and over a long period of time had created conditions in which the students respected their teacher and appreciated the experiences that she was sharing with them over time. For example, Nick particularly respected Catherine because he saw her as his teacher. This positioning also gave a sense of his own role as the student learning from Catherine. Interactions over a period of time also allowed special relationships to grow among its participants. For example, Emily became particularly interested in Nelle and how different her profession was from OT. Dena developed an interest in Nick and his anticipated career of a street nurse.

Additionally the students in the PAT group showed forms of engagement that was reflective of the discourses that informed their health professions. For example, in describing their roles in the PAT group, Emily and Dena said that they were there to “represent” their health professions. It seemed that Emily and Dena were seeing their professional roles in a more homogenous way than Nick, for example, who wanted not to represent his profession but to show to his group how diverse the role of the nurses was. This homogeneity, indicating a biomedical discourse in medicine (MacLeod, 2011), also manifested when Emily and Dena described patient-centred
care as giving options to patients and having them choose a treatment. The discourse seemed to be very different when Nick and Nelle answered the same question. They replaced the word “patient-centred care” with family-centred care and client-centred care respectively suggesting an emphasis to social and holistic aspects in care. These points are further explored in the following chapter in relation to the professional identities of the students.
Chapter 7: Professional Identity

This chapter builds from the discussions in chapters 4 to 6 to discuss the developing professional identities of the PAT students. According to ethnographic reporting of data, the discussions in the previous chapter culminate in this chapter which discuss the conclusions of the study and demonstrate the findings if the study in relation to the research question of professional identities.

In the PAT group, Catherine was positioned at the centre of a community of practice as the teacher of the group. She led the discussions drawing from her experiences with schizophrenia and she responded to questions generated by her students. This way of learning, centred on a patient’s experiences, provided the context in which the students had the opportunity to learn about patient-centred care (see Bleakley & Bligh, 2008). The experiences of a patient at the centre of learning also helped the students to relate the experiences of their teacher to their professional identities and to learn at the same time about other health professions.

This chapter addresses the second research question of the study: How can situated learning in the interprofessional group involving a patient as teacher inform the professional identities of the students? The chapter explores and examines three distinct themes arising from the findings of the study: 1) Institutional positioning enabling patient-centred learning; 2) Multiple ways of learning; and 3) Patient-centred learning and health professional experience. These titles respect the way themes are presented in thematic analysis. First, the titles of the themes are chosen to be short and “concise” to “give the reader a sense of what the theme is about” (Braun & Clark, 2006, p. 93). Second, each theme is distinct and at the same time links back directly to the research question (Braun & Clarke, 2006). To facilitate reading, the contents
of the second and the third theme are organized into parts. To avoid confusion, using the term “sub-theme” is strongly avoided. Rather, these parts are connected to one another and together they inform the theme to which they belong.

7.1 Institutional Positioning Enabling Patient-centred Learning

The findings from this study showed that the students learned from Catherine not necessarily because she was a patient with a chronic condition: more importantly because she was positioned in the PAT group as the teacher for these students. The social practice in which the PAT group was engaged was established in the first place, by the PAT program that was a constellation of such practices (Wenger, 1998). In other words, a social structure was established by educators and administrators in the university, to enable the practice of storytelling, discussion and reflection in the PAT group. As such, the word “social” had a meaning beyond merely an existence in a social setting; rather it included a broader social structure that, in the case of the PAT group, entailed an institutional commitment on the part of the university to create a program like PAT. In this social structure, patients were given roles: to be the teachers. Their responsibilities included sharing their experiences with the health professional students guided by the PAT Handbook, an artefact (Lave & Wenger, 1991) that suggested the topics for each meeting. While the PAT Handbook always invited the participants to discuss the topics as a group, it primarily invited the students to listen to the story of their teacher (M3) while describing teachers as “experts by lived experience.” Centring the discussions of the PAT group on the experiences of a patient allowed the students to see their professional identities in the same light. The creation of a such a social structure by the university suggests legitimizing and recognizing patients’ experiences as a form of expertise on the part of an institution. This
structure came into being in an era in which recognizing patients’ experiences and calls for patient-centred care were gaining ground (Duffin, 2010).

At the same time, the legitimacy and recognition of a patient’s voice created conditions for a kind of relationship between the teacher and her students that was accompanied by students’ respect and gratitude in learning from their teacher (e.g., Nick, J3; Emily, J3) and wanting to continue the relationship with her (M6). The manners that the students showed in relation to their teacher suggested developing a professional identity suitable to what was put into place by the university (MacLeod, 2011). It indicated an institutional identity (Monrouxe, 2010) that was developing from legitimate patient experiences. One example is the time when Nick said (I) that Catherine was a patient but not his patient and that he learned so much from that (see 6.3.1). It seemed that the position of Catherine, as a teacher in the PAT and not as his patient, had a different impact on how Nick saw his learning and his growing professional identity. In the case of the hospital patients, they were “his” patients who he tended to and provided care for, whereas Catherine was “a” patient and more importantly his teacher who he learned from. So it did not seem that learning came from a “patient” per se. Rather it was the institutional positioning of a patient as a teacher and as an old timer in PAT, that made Nick view this as a learning opportunity. This may be the reason that hierarchies are created at the level of the institution and that the system needs to change “bottom-up” (Dena, M6) for a change to take effect. And that is why words such as “patient” can be so disempowering (Catherine, M2). Viewing Catherine in the position of their teacher and leading the group discussions allowed the students to see her as an expert (Emily, J6). It was indeed this positioning that made the difference— as lowering the status of the patient to a participant present in the sessions in fact can prevent the students from seeing the patients as such (Cooper & Spencer-Dawe, 2006).
Other particularity about this PAT group was that the students were learning from Catherine in a non-clinical setting. The literature on professional identities involving patients in clinical wards showed that the students developed biomedical attitude toward patients and this happened where students were providing care for patients (Barr et al., 2015; Warmington & McColls, 2017). The power differences in these settings resulted in developing an “adversary” position toward patients (p. 158). Perhaps the non-clinical setting of the PAT group meetings also explains why the students in the PAT group respected their teacher and developed patient-centred values in learning from her. In the cited literature, in addition to a clinical setting, there was a clinical instructor who was facilitating the sessions. In the case of the PAT group, it seemed that the absence of an instructor and instead having a patient as leading the meetings have made the difference in the way the students learned (e.g., Emily, I).

This section concludes that the institutional recognition involving a power position (i.e., institutional legitimacy conferred) for a patient was important in fostering a patient-centred learning environment. This dynamic gave way to fostering professional identities accompanied by respect and gratitude toward a patient. Patient-centred learning in the PAT group would have not been possible had a patient not been given power and a legitimacy (Lave & Wenger, 1991) to share her experiences. Institutional positioning is particularly important because institutions determine the process of identification to a large extent (Monrouxe, 2010), and it is the institution that subsumes particular discourses in the education of health professionals (MacLeod, 2011).

7.2 Multiple Ways of Learning

Given that professional identity “is learned” (Barr et al., 2015, p. 333), it is important to understand the learning that occurred in the PAT group and how it influenced the developing
professional identities of the students. Based on the reflective journals of the students and what they shared in the interviews, it appeared that the students were engaged in multiple ways of learning as a function of their patient-centred learning. These ways of learning had direct influence on the developing professional identities of these students. The discussion around multiple ways of learning can be organized into Catherine’s clinical experiences, cognitive, relational, and social ways of learning, uncertainty, and developing multiple perspectives in learning.

7.2.1 Catherine’s clinical experiences, cognitive, relational and social ways of learning

Learning in the PAT program showed to contain learning in relation to Catherine’s clinical experiences, as well as cognitive, relational and social aspects of learning for the participants of the study. This finding extends the conceptualization of learning in the theory of situated learning that maintains that learning involves participation in a social context (Lave & Wenger, 1991; Wenger, 1998).

Developing learning from Catherine’s clinical experiences was an aspect of the patient-centred learning experience of the students in the PAT group. Despite Catherine’s lack of educational or professional background in schizophrenia, her lived experience with the illness had led to a kind of learning that contained clinical information. How the illness impacted her body and her brain was a unique experience that Catherine shared with the students (Nick, J2). The learning was in-depth because Catherine shared real examples and scenarios from her life that herself had experienced during psychotic episodes. Her mental stimulations during an episode and how they impacted her body while she was engaged in a daily routine such as heating up the food in a microwave or answering the phone, enabled the students to visualize and
imagine (Wenger, 1998) the kinds of experiences that a person can have while having a mental episode. Catherine’s awareness of these stimulations and reactions and sharing those with her students in the PAT group was related to the students’ professional identities as they were going to encounter patients like Catherine in their professional practice.

The students also learned from Catherine about the medication that she took to manage her illness (M4). Particularly unique about medication was the fact that Catherine told the students that she changed the dose of her medication when she experienced significant events or changes in her life. It was her awareness of her physiological reactions that enabled her to make these decisions. It was the same awareness that enabled her to decrease the dose when she knew her body was becoming less reactive. These perspectives were so unique that the students could have not learned from a textbook (Nelle, J8) or an instructor (Emily, I). These perspectives became evident only in direct exchanges that the health professional students were having with their teacher in the group meetings (e.g., Stockhausen, 2009).

Learning from Catherine’s clinical experiences can also be substantiated from the way the students used this learning in other clinical experiences. For example, having been in the PAT group and having learnt from Catherine, and later on learning about schizophrenia in her medical program (Dena, I), Dena found that her understanding of the illness was more real and authentic compared to the students who had not had an earlier exposure and exchange with a person with schizophrenia as she had. In this sense, Dena was an old timer (Lave & Wenger, 1991) in the schizophrenia week which had direct implications for her growing professional identity (Wenger, 1998).

