Understanding Patient-centred Care as Individuals and as a Collective Provider: A Constructivist Grounded Theory Secondary Analysis

by

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements of the degree of

MASTER OF SCIENCE

College of Rehabilitation Sciences

University of Manitoba

Winnipeg

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Abstract

Background: Although primary care providers are expected to practice in a patient-centred manner within teams, patient-centred care (PCC) tends to be studied within the provider-patient dyad, often to the exclusion of team relationships. **Purpose**: To explore how PCC is understood in the context of inter-provider relationships in Shared Mental Health Care teams. **Method**: Previously collected data formed the basis of grounded theory qualitative secondary analysis. Focus group transcripts from six teams were analyzed using constant comparison methods. Coding, memoing and diagramming were used to construct categories and themes. **Findings**: Providers understood PCC as individuals and as a team. Working with each other over time, these providers developed a shared identity, termed the "Collective Provider", and characterized by well-functioning inter-provider relationships in a collaboration supportive context. In these conditions, PCC was mobilized in a relationship-enhancing manner within the team. **Conclusions**: Attention to the quality of relationships between providers may be important for team-facilitative use of patient-centred rhetoric.

Key words: Patient-centred care, interprofessional collaboration, Shared Mental Health Care, primary care, qualitative secondary analysis

Dedication

This thesis is dedicated to Dr. Susan Yamamoto. Thank you for challenging my thinking and for always taking the time to read, re-read...and re-read my work.

Acknowledgements

I would like to thank my committee Dr. Pamela Wener, Dr. Jacquie Ripat and Dr. Roberta Woodgate for their expert teaching and guidance, and for their seemingly infinite patience with my (sometimes) recalcitrant ways. This thesis also represents the coming together of valued coursework completed in the first year of my Master of Rehabilitation Science. Through various assignments, I had the opportunity to refine my research plan, execution and writing as I continued to learn. Thus, I would like to thank Dr. Laura Funk, Dr. Leanne Leclair, and Dr. Genevieve Thompson for their valuable teachings, guidance and feedback. Lastly, I would like to thanks the University of Manitoba and the Canadian Occupational Therapy Foundation for their financial support in completing my studies.

Author's Note

In perusing my thesis the reader will note a memo-like exploratory persuasion to my writing for which I feel I must offer some explanation. In constructing this document, I had great difficulty getting down to the business of writing. Naturally, I looked at samples of other works in similar subject areas which, as a student looking for that hard to pin down *how to* manual, I felt compelled to approximate. Yet I always had two versions of my manuscript that I was seemingly unwilling to abandon entirely. First, a shortened or what I felt was at least a journal-amenable version and a second, more candid, lengthy and personal account of how my research project unfolded. What follows is very much the latter. In this I acknowledge that while my paper falls short of experimental writing, as depicted, it would appear to be more inclusive and perhaps theoretically dense than what is more commonly be found in healthcare platforms lying somewhere in between “work as process” and “definitive representation" (Richardson, 1998, p. 360).

My decision to adopt this manner of writing was not only motivated by design considerations, such as philosophical coherence, but also by my style and preferences at this early stage in my developmental journey towards becoming an independent researcher, as favoring the process of *writing to learn*. I am inspired by attempting to delve into the nuances of meaning making in the social world and by tackling debates of methodological concern. Through writing, I sought to gain an in-depth and self-negotiated understanding of grounded theory that (in my mind) only writing to learn can produce; an understanding with particular emphasis on how constructivist thinking and analyses play out with all the tensions and lessons that follow. Adopting a posture of writing to learn as well as to describe or to account for, I felt, would allow me to grapple with and achieve, in my own way, a more nuanced and richly felt analytic skill set

characteristic of qualitative means of inquiry lying along the more interpretive end of the spectrum.

In writing as such I also aspired to Richardson's conceptualization of qualitative writing as a method of inquiry, as a creative process that must rebel against the "homogenization" of qualitative writing that seeks to suppress the writer's individual voice and to promote the self-eviscerating view of the self in inquiry as pollutant (1998; p. 347). In her book on Constructing Grounded Theory (2014), from which I have drawn heavily, Charmaz acknowledges that remnants of mid-19th century positivist dominance continues to shape how we are expected to present our writing as qualitative inquirers. In a similar thread Richardson warns new researchers that adopting writing conventions in which "...inductively accomplished research is to be reported deductively…increases the probability of one's work being accepted in the "core" social science journals...," (1998, p. 353) but adds that this not in and of itself indicative of more or less verity, merit or significance than writings employing other traditions and is particularly challenging for yet-to-be established thinkers.

Since graduating in 2012 with a Master of Occupational Therapy, I have had the privilege of learning how to conduct research in rehabilitation with educators, mentors, colleagues and collaborators at the University of Manitoba. In my experiences thus far, including this thesis, like others before me I have grappled with a kind of cognitive dissonance between my own research lens and the logico-deductive push so often felt in allied healthcare professions when writing up our work for publication. In this I felt keenly Thorne's (2016) description of nursing research, much like occupational therapy, as an enterprise that "...indelicately straddles the social and biomedical sciences to find its methodological direction" (p. 15). Indeed, reconciling my preferred writing style and manner of thinking and learning with the breadth of my anticipated

audience was and continues to be one of my greatest challenges, and I hope that in years to come I will become more comfortable with operating in shades of grey.

Charmaz (2014) situates writing as a social process that, whilst involving a breadth of actors, colleagues, mentors and friends, must be written for “yourself and your grounded theory first”, that ultimately "you are the expert..." and that "the grounded theory is yours" (p. 176). She recommends that that grounded theorists do the work first and to later determine how to render that work to a targeted audience. Thus, while what follows may be regarded by some as unnecessarily drawn out, I assure the reader that my intentions were that of learning. I thank the reader, and of course my committee, for your patience and hope that this forward useful if not thought provoking. Happy reading.

Structure and Organization of the Thesis

In Chapter 1, I offer an introduction to patient-centred care and interprofessional collaboration to set the stage for the combined study of these phenomena. Chapter 2 contains a review of the literature organized into four parts: (1) Primary care and Shared Mental Health Care; (2) Patient-centred Care and Patient-centredness; (3) Interprofessional Collaboration and Teamwork; and (4) Links in the Study of Patient-centred Care and Interprofessional Collaboration. In Chapter 3 I introduce Crotty's (1998) methodological scaffold in qualitative study design and explore each of the design levels of epistemology, theoretical perspectives, methodology and methods as applied to my study. In Chapters 4 and 5, I offer a more detailed account of data collection and data analysis respectively. Chapter 6 is focused on quality measures, and in Chapter 7, I offer a brief description of ethics. My findings are detailed in Chapter 8 followed by the discussion in Chapter 9. In Chapter 10, I explore study limitations with respect to myself as a student researcher, the data set and as related to qualitative secondary analysis. My plan for knowledge mobilization is described in Chapter 11, followed by conclusions and implications for practice and future research in Chapter 12. A list of references is provided after the appendices.

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Chapter 1: Introduction

Interprofessional collaboration and patient-centred care have been increasingly featured in healthcare research, policy and reform over the past 50 years, with both considered essential to delivering high-quality healthcare (Australian Quality Framework for Health care [ACSQHC], 2011; Institute of Medicine [IOM], 2001; Reeves, Lewin, Epsin, & Zwarenstein, 2010). In advocating for these movements, healthcare planners and researchers commonly link patient-centred care and interprofessional collaboration to strategic benefits for providers and patients. Interprofessional collaboration, for example, has been associated with improved provider satisfaction (Raab, Brown, Richards & O'Mara, 2013), patient safety (Baker, Gustafson, Beaubien, Salas, & Barach 2003; Firth-Cozens, 2001; Manser, 2009; Raab, et al., 2013), patient satisfaction (Nolte & Tremblay, 2005), and patient outcomes (Baggs et al., 1999; Martin, Ummenhofer, Manser & Spirig, 2010; Zwarenstein, Reeves, & Perrier, 2005). Likewise patient-centred care has been shown to positively impact provider job satisfaction (Rathert & May, 2007), patient-satisfaction (Frampton et al., 2013), patient adherence to treatment plans (Hibbard, Greene, & Overton, 2013; Stewart et al., 2014; Thompson & McCabe, 2012), and patients' self-reported physical and psychologic health (Stewart et al., 2014).

Patient-centred care and interprofessional collaboration, with their mutual focus on sharing power and responsibility, have also been put forth as a means of supporting healthcare sustainability. In discussing the urgent need for reform, the Canadian Medical Association (n.d.) has referred to the increasing challenge of meeting Canadians' comprehensive healthcare needs while remaining "affordable for the public purse" (p.iii). These authors propose a five-part framework for transforming the system, including

creating a culture of patient-centred care and enhancing collaborative team-based care. Similarly combining patient-centred care with team-based care, integrative medicine in the United States has been offered as a possible solution to the contemporary economic crisis arising from increased chronic disease (Maizes, Rakel, & Niemiec, 2009). In their Framework for Action on Interprofessional Education and Collaborative Practice, the World Health Organization (WHO; 2010) has also recognized the shared role of interprofessional collaboration and patient-centred care in alleviating the global health workforce crisis.

Despite much distinguished endorsement, proponents of the interprofessional collaboration and patient-centred care movements highlight a gap between rhetoric and practice. Researchers in interprofessional collaboration have referred to the "*stunted*", "*stalled*" (Bell, Michalec, & Arenson, 2013, p.98) or "*elusive*" (MacMillan, 2012, p. 410) adoption of interprofessional collaboration despite considerable supportive evidence. Critical thinkers in occupational therapy such as Whalley Hammell (2014) have pointed to a lack of collective achievement of client-centred practice despite the profession's much reported commitment to the philosophy. In a similar vein, scholars in medicine suggest that in the area of patient-centred care "there is still much work to be done!" (Stewart et al. 2014, p. 415). Paradis, Leslie and Gropper (2016), for example, have highlighted that despite being espoused for some decades the patient-centred care movement "has yet to revolutionize care delivery" (p. 745).

In recent years, researchers in both areas have questioned the nature of the relationship between patient-centered care and interprofessional collaboration; specifically, how and why these phenomena are related (Gitell et al., 2012; Stewart et al.,

2014) and by what mechanisms (Aase et al., 2016; Bennett et al., 2015; Gachoud, Albert, Kuper, Stroud, & Reeves, 2012; D'Amour & Oandasan, 2005; Mior et al., 2010;). In existing research patient-centred care may be presented as both precursor to (CAN, 2011; CIHI, 2010) and outcome of interprofessional collaboration and teamwork (Papadimitrious & Cott, 2014) and vice versa. Patient-centred care is often loosely connected to interprofessional collaboration in a *by extension fashion*, with the assumption that interventions targeting enhanced interprofessional collaboration will simultaneously further patient-centred aims. Scholars studying interprofessional collaboration may subsume elements associated with patient-centred care into their work using hybrid terms such as "collaborative patient-centred practice" (Herbert, 2005) and "interprofessional collaborative person-centred practice" (Khalili, Orchard, Spence Lascchinger & Farah, 2013). Similarly, researchers examining patient-centred care may suggest that elements of interprofessional collaboration are part of their work by using terms such as "patient-centred teams" (Bennett, Hassinger, Martin, Harris & Gold, 2015). This breadth in language has resulted in an abundance of available terms whose seeming *prima facie* meaning create fertile grounds for inconsistent if not unintentional use.

Furthermore, in healthcare, while there are often broad or common-sense links made between patient-centred care and interprofessional collaboration, patient-centred care as a phenomenon is often studied within the provider-patient dyad (Amenic, 2016), when in reality, patient-centred care is commonly delivered by teams of providers (D'Amour, Ferrada-Videla, San Martin Rodriguez & Beaulieu, 2005). Frampton et al. (2013) have argued that for advances in patient-centred care to be meaningfully achieved across environments, a culture shift must occur away from a disconnected isolated care

approach to providers working effectively together. Yet while the challenge of delivering patient-centred care as a team is well documented in healthcare (Frampton et al., 2013), patient-centred care is also commonly studied in a professionally siloed or discipline-specific manner (Kitson et al., 2012; Papadimitriou & Cott, 2014; Schwind, McCay, Metersky & Martin, 2016) often to the exclusion of the interprofessional team and the relational dynamics therein.

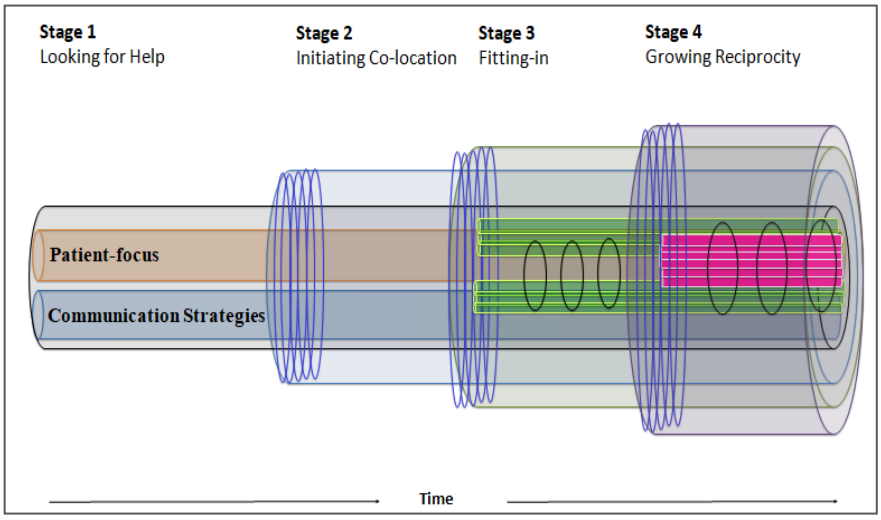
Key governing documents in primary care focus on teamwork, access, and coordination, with the ultimate objective of delivering patient-centred care (College of Family Physicians, 2019; McMaster Health Forum, 2016). With both patient-centred care and interprofessional collaboration as major tenets of family practice, and as primary care teams continue to expand to incorporate diverse professional groups as in the case of Family Health Teams, My Health Teams, the Family Medicine Group Model, and Shared Mental Health Care teams in Canada and the patient-centered medical home model in the United States, primary care teams offer rich context for studying the interplay of patient-centred care and interprofessional collaboration.

In 2016, Wener and Woodgate undertook a qualitative study with the aim of developing a theoretical understanding the interprofessional collaborative relationship building process in a Manitoban primary care Shared Mental Health Care setting. In conducting this study, these authors accrued a large dataset including transcripts from interprofessional focus groups with established teams including family physicians, nurse practitioners, shared care counsellors, and psychiatrists. The resulting grounded theory, the Interprofessional Collaborative Relationship Building Model (ICRB), outlined four stages to the relationship development process of providers including: (1) Looking for

help, (2) initiating co-location, (3) fitting-in and (4) growing reciprocity, with the processes of "patient-focus" and "communication strategies" running throughout.

Figure 1

The Interprofessional Collaborative Relationship Building Model (ICRB)



Reprinted from Collaborating in the context of co-location: A grounded theory study, (Doctoral dissertation) by P. Wener, P. (2016). University of Manitoba. *An earlier version of this image was originally published by BioMed Central.

Wener and Woodgate's work included a detailed exploration of communication strategies used during the relationship building process. However, while these authors aligned the concept of "patient-focus" with a patient-centred approach, attention to defining and delineating this aspect of the model was limited. A deepened understanding of the element of "patient-focus" and its relatedness to the overall interprofessional relationship building process is needed to more fully understand how patient-centred care is used in the context of interprofessional collaboration and inter-provider relationship

building in Shared Mental Health Care.

The richness and abundance of the data set from the Wener and Woodgate (2016) study, originally collected as part of Dr. Wener's dissertation, thus presented an opportunity for qualitative secondary analysis, particularly for myself as a student researcher operating at a master's thesis level. With the core element of “patient-focus” in the ICRB, a new yet related research question pertaining to patient-centred care presented a good fit, ripe for the discovery of theoretically relevant information regarding patient-centred care and interprofessional collaboration in a team-based Shared Mental Health Care context that could be understood in new and different ways.

Purpose

Drawing on a previously collected data set from Wener and Woodgate (2016), the purpose of this qualitative secondary analysis was to gain a theoretical understanding of the social processes involved in the interplay of patient-centred care and interprofessional collaborative relationships between providers in Shared Mental Health Care teams.

Research Question

How do providers understand and use a patient-centred approach within established Shared Mental Health Care teams?

Objectives

In undertaking this study, I sought to advance our understanding of the role of patient-centred care in an interprofessional collaborative team-based Shared Mental Health Care setting by:

1. Exploring how patient-centred care is understood and defined by the teams of participating providers;

2. Detailing participants' experiences and perceptions of patient-centred care; and
3. Exploring links between patient-centred care, the interprofessional collaborative relationship building process and overall patient care.

Chapter 2: Literature Review

This Chapter includes four areas of review. First, I describe the practice setting context for this study, primary care, and specifically, the Shared Mental Health Care Program. Sections on patient-centred care and interprofessional collaboration follow. Lastly, I examine areas of distinction and overlap in the study of patient-centred care and interprofessional collaboration.

Primary Care and Shared Mental Health Care

Primary care, not to be confused with primary health care, is a branch of primary healthcare that operates at the level of individuals and families, referring to family-doctor-type care as an entry point to the healthcare system (Canadian Nurses Association, 2005). Key governing aspects of primary care in Canada include comprehensive team-based care with physician leadership and patient-partnered care, with the latter defined as family practices that "respond to the unique needs of patients and their families within the context of their environment" (College of Family Physicians of Canada, 2019, p.25).

Shared Care or the Shared Care Mental Health Care Program, encompassed under the umbrella of primary care, was established in Manitoba in 2003 to address the need for greater mental health services within a primary care setting. Within the Shared Mental Health Care program, specialized mental health care providers such as counsellors, psychologists and psychiatrists are co-located with primary care providers (Goossen et al., 2012). These providers work collaboratively to deliver timely access for primary care patients to mental health services. The program is intended, as such, to support both providers and patients in managing complex care issues that span physical and mental health.

In a program evaluation, Goossen et al. (2012) emphasized the success of the Shared Mental Health Care program as contingent on collaboration in the context of effective collaborative relationships between primary care providers and mental health specialists. With the foundations of patient-centred care and interprofessional collaborative teamwork, Shared Mental Health Care teams represented an optimal context for examining the interaction between interprofessional collaborative relationships and patient-centred care.

Patient-centred Care and Patient-centredness

The IOM has defined patient-centred care as "providing care that is respectful of, and responsive to, individual patient preferences, needs and values and ensuring that the patient values guide all clinical decisions" (IOM, 2001, p. 3); however, in a conceptual exploration, Bensing (2000) has referred to the patient-centred concept as a "fuzzy" or "global" concept (p. 21), meaning that while many will recognize an overall meaning the concept will mean different things to different people in different contexts. With the co-existence of many definitions, a singular shared understanding of patient-centred care across stakeholders has not been established.

In defining patient-centred care, authors commonly trace broad paradigms shifts in healthcare in the latter half of the 20th century from a paternalistic illness-focused lens towards patient-centric humanistic thinking. For example, seeking to address the challenge of ambiguity and measurement of the patient-centred concept, Mead and Bower (2000) reviewed the conceptual and empirical literature examining patient-centredness within the doctor-patient relationship. These authors differentiated patient-centred medicine from what has historically been more positivistic biomedical medicine

through five conceptual dimensions including: (1) the biopsychosocial perspective, (2) patient-as-person', (3) 'doctor-as-person', (4) sharing of power and responsibility, and (5) the therapeutic alliance. Stewart et al. (2014), much like Mead and Bower (2000), have focused on positioning patient-centered practice in contrast to conventional biomedical or illness focused medicine to get at a core holistic and humanistic meaning. Likewise, authors such as Kitson, Marshall, Bassett and Zeitz (2012) have referred to the fundamental tension between patient-centred care or holistic care and a more traditional reductionist illness-focused approach as the deeper philosophical challenge in realizing patient-centred care. As a departure from historical models of care, in a contemporary context, an active situated patient bringing unique needs and preferences to the care relationship is expected across a breadth of stakeholders including providers and patients alike.

At a practical level there are also a variety of terms used to describe the patient-centred concept that stem from the different groups of knowledge producers and users. Preferred terms may depend on the practice setting and/or professional affiliation of the provider or researcher. While the term “person-centred” may be favored in long term care contexts (Sidani & Fox, 2014), the term is more commonly used in acute and primary care settings. Professional groups such as nursing and medicine may prefer “person-centred” and “patient-centred” respectively (McCormak & Karlsson, 2010; Papadimitriou & Cott, 2014), while occupational therapy and social work espouse the term “client-centred”. The term “client” within "client-centred" may also refer to individuals, family or groups. For example, within a community practice paradigm in occupational therapy, “client” may refer to a single person or may extend beyond the individual service user to

encompass the family, groups and communities (Scaffa & Reitz, 2014). Comparing this to conceptualizations in nursing, the term "client-centred care" has been used to refer to both patient-focused care with respect to the management and structuring of services (as an approach or technique) as well as a broader philosophical orientation or posture (Cott, 2004).

Furthermore, while commonly used interchangeably (Cott, 2004), patient/client/person-centredness and patient/client/person-centred care have distinct meanings. Where patient-centredness suggests a posture or attitude, patient-centred care represents a more tangible approach, that is, observable actions emanating from that core stance of patient-centredness. Termed a construct, client-centredness in occupational therapy is considered to be a "spirit and attitude" of providers (Ripat, 2017, p.69), that denotes power sharing, listening, respect for diversity, acknowledgement of client knowledge and expertise and intent to facilitate choice, hope and participation in decision-making (Law, Baptiste & Mills, 1995; Mroz et al., 2015; Ripat, 2017; Sumsion & Law, 2006; Sumison & Smyth, 2000; Scaffa & Reitz, 2014). Where client-centred practice may be evidenced in providers' observable client-centred skills and behaviours, such as client-centred interviewing, client-centeredness as a belief or value is cultivated through a developmental process of internalization (Ripat, Wener, Dobinson & Yamamoto, 2014).

Given the inconsistent understanding and use of patient-centred terms, it is important for researchers to identify their situated understanding of the patient-centred concept at the outset of an investigation. In this study, I understood patient-centred care as an approach rather than philosophical orientation, that is, patient-centred care as an

observable practice employed in the everyday work life of providers. In bringing together the literature on patient-centred care as a practice, I take the view that patient-centred care implies several key foci including: (1) attention to issues power and partnership; (2) flexibility and responsiveness (commonly thorough the process of reflexivity as a living process rather than end point); (3) an individualized collaborative approach to planning (both amongst the team and with the patient) that purposefully takes into account the patient's preferences, needs and broader life situation; (4) involvement of the patient in decision-making; and (5) a necessary focus on building effective working relationships amongst a breadth of stakeholders including service providers, patients and families.