Cognitive forms of learning surfaced in the PAT group in at least two ways. First, the professional identities of the students enabled them to share content that they had learned in their
programs using brokering (Wenger, 1998). This was the case when Nelle talked about lift and transfer, when Dena talked about the pancreatic cancer, when Nick talked about giving I.V. fluids to his patients, and when Emily shared information about medication. Second, the students manifested cognitive learning using reflection when they visualized their professional practice (Wenger, 1998). For example, the group discussion around the use of terms like “health,” “patient,” and “client,” (M2) resulted in a reflection by the students that involved thinking and negotiating when to use each term and/or how the use of a particular term may affect the people they were serving. Cognitive forms of learning as well as learning from Catherine’s clinical experiences in the PAT group extended the conceptualization of learning in the theory of situated learning that focuses mainly on learning as social participation (Edwards, 2005).

Relational learning concerns the ability to work alongside other people while engaging with the world (Edwards & Mackenzie, 2005, p. 294). Relational learning becomes important in health professional education in creating “a common knowledge based on shared experiences” (Edwards, 2010, p. 42) where a practitioner, in addition to using content from their profession, needs to recognize and respond to others’ viewpoints in practicing care. Learning in the PAT program seemed to have evolved relationally as the group members learned alongside one another. Catherine’s experiences were described as “an open book” (Nick, J1, L18) different from what a person “would read in a textbook” (Emily, J1, L7-8) that guided the students to learn specifically in relation to Catherine. From the perspective of the theory of situated learning, in this form of learning, the PAT participants were involved as whole human beings (Lave & Wenger, 1991) connecting Catherine’s stories to their own experiences and the experiences shared by their peers. As such, the process of learning in the PAT group suggested that the students learned about healthcare in a way that was more experiential and relational. The
relational forms of learning revealed forms of convergence and divergence among the PAT participants (Lingard et al., 2017). This meant that in their relational learning, they shared knowledge, insights, and values (convergent) and at the same time, each participant had unique and distinct perspectives that was not shared by the team (divergent). The uniqueness of perspectives is discussed in-depth in 7.3.

Cognitive as well as relational forms of learning were evident in the learning objectives that the PAT program pursued. Instead of giving discrete objectives to master, the PAT program provided flexible and guiding objectives for group discussions. The meeting outlines in the PAT Handbook suggested a few questions for the participants to discuss during each meeting. The participants were also encouraged to explore their own questions. The group meeting objectives used words such as “relate,” “explore,” “explain,” “give examples,” “compare,” “elaborate,” “describe,” and “illustrate” in relation to the experiences of the participants. The meetings followed an open structure and they were “loosely” (Nelle, J2, L13) shaped according to the topics that were being discussed. Students were not expected to provide care. The learning objectives encouraged the students to openly explore their learning through the reflective journals that they wrote after each PAT meeting or event. In this process, the students directed their own learning while at the same time being part of a collaborative knowledge (Confessore, 1997) created in the PAT group. The objectives for the reflective journals asked the students to describe “what,” “why,” and “how.” These objectives worked as an explicit invitation for the students to participate in dialogue, ask questions and inquire, and develop relationships.

The relational aspect of learning (Edwards, 2010) in the light of calls for patient-centred care, opened the opportunity for developing a professional identity: for the students to take their learning beyond what Catherine offered to them immediately and to reflect on it in a broader
perspective. For example, when reflecting on Catherine’s job loss, Nick connected the loss to the approaches that health professionals needed to take. In his reflection, Nick created a bridge between a topic that may have been perceived as irrelevant to health care (job loss) and identified it as central to health care: tending to “physical, mental and social needs” (J5, L20) of the patients. This also happened when, in writing their reflections about the PAT meetings and Catherine’s stories, the students visualized (Wenger, 1998) what their future practices with clients might look like (e.g., Emily, J8; Nelle, J4; Nick, J2, J3).

Hearing the stories from Catherine over time made the students learn about the health care system and the support services available to people with mental illness. For example, it was the discussion about Catherine’s executive coach in the third meeting that led Nick to introduce case managers and their relation to social workers and other health professionals as part of the care system available for people with mental illness. The discussions centred on the experiences of a patient helped the students to imagine (Wenger, 1998) their own roles in the health care system in relation to those experiences. Through these kinds of imaginations, the students were able to make sense of their own professional identities in the health care system (Wenger, 1998). These same experiences and the group discussions about those experiences enabled the students to see the gaps in the health care system (Nelle, J1) and to offer solutions to address them (e.g., Dena, M6).

Last, learning in the PAT program was social. Lave and Wenger (1991) described the term “social” as the way of engaging with the world as whole human beings and “that agent, activity, and the world mutually constitute each other” (p. 33). Lave and Wenger (1991) also described the term “social” as the “milieu in which the community of practice is located” (p. 92). They exemplified this social milieu differently for each of the CoPs that they described. The
social milieu for the tailors included sponsorship in exchange for labor, and the social milieu for the Yucatec midwives was described as membership in a family (Lave & Wenger, 1991).

The social milieu for the PAT group, and as discussed in 7.1 and 5.1.4, consisted of the PAT program, a constellation (Wenger, 1998) and a social structure that the university had deliberately established to help the health professional students learn patient-centred care in relation to the experiences of their teacher and in relation to their peers. This social structure also consisted of roles and responsibilities for each of the patients and the students. The patients were positioned as teachers who shared their lived experiences with their students. The students were positioned as coming from health professional programs while bearing the professional identities belonging to each. Assigning roles showed that social learning also had a historical sense to it (Wenger, 1998). The practice of the PAT group, and its recognition by an educational institution was also situated in a broader social movement that contained recognition of the social contract of health (Duffin, 2010) and the call for patient-centred care in which patients were encouraged to have their voice heard in the health care system. Learning from Catherine`s experiences, as well as cognitive, relational and social ways of learning worked as resources (Duguid, 2009) that the PAT learners deployed throughout their PAT practice.

7.2.2 Uncertainty

Participation in the PAT program helped the students to think about care in a way that was “less certain” than what they were learning in some other parts of their program.

The holistic ways in which the students learned about Catherine`s experiences created uncertainty (Lingard, Garwood, Schryer, & Spafford, 2003; Monrouxe, 2009) in some aspects of their learning and how they would use this learning in the future. For example, Nelle (J2) wrote about not knowing how to overcome the power differential that existed between patient and
health professional which, for her, was a case of uncertainty. She wrote that the difficulty lied in providing service for a patient like Catherine who was *highly aware* of “the uncertainty of tomorrow” (L42). This reflection suggested the influence of a kind of a discourse that discourages uncertainty in the relationship between the patient and the health professional (MacLeod, 2011). That seems to be the reason that Nelle was feeling uncomfortable about the situation. This discourse also tends to discourage the patient from seeing these uncertainties because patient’s ability to perceive the uncertainty threatens the professional identity of the competent health professional (Monrouxe, 2010). Therefore it leaves it to the hands of the health professional to manage the health services and to come up with clean and certain answers to even complex situations.

Another example of developing uncertainty was Nelle’s open-ended questions about her role in the health care system (J4). She wrote that she felt “anxious and curious to learn more” (L28) about how to adjust her practice for “each and every client” (L30). In her reflections on Catherine’s experiences, Nelle drew a picture of the health care system and her own role within it. This picture was not perfect and in it, she visualized gaps and uncertainties that made her concerned. Uncertainly and realizing that “certain therapies are not going to be clear” (Emily, I, L312) were also part of Emily’s growing professional identity.

The uncertainties carried by the PAT students may have reinforced the fact that the students were mainly influenced by a biomedical discourse that permeated their education as these uncertainties revealed the “discomfort, awkwardness, or a lack of confidence” (MacLeod, 2011, p. 381) that the students were having with uncertainty. These excerpts also revealed what might be called as a discourse of fear in which the students “stumble, seem uncertain, and
occasionally express concern” (MacLeod, 2011, p. 383) about situations that seem to be complex.

Managing uncertainty, for the PAT students, seemed to be connected with the narrative of “uncertainty of medicine” (Monrouxe, 2009, p. 51) that has been attributed to the changes in the way of thinking in the society as “an evolution moving from deferential acceptance to active consumer-based critique” (Monrouxe, 2009, p. 51). These changes vis-à-vis the education of health professional students may contribute to the uncertainties that they develop during learning. The uncertainty of medicine has been discussed as a counter narrative to the narrative of the “certainty of medicine” (Monrouxe, 2009, p. 47). Whereas the certainty of medicine “reflects the ideology of authoritative certainty which characterises the dominant discourse in medicine: the use of medical terminology, objectively describing physical symptoms, and the classifying illnesses within the biomedical model” (p. 47), the uncertainty of medicine “explores the epistemological basis informing and supporting that role [role of medicine]: what comprises knowledge? It requires the narrator to accept uncertainty in both the limits of their own knowledge and in the body of knowledge that medicine draws from” (p. 51).