Interprofessional Collaboration and Teamwork

The Canadian Interprofessional Health Collaborative (CIHI, 2010, p. 8) has defined interprofessional collaboration as "the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/families and communities to enable optimal health outcomes". The WHO (2010) defines collaborative practice as occurring when health workers with different professional backgrounds work with one another and with patients to enable the highest quality care by allowing health workers to “engage any individual whose skills can help achieve local health goals” (p. 7). Both of these definitions, although different, link the purpose of interprofessional collaboration to improving health outcomes.

Much like patient-centred care, articulating a singular understanding of interprofessional collaboration is challenging. According to Wener (2016), while there is no one uniformly accepted definition of interprofessional collaboration there are several common "themes". Interprofessional collaboration involves the bringing together of

providers from different professional groups whose main contributions stem from their respective scopes of practice, with the assumption of shared-decision making between providers and with the patient. The interprofessional collaborative process is shaped by a breadth of factors including leadership, communication, relationship building and the physical and social environment (Wener, 2016). D'Amour et al. (2005) have similarly suggested that while the term collaboration may be used in different ways and carry a variety of meanings, identifiable common characteristics include the conceptualization of collaboration as an inherently dynamic process, partnerships characterized by openness, honesty, trust and mutual respect, professionals as interdependent, the sharing of responsibility and care philosophies, and shared power as a fundamental product of the relationship between professionals.

Despite the identification of common conceptual elements or themes, a unified understanding of interprofessional collaboration has not been established. In a review of the literature, D'Amour et al. (2005) observed that the terms used to describe the teams in which collaboration takes place are seldom defined and often used interchangeably. Specifically, the terms used to describe a team such as interdisciplinary, multidisciplinary, and transdisciplinary may be considered synonymous by some, although each label carries distinct meanings suggestive of differing levels of collaboration and role overlap. Still further, other related terms referring to processes or structures with these common characteristics or themes may have relevance when seeking to pull together research examining interprofessional collaboration. For example, in a concept analysis Baik (2016) found the term "team-based care" to be consistent with interprofessional collaboration, with the elements of (a) two or more team members from

different professionals; (b) understanding of the different roles and responsibilities; (c) mutual respect; and (d) organizational support, while also containing the core attribute of a patient-centered approach (Baik, 2016). Thus, like patient-centred care, the study of interprofessional collaboration has been complicated by an abundance of terms with varying degrees of conceptual overlap coupled with the lack of common understanding and use of such terms.

Moreover, while researchers commonly refer to health care "teams" in general terms, not all groups may operate as a team. Cohen and Bailey (as cited in Orchard & Bainbridge, 2015, p. xvii) define a team as embodying three key dimensions including: (1) interdependency in their work; (2) shared responsibility for outcomes; and (3) management of relationships such that there is common awareness of the team (as perceived by the team and by extrinsic actors) as a kind of social unit. While in health care settings a group of providers may be referred to as a team, this may not be the case in day-to-day practices and in the view of the "team" and others.

In this study, I purposefully sought to explore how patient-centred care and interprofessional collaboration interact in established Shared Mental Health Care teams, with interprofessional collaboration defined as two or more providers from different professional backgrounds coming together in established working relationships to deliver better care. In looking to study *teams* rather than *groups* of healthcare providers, in which members identified as a team and had a substantial history of working together, my intention was to examine how patient-centred care was understood and used by providers in the context of established well-functioning inter-provider relationships. These teams were originally selected in the primary study (Wener & Woodgate, 2016) as exemplar

teams as reported by the providers and by their health authority regional leaders, and thus the assumption that these are well functioning teams was continued in the present investigation.

Links in the Study of Patient-centred Care and Interprofessional Collaboration

While the patient-centred care and interprofessional collaboration movements are widely accepted, the frequency of shared use of these terms and their inherent conceptual overlap makes their exact relatedness unclear. Patient-centred care and interprofessional collaboration have become so much a part of the contemporary healthcare lexicon that a quick search of the databases may reveal a breadth of generalized statements linking the two concepts. Reviewing as selection of these articles, authors will commonly employ these terms in an introductory or concluding abstract statement, perhaps as rationalization for a particularly study, without meaningful exploration of one or both concepts and their relationship. Broad statements such as "Interprofessional collaboration supports patient-centred care and takes place through teamwork" (McDonald & McCallin, 2010, p. 285), while useful in contextualizing a piece about another - related - phenomenon, present a significant cloud-factor when engaging in a literature search with intent to understand and trace the relationship between patient-centred care and interprofessional collaboration. As described by Fox and Reeves (2015), patient-centred and collaborative discourses may be "simultaneously at play at any given time" and indeed aspects of these discourses may be "'borrowed' and “repackaged" (p. 115) by different authors to different ends.

That patient-centred care and interprofessional collaboration are often grouped together seems reasonable in view of the overlap in not only conceptual elements, but also in factors or processes thought to somehow influence these phenomena. For

example, the skills providers employ in interactions with patients as part of a patient-centred process, such as listening, so too contribute to effective interprofessional collaboration. Patient-centred care and interprofessional collaboration are both shaped by shared decision-making (patient-centred care and interprofessional collaboration, Chong, Aslani & Chen, 2013), power dynamics (patient-centred care, Stewart et al., 2014; interprofessional collaboration, Rieck, 2014), and provider knowledge and abilities (patient-centred care, Stewart et al., 2014; interprofessional collaboration, Zabar et al., 2016). Other shared practice setting factors include organizational culture (patient-centred care, Fix et al., 2018; Luxford et al., 2011; interprofessional collaboration, Wei, Webb Corbett, Ray & Wei, 2019), polices, the physical and social environment (patient-centred care and interprofessional collaboration, Bilodeau et al., 2015) and even the personal history or disposition of specific providers therein (patient-centred care, Amenic, 2016; interprofessional collaboration, Avrech Bar, Katz Leurer, Warshawski, & Itzhaki, 2018).

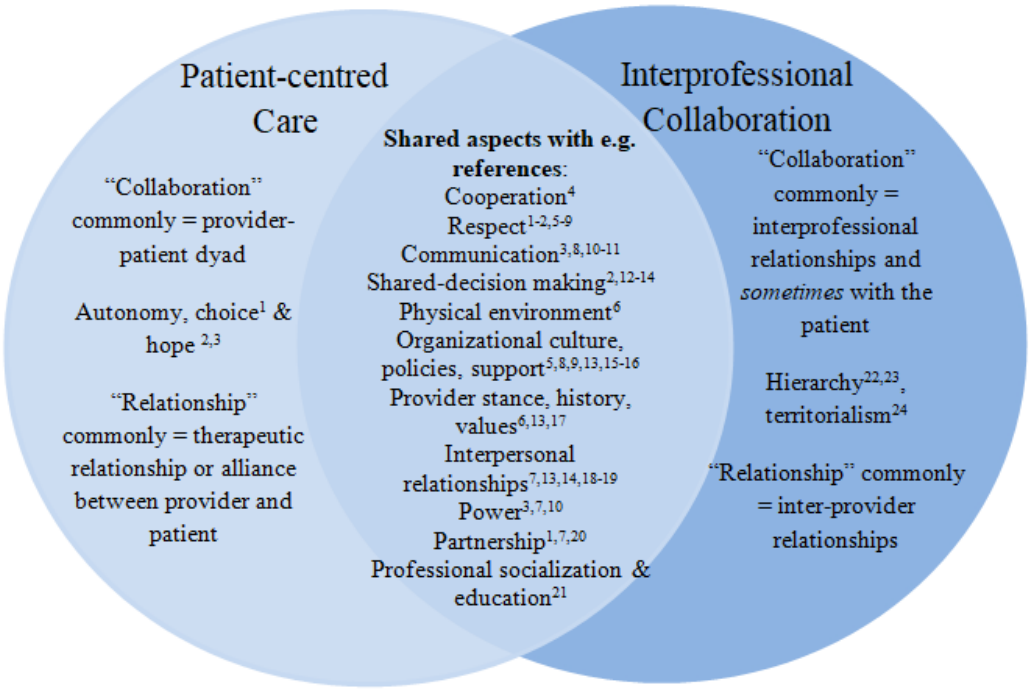
An examination of how the terms "collaboration" and "relationship" are most commonly used by researchers in the areas of patient-centred care and interprofessional collaboration helps to reveal similarities and differences in the study of these concepts. In the interprofessional collaboration literature, the term collaboration typically refers to inter-provider dynamics and, to a lesser extent, collaboration between the interprofessional team and the patient (Marshall, Kitson, & Zeitz, 2012; Shaw, 2008). D'Amour et al. (2005) have pointed out, for example, that despite being the very impetus for collaborative care, the patient is rarely meaningfully integrated into health professionals' understanding of the healthcare team; a sentiment echoed by Orchard and

Bainbridge (2013) in their book on patient-centred care. In contrast, examinations of collaboration in patient-centred care tend to focus on collaboration within the provider-patient dyad (Amenic, 2016; McCormack & Karlsson, 2010; Mroz et al., 2015). With that focus on the provider-patient dynamic, researchers may explore patient-centred care by looking at the experience of disability or illness as related to the care experience, labeling processes such as instilling a sense of hope (Mroz et al., 2015; Sumsion & Law, 2006) and exercising autonomy and choice (Law, Baptiste & Mills, 1995). Where in the patient-centred care literature the term "relationship" commonly points to the therapeutic alliance or partnership between provider and patient, in the interprofessional collaboration literature, the focus is most often on inter-provider relationships.

Furthermore, while discussions of both patient-centred care and interprofessional collaboration explore issues of power, in the interprofessional collaboration literature there is frequent reference to hierarchy and power amongst the different interprofessional players. For example, in examinations of interprofessional collaboration the influence of historical relationship dynamics between different professional bodies such as medicine and nursing (Price, Doucet, McGillis Hall, 2014) is common, while the power dynamic between patient and provider(s) is less often discussed. In Figure 2, I provide a visual rendering of general points of overlap and distinction in the study of patient-centred care and interprofessional collaboration.

Figure 2

Links Between Patient-centred Care and Interprofessional Collaboration



[1]Law, Baptiste, & Mills, 1995; [2]Mroz et al., 2015; [3]Sumsion & Law, 2006; [4]Papadimitrious & Cott, 2014; [5]Baik, 2016; [6]Bilodeau et al., 2015; [7]D'Amour et al., 2005; [8]Kitson et al., 2012; [9]van Dongen et al., 2016; [10]Gaboury et al., 2009; [11]McDonald & McCallin, 2010; [12]Chong et al., 2013; [13]McCormack & McCance, 2006; [14]Wener, 2016; [15]Luxford et al., 2011; [16]Sumsion & Smyth, 2000; [17]McCormack & Karlsson, 2010; [18]Sidani & Fox, 2014; [19]Shaw, 2008; [20]Ripat, 2017; [21]Khalili et al., 2013; [22]Bell, Michalec & Arenson, 2013; [23]McInnes et al., 2015; [24]Axelsson & Axelsson, 2009.

In this study I looked at meaning making processes related to patient-centred care in an interprofessional team context. I sought to inductively derive information regarding patient-centred care as played out in an interprofessional forum in which two or more providers (as social actors) from different professional backgrounds collectively explored the patient-centred concept as related to their everyday work as a team.

Significance

In this study I aimed to contribute to a small but developing body of work explicitly examining the links between patient-centred care and interprofessional collaboration and teamwork, specifically how patient-centred care may influence inter-

provider relationships beyond and outside of the provider-patient dyad. As a secondary analysis, I also provide an illustrative example of how revisiting qualitative data with a new research question may be an asset in the study of patient-centred care. Methodologically, I demonstrate how more interpretive and reflexive approaches are needed in addition to positivistic lines of inquiry to deepen our understanding of the complexities of patient-centred care in healthcare teams. Lastly, in an applied sense, findings from this study may be considered in the development of interventions targeting improvements in patient-centred care where delivered in similar interprofessional collaborative team circumstances.

Chapter 3: Study Design (Interpretive Frameworks, Methodology and Methods)

In this study I undertook a qualitative secondary analysis using constructivist grounded theory as described by Charmaz (2014). Mindful of the conceptualization of good practice in establishing qualitative rigor as a dynamic and ongoing process, to be meaningfully considered throughout the life of the project rather than as (perfunctory) afterthought (Morse, Barrett, Mayan, Olson & Spiers, 2002), similar to Wener and Woodgate (2013), I took direction from Crotty (1998) using his process of methodological scaffolding.

In the methodological scaffold, Crotty (1998) offers guidelines to qualitative researchers for supporting philosophical continuity when designing a study. He proposed a staged process of critically reflecting on and evaluating your epistemology, theoretical perspectives, then methods, and considering goodness-of-fit across these levels. In this chapter, I explore each of Crotty's levels of qualitative study design in relation to my study as outlined in summary Table 1.

Table 1

An Application of Crotty's Methdological Scaffold

Design Elements	**Yamamoto & Wener (2020)**
Epistemology	Constructivism (e.g. Creswell, 2013; Crotty, 1998; Schwandt, 1998)
Theoretical Perspectives	1. Symbolic Interactionism (Blumer, 1969; Powell, 2013; Swandt, 2007) 2. Interprofessional Collaborative Relationship Building model (ICRB; Wener & Woodgate, 2016) 3. The Patient-centered Clinical Method (PCCM; Stewart et

	al., 2014)
Methodology	Grounded Theory (Charmaz, 2014)
Methods	Secondary data collection and sampling (Heaton, 2008; Largan & Morris, 2019; Szabo & Strang, 1997) Data gathered using focus group methods (Funk, Allan, & Stajduhar, 2009; Schwandt, 1998)

As the researcher's assumptions will ultimately determine the chosen variant of grounded theory (Charmaz, 2014), constructivism and the grounded theory variants are explored in some detail along with theoretical perspectives. I have allocated an early memo outlining my positionality as a researcher in the study of patient-centred care to Appendix A, which consistent with constructivist grounded theory, is needed to give the reader a "sense of the analytical lenses through which the researcher gazes at the data" (Mills, Bonner, & Francis, 2016, p. 12).

Interpretive Frameworks

Epistemology. Qualitative approaches are indicated when the interest is in understanding how social agents ascribe meaning to a particular experience (Creswell, 2013). Patient-centred care and interprofessional collaboration are negotiated and contextually situated social phenomena consistent with a qualitative lens. In healthcare situations, both teamwork among providers and with the patient is a dynamic and interactive experience that does not carry meaning in and of itself without the engagement of human actors. When providers and patients come together, meaning is co-

constructed, and individual actors may ascribe disparate, yet equally valuable meanings to the same situation (Wener & Woodgate, 2013, p. 307). For example, when a physician consults a counsellor regarding non-pharmacologic methods of depression management, the physician is more likely to endorse the counsellor's recommendations as part of the care plan if he or she agrees with the counsellor's clinical reasoning (Wener & Woodgate, 2013, p. 307). Similarly, patient-centred care is considered within the social context of the therapeutic relationship and the same encounter may be experienced differently on the part of providers and patients or even amongst providers. This is seen in the sometimes incongruent, nonetheless equally informative, reported experiences of patient-centred services between providers and patients; while their perceptions may differ, both have important systems planning and reform implications. Thus, at the broadest level of the methodological scaffold, I employed a constructivist epistemology as the phenomena of interest are consistent with the view that reality is co-constructed though interaction by social agents.

In the constructivist view, truth and knowledge are not discovered as would be assumed in objectivist or empirical realist schemes, but rather are created and are the result of perspective (Schwandt, 1998). Constructivists believe that interpretation is required to understand meanings or constructions and that in presenting one's findings, the researcher is, in essence, offering his or her "construction of the constructions of the actors one studies" (Schwandt, 1998, p. 222). Constructivism is consistent with Charmaz's (2014) variant of grounded theory in which researchers are considered a part of the studied world, constructing rather than discovering grounded theories through shared experience. Mills, Bonner and Francis (2006) have described that the researcher

undertaking constructivist grounded theory, as a co-creator of knowledge, can write in her or his own voice, in order to "present [oneself] as a human being" rather than "disembodied data-gatherer" (p. 11). Speaking to the dilemma of "silent authorship" (p.174), Charmaz (2014) has suggested that grounded theorists can also remain present, albeit in the background and as interpreters of what is unfolding, through evocative writing, through the conspicuous presence of a human voice that seeks to incite interest and to captivate the reader. Thus, consistent with my constructivist epistemology (as a meaning maker who does not aspire to positivistic objectivity) I acknowledge here that I have chosen to write this thesis as transparently as possible and in first person to support "meaningful coherence" as described by Tracy (2010, p. 848) as using representation techniques that harmonize well with chosen paradigms and theories.

Theoretical Perspectives

In the next layer of the methodological scaffold, my constructivist epistemology aligns with the theoretical perspectives of Symbolic Interactionism (Blumer, 1969), the Interprofessional Collaborative Relationship Building Model (ICRB; Wener & Woodgate, 2016), and the Patient-Centred Clinical Method (PCCM; Stewart et al., 2014). In the sections below, I offer brief descriptions of these perspectives to orient the reader. I then draw key links to my study.

Symbolic interactionism. In this study, I took a symbolic interactionist perspective of the Blumer-Mead persuasion (Blumer, 1969; Swandt, 2007). As described by Crotty (1997), symbolic interactionism examines issues such as language, relationships, and communication, in other words, human social interaction. As a theoretical perspective, symbolic interactionism (SI) has several distinguishable features.

The focus of SI is on how things are managed in the interpretive process, with the idea that human action towards objects or events is based on interpreted meanings. This pragmatic understanding of humans as purposive agents is commonly positioned in contrast to a stimulus-response understanding of behaviour in which action is caused (Powell, 2013). That is, the situation does not make the person do something, it is the internal process of interpreting the situation that mediates the individual's response. In this way, different actors may respond to the same situation in different ways, and while human action is still situated, may be shaped by historical, contextual and social forces, it is not determined by them but by the individual's internalized process of meaning making (Powell, 2013).

Another important defining feature of SI is that this meaning making process necessarily occurs through social interaction, or in everyday language, through communication (Swandt, 2007). There is no social reality independent of the mind, and SI can account for all forms of human association (Powell, 2013). In this view, actors must define, interpret and communicate in situations using symbols, with symbols being embodied in language. Symbols may be abstract (e.g. love) or concrete (e.g. a desk) and often imply action (a desk is where you sit to study). Importantly, different actors may assign different meanings towards events, objects, or people, and these meanings are not permanent but rather can change, can be created and re-created over time with the integration of new experiences. To return to the example of a desk, for actor A, a desk could be a torturous place where one is subjected to the pains of academia but for actor B, a desk could be a place of creativity, inspiration and learning. The definition of symbols as such is necessary for communication both as a starting point for interpretations and to

support social beings in negotiating the problems of day-to-day living. For Actors A and B, one could take action to avoid the torturous desk or enthusiastically seek it out, or perhaps with further experience a kind of hybrid understanding of the desk symbol is created for one or both these individuals. Thus, through that internal meaning making process on the part of individual actors, meanings become established and modified, and human action can be pieced together to establish patterns of group life that exist and carry on, though only in so far as the same schemes of interpretation are maintained and continually confirmed (Powell, 2013).

What does this mean in terms of the research process? In the symbolic interactionist view, the meanings human actors ascribe to their activities are of central analytic import (Dennis & Smith, 2015). Using SI, the researcher examines how people go about acting and interacting in day-to-day life (Oliver, p. 411). Rather than looking at society as a whole, the inquirer narrows their lens to what occurs between individual actors. Adopting this view, the inquirer enters a delineated context (where the actors of interest operate) to examine their unique definition of the situation including the intricacies of their meaning making processes as related to certain symbols (Swandt, 2004, p.284). Applied to this study, I sought to examine the meaning making processes of healthcare team members as related to the phenomena of patient-centred care (an abstract symbol) in a team-based Shared Mental Health Care setting in which inter-provider relationships are well-established and longstanding (a delineated context).

Interprofessional collaborative relationship building model. Developed by Wener and Woodgate (2016), the Interprofessional Collaborative Relationship Building Model (ICRB) describes how primary care providers build and sustain relationships with

each other including the stages of: (1) Looking for help (identifying a need for help from other providers and looking to and learning from other providers' unique expertise); (2) Initiating co-location (with organizational support, the coming together of providers in shared work spaces with elements such as face-to-face interaction as an asset to the relationship building process); (3) Fitting-in (newcomers work flexibly to align themselves and their practices with the existing clinic culture); and (4) Growing reciprocity (providers come to know, value and care about one another, and begin to recognize shared values that further enhance cohesion). In the ICRB view, the experience of the relationship building process is situated or context-specific and not all stages may be reached. Additionally, running throughout this four-stage developmental process are the components of "communication strategies" and "patient-focus", with the latter being aligned with a patient-centred approach. According to Wener and Woodgate, flexible development of effective communication strategies and a patient-focus is necessary to inter-provider relationship building and collaborative practice.

As a secondary analysis, in this study I examined the original raw data set that informed the development of the ICRB, albeit with a different research question specific to patient-centred care. With the lens of the ICRB I was directed to a process-oriented developmental understanding of relationship building while acknowledging its inherent complexity and situatedness. In adopting this view, I also identified at the outset, the presumed link between patient-centred care (patient-focus) and interprofessional collaboration, with patient-centred care within the ICRB as a core aspect throughout the interprofessional collaborative relationship building process. Finally, as the ICRB was developed by my mentor and advisor I endeavored to exercise caution in my process to

avoid qualitative secondary analysis as verification as described by Heaton (2008). The need for reflexivity and transparency becomes still more significant when adding a constructivist lens to secondary analysis, as different researchers can and indeed some would say (as uniquely situated interpreters) reasonably should be expected to produce different analytic readings of the same material (Braun & Clarke, 2013).