Uncertainty has been discussed in clinical medical education (e.g., Luther & Crandall, 2011; Monrouxe, 2009) where, despite the scientific and technological advances, the learners are less prepared and less tolerant of ambiguity and uncertainty in care (Luther & Crandall, 2011). Luther and Crandall (2011) suggested that the students who were less tolerant of uncertainty in clinical practice were less willing to serve underserved populations that may have more complex conditions. This point is related to the kinds of learning objectives used in the curriculum. From this point, it could be argued that dissecting complex phenomena into observable and discrete learning objectives may contribute to the lack of tolerance for ambiguity and uncertainty. In
contrast, the relational way of learning, that allowed the PAT students to follow flexible objectives and to explore their learning openly, seemed to enable them to deal with uncertainties in multiple ways.

7.2.3 Developing multiple perspectives

The PAT students showed instances where they had developed multiple perspectives regarding the various experiences that Catherine shared. Having to deal with uncertainty and tackling it created cognitive disequilibrium (Kay, Berry, & Coles, 2018) the negotiation of which helped expand students’ horizons to see problems from different lenses. An example can be brought in relation to Emily. After discussing the access to and sharing of information (M5), in her reflective journal (J7), Emily connected Catherine’s dissatisfaction in sharing her medical history with health professionals with her own experience in accessing health professionals. She wrote how vulnerable patients can be when interacting with health professionals: that while patients are expected to disclose their personal history to the health professionals, this sharing is not reciprocated by the health professional (J7). This dynamic creates an unbalanced relationship between the two and makes the patient vulnerable. This nuanced form of reasoning by Emily revealed a professional identity that was tackling a problem from a different perspective. This perspective was enabled by the holistic way in which Emily was learning from her teacher, connecting it to her own experiences and making a conclusion that was beyond the immediate story shared in the meeting. In this process, she was negotiating between her own perceptions and what was shared by her teacher to find an explanation for an intricate situation (Wenger, 1998).

Uncertainty in learning and multiple perspectives were related to one another to the extent that, at times, the students developed multiple perspectives in response to an issue that had
created uncertainty for them. This was an approach that the students used to cope and to feel comfortable with uncertainty. For example, when Catherine was at risk of disclosing her mental illness to her professional board, Nelle questioned her own position in the health care system, mentioning that the issue took away control from her and from her teacher and that she did not know how she could help a client in a similar situation (J3). Disclosure was an issue that kept recurring in group conversations. It also showed itself in the reflections of the students. For example, Nelle continued to write about the issue. From the reflections in her third and fifth journal entries (sections 4.3 and 4.5), it appeared that Nelle was struggling to find an answer to the problem of disclosure that her teacher had. This struggle reflected an “engaged dilemma-driven” (Lave & Wenger, 1991, p. 33) form of learning for Nelle that evolved into a resolution according to her later journal entries. In a reflection that Nelle wrote toward the end of the PAT program (J7), she tried to settle and resolve her uncertainty about disclosure by creating a cycle for disclosure (see 4.7). She then wrote about the processes involved in disclosure, including how disclosure could be a beneficial experience. In doing so, she referred to an instance where Catherine had disclosed her illness to a friend. In trying to address the uncertainty in relation to disclosure, Nelle articulated multiple perspectives highlighting societal and personal issues in disclosure. In doing this, she tried to develop a resolution for an underlying conflict (Lave & Wenger, 1991) — the problem of disclosure— by referring to the positive consequences of disclosure, “friendship deepened” and “disclosing reciprocated.” She solidified her resolution by using language, such as “disclosure as education” and “normalizing a stigmatized topic” which were positive descriptions for an otherwise difficult dilemma.

In another example, when Dena reflected in one of her journals (J5) about the complexity of Catherine’s experience (see section 4.5), her reflection included a consideration that losing a
job had both some obvious consequences for Catherine, as well as some “less obvious” consequences that could impact her health. This reflection suggests that Dena was coming to perceive Catherine’s experience from multiple perspectives: the perspective of a general observer, the personal perspective of Catherine, and the socio-economic aspects of her experiences that confounded her health.

Discovering the various forms of learning in the PAT group informs the processes in which the professional identities of the students were evolving. This is particularly relevant given that the process of identification among the students is formed by these cognitive, relational and social processes that are further enhanced by the use of artefacts (Monrouxe, 2010). However, it is important to note that these cognitive, relational and social processes occurred in a setting that was led by a patient and that was non-clinical. A question that needs further investigation is the learning processes that are involved in a clinical setting that are often led by clinical instructors.

For example, while Dena’s reflection showed a resolution and comfort in relation to a previously uncertain situation in a non-clinical setting, it would be interesting to know how her perception would evolve once she began her clinical rotations. A point that becomes relevant in relation to this finding, is that the narrative of uncertainty of medicine has a stronger presence in earlier years in medical education and as the students move toward their clinical years, they begin to question this narrative (Monrouxe, 2009). This is done so given the emphasis that is given for developing a competent and confident demeanour throughout the curriculum (MacLeod, 2011).

Evidence from the data suggests that the PAT students were approaching their learning from multiple perspectives. Learning in a patient-centred context based on the experiences of Catherine allowed a holistic way of learning to take place. It included learning from Catherine’s
clinical experiences, cognitive, relational and social ways of learning as well as tackling uncertainties and developing multiple perspectives in relation to those uncertainties.

7.3 Patient-centred Learning and Health Professional Experience

This theme discusses that the patient-centred learning in the PAT group allowed the students to see their own roles in the health care system. In this way, they related to one another interprofessionally and saw the role of their own profession in relation to Catherine’s experiences. The analysis of findings suggests that, for this particular PAT group led by Catherine, interprofessional collaboration was a sequence to patient-centred learning. It also suggests that developing professional identities within students’ own professions was more pertinent to this particular patient-centred learning context. This section corroborates this conclusion.

7.3.1 Interprofessional learning as a sequence to patient-centred learning

The meeting discussions and the interactions of the students showed some interprofessional learning that informed their growing professional identities. More importantly, it was centring those discussions on the experiences of one patient that gave meaning to the interprofessional relations among the PAT group students.

The growing professional identity among the PAT students encompassed interprofessional competencies (Orchard et al., 2010) that they were practicing in the group. They talked about patient-centred care that was included as a learning outcome in their programs (e.g., Emily, I; Nick, I). They learned to collaborate with one another as a team in a non-clinical setting. This became evident in their collaboration in creating a board for the symposium that was centred on the experiences of their teacher (e.g., Nelle, I). They also practiced interprofessional communication (Orchard et al., 2010) by interacting with the students in
different health professions. This was evident in places where the students talked about or reflected on how their own profession fitted in, in relation to other health professionals (M3). Another example included gaining insights into other professions through the types of questions that each student asked (Emily, J3). Through participation in the PAT, the students were able to gain “role clarification” (Orchard et al., 2010) about other health professions. By bringing knowledge from their own disciplines and then engaging in interprofessional collaboration with peers, the students seemed to be developing what Sterrett, Hawkins, Hertweck, and Schreiber (2015) described as an “interprofessional identity” (p. E2), a term that has yet, but may begin, to appear in the wider literature in interprofessional education. The interprofessional instances of learning also gave light into the relational ways of learning among the students (Edwards & Mackenzie, 2005; Lave & Wenger, 1991). Despite the various instances of interprofessional learning among the students in this PAT group in the duration of the PAT program, my analysis based on this particular data suggests that interprofessional collaboration for these students in this particular PAT group was not a long-term goal. In fact, the students only talked about the importance of interprofessional learning when I directly asked them about it.

It seemed that learning from their teacher and applying it in their individual programs took precedence for the students. All the students mentioned that they valued learning from Catherine, and that if they had professional practice, they would apply what they were learning from Catherine in that practice. The students talked more about what they learned from Catherine than from their peers. They were also interested in continuing the relationship with their teacher but not necessarily with their peers as they believed they had different career trajectories (e.g., Dena, I; Emily, I). When I asked the students whether they wanted to have more interprofessional learning opportunities in the health professions, they replied that they
were interested to have it “maybe if there are some overlaps” (Dena, I, L994-995) in their programs. This suggest that the students did not see that their programs had much in common. Emily iterated the same idea when she said that “once we leave, we kind of are very much just doing our own lives and our own things” (I, L442-443).

Another example is the time when Nelle said that the meetings were more focused on Catherine and that it was in the preparation of the symposium that the students began to have a more active participation and collaboration with one another (I). This statement reinforced the centrality of Catherine’s position in the PAT group. From Nelle’s perspective, it seemed that the students were on the periphery on the PAT group learning from Catherine as she led the discussions (Lave & Wenger, 1991). As noted in Chapter 2, periphery is a notion that suggests that regardless of the role a person has in a community of practice, being on the periphery entails a productive form of participation for the learners (Wenger, 1998). In this case, while the students discussed with Catherine about her life experiences during the meetings, took notes and wrote reflective journals as reifications from the meetings, they later converged these forms of participation to inform their full participation in the symposium.

The issue of interprofessional learning surfaced in the third meeting where each student introduced her or his profession. Although interprofessional learning was given particular focus in this meeting, it did not have prominence in the interactions in that session. Neither did the students give particular attention to interprofessional learning in their reflective journals (J4) that they wrote after this meeting. Catherine said in that meeting (M3) that her only health care team was her psychiatrist. She also said that if she needed any help beyond a psychiatrist, it was more about holistic chronic care, having consistent access to a family doctor, and other stabilities in life for her “multifaceted” (M3) care needs. It is important to highlight that Catherine’s stance
was due to the fact that services for people with mental health were being withdrawn and that she could not access a new psychiatrist once her old one retired. In spite of this situation (lack of access to mental health services), and considering the services that were available to her at the time, direct access to an interprofessional “health care team” did not seem to be a priority for Catherine. This may explain why interprofessional collaboration was only sequential to patient-centred learning for the students, as they centred their learning only on the experiences of Catherine who said that she did not need a health care team.