Patient-centred clinical method. The patient-centred clinical method (PCCM) is a practice approach that presupposes a shift in thinking away from the conventional medical model. In this view, providers (primarily directed at physicians but according to the authors the model can be applied to "clinicians" broadly) seek to share power with an active empowered patient, a shift Stewart et al. (2014) refer to as the "moral imperative of patient-centred practice" (p. 3). In the PCCM, a holistic understanding of health and wellbeing is embraced and distinction is drawn between the more historical picture of a detached, objective, paternalistic provider and a both subjective and objective provider that balances a scientific approach to care with a caring posture that is sensitive to human suffering and the illness experience. According to Stewart et al. (2014) the PCCM works in concert with rather than opposing evidence-based practice. The model itself contains four main components: (1) Exploring health, disease, and the illness experience (understanding from the patient's perspective); (2) Understanding the whole person (integrating component one concepts into a meaningful whole); (3) Finding common ground (a shared process between patient and provider that focuses on defining the problem, setting treatment goals, and clarifying roles); and (4) Enhancing the patient-clinician relationship (seeking to cultivate the relationship with each encounter). As a method, the PCCM focuses on the relationship between patient and provider. With roots

in the work of Rogers (1951), the PCCM shares many features with the occupational therapy understanding of client-centred practice, and as both "moral imperative" and approach, lies somewhere between client-centred practice and client-centredness. As the PCCM employs the language of primary care and my area of focus is patient-centred care, I felt this interpretive framework was well suited to this study. In an analytic sense, the PCCM directed me to consider, compare and contrast how patient-centred care was understood on the part of individual actors; for example, did the meaning construction process carry a values-oriented flavor (as "moral imperative") as espoused by the model's authors? Does the provider understanding appear to be otherwise motivated? And if so, how?

Assumptions. In their discussion of “circles within circles” of theory, Ely, Vinz, Downing and Anzul (1997) have explored how stratifications of theoretical understanding filter the perspectives of the inquirer. Drawing on this work, I consider symbolic interactionism, in the capacity of a broader “universal” perspective, with the ICRB and PCCM more proximal to the research question. Crotty (1998) explains how the researcher’s elaboration of theoretical perspectives help to reveal the assumptions of the inquirer, allowing the reader to make judgments about the research process. Thus important assumptions arising from my theoretical orientations included:

1. Meaning is co-constructed in a particular setting with each actor engaging in individualized meaning making such that multiple realities exist (constructivism, symbolic interactionism).
2. When providers come together in teams they progress through developmental stages, adopting group roles and behaving in predictable ways (ICRB).

3. Patient-centred care is necessarily concerned with the process of relationship development both with patients and between providers (PCCM & ICRB).
4. Patient-centred care and interprofessional collaboration are situated, social processes, shaped by the multiple layers of the environment in which both patients and providers reside (PCCM & ICRB).

Methodology

The next layer of Crotty's qualitative design scaffold (1998), methodology, lies somewhere in-between the researcher's guiding philosophical framework and methods. To ensure philosophical cohesion (Tracy, 2010), the chosen methodology should work well with the researcher's understanding of the nature of knowledge (ontology), how knowledge is known (epistemology), as well as technical procedures (methods) chosen for generating qualitative data (Swandt, 2007).

Grounded theory is a qualitative methodology that is used when the interest is in process and in developing theory (Creswell, 2017; Strauss & Corbin, 1994). In this study, grounded theory was used to develop a theoretical understanding of how providers use a patient-centred approach in the context of inter-provider relationships in a team-based Shared Mental Health Care setting. In planning for and executing this thesis, I grappled with the sheer complexity and breadth of this methodology as a new researcher. In that vein of *writing to learn*, in this section I explore the origins and evolution of the grounded theory methodology and then tackle some of the special considerations arising from philosophical considerations related to the social constructivist variant I employed.

What is grounded theory? Variants, Issues and Applications

In seeking to understand grounded theory, Creswell (2013) provides a helpful

discussion on the position and function of theory in a research study, comparing quantitative and qualitative approaches, and in exploring the distinct ways in which theory is positioned within the traditional qualitative streams. In quantitative research, theory is positioned at the beginning, perhaps in the literature review or following statement of the research question (p. 60). The function of theory is deductive, that is for confirmation, verification or objective testing. This stems from a realist position, that there is one objective reality that can be measured or observed (Creswell, 2013). Qualitative inquiry using grounded theory is positioned in contrast whereby theory is viewed as an end product (Creswell, 2013, p.65). In a ground-up sense, theory is developed from the data through an inductive process of discovery (Charmaz, 2006; Creswell, 2013, Creswell, 2017). In understanding the unique place of grounded theory, Creswell (2013) further contrasts this with the positioning of theory in other qualitative methodologies, such as ethnography, where the researcher may begin with a tentative theory that informs the study by, for example, influencing what questions are asked, or in phenomenology, where there is no clear delineation of theory, but rather the researcher relies on constructing a kind of core meaning of experience from a number of individuals (Creswell, 2013).

With the understanding of theory as end product in grounded theory, Heath and Cowley (2004) highlight the issue of discovery vs. confirmation, referring to the notion that, in theory development, emergence is incompatible with building on previously contrived concepts. So how does a healthcare researcher even know where to start? The answer to this dilemma would seem to depend on the epistemological variant of grounded theory being employed. Indeed, the idea that grounded theorists may have different

paradigmatic leanings, imparts a sense of confusion that Charmaz (2008) has referred to as "the congested logic of grounded theory" (p. 339). For example, in achieving philosophical alignment, the researcher may have to take care to ensure that even subtle language reflects the notion that she or he is seeking to make assertions that draw from interpretations of participants' interpretations (of many realities) vs. making claims about the discovery of a singular truth (Suddaby, 2006), that is, constructivist vs. positivist grounded theory.

In my studies, I have noticed that researchers in rehabilitation commonly draw on Creswell, who situates most of his work as a qualitative researcher in a post-positivist light. This lens is seen in Creswell's preference for grounded theory as described by Strauss and Corbin (e.g. 1990), although, in his chapter on the methodology (Creswell, 2017), he also draws on constructivist grounded theory as described by Charmaz (2014). Charmaz (2014) points out the irony that while grounded theory was originally conceived as a counter to the dominant positivist philosophy of the 1960s, it was later became known for its positivistic assumptions (p. 9). Given the complexity of its philosophical roots, grounded theory presents unique challenges to new researchers.

According to Suddaby (2006), grounded theory is best understood through historical examination. In reviewing the methodological literature, I observed that authors invariably seem to provide a historical overview before launching into more practical considerations, which (having seen the value of) I continue here. Five variations of grounded theory are commonly discussed, including the original described by Glaser and Strauss (Glaser & Strauss, 1999), Straussian grounded theory (Corbin & Strauss, 1990), Glaserian grounded theory (Glaser & Holton, 2004), social constructivist grounded

theory (Charamaz, 2006) and situational analysis (Clarke, 2003). Drawing on Ludwig Wittgenstein's concept of "family resemblances" (as cited in Charmaz, 2006), Bryant and Charmaz have likened the different variations of grounded theory to differences among family members, as having "resemblances and similarities" as well as "differences and disputes" (p.11). Perhaps the most defining disputes being philosophical orientation, with the different variations ranging from post-positivism, to constructivism and post-modernism.

More specifically, the original by Glaser and Strauss, merged positivism with pragmatism, offering a middle ground between empiricism and relativism (Suddaby, 2006, p. 634), by detailing a flexible yet systematic approach to qualitative analysis (Charmaz, 2006). In developing the methodology, Glaser and Strauss simultaneously acknowledged epistemological concerns at the time while providing researchers with useful practical guidelines (Charmaz, 2006). The inception of the grounded theory methodology helped to shift the perceived value of qualitative research from a marginalized function of developing 'hunches' (Creswell, 2013) to a legitimate approach in its own right (Charmaz, 2006). However, these authors ultimately disagreed on the role of literature, hypotheses, and emergence vs. deduction (Heath & Cowley, 2004), giving rise to the Glaserian and Straussian streams. In brief, in Glaserian grounded theory, referred to as classic grounded theory, emergence and constant comparison are supreme, and in the Straussian persuasion, there is some role for deduction and verification (Heath & Cowley, 2004, p. 143) with a relative emphasis on technical procedures (Charmaz, 2006). In Charmaz's interpretivist variation, social constructivist grounded theory (2014), the resulting theory is acknowledged to be a construction of reality, both on the part of

participants and researcher (Charmaz, 2006), and finally, Clarke's situational analysis reflects a post-modern view (Clarke, 2003).

In a practical sense, grounded theory is often explained in terms of what is shared amongst the different variations and in terms of how it is (often) mistakenly used. Shared features are listed here as described by Thorne and Charmaz (2006), that is, in grounded theory: the focus is on constructing theory over application or description; theoretical sampling is used; data collection and analysis occur simultaneously; the focus is on processes and actions; systematic analysis is used; new conceptual categories come from the data; researchers look for variation; and seek to develop a category over complete coverage of an empirical topic (p. 155). In contrast, Sudday (2006), offers a helpful discussion on what grounded theory is not, that is to say, grounded theory is not: "an excuse to ignore the literature" (p. 634); "presentation of raw data" (p. 635); "theory testing, content analysis or word counts" (p. 636); "routine application of formulaic techniques to data" (p. 637); "perfect" (p. 638); "easy" (p.639); or "an excuse for absence of methodology" (p. 640).

Both Charmaz (2006) and Sudday (2006) argue that most criticisms of grounded theory stem from instances of misguided application, and that inquirers must pay close attention to their epistemological assumptions throughout the research process, making these transparent to the reader. In view of the breadth of grounded theory variants and this potential for misuse, as a researcher, claiming and defending one's chosen variant then becomes particularly important, carrying potentially damning implications for rigor. To take an illustrative example from Tracy (2010, p. 848), it would not be philosophically coherent for a post-modernist to use classic grounded theory, due to the

researcher's assumptions about a fragmented reality. Thus, in keeping with my proposed constructivist epistemology, I used Charmaz's grounded theory in this study.

Depending on the reader's philosophical orientation, however, one may or may not also raise the issue of the role of tacit or pre-existing knowledge and '*bias*' in a grounded theory scheme in which theory is discovered from the data. A central defining feature of social constructivist grounded theory is that meaning is co-constructed between participant and researcher in a situated manner at the time of data collection, in-between and beyond, during analysis and in even in the process of writing. For Charmaz, the answer to such purported issues would seem to lie in the process of reflexivity and, in my understanding, the debunking of the argument of 'bias' within a constructivist qualitative paradigm. In Glaserian Grounded Theory, the researcher is instructed to delay comprehensive review of the literature to mitigate the risk of imposing existing knowledge on the data rather than a process of emergence (in the sense of pure induction) and discovery (Lempert, 2007). As is commonly put, the researcher is instructed to embark on her or his analysis as tabula rasa or blank slate. In contrast, Charmaz (2014) describes how pre-existing knowledge of the literature may be a valuable means of appreciating the lay of the land so to speak in order to meaningfully guide the development of a worthy or needed study; an essential aspect of quality as described by Tracy (2010).

In her discussion of quality markers, Tracy (2010) raises the question of sincerity (not to be confused with a single objective truth) as achieved through vulnerability, transparency and self-reflexivity of the researcher. Reflexivity creates a space for researchers to consider how "our value commitments insert themselves into our empirical

work" (Mills et al., 2006, p. 10). Thus, engaging in reflexivity is not about reducing bias but rather about being honest, making your voice explicit and ultimately acknowledging the situated nature of your research (Funk, 2017d). As described by Tracy, reflexivity should ultimately become apparent through an interlacing of the researcher's reactions throughout her or his writing rather than a compartmentalized reporting per se; for example, she notes the use of "I" statements remind the reader of the inquirer's presence and voice (p. 842). As a co-creator of knowledge, the social constructivist researcher is unapologetic about her presence in the meaning making process, but rather through reflexivity, is transparent (commonly brought forth through the grounded theory process of memoing) about how meaning may be shaped from her unique world view. As a result, in addition to outlining epistemological assumptions, researchers engaging in constructivist grounded theory so too must consider their unique standpoint as related to the topic of inquiry, making this available to the reader. That different researchers can perceive different meanings in the same data set is not cause for alarm; rather, by adopting that reflexive and curious stance, the constructivist researcher is able to cultivate an awareness of presuppositions and to engage in a necessary process of tackling how such presuppositions may impact the research process. Thus, great importance lies on the practice of reflexivity, in that sense of being aware and being transparent rather than seeking to eliminate the researcher's voice in the pursuit of objectivity.