The conclusion that interprofessional learning in this group was not a primary goal can be explained in at least two ways. First, the fact that Catherine was a “high functioning” (M3, L215, L263) patient who could manage her illness in her own ways, may have made Catherine needless of accessing a health care team and hence not setting it as a priority for her students in the group meetings. Indeed, in those meetings, she was more concerned about having one stable family physician who would refill her medication or write referrals for her when she needed (M3; M6). Second, perhaps the prominence of interprofessional team comes better into place in acute care settings. The interprofessional learning literature, that I searched and found, usually showcased interprofessional learning in clinical and acute care settings (e.g., Bridges, Davidson, Soule Odegard, Maki, & Tomkowiak, 2011; Conte, Scheja, Hjelmqvist, & Jirwe, 2015). Catherine’s illness was chronic and managing it required having several stabilities that she had learnt to bring into her own life over the years. This included choosing a particular lifestyle and avoiding situations that could trigger a psychotic episode. She had also chosen to have a psychiatric and a life coach to help her navigate through life events and decisions.

The focus on patient-centred learning as primary and interprofessional learning as a sequence of patient-centred learning may also be explained by the fact that the meetings were
focused on Catherine’s experiences and were led by her. The discussions in these meetings were centred on Catherine’s unique care needs that were likely different from another patient. This is essentially not a problem: if the purpose of patient-centred care is to have health care services centred on the experiences of the patients, then it is reasonable that the patients lead the discourses in education and care (Bleakley & Bligh, 2008). In the same way, it is reasonable that patients’ concerns and perspectives take precedence over interprofessional perspectives. It is also reasonable to acknowledge that the health care needs of different patients determine the scope of interprofessional involvement differently for each. This is what Catherine described as the “unique human care” (I, L457). After all, it is the needs of the patient that determine the extent of interprofessional involvement.

In spite of the lack of emphasis on interprofessional learning in this PAT group, the students learned significantly from their teacher and wanted to use these experiences in their own careers giving insight into their developing professional identities.

7.3.2 Professional identification in the PAT group

My analysis revealed that each health profession had its particular influence in the developing professional identities of the students grounded in particular discourses (Frost & Regehr, 2013; MacLeod, 2011). Each profession was influenced by a particular discourse and the students were being socialized into acquiring a professional identity unique to that profession. This socialization (Wilson et al., 2013, p. 370) became visible through the language that the students used (“patients” and “cases” for Nick, Emily and Dena, and “clients” for Nelle), as well as the kinds of questions that each asked (close-ended questions for Dena and open-ended questions for Nelle). This socialization was also made visible through the ways the students made sense of their professional identities inspired by Catherine’s experiences.
From the first meeting, the students began identifying as a health professional in relation to the experiences of Catherine. This was evident in Emily’s reflection (J2) on the different meanings that different terminologies had and what their implications were for her role as a pharmacist. In the same vein, Nick reflected (J2) on terminology and how he can apply what he learned in his practice with his patients. In all these reflections they either used or imagined (Wenger, 1998) how to conduct their professional practice in relation to the experiences of a person like Catherine. In almost all of the journals, the students reflected on what these experiences meant in relation to their own profession.

In the case of Emily, she was embodying in the PAT group the identity of a pharmacist, a role that she was yet to practice. In her own words, she was representing her field and where her knowledge in pharmacy was placed in the health care system (I). Emily’s position in this group seemed to be productive and competent (Wenger, 1998), and added to the construction of knowledge in the group (Lave & Wenger, 1991). She was described as seeming “to know a lot” (Dena, I, L578). This was evident in the scientific inputs that she shared in the group when they discussed medication, and how certain kinds of medication impacted the person’s physiological responses. The ways in which Emily was participating in the group discussions suggested a form of socialization taking place within a scientific or biomedical discourse to medicine (MacLeod, 2011) with precise solutions to health problems.

One area of the social influence for Emily was the curriculum in pharmacy. She said that her pharmacy program pushed for patient-centred learning as well as integration with “other fields” (i.e., health professions). Participation in the PAT program helped augment the social discourse of medicine (MacLeod, 2011) for Emily where learning was more “self-guided” (L239). Emily said that in the pharmacy school the objectives were pre-specified but in PAT
“you choose what you get out of this program” (L249-250) which in and of itself grew in her belongingness to the community of PAT and her developing professional identity (Wenger, 1998). Nonetheless, from Emily’s descriptions, it was evident that the pharmacy program was mainly influenced by the biomedical discourse to medicine (MacLeod, 2011). Of patient involvement in her program, she mentioned that the encounters were “time-restricted” (L241) and followed “specific objectives” (L240) and that the students had to ask questions particular to the case with which they were presented.

Nelle’s holistic approach to learning reflected the high value of the social discourse (MacLeod, 2011) in her profession. This was evident in her asking open-ended questions, seeing Catherine’s problems as uncertain that did not have one or quick solutions, and also seeing her profession as the “good guy” (I, L, 513) among the health professions with a less authoritative role. Also in comparing her program to other health professions, she said that she favored OT because it “has really got the physical component, has got the advocacy that I really like and it’s got mental health in it as well” (Nelle, I, L637-639) in an emphasis on holistic ways of learning. This was also evident as she said that the OT program modelled client-centred care for them (I), or that the OT program held courses on neoliberalism for the students congruent with occupational therapy’s emphasis on critical learning (e.g., Whalley Hammell, 2015). Her values distinct from those possessed by her fiancé accentuated her different perspective. For example, she recounted that her fiancé would laugh when she used the word “client” or that he had a different lens than her toward patients. From her accounts, it was obvious that her and her fiancé were growing into different professional identities according to the professions they were at. This difference showed two different identities belonging to different professions: none being better
than the other necessarily, but each having a different emphasis on social and biomedical discourses of medicine (MacLeod, 2011).

When Nelle talked to me about the importance of teaching neoliberalism to interprofessional groups of students, she said that the best place for students to learn about neoliberalism was there at school before they went into their careers (I). Nelle wanted the social discourse (MacLeod, 2011) to be taught to all health professions but at the same time she was acknowledging that each health professional student was being immersed in a different discourse once they entered their careers. Interprofessional education helps the students to better understand the role of other health professions, and yet at the same time it can reinforce the stereotypes that are attached to each profession (Burford, 2012). Such was the case in the PAT group when negative attitudes toward physicians seemed to remain unchanging (Emily, I; Nelle, I; M6).

Similarly, Dena was being socialized into the medical profession suggesting a developing professional identity of physician within a biomedical discourse (MacLeod, 2011). For example Dena asked kinds of questions that were different from Nelle’s. She also used a biomedical rhetoric when she wrote about Catherine’s compliance with the rules of the hospital (J3). At the same time, she was critiquing this rhetoric when she referred to compliance as the only way that helped Catherine to get out of the hospital, to get out of the biomedical system, and “get back on track” (L45) with her life. It seemed that while the biomedical discourse was influencing her approach and her language, she made an individual effort to embed her participation in a social discourse (MacLeod, 2011).

Dena was simply a student, but when there were talks of physicians, a professional identity of a physician became prominent (Wenger, 1998) for her. The PAT group meetings were
replete with critiques about physicians’ attitudes particularly when narrated by Catherine. This kindled the professional identity of a physician in Dena. It seemed that Dena felt the need to react in ways to either confirm the critical notions about physicians, or to justify why some behaved the way they did (M4). She confirmed the negative views about physicians by telling how some of the people in her medical program refused to be called by their first names or by titles other than “Doctor” or “Dr. whoever his last name” (M4, L299). Other times Dena would justify their attitudes by explaining how paternalistic medical education was in the previous generations and that today’s generation is different because the medical students are being taught about patient-centred care and the focus on illness as affecting person’s whole life rather than the disease (M3). In these instances, it seemed that Dena was trying to protect the community of medical professionals with which she identified (Burford, 2012). Yet at the same time, she was struggling to not say or do anything that might suggest that medical profession was superior to other professions- a struggle that medical students face in interprofessional collaboration (Gallé & Lingard, 2010). This struggle also suggests that a medical student can experience dissonance between her personal core values and the values proposed by her profession of choice (Goldie, 2012). These discussions enabled Dena to negotiate her growing professional identity in multiple ways. By suggesting a resolution to the dilemma of physician’s behaviors, she created “reconciliation” (Wenger, 1998) for her professional identity in different communities: the community of the PAT group and the community of medical education.

In spite of any reconciliation, medical education was viewed as influenced by the biomedical and scientific discourse of medicine (MacLeod, 2011). The PAT students, through their reflections, confirmed this finding. Dena being a patient-centred medical student, did not change Nelle’s or Emily’s perception of physicians. In fact, “perception of the other” is one way
in which the learners categorise team members with whom they come into contact (Lingard, Reznick, DeVito, & Espin, 2002). This strategy helps the learners to cope with “social chaos” (p. 729) that may surface in interprofessional collaboration. In this sense, Dena’s patient-centred identity was an “add-on” (MacLeod, 2011, p. 386) that she was bringing to her medical program as her “personality” and not as a characteristic of the biomedical discourse of medicine. Otherwise, identification in the medical profession seemed to be viewed as more or less the same.

Changing fields from engineering to nursing and choosing a profession that had historically been associated with women, Nick was ongoingly negotiating his professional identity. Nick explicitly stated that he wanted to become a street nurse specializing in mental health. This is how he saw himself (Monrouxe, 2009) given his goals and past experiences. Nick’s position as a nursing student provided him with some conditions (i.e., past experiences in Urban Core, current membership in the PAT community of practice, access to clinical practice, and his goal to become a street nurse) that were necessary in developing an identity of mastery (Lave & Wenger, 1991, p. 41), or in becoming a master practitioner in nursing. Having access to an arena of “mature practice” (Lave & Wenger, 1991, p. 110) enabled him to directly apply in clinical practice what he had learned from the PAT group discussions. By transferring his knowledge from one situation to the next (Ewertsson et al., 2017), Nick was able to blend PAT participation with clinical practice and draw upon his past experiences as an aid worker, in developing his professional identity (Lave & Wenger, 1991): intention to become a street nurse specializing in mental health and working in the Urban Core.

From the accounts given by Nick, particularly his experiences in the hospital, it may have appeared that the biomedical discourse (MacLeod, 2011) was weighed heavier in the nursing
program, however there was also some emphasis given to the social discourse. Nick had relational courses, policy courses and science courses in the nursing program (I). He said that there were fewer credits for relational and policy courses, and that more credit was assigned to science courses. He said, however, that sometimes the workload required for completing the relational and policy courses was more than the science ones. As such, though biomedical discourse had precedence in his school, it seemed that the demand for social discourse was equally substantial. Therefore, there seemed to be an equilibrium between social and biomedical discourses (MacLeod, 2011) to learning in Nick’s growing professional identity: what Frost and Regehr (2013) described as a hybrid of discourses.

The conclusion from this analysis suggests that the diversity of discourses among the health professional programs was indeed a merit. Each student in the PAT group had willingly chosen their own career path and shaping her or his identity in that trajectory. Their motivations for engaging in the PAT group were different but seemed to be fitting in their interprofessional collaboration in the group (Clark, 2014). While it is important for the health professional students to have exposure to various discourses, it seems that the different perspectives, discourses, and worldviews within each profession is the essence based on which each profession performs. It is the presence of these discourses that enable the health professional to establish and make sense of their professional identities (O’Flynn & Britten, 2006). To make these professions homogeneous or pursuing similar worldviews may threaten the sense of professional identity that each profession beholds and possesses.

7.4 Summary

This chapter continued the discussion from the previous chapters. It drew from the description of the data and interpretations to address the second research question of the study:
How can situated learning in the interprofessional group involving a patient as teacher inform the professional identities of the students? Several points were raised to address the question of professional identities as developed in the PAT group. Learning and socialization that took place in the PAT group meetings and the reflections thereafter revealed a patient-centred way of learning among the students. This form of learning influenced the ways in which the professional identities of the students were taking shape.

First, the institutional positioning of a patient as a teacher in the group leading the meetings legitimized the teacher’s perspective as informing the knowledge that was being shared and constructed in this group (Lave & Wenger, 1998). It also created a dynamic in which the students respected their teacher. They applied what they were learning from her in other aspects of their professional program in a way that they would not have from a patient. It was the institutional positioning of a patient as a teacher that gave way to developing an institutional professional identity (Monrouxe, 2010) that was suitable to this context: a context that was centred on the experiences of a patient and that was led by a patient.

Second, centring the group discussions on the experiences of a patient enabled learning from Catherine’s clinical experiences and developing cognitive, relational and social forms of learning. The students learned about the physiological aspects of schizophrenia, and they visualized their own professional identities in practice (Wenger, 1998). These forms of learning were enabled because the students were relating their teacher’s experiences to their own professions while considering the larger social structure and the health care system in which their professions operated. These forms of learning, given their holistic nature, created uncertainties for the students that are inherent in learning about real-life situations that are often complex (Monrouxe, 2009). Negotiating uncertainties enabled the students to develop multiple
perspectives in resolving those situations (Lave & Wenger, 1991; Wenger, 1998). It was the 
centring of the discussions of the group meetings on the experiences of one patient that allowed 
the students to learn in varying ways and to develop resolutions to the uncertainties that had 
created discomfort for them in their learning.

Third, centring learning on the experiences of a patient as a teacher set the medium of 
what was important to learn and to use in their professions. In this particular group with 
Catherine as the teacher, interprofessional learning occurred; however, it was sequential to 
patient-centred learning. It was the patient-centred learning and solo identification in response to 
their teacher’s experiences that indicated a growing professional identity among the students. 
Interprofessional learning in the PAT group was enabled by centring the learning on the 
experiences of a patient: this allowed interprofessional competencies to evolve around the 
experiences of the patient. The students steered their professional trajectories mainly in relation 
to Catherine’s experiences.

Centring learning on Catherine’s experiences also gave insight into professional identities 
that were distinct for each student according to the profession in which they were studying. The 
analysis of the data showed that each health profession was influenced by social discourses, 
biomedical discourses (MacLeod, 2011) or a hybrid of the two (Frost & Regehr, 2013). While it 
was important to expose students to discourses other than the one that permeated their own 
profession, it seemed that the dominating discourse in each profession was an asset in developing 
their professional identities and not necessarily a problem (Clark, 2014).
Chapter 8: Conclusion

Given contemporary health care needs and the growing demand for patient-centred care, a call for patient-centred learning for health professional education is gaining ground (Bleakley & Bligh, 2008). This dissertation explored patient-centred learning by addressing the question: How can situated learning in the interprofessional group involving a patient as teacher, inform the professional identities of the students? This question was examined in the context of the PAT program.

The PAT program was a longitudinal interprofessional program that was offered in the curriculum of the health professions at the West Gardens University. The group studied was one of 52 PAT groups and consisted of a teacher who was living with schizophrenia and four students each from a different health program: medicine, nursing, occupational therapy, and pharmacy. This study set out to explore developing professional identities for the students participating in this PAT group.

The theory of situated learning was used as the theoretical lens to examine learning and developing identities in the PAT group. In doing so, the PAT group was conceptualized as a community of practice. In other words, the ways in which the participants interacted with one another over a long period of time suggested forming of a community that had what is characterized as a community of practice. These ways included the mutual engagement among the PAT participants, their joint enterprise and shared repertoire (Wenger, 1998) that included accountability to each other and to their practice, developing common values, and forms of engagement and reifications that were unique to this group. The participation in this group was also accompanied by negotiation of meaning and peripheralities that gave meaning to the unique
participation and positioning of each participant in the group according to her or his unique interests and needs.

The literature on developing professional identities is mainly studied in relation to career calling, professionalism and hidden curriculum (e.g., Gaufberg et al., 2010; Wilson et al., 2013). There were fewer studies that explored developing professional identities with the involvement of patients in the education of health professional students (e.g., Barr et al., 2015). These studies involved clinical learning sessions that were directly led by clinical instructors. It was found that in clinical education the students had mainly developed negative attitudes toward the patients (e.g., Warmington & McColls, 2017). My dissertation addressed a gap in the literature by studying the development of professional identities in a context that was non-clinical and in which a patient was leading the learning sessions in the absence of any instructor.

A qualitative approach to research using ethnographic methods was used. The methods of data collection included recordings of the group meetings, students’ reflective journals, as well as the interviews. These methods were combined for the purpose of triangulation and establishing consistency and credibility of findings. A distinction was made between the methods for collecting data and the data that was analyzed using thematic analysis (Braun & Clarke, 2006). This data included transcripts of the recordings of meetings and interviews as well as the students’ reflective journals. Thematic analysis was used with this data and it involved both inductive and deductive approaches. The inductive approach was used to identify codes in the data. The deductive approach used concepts from the theory and the research question as sensitizing concepts in examining the data. The analysis of the data involved five phases. Toward the end of the analysis, the inductive and deductive analyses interacted with one another to inform the themes of the study.
This final chapter is organized into three main sections. In the first section, I articulate the findings and implications of the study. In the second section, research limitations are described. In the third section, I provide suggestions for future research. The chapter ends with a summary.

8.1 Findings and Implications of the Study

This dissertation adds to the extant literature on professional identity formation given that identity and identification are marginalized in the literature of health professional education (Monrouxe, 2010). The findings from this study become particularly important given the context in which developing professional identities was taking place: a non-clinical setting led by a patient as teacher who was teaching the students about her experiences living with paranoid schizophrenia.

First, this study found that it was the institutional positioning of the patient as a teacher that made possible and legitimized learning from her. An implication for this finding is that other universities can create programs that have a structure similar to PAT. A legitimate position for patients given by the university allows a particular kind of relationship to occur among the students and their teacher, and hence a different form of professional identity to grow: one characterized by respect and reciprocity.

Second, the holistic structure of the PAT program allowed the students to learn not only from Catherine’s clinical experiences, but also in cognitive, social and relational ways. This has implication for patient-centred care. If the students are to learn patient-centred care, affordances need to be made to create context for holistic learning based on the lived experiences of the patients. One implication for this finding is that the health professional curricula can create more programs that directly engage students in learning sessions that are led by patients and that build on patient experiences over time.
Learning throughout the PAT program was accompanied by developing professional uncertainties on the part of the students. The students encountered uncertainty in the experiences that their teacher was sharing with them and at times, became more comfortable with it as they tried to develop resolutions to it. These resolutions came to the fore as the students developed multiple perspectives in relation to the experiences that Catherine shared with them. An implication for this finding is to create programs that follow an open structure with guiding objectives. Such a context could allow the students to encounter uncertainties, negotiate them over time and become comfortable with them.