Lastly, to return to the issue of discovery vs. confirmation, depending on the chosen variant of grounded theory, the distinction is also be made between pure induction and abduction (Thornberg & Charmaz, 2014). In the Glaserian sense, pure induction is realized when emergent categories are discovered from the data alone; but for

constructivist grounded theorists there is continual vacillation between induction and a process referred to as abduction. In abductive reasoning, which in my mind, lies somewhere between inductive and deductive thinking with the latter being qualified in a particular way, the researcher is not trying to force a fit based on preconceived ideas (and so remains open to discovery) but is nonetheless equipped with preexisting knowledge that allows for a number of possible threads or explanations (hunches vs. hypotheses) to be pursued. Such threads are very much provisional (Charmaz, 2014) and the researcher is open to abandoning a given stream of thinking in light of new discoveries. In the current analysis this meant that, based on my pre-existing knowledge, experiences or theoretical knowledge I might develop certain (provisional) hunches as related to a particular meaning making process. I might pursue one particular hunch, but ultimately the process of constant comparison would determine whether the line of analytic thought was worth continuing to explore, or must be discarded to examine other potential leads.

Methods

The final layer of Crotty's methodological scaffold concerns methods, specifically the technical procedures used to collect and analyze data. As data collection and analysis for this study are described in detail in Chapters 5 and 6 respectively, I focus here on describing data collection and analysis in the primary study by Wener and Woodgate (2016) to provide context. I also explore qualitative secondary analysis broadly including benefits, concerns, and my rationale for focusing the analysis on the focus group data from the primary study.

Methods in the Primary Study by Wener and Woodgate (2016)

Participants and recruitment. Wener and Woodgate (2016) used purposive

sampling to seek out participants working in a Manitoban health region's interprofessional Shared Mental Health Care program. Using maximum variation sampling (Creswell, 2005), Wener and Woodgate initially sought to capture diverse providers in their participant grouping by gender, location of practice and physician remuneration model (fee-for-service or salary, p. 4). All providers participating in the health region's Shared Mental Health Care program were invited to participate in the study via recruitment flyers.

Data collection. Data collection in the primary study was undertaken by the first author, Dr. Wener. Participant demographic information, such as age and number of years in practice, were collected using a questionnaire. Wener and Woodgate (2016) generated data using in-depth semi-structured individual interviews and focus group methods. The guides for both interviews and focus groups included a series of open-ended questions broadly focused on the participants' experiences of collaboration. Interviews were conducted first, with focus group guide later being developed based on preliminary themes that had been inductively derived from the interview phase.

Data analysis. Wener and Woodgate (2016) used descriptive statistics to analyze the demographic questionnaires. All individual semi-structured interviews and focus groups were audio recorded and transcribed verbatim. Using Charmaz's constructivist grounded theory (2014), Wener and Woodgate undertook simultaneous data collection and analysis, initial and focused coding, employing constant comparison methods, memoing and diagramming to inductively derive the major categories and themes. Both authors met frequently throughout the data collection and analysis to discuss their readings of the data. To share and gather feedback on preliminary findings, a newsletter

was developed and mailed to all participants. Following this process, no additional changes were made to the analytic scheme. Wener and Woodgate used the following strategies to support rigor: (1) paradigmatic alignment of research questions with data collection and analysis methods; (2) collection of data over a long period of time and with a diverse group of providers including men, women, different clinic settings, professional affiliations, and remuneration models; (3) maintenance of reflexive journals; (4) development of an audit trail outlining analytic decisions; and (5) scrutiny of the depth and adequacy of their developing analysis by seeking feedback from participants and from peers.

Qualitative Secondary Analysis

The method of secondary qualitative analysis offers researchers the opportunity to gain a richer understanding of what is oftentimes laboriously collected qualitative data beyond the scope of research questions intended in the primary investigation (Thorne, 1998). Yet while the secondary analysis of quantitative data is commonly treated without skepticism, secondary analysis of qualitative data has received criticism despite its considerable potential for advancing knowledge in the healthcare sphere (Thorne, 1998). Wasterfors, Akerstrom and Jacobson (2014) have argued that the secondary use of qualitative data, as a process that "slows down analysis" (p.467) in a manner that encourages comparison, re-framing, knowledge exchange and debate, represents an important means of advancing qualitative research as a whole. These authors have suggested that secondary analysis may carry particular utility in advancing theory. Moreover, secondary analysis presents unique learning opportunities for student researchers like myself. For example, Szabo and Strang (1997) have argued that the use

previously collected data affords new researchers the ability to focus their efforts on learning the complex process of qualitative analysis. Still further, secondary analysis carries the added benefit for participants of limiting intrusion by leveraging the use of existing data (as cited in Funk et al., 2015).

Secondary analyses may vary substantially in scope. Some researchers will draw from multiple data sets or combine different forms of data. As this was a small-scale study, I used one rather than multiple data sets, what Largan and Morris (2019) have refered to as a "single strategy" (p. 82). According to these authors, a single strategy in secondary analysis is appropriate when the researcher seeks to explore one data source that matches the research question in great detail, favoring depth over breadth. For this to occur, the data source must be a good-fit with the secondary research question and of sufficient size to be able to adequately mine the data. A relevant research question, the abundance of the Wener and Woodgate data set, and the alignment of the core theoretical process of patient-centred care within the ICRB made for a good-fit with a secondary study approach.

Without this fit, the decision to undertake a secondary analysis using constructivist grounded theory could be considered somewhat precarious. At the self-proclaimed risk of being accused of orthodoxy, Hood (2007) has referred to the "troublesome trinity" (p. 163) of grounded theory as requisite features that set the methodology apart from a generic inductive qualitative model. That is, without the defining elements of (a) theoretical sampling; (b) constant comparison of data using theoretical categories; and (c) the theoretical saturation of categories with the overarching aim of developing an inductive theory, the qualitative inquirer risks committing the all

too common blunder of misusing the grounded theory label (Hood, 2007).

In planning my thesis, I acknowledged at the outset that, as a secondary analysis in which I did not intend to generate new participant data nor to draw from other data sources, true theoretical sampling may not have been possible. For example, I may have found that the collection of additional data was needed to further develop my theoretical category(ies), yet to be constructed through the method of constant comparison (Charmaz, 2014). However, due to the abundance and richness of the data from primary study, I was able to flesh out my major categories with existing data. Indeed, other authors have been similarly successful in carrying out secondary analyses using grounded theory. Szabo and Strang (1997), for example, outlined a secondary grounded theory analysis that was successfully carried out by virtue of having a primary data pool large enough so that theoretical sampling was undertaken appropriately.

Data Collected Using Focus Group Methods

With respect to data sources, grounded theory researchers commonly employ interview data collection methods; however, data may come in other forms such as through observation, video tapes, books, and newspapers (Corbin & Strauss, 1990). In the primary study, data collection methods included a demographic questionnaire, in-depth semi-structured individual interviews, and focus groups with existing Shared Mental Health Care teams. In undertaking my study, following preliminary data screening, the focus group transcripts along with related fieldnotes and memos were identified as uniquely germane to the new research question focused on patient-centred care.

These particular data were selected for several reasons. Different methods may shape the meaning making process in different ways placing ownership on the researcher

to consider methods with intentionality of design. While the individual interviews from Wener and Woodgate study (2016) focused on the inter-provider relationship building process, the semi-structured focus groups yielded more theoretically relevant data as the interview guide included a prompt to open up potential discussion around patient-centered care explicitly, allowing for greater fit with secondary study objectives. In keeping with my constructivist epistemology and intent to look at patient-centred care in an interprofessional context, the focus groups and associated data were also considered to be suited to the study of how patient-centred care is used in interprofessional team relationships, as focused on exploiting group interaction in the meaning making processes of participants as social beings. Smithson (2000), for example, has referred to social features or patterns that play out in the context of focus groups such as dominant voices, constructing the Other, conflicts, and the emergence of normative discourses that the researcher may explore in the analysis. In this regard, the focus groups allowed for a particular kind of meaning generation that may not be possible in an individual interview context. Lastly, there is some evidence in the interprofessional collaborative literature to suggest that providers may talk about patient-centred care in unique ways in uniprofessional vs. interprofessional forums (Aase et al., 2016). Thus, drawing from the focus group data, I intended to consider how meaning was constructed in relation to patient-centred care in an interactive or relational sense, amongst the different members within existing teams**.**

Chapter 4: Data Collection

To support the reader in making decisions around transferability, I begin by offering a description of the participants from the original study. In the second part of this chapter, I explore how I collected data in this study as a secondary analysis.

Participants and Data Collection in Wener and Woodgate (2016)

Participants in the primary study were primary care providers working in a Manitoban health region's Shared Mental Health Care program. In the first phase of this study, 16 primary care providers were interviewed individually (family physicians N=11; nurse practitioners N=5). Wener and Woodgate then conducted six semi-structured focus groups with existing Shared Care Program teams that included family physicians, nurse practitioners, Shared Care Counsellors and psychiatrists. The focus groups were conducted over a six-month period spanning 2012 - 2013.

In carrying out the focus group phase, the authors of the parent study used a semi-structured guide (Appendix B) that incorporated questions about the interprofessional collaborative process of providers with a focus on different aspects of team-based care such as roles, barriers and facilitators of collaboration, patient-centred care and the perceived role of the patient. The focus groups in the primary study were interprofessional in nature, containing a minimum of two providers from different professional backgrounds with up to four participants per group. Two of the participants from different provider groups/clinics participated in more than one focus group. This was because these individuals serviced more than one clinic site and so were members of multiple teams. Informed consent was obtained prior to participation.

Data Collection as a Secondary Analysis

In this secondary study, data collection involved a kind of purposeful re-harvesting of data from the primary study data pool. In this I engaged the secondary mode of "informal data sharing" (Heaton, 2008) in which the primary researcher (Dr. Wener) shares data with a researcher not involved in the primary study but who remains a part of the secondary analysis team. Here, I did not collect direct participant data but rather, after obtaining ethical approval (as the secondary use of data was linked to a new research question), was granted access to the data from the primary study by Wener and Woodgate (2016). Once obtained via USB, all de-identified data were stored in a locked research space at the College of Rehabilitation Sciences at the University of Manitoba, where the analysis took place.