Third, this study found that patient-centred learning took precedence over interprofessional learning. This finding implies that more investigation needs to be done as to whether and to what extent health professional curricula indeed need interprofessional exposure. Such investigation would help with designing interprofessional programs that are relevant to the needs of the professions. Simple interprofessional exposure may not seem to be meaningful for the students if they do not directly use it in their practice alongside a patient, or if this is not something that is needed by the patients in the first place.

This study also found that different health professions, were immersed in particular discourses which in turn, may have given way to developing professional identities informed by the dominant discourse in the profession. This was manifested in the way in which the PAT students led their participation trajectories influenced by the discourses that dominated their health profession. The implication to this finding is that if health professional curricula want to foster a particular kind of professional identity, it is important that they encourage creating discourses in education that help cultivate the intended identities.
8.2 Limitations of the Study

There are at least four issues that may be considered a limitation of the present study. First, given the qualitative nature of inquiry, this study may have been influenced by researcher bias in data collection and interpretation. Bias can become problematic particularly in ethnographic reporting that needs to be faithful to the voices of the research participants. As a researcher, I was inserting an interpretive lens and I understand that my position shaped the construction of the findings. My intention all along was to see the world from the participants’ point of view. I tried to minimize bias in data collection by using triangulation with different sources of data. I also tried to minimize bias in data analysis by using a systematic method in analyzing the data. In doing so, I examined the codes across all three types of data in multiple iterations (see Chapter 3). I also tried to eliminate bias by member checking the findings from the study. All five participants of the study were contacted for member checking. One-on-one phone conversations were conducted with the three participants who took up that invitation. They were informed about the ways in which their words and quotations had been used and represented in the study. All three confirmed these representations. Last, this dissertation was reviewed by the supervisory committee several times over the course of three years of writing it. The conversations with the supervisory committee helped highlight and address the biases that had surfaced in this work.

The second limitation to consider is that the findings are not generalizable given the qualitative nature of the study. The small number of the participants helped me study and analyze the participants’ input rigorously and in-depth using different forms of data. Using triangulation, this research captured the perspectives of these five participants regarding their experiences in the PAT program. Still, based on these data, I cannot claim that the findings are generalizable to
a larger population or to what is happening in other settings. In other words, what was discussed and found in this study were drawn only from the experiences and perspectives of Catherine, Dena, Emily, Nelle and Nick. In this regard, the concept of transferability becomes relevant. Transferability is defined as the “degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. The researcher facilitates the transferability judgment by a potential user through thick description” (Korstjens & Moser, 2018, p. 121). In transferability, the reader of a research report assesses whether the findings are transferable to her own setting based on the process of the research and the thick description of the participants. My research does not support generalizability to a population but an in-depth analysis of these participants’ experiences may support forms for transferability in pertinent settings.

Third, this study focused on one group in the PAT program among 52 groups that participated in the PAT cohort of September 2014. These groups consisted of teachers who were living with chronic conditions or were caregivers of people with chronic conditions. These chronic conditions were diverse including physical health and mental health conditions. If this dissertation studied any of the other groups, it would have been likely that the findings of the research would be different from the ones obtained by studying Catherine’s group.

Fourth, one of the findings of the study noted that the professional identities of the students seemed to be developing in relation to the teacher and their peers. Their reflections, visualizations of future practice, or clinical practices at the time, were used as evidence to highlight their developing professional identities. However, to suggest that the students changed professional identities beyond what this data shows, may require a long-term and in-depth follow-up with the PAT students over time and in different places in terms of their motivation,
their social membership, and their “access to arenas of mature practice” (Lave & Wenger, 1991). For example, the identity literature in medical education shows that the patient-centred identity that the students develop in preclinical years, tend to be replaced by a doctor-centred identity in later years (Monrouxe, 2010). Other literature shows that at the end of the pre-clinical years, several students have diffuse and unclear status of their professional identities (Niemi, 1997). Thus, this study cannot claim that the professional identities of the students changed over time beyond what was gathered during the period of data collection for this study.

8.3 Suggestions for Future Research

The first important follow-up question to this study is how the professional identities of the PAT students develop beyond the PAT program and to what extent they put it into their professional practice what they learned in the PAT program. When I interviewed the participants three months after the PAT program had ended, I could only get a glimpse of what had changed for each. One recommendation for a future study is to follow the students of the PAT group after their graduation and once they are practicing their professions in a health care setting, and to see how or whether they put into practice what they learned from their teacher. It would be interesting to study the long-term impact of a program like the PAT.

Second, it will be interesting to study developing professional identities in clinical versus non-clinical settings. My dissertation findings attributed the patient-centred learning of the PAT program to its non-clinical setting. It highlighted that learning in the PAT program was unique and different from health professional literature that often focused on clinical education. A separate systematic study is needed to understand how developing professional identities differ from clinical settings to non-clinical settings and whether the two can inform one another to help
shape a better-grounded professional identity for the students and to prepare them for future practice both in its wholeness and its uncertainties.

8.4 Summary

This study was conducted as part of a new movement in including patients in health professional education. Particularly, this study paid attention to the ways in which four students in different health professions learned from a person with schizophrenia and from each other. It investigated learning and professional identity development in the PAT program. The study, as suggested in the implications, has potential to inform health professional programs about the benefits and means of including patients as teachers in education in informing their developing professional identities. The limitations of the study were discussed in relation to bias, generalization, the particular group chosen for the study and the long-term sustainability of the findings. Suggestions for future research were provided accordingly.
References


https://doi.org/10.1007/s10459-019-09900-w


Appendix A: Consent for Teacher

Consent Form
Patient Expertise: Implications for Community of Practice in Health Professional Education

Principal Investigator: Dr. Jennifer Vadeboncoeur, Associate Professor, Department of Educational and Counseling Psychology, Faculty of Education (tel: 604-822-9099)

Co-investigators: Dr. Angela Towle, Faculty of Medicine, UBC and Co-director, Division of Health Care Communication, College of Health Disciplines (tel: deleted); Wafa Asadian, PhD candidate, Department of Educational and Counseling Psychology, Faculty of Education (tel: deleted).

Purpose: The aim of this study is to explore the experience of the students, mentors, and faculty in the [deleted] program. This study specifically seeks the ideas of the students, mentors, and faculty about patient expertise and the constituents of expertise as it unfolds in the [deleted] Program. The results of this study will be reported in a graduate dissertation; they may also be published as scholarly journals and presented in conferences. You have been asked to participate because you are taking part in the [deleted] program as a teacher. Your position as a patient and a teacher, and your input to this study is essential as the study focuses on the knowledge and expertise possessed by patients.

Study Procedure:
Electronic communication: If you give consent to this study, the researcher, Wafa Asadian, will join your group communications via email or other social media. Your input and interactions will be read and analyzed as to how they contribute to the development of communities of practice.

Video observation: If you give consent to this study, your activity and interactions during the [deleted] sessions will be video and audio recorded by the researcher. After setting up the recorder, the researcher leaves the room. She does not interact or ask any questions and you may participate in the [deleted] sessions as always. You may withdraw your consent at any time and may turn off the recorder at any time. The video-recordings will be kept in a password protected hard drive and will be placed in a locked cabinet in researcher’s office at UBC. The videos will be destroyed within 3 years after the data collection. Those who do not consent to participate, will not be video-recorded.

Interviewing: You are asked to take part in an interview (30-60 minutes). During the interview you will be asked about your experiences as a teacher in the [deleted] program. With your permission the interview will be audio-recorded. You may withdraw
your consent at any time and may ask for the recorder to be turned off at any time and the researchers will turn off the recorder.

**Confidentiality**: Any personal information resulting from this study will be kept strictly confidential. Only the investigators listed above will have access to information that may identify you. You will not be identified by name in any records or reports in the completed study. Data records that are kept on an encrypted hard drive will be secured by password, and other information will be kept in a locked filing cabinet. The recording will be transcribed and any names or personal references will be removed.

**Contact**: If you have any questions or want further information about the study, you may contact Wafa Asadian at [deleted] or [deleted].

If you have any concerns about your treatment or rights as a research participant you may contact the Research Subject Information Line in the [deleted] at [deleted].

**Consent**: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw at any time from the study without jeopardy to your participation in the [deleted] program or access to health care or other resources.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature below indicates that you consent to participate in this study.

Signature of participant: ________________________________ Date: __________________

Print name of participant: ________________________________
Appendix B: Consent for Students

Consent Form
Patient Expertise: Implications for Community of Practice in Health Professional Education

Principal Investigator: Dr. Jennifer Vadeboncoeur, Associate Professor, Department of Educational and Counseling Psychology, Faculty of Education (tel: 604-822-9099)

Co-investigators: Dr. Angela Towle, Faculty of Medicine, UBC and Co-director, Division of Health Care Communication, College of Health Disciplines (tel: deleted); Wafa Asadian, PhD candidate, Department of Educational and Counseling Psychology, Faculty of Education (tel: deleted).

Purpose: The aim of this study is to explore the experience of the students, mentors, and faculty in the [deleted] program. This study specifically seeks the ideas of the students, mentors, and faculty about patient expertise and the constituents of expertise as it unfolds in the [deleted] Program. The results of this study will be reported in a graduate dissertation; they may also be published as scholarly journals and presented in conferences. You have been asked to participate because you are taking part in the [deleted] program as a student. Your perspective as a student is unique in giving insight about how you perceive the expertise and knowledge of your mentor in the [deleted] program.

Study Procedure:
Electronic communication: If you give consent to this study, the researcher, Wafa Asadian, will join your group communications via email or other social media. Your input and interactions will be read and analyzed as to how they contribute to the development of communities of practice.