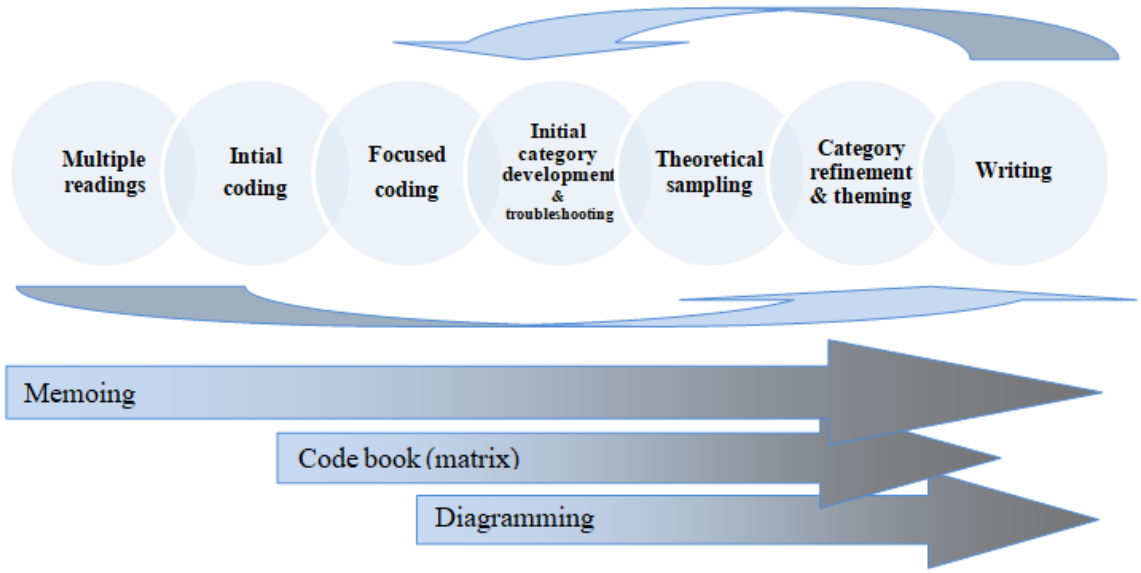
An initial sampling process was then undertaken whereby all data from the Wener and Woodgate (2016) study were screened for inclusion through a process of evaluating goodness-of-fit with the new research question (as cited in Funk, Stajduhar & Outcalt, 2015). The data set included individual interviews and focus groups, but also related documents generated in the course of the primary study such as researcher field notes and memos. Upon screening, I honed in on the focus groups and related documents as uniquely suited to the research question. As a grounded theory analysis, data collection and analysis occurred simultaneously. However, to support a posture of being open to discovery (in my position as a student undertaking secondary analysis of my advisor's dissertation data, as detailed in Appendix A: Positionality of the Researcher), among the focus group data including the transcripts, fieldnotes and memos, I intentionally delayed looking at memos from the primary study that were specifically analytic in nature until I had established a core analytic direction from my readings of the transcripts alone.

Chapter 5: Data Analysis

Data analysis proceeded with direction from Charmaz (2014). In Figure 3 I provide a diagrammatic representation of the analysis , followed by a narrative of my analytic process. I acknowledge that, while I have attempted to present my plan in a step-wise fashion as described by Charmaz (2014), while we ultimately begin with generating data and conclude with a write-up, the grounded theory research process is far from linear.

Figure 3

Data Analysis



Gradient in shading of arrows reflects trend towards increasing maturity, depth and integration. Overlap in progression of analytic phases is intended to suggest vacillation between and among stages, as an iterative rather than linear process. The Code book (matrix), as a working document, was modified and refined as the analysis progressed.

When embarking on a grounded theory analysis immersion is key as a thorough and nuanced appreciation of, and engagement with, the data is necessary for cultivating analytic generalizations (Polit & Beck, 2010). Thus, I began my analysis with multiple

readings to encourage familiarity with the data and to generate a sense of the whole, noting any initial impressions as well as the overall tone of the focus groups as described by Thomas (2006). I then moved to an open coding process, asking broad questions of the data, such as "what am I seeing here", and in the grounded theory tradition, fairly quickly and spontaneously assigning labels to what I was seeing (Funk, 2017a).

Initially, in coding the data I remained very close to the data, (Sandelowski, 2010) or 'nvivo' (Coffey & Atkinson, 1996), commonly employing the words of the participants with intent to move towards greater levels of abstraction later on. However, so as not to lose any preliminary analytic insights, I documented any emergent analytic thoughts in the form of analytic memos. Charmaz (2014) refers to this first phase of coding in the grounded theory process as "initial coding" (p. 43). During the initial coding process I followed her strategy of using parentheses and a question mark to flag ideas that were perhaps less apparent in the data but may later pique my analytic curiosity.

My initial coding process created scaffold for moving forward with the analysis. Early on, I did not limit the number of codes generated. Consistent with my proposed constructivist lens, I asked questions of the data such as "do I need to look at this in a different way to capture the richness of the data?" and "am I coding primarily for meaning or description?" Taking direction from Charmaz (2014), I endeavored to use action words to articulate codes thereby encouraging a focus on process and action rather than description. In the tradition of constructivist grounded theory memoing, I also asked questions of the data related to the meaning making processes of the participants as social agents; for example, "what is this person doing?", "constructing the Self", "Othering?"

“is there conflict?”, “is the participant reproducing or challenging dominant social ideas?”, “engaging in social comparison?” (Funk, 2017b), “repetition?" (that is with some sort of contextualized meaning beyond mere frequency), “using interpersonal strategies?”, "with whom?" and "under what conditions?" (Charmaz, 2014; Lempert, 2007; Thorne, 2008).

At an early stage, I had an overabundance of codes with a fair amount of repetition. Initial codes (containing repetition) were entered into a matrix in Microsoft Word along with representative quotes, a qualitative data management process borrowed from Dr. Woodgate and Dr. Wener. With respect to the number of codes, Thorne (2008) cautions the neophyte researcher to be mindful that, however much intellectual energy or time it may have taken to develop, you must remain open to abandoning your initial system if needed. Charmaz (2014) refers to such flexibility as remaining open to different possible theoretical pathways being inductively developed through your readings (p. 46). She refers to initial codes as “provisional” (p. 48), in the sense that the researcher remains open to change and discovery but also that the language of the code may be revised to enhance the goodness-of-fit over time. As a working document, the matrix served as a codebook (Funk, 2017c) that, combined with my memos, I used to simultaneously advance my analytic thinking while evidencing my analytic process over time through successively dated documents. Using the matrix, codes were collapsed by moving like codes proximal to each other to get a sense of what might constitute shared meaning and subsequently removing repetition. All versions of the matrix and memos were saved and logged so as not to lose any data that may have later became relevant depending on the as yet unanticipated direction of the analysis.

Throughout the analysis, constant comparative methods (Charmaz, 2014) were used, in which I engaged in a process of moving back and forth, of making comparisons within the data to help make analytic sense of what I was seeing (p. 54) and to move from descriptive to conceptual categories (Funk, 2017d). In Charmaz's grounded theory, "initial" coding gives way to a more selectively flavored "focused" coding phase once the researcher has constructed a core analytic path. The movement from initial-to-focused coding is in many ways entrenched in the analytic dilemma of achieving interpretive richness. During focused coding, which allows inquirers to manage a greater abundance of data (p. 11), the researcher builds off of the "most significant or frequent initial codes" (p. 46). As a new researcher I asked "but how will I know what is most significant?"

In answering this question, the process of grounded theory memoing seemed to offer a sense of direction. According to Lempert (2007), memos form the backbone of a grounded theory process, creating a space for the researcher to engage with the data in a way that supports conceptualization, the discovery of emergent social patterns, movement beyond description towards abstraction, and ultimately a record of the research process. Lampert cautions that unseasoned researchers may grow tired of memoing leading to fixation on a more readily apparent descriptive pattern, advising the neophyte to embrace the inherently messy and iterative nature of memoing, accepting uncertainty in the knowledge that, over time, the memos will advance in clarity, depth and integration with the eventual outcome of theory development (p. 249). As a new researcher I gave myself permission for - particularly early memos - to be imperfect, disjointed and even somewhat chaotic accounts of my ongoing dialogue with the data. In these memos I sought to incorporate, not only my thoughts and conversations with the data but also the

voices of the participants, as described by Lempert (2007), as a means of remaining grounded in the data, avoiding overrepresentation of certain elements, and to evidence my chosen analytic path (p. 256). Again, mindful of my pre-existing knowledge of the literature and wanting to support an inductive process, I also endeavored to maintain an open posture conducive to discovery by noting and exploring through memoing, any thoughts that emerged pertaining to extant literature. In this, I sought to trust in the constant comparison process, as described by Wuest (2000), as serving as a buffer against seeing what you want to see in that "hunches" will only survive if supported by the data.

A process of theoretical sampling proceeded at the stage in my analysis in which I had developed tentative categories such that I was able to direct sampling by theoretical intent, allowing me to narrow my analytic focus (Charmaz, 2014). I began to create preliminary category definitions and to explore possible explanations. Ongoing memoing helped me to fill out and cultivate my major categories. According to Charmaz (2014), the timing and emergent nature of theoretical sampling has important implications for the richness of the resulting analysis. In following potential leads, she offers the strategy of asking "so what?" (p. 107) to avoid common missteps such as developing fuzzy categories, overreliance on obvious statements for fleshing out categories, and early determination and closure of categories (p. 107). Holton (2007) adds that researchers new to grounded theory may have reservations about abandoning certain data in pursuit of the core category. This was extremely difficult for me. Mindful of my newness to the methodology I also reminded myself, as described by Holton, grounded theory is about the concepts inductively derived from the data rather than the data itself, and that theoretical coding requires both patience and discipline (p. 266). As a new researcher,

presented with different potential threads of meaning to pursue, I sought ongoing dialogue with my academic advisor, who helped me to develop the skill of letting go of data that (while interesting) was not theoretically relevant to my purpose.

Throughout, and certainly as my codebook was continually refined, I also took the approach of visually mapping out my codes in my memos to support movement towards greater abstraction. Lempert (2007) has described how diagramming in grounded theory assists the inquirer in undertaking the challenge of integration. She suggests that diagramming is an important tool for organizing and furthering the analysis by virtue of gaining a certain "analytic distance" that allows for abstract conceptualization (p. 258). Charmaz (2014) similarly refers to the notion that to avoid analytical problems such as generating categories that are superficial, the researcher requires a certain degree of time and distance (p. 104). My advisor helped me to work out a schedule whereby I worked here and there rather than in marathon form (as my instincts would have me do), to allow me to take a step back to better appreciate and see what was unfolding through my work. Charmaz further describes the uniqueness of grounded theory diagramming as focused on the theoretical development of the researcher's analysis, suggesting that diagramming, in particular, can help generate an understanding of the relationship between theoretical categories (p. 121). Through diagramming, I was better able to organize categories, to consider the relationship between categories, as well as my preliminary thoughts regarding broader themes. As part of this process, I also took direction from Attride-Stirling's (2001) thematic mapping (web-like illustrations) as an analytic device for making sense of qualitative data, for generating movement from "text to interpretation" (p. 388). As I engaged in diagramming, I asked questions of the data such as, "what

elements relate to a similar idea?" "am I identifying any patterns?" "what am I seeing here that might have meaning related to the social worlds of the participants?" "how do my memos relate?"

Finally, I discontinued gathering data from the pool of the primary data set when the pursuit of additional data did not appear to further my theoretical interests or the point where I was not able to derive new properties of my categories (Charmaz, 2014; Dey, 1999). Drawing on recommendations from Dey (1999), I claimed theoretically saturation with skepticism, ensuring I was open to moving back to the analysis if my analytic claim of sufficiency was not meaningfully defensible as grounded in the data. In considering such relationships and in seeking to generate meaning at the level of themes, I sought to identify that common thread of meaning that may be implicated by presence, repetition and seeming importance or weight as described by Morse (2008) as representing a kind of underlying a pervasive essence that is weaved throughout the data. Morse adds that in grounded theory, categories are negotiated as the analysis matures, but that themes are used later on in the research process to "tie it all together" (p. 727). As a new researcher, I sought ongoing dialogue with my advisor to grapple with this challenging intellectual work.