Video observation: If you give consent to this study, your activity and interactions during the [deleted] sessions will be video and audio recorded by the researcher. After setting up the recorder, the researcher leaves the room. She does not interact or ask any questions and you may participate in the [deleted] sessions as always. You may withdraw your consent at any time and may turn off the recorder at any time. The video-recordings will be kept in a password protected hard drive and will be placed in a locked cabinet in researcher’s office at UBC. The videos will be destroyed within 3 years after the data collection. Those who do not consent to participate, will not be video-recorded.

Interviewing: You are asked to take part in an interview (30-60minutes). During the interview you will be asked about your experiences as a student in the [deleted] program. With your permission the interview will be recorded. You may withdraw your consent at any time and may ask for the recorder to be turned off at any time and the researchers will turn off the recorder.
In addition to the above methods, your reflecting journals might be used for data analysis in this study. Your reflective journal will not be used if you have not previously given consent to its utilization for research studies.

**Confidentiality:** Any personal information resulting from this study will be kept strictly confidential. Only the investigators listed above will have access to information that may identify you. You will not be identified by name in any records or reports in the completed study. Data records that are kept on an encrypted hard drive will be secured by password, and other information will be kept in a locked filing cabinet. The recording will be transcribed and any names or personal references will be removed.

**Contact:** If you have any questions or want further information about the study, you may contact Wafa Asadian at [deleted] or [deleted].

If you have any concerns about your treatment or rights as a research participant you may contact the Research Subject Information Line in the [deleted] at [deleted].

**Consent:** Your participation in this study is entirely voluntary and you may refuse to participate or withdraw at any time from the study without jeopardy to your participation in the [deleted] program or your academic standing.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature below indicates that you consent to participate in this study.

Signature of participant: ________________________________ Date:
____________________

Print name of participant: ________________________________
Appendix C: Interview Protocol for Teacher

Before the interview, explain the research procedure, reassure the interviewee about: confidentiality, anonymity, transcriptions, freedom to turn off the recorder or withdraw their consent anytime.

The order of questions in the interview follow this pattern: First, the interview explores who the interviewee is, what they do, and how they joined the PAT. It then explores their role in PAT and what they teach to and/or learn from other participants in the group. After exploring these concrete experiences of the respondents, the interviewer gradually moves toward more abstract ideas. She first engages the interviewees in some artefact-mediated questions about patient-centred care and CanMEDS. Then she guides the interviewees as to how the exchanged ideas can translate to some specific strategies in contributing to a “patient-centred learning” and improved health professional education.

Demographics

Wa: To begin, I would like to ask you some demographic questions that will help me situate the experiences you bring to the PAT program.

1. Would you mind telling me how old you are?

2. Would you mind telling me what level of education you completed?
   a. Was it a bachelor’s degree at university or higher?

3. Would you please share with me your professional field?
   a. And what’s the title of your position or previous position?

Describe PAT Program and Role

Wa: Now, I’d like to ask you some questions in relation to your role as a teacher in PAT program.

4. Can you tell me a bit about how you learned about the PAT program?
   a. How long ago was that now?

5. Please describe your role as a teacher.
   a. What sorts of activities do you engage in?
   b. What responsibilities do you have?
   c. What do the meetings look like?
6. Why did you decide to become a teacher in the PAT program?
   a. How long have you been involved?
   b. How many different groups of students have you worked with?
   c. In what ways were the groups similar over time?
   d. In what ways were the groups different over time?
7. Has your engagement with PAT met your expectations?
   a. What sorts of expectations have been fulfilled?
   b. Has anything surprised you in your role as a teacher?
8. Have you been involved in other roles beside teaching in the program?
   a. If so, which roles? [interviewing new teachers ….]
9. How much longer will you be involved in the PAT program?

**Teaching and Learning in PAT**

Wa: Now, I would like to ask you more about your role in the PAT program related to teaching and learning experiences.

10. How would you describe yourself as a teacher?
    a. Are you a guide, a facilitator, a teacher, a support person?
11. How do you share your experience with your students?
    a. What are the topics that you decide to share?
    b. Are there topics that you decide not to share?
12. Did you use any objects (artefacts) in your teaching?
    a. What about the PAT handbook?
    b. The symposium materials (poster and survey)?
    c. Other objects?
13. What do you intend the students to learn?
    a. How did they change over the 18 month program? Ask about each student
    b. In what ways did they grow given your experience?
14. Is there a particular message that you aim to provide for the future health professionals through your role as a teacher?

15. How do you think the students learn through the process of teaching?
   
   a. Do they learn by asking questions in meetings?
   
   b. Do they learn by providing comments in meetings?
   
   c. Do they interact with you in other ways? E.g., sending emails?
   
   d. Did you have the chance to read their journals? What do you think about their learning experience?

16. What has changed in your experience having taught several cohorts of students?
   
   a. What was your experience like with Cohort 1?
   
   a. Does anything stand out as something that worked well?
   
   b. Does anything stand out as something that you needed to change?
   
   c. What was your experience like with Cohort 2?
   
   d. Does anything stand out as something that worked well?
   
   e. Does anything stand out as something that you needed to change?
   
   f. Did you learn anything by teaching a cohort that influenced your own life?

17. (opinion and value) Just thinking about the most recent cohort now, how do you think your teaching has influenced your students?
   
   a. Before and in the early days of PAT course
   
   b. During the course
   
   c. After finishing it

18. How does your contribution to the PAT matter? (given your position as a person with a chronic condition?)
a. What are the particular experiences that you as a patient with chronic condition offer to the education of HPs?

19. Are there other experiences that you have not had a chance to share in PAT program, and you wish that health professionals could learn?

20. Just thinking about the most recent cohort now, you worked with 4 students of 4 different health professions (medicine, nursing, pharm, OT). How has your perception about the health professionals changed (if at all) after becoming a teacher in PAT?

   a. Your perception about doctors?
   b. Your perception about nurses?
   c. Your perceptions about pharmacists?
   d. You perception about occupational therapists?

21. How has your perception about health professions changed (if at all) after becoming a teacher in PAT? [O]

   a. Your perception about doctors?
   b. Your perception about nurses?
   c. Your perceptions about pharmacists?
   d. You perception about occupational therapists?

22. From your perceptive, what does a HP student learn in your group from the other students in the group? (e.g., what does the nursing student learn from MD, OT, and PHRM students?)

   a. Prompting (what about X, what about Y)

_Patient-centred care_

Wa: Now I’d like to ask you a few questions about “patient-centred care”

23. When you think of the term “patient-centred care,” what comes to your mind?
24. This table illustrates PCC as described in the literature (showing the table). Looking at these principles, what do they each mean to you? You don’t need to think of these as having distinct meanings. There are overlaps among these principles. Let’s go over them one by one.
   a. Biopsychosocial perspective
   b. Patient-as-person (patient as a whole person)
   c. Shared power and responsibility between patient and doctor
   d. Therapeutic alliance
   e. Doctor-as-person
25. Are each of these equal, in your perspective, or are some more important than others?
   a. Which ones?
   b. Why?
26. Based on your own experience, how would PCC look in practice?
   a. How might doctors treat her?
   b. Would she have a team?
   c. More prompts
27. In your sessions with students, you referred to some occasions in which you were mistreated and silenced in the health care system.
   a. Would a PCC approach have reduced these instances? How or why?
   b. In what ways are those experiences related to the education of health professionals? How? or lack of PCC in education?
28. What changes would you advise for educational programs that educate health professionals (Med, OT, Pharm, Nursing) to contribute to PCC?
a. Do you see any other factors that may hinder practicing PCC by future health professionals?

CanMEDS
Wa: Now I’d like to hear your opinion about the CanMEDS competency framework
29. Here are the CanMEDS competencies originally created for physicians (showing the CanMEDS flower). Are you familiar with it?
30. What does this image mean to you?
31. How would you define the competencies that are shown in it?
32. In what ways might you also play these roles as a teacher?
   a. Communicator
   b. Collaborator
   c. Leader
   d. Health Advocate
   e. Scholar
   f. Professional
   g. Medical Expert (the integrating role)
33. Any other experiences you can think of?
34. Do you know of the experiences of patients with other health conditions that may unfold in each of these roles?
   a. E.g., Physical ability
   b. E.g., Mental ability

Learning and HP education
Wa: Now, I would like to hear about how your experiences can be brought into education, and how the HP students may apply their learning in their practice.
35. So far we talked about the experiences that you shared with your students and the experience that they shared with each other. How could these experiences that you mentioned be incorporated in the educational curricula?
   a. Clinical education?
   b. Theoretical and factual education?
c. What about various educational methods? (Lecture-based, observation, experiential, PBL, etc.)

d. Others?

36. In general, how do you think the PAT program influences health practitioners?
   a. More specifically how do you think your students might apply what they learned in PAT in their professional practice in the future?

37. In what ways do you think about your experience as expertise?

38. Is this form of expertise important for Health Professionals?
   a. Why/why not?

**Conclusion**

39. Are any questions that you wish I had asked?

40. Are there any other thoughts you’d like to share?

Thank you for your time.
Appendix D: Interview Protocol for the Students

Before the interview, explain the research procedure, reassure the interviewee about: confidentiality, anonymity, transcriptions, freedom to turn off the recorder or withdraw their consent anytime.

The order of questions in the interview follow this pattern: First, the interview explores who the interviewee is, what they do, and how they joined the PAT. It then explores their role in PAT and what they teach to and/or learn from other participants in the group. After exploring these concrete experiences of the respondents, the interviewer gradually moves toward more abstract ideas. She first engages the interviewees in some artefact-mediated questions about patient-centred care and CanMEDS. Then she guides the interviewees as to how the exchanged ideas can translate to some specific strategies in contributing to a “patient-centred learning” and improved health professional education.

Demographics
Wa: To begin I would like to ask you some questions on demographic questions that will help me situate the experiences you bring to the PAT program.

1. Would you mind telling me how old you are?
2. Would you mind telling me what level of education you completed?
3. What do you study now?
   a. What year are you in?
   b. What kinds of activities do you do here? (courses, research, other projects)

Patients in your program
Wa: Now, I’d like to ask a few questions about the role of patients in your program.

4. Have you had experiences with patients in your program? (Med, OT, Pharm, Nursing)
   a. In which parts of the program?
5. (depending on the answer) What was the experience (X) like? how was experience Y like? …
   a. What did you learn?
6. What other roles do patients have in your program?
Describe PAT Program and Role
Wa: Now, I’d like to ask you some questions in relation to your role as a student in the PAT program.
7. Can you tell me a little bit about how you learned about the PAT program?
8. Why did you decide to participate in the PAT course?
9. How does PAT meet the objectives in your program? Which objectives in your program does PAT meet?
   a. How do you think a course like PAT helps your future practice as a doctor, nurse, pharmacist, OT?

Learning in PAT
Wa: Now, I would like to ask you about your learning experience in PAT.
10. How was the learning experience in PAT different from other instructional methods that you have seen and experienced in your program?
    a. Earlier you referred to X
    b. Talked about Y
11. Particularly, how do you think PAT influenced your learning?
12. Can you refer to some particular lessons that you have learned from your teacher?
13. How helpful were the PAT (artefacts) used in your learning?
    a. The symposium (poster and survey)
       i. The process of creating the poster
       ii. The survey experience
    b. The PAT handbook
    c. Other objects? E.g., articles to read?
14. What were other ways/experiences that helped you learn in PAT?
15. What you think of the ways that you learned over the course of 16 months in the PAT program, what methods of learning stand out for you?
    a. Did you engage in research on a particular topic or question?
    b. Did you contact your teacher with additional questions/issues?
       i. Emails?
       ii. Phone calls?
c. Did you ask questions in the meetings?

d. Did you give comments?

e. Did you complete group work with your peers?

16. How do you see your own role in the PAT group?

a. As a student?

b. In relation to other participants?
   i. Your teacher
   ii. Other students

17. How did your perception as a (dr, nurse, OT, pharmacist) regarding patients with mental illness change (if at all) since before you took part in the PAT program?

a. What was your perception of people with chronic condition (in this case mental illness) before you took the course?

b. What was your perception during/at the time that you were taking the course?

c. What is your perception now? How has it changed you think?

18. There were 4 students from 4 different health professions (medicine, nursing, pharm, OT) in your group. Given your experience in this group, how has your perception about the other health professions changed (if at all)? [CHOOSE 3 OF THE a,b,c,d DEpending ON THE STUDENT’S PROFESSION]

a. Your perception about doctors?

b. Your perception about nurses?

c. Your perceptions about pharmacists?

d. Your perception about occupational therapists?

19. What did you learn from your peers? (probe after, based on what student says)

a. How do you think X…Z influenced your learning?

20. What did “you” offer to this group? What kind of experiences?

**Patient-centred care**

Wa: Now I’d like to ask you a few questions about “patient-centred care.”

21. When you think of the term “patient-centred care,” what comes to your mind?

   a. How might you define it?
b. How might taking a patient centred approach impact patient care?
c. What are the sorts of principles that might shape the behavior of a (depending on profession of the student) dr, nurse, OT, pharmacist?

22. This table illustrates PCC as described in the literature (showing the table). Looking at these principles, what do they each mean to you? You don’t need to think of these as having distinct meanings. There are overlaps among these principles. Let’s go over them one by one.
   a. Biopsychosocial perspective
   b. Patient-as-person (patient as a whole person)
   c. Shared power and responsibility between patient and doctor
   d. Therapeutic alliance
   e. Doctor-as-person

23. Are each of these equal, in your perspective, or are some more important than others?
   a. Which ones?
   b. Why?

24. How do you think PCC should be practiced in X, Y, Z, ZZ?
   a. How to treat the patients
   b. Interprofessional practice
   c. More prompts

25. Your teacher referred to instances when she was mistreated and silenced in the health care system,
   a. Would a PCC approach have reduced these instances? How or why?
   b. In what ways are those experiences related to the education of health professionals? How? or lack of PCC in education?

26. What advice do you have for the educational programs (Med, OT, Pharm, Nursing) to better education future health professionals toward PCC?
   a. Do you see any other factors that may hinder practicing PCC by future health professionals?

CanMEDS

Wa: Now I’d like to ask your opinion about the CanMEDS competency framework.
27. Here is the CanMEDS competencies originally created for physicians (showing the CanMEDS flower). Are you familiar with it?

28. What does this image mean to you?

29. How do you define the competencies that are shown in it?

30. In what ways your teacher might play these roles?
   a. Communicator
   b. Collaborator
   c. Leader
   d. Health Advocate
   e. Scholar
   f. Professional
   g. Medical Expert (the integrating role)

31. Any other experiences you can think of?

32. Do you know of the experiences of patients with other health conditions that may unfold in these roles?
   a. E.g., Physical ability
   b. E.g., Mental ability

**Learning and HP education**

Wa: Now I would like to ask some questions about how the experiences can be brought into education, and how the HP students may apply their learning in their practice.

33. So far, we talked about the lessons that you learned from your teacher and your peers and the experiences that you shared. How can these experiences that you mentioned be incorporated in the educational curricula?
   e. Clinical education?
   f. Theoretical and factual education?
   g. What about various educational methods? (Lecture-based, observation, experiential, PBL, etc.)
   h. Others?

34. In general, how do you think the PAT program influences future health practitioners?
   a. Specifically how do you think you will apply what you learned in PAT in your professional practice in the future?
35. In what ways do you consider your teacher’s experience as expertise?
36. Is this form of expertise important for health professionals? Why/why not?
   a. For doctors
   b. For nurses
   c. For OTs
   d. For pharmacists

Conclusion
37. Are there any questions that you wish I had asked?
38. Are there any other thoughts you’d like to share?
Thank you for your time.
Appendix E: Table on the Principles of Patient-centred Care

Artefact

*Perspectives and principles of patient-centred care*

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Biopsychosocial perspective</td>
<td>Understanding the difference between health, disease and illness</td>
</tr>
<tr>
<td>2 Patient-as-person</td>
<td>Patient as a whole person</td>
</tr>
<tr>
<td>3 Shared power and responsibility between patient &amp; doctor</td>
<td>Common ground for cooperation between doctor and patient</td>
</tr>
<tr>
<td>4 Therapeutic alliance</td>
<td>Enhancing doctor-patient relationship</td>
</tr>
<tr>
<td>5 Doctor-as-person</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: CanMEDS Competency Framework

Artefact

CanMEDS Competency Framework
**Appendix G: Transcription Convention**

Transcription key adapted from Schiffrin, 1987a

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling intonation</td>
<td>When speakers finishes up a sentence or thought, sometimes the sound gradually fades away</td>
</tr>
<tr>
<td>Rising intonation</td>
<td>When the sentence or the expression that ends is followed quickly by another sentence as if they are both part of the same terrain of thought.</td>
</tr>
<tr>
<td>Animated tone</td>
<td>Rising intonation when asking question</td>
</tr>
<tr>
<td>Pause</td>
<td>Animated tone at the end of the statement</td>
</tr>
<tr>
<td>Audible expressions</td>
<td>Pause</td>
</tr>
<tr>
<td>Emphasis/stress</td>
<td>Audible expressions person makes when thinking, connecting thoughts, excited. The expression written in a way that closely imitates the sound that speaker is making.</td>
</tr>
<tr>
<td>When a second speaker interrupts and continues the conversation</td>
<td>e.g., Hmm, hm, eh, oh, uh, hoo, whoo, woof, huh, heh, hehe, pouh</td>
</tr>
<tr>
<td>Describing audible expression, the level of clarity, and volume, describing bodily expressions</td>
<td>Emphasis/stress or raised voice when saying some words and phrases</td>
</tr>
<tr>
<td>When a person talks at the same time with speaker; overlapping talk</td>
<td>Emphasis/stress or raised voice when saying some words and phrases</td>
</tr>
<tr>
<td>Recounted speech</td>
<td>Recounted speech: When speaker quotes a third person not present in the conversation, or reads from a text. Note: When two quotations belonging to two different speakers come consecutively, a comma (,) comes in between.</td>
</tr>
<tr>
<td>For anonymity and confidentiality</td>
<td>For anonymity and confidentiality:</td>
</tr>
<tr>
<td>- When proper name is used</td>
<td>(name)</td>
</tr>
<tr>
<td>- Description of the name of the country</td>
<td>(a country in Europe)</td>
</tr>
<tr>
<td>- Nationality or mother tongue</td>
<td></td>
</tr>
<tr>
<td>The name of a discipline when standing alone.</td>
<td>First letter capitalized, e.g., Nursing, Medicine, e.g., nursing student, medical program, doctor, nurse”</td>
</tr>
<tr>
<td>But not capitalized when comes as a descriptive adjective or as a profession.</td>
<td></td>
</tr>
</tbody>
</table>