Chapter 6: Quality Measures

In developing a plan for rigor in undertaking a constructivist grounded theory study, I took direction from Charmaz (2014), Mills et al. (2006), and more broadly as related to qualitative inquiry from Tracy (2010) and Shenton (2004). As a secondary analysis in which direct participant data collection had already taken place, the bulk of strategies focused on my plan for analysis and reporting. Action steps to support quality included:

(1) Prolonged period of engagement with the data set.

(2) Detailed description of my theoretical orientations including statement of my assumptions and an account of how these may have been challenged or refined as my project progressed.

(3) Rich description of study context and participants to support the reader in making judgments around transferability (Tracy, 2010), "naturalistic generalization" (Stake & Trumbull, 1982) or so-called "reader generalization" (Misco, 2007).

(4) Involvement in the analysis of the principal investigator of the primary study who is familiar with the data and is an expert in the area of interprofessional collaboration and qualitative research. Her frequent involvement throughout the research process was intended to support quality control (as I am a student-researcher), to mitigate the risk of misrepresentation in secondary analysis (as cited in Funk et al., 2015), and to encourage the constructivist aim of triangulation as seeking completeness and depth rather than validation or convergence (Breitmayer, Ayres & Knalf, 1993)

(5) Maintenance of a detailed research log and memos (including reflexive memos) to support transparency in my processes of selecting, managing, organizing and analyzing the data including explicit detailing of my analytic choices and thinking.

(6) Solicitation of feedback following presentation of preliminary findings at conferences and other provider forums to support "peer scrutiny" (Shenton, 2004) and to examine the "face-value" (as cited in Tracy, 2010, p. 841) of my findings.

Chapter 7: Ethics

As the secondary use of data from the primary study by Wener and Woodgate (2016) was linked to a new research question specific to patient-centred care, ethics approval was obtained from the University of Manitoba Health Research Ethics Board (H2019:036 (HS22508)) prior to accessing the data for secondary purposes.

Chapter 8: Findings

In this study, I found that providers constructed a context-specific understanding of patient-centred care through talk as they explored the experiences of their day-to-day work life. In generating their understanding of patient-centred care, two distinct patterns of meaning making were inductively derived from these data: (1) understanding patient-centred care as delivered by individual providers or within the provider-patient dyad, and (2) understanding patient-centred care as delivered by the team, as a unified group of providers with common patients.

The movement from an individually-oriented to team-focused understanding of patient-centred care was mediated by the presence of a particular social entity gleaned from these data, the Collective Provider. Working with each other over time in a collaborative Shared Mental Health Care setting, these providers developed a shared identity, termed the Collective Provider in this analysis, and embodied in the phrase working together "makes us a better provider" (FG4). The Collective Provider was comprised of a cohesive team of providers characterized by well-functioning inter-provider relationships grounded in genuine positive regard for one another. The Collective Provider appeared to be developed over time, with established history and experience working with one another, and in a practice setting that supported interprofessional collaboration and collaborative relationship building.

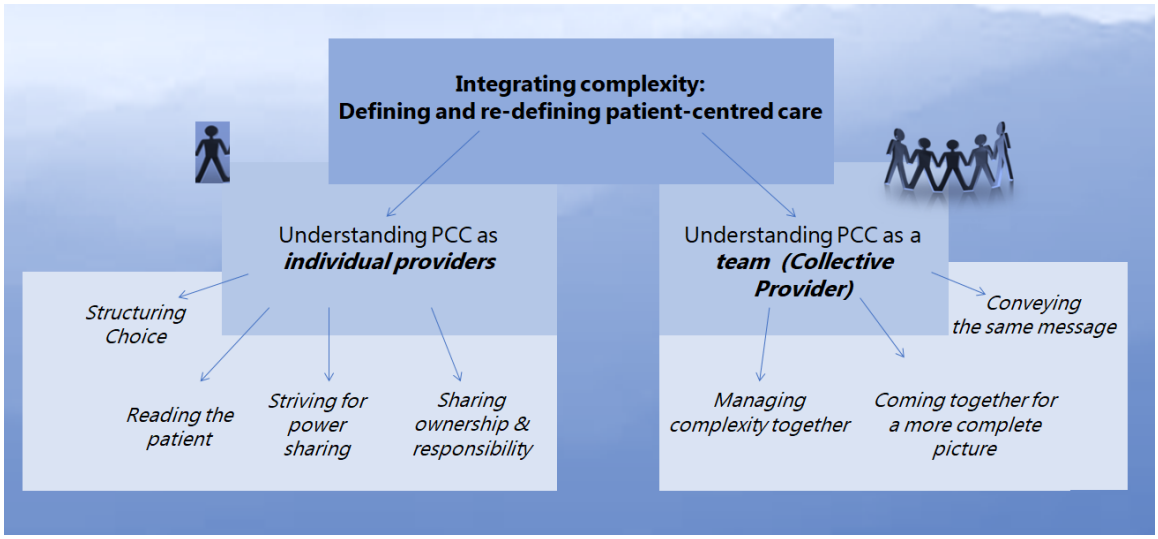
Within the Collective Provider, robust inter-provider relationships nurtured a team-facilitative use of the patient-centred concept, that is, as a means of bringing providers together in a way that improved cohesion and teamwork. Thus for these teams, the Collective Provider suggested the pivotal importance of inter-provider relationships

beyond and in addition to individual provider-patient relationships or the provider-patient dyad in implementing a patient-centred approach in a team setting.

The core category of integrating complexity: defining and re-defining patient-centred care reflected an overarching meaning making process in which providers, drawing from their everyday practice experiences, increasingly integrated the complexities and challenges of delivering patient-centred care in a Shared Mental Health care setting into their definition of patient-centred care. . That is, when first asked about their understanding of the patient-centred concept, providers tended to explore patient-centred care as delivered at the level of individual providers and patients. Here, providers explicitly spoke to their understanding and definition of the patient-centred concept. Initial definitions focused on patient-centred care broadly as values system or ideological commitment. As providers delved into their understanding of patient-centred care further, an elaborated definition was identified in which patient-centred care was translated into actionable or doable steps in their everyday work with patients. Still further, as providers continued to describe their experiences, there was an increasing focus on exploring how patient-centred care was carried out as a function of inter-provider relationships within the team, that is, as a collective team endeavor.

In the sections below, each of these elements are explored in detail with illustrative quotes from the data set. A breakdown of the core category, categories and subcategories is provided in Figure 3**.** Consistent with primary study data collection procedures, in the transcript excerpts, focus groups are indicated by the short form (FG) followed by the focus group number (1-6).

Figure 4



Understanding Patient-centred Care as Individual Providers

Participants' opening or initial articulations of patient-centred care tended to focus on patient-centred care as an ideal, that is, with a kind of moralistic flavor in which the concept was referred to in broad terms as a values system, belief or ideological commitment. As described in focus group four: "Client centred I think it, or patient centred. Um. I think it starts with the absolute belief that everybody that comes in has potential, potential to change something in their life or potential for, potential for things to be different or better than they are currently." (FG4).

Following this starting point for exploration of the patient-centred concept, providers moved towards exploring patient-centred care as an actionable practice, that is, how patient-centred care - beyond a belief system - played out in everyday clinical interactions with patients. Here, providers tended to explore practice experiences at the level of individual providers working with patients or one-to-one. These providers did not go into detail around explaining or defining what the provider-patient dyad or the individual level is in the context of delivering patient-centred care, as this appeared to be

assumed to be common knowledge amongst providers. In constructing how patient-centred care was broken down into actionable or doable terms as individual providers, four elements were identified from the provider perspective as contributing to a patient-centred process in a Shared Mental Health Care setting including: (1) structuring choice; (2) reading the patient; (3) striving for power sharing; and (4) sharing ownership and responsibility with the patient.

Structuring Choice

From the provider perspective, patient-centred care occurred at the individual level when both the provider and patient's unique, yet valued, forms of expertise were seen to be heard, respected and ultimately accounted for in the decision-making process. In the context of the provider-patient dyad, acknowledgement and respect for different forms of expertise was thought to be made actionable through shared participation in a particular kind of structured choice, that is, a controlled choice or choice within certain limits. Here, patients were situated as the ultimate decision-maker, but were expected to do so within the parameters of certain, provider-identified, options.

More specifically, in supporting an active patient, providers created a scaffold for patient choice by offering a list of evidence-based care options using their practice knowledge, experience and expertise. In doing so, they communicated their expertise as providers. Respect for provider expertise was then thought to be acknowledged on the part of the patient, in the action of selecting a treatment direction from those - provider identified - options. As described in focus group three: "It's about working with the patient. It's about you journeying together. Uh, huh. But it's also using our expert role. Right. to have, teach somewhat the reasonable options are and the potentially helpful

options." **(**FG3). In a primary care context, where providers worked with the same patient over a length of time, even across the lifespan, the level of patient trust in the provider was thought to be important in enacting structured choice. With the development of trusting, long-term relationships, there was greater perceived comfort on the part of patients with deference to provider expertise.

As perceived by these providers, the patient role in structured choice involved communicating their expertise as individuals regarding their preferences, needs and life situation, and using that expertise to select a treatment path. As described in focus group four: “they’re [clients are] the experts at their own life...they know what it is that’s going to make them better. We’re there to provide suggestions, to provide options and to move with them as they explore what their options are." (FG4)

The need for structuring choice as part of a patient-centred process was commonly situated within the complexity of mental healthcare, the idea that in any given situation, there are often a number of treatment paths that may be pursued. In planning treatment "...there isn't necessarily an absolute right way..." (FG2). As explored in focus group one: "I usually present a lot of options to people and, you know...we could do or we could do this. And then I really do try and get, let them make their own decisions, um, because there usually isn’t one right answer. Um. Especially in mental health. Oh God, exactly. Yea." (FG1)

Structuring choice was often a complex process. Providers identified that the patient’s agenda may sometimes differ from that of the provider, in a way that was potentially unsafe from the provider's evidence-informed lens. For example, focus group two explored a patient whose relationship with alcohol was impacting his health and

economic wellbeing from a provider perspective, but where the provider wanted to explore alcohol use as a health priority, the patient was there to talk about grief. In this regard, structuring choice was also about balance, the need for reciprocity between provider and patient. In integrating the complexities and challenges of delivering patient-centred care into their definition of the concept, these providers situated patient-centred care in terms of what it is, but also, by what it is *not*. Patient-centred care was "...not simply being polite..." (FG2), was about balancing patient preferences and readiness for change with "...some of the responsibility that we [providers] have around health behavior change" (FG2). In a tempered or balanced way, patient-centred care, (with that expectation of patient-provider reciprocity) also involved acknowledging the expertise of the provider. As described in focus group three: "Any option we present is ultimately we're using our expertise to inform those options...just say, here's a whole range of anything you could choose, now choose it...that's not being an expert." (FG3)**.**

For these providers, part of structuring choice was also purpose around supporting the patient in remaining open to different care options. As described in focus groups one and two: "And so, for me, it's about teasing out how they want to proceed or how they envisioned themselves proceeding and talking a little bit about, um, why they have those ideas and their openness to consider other tools in terms of therapy." (FG1).

In the context of structuring choice, beyond the list of expert-informed options there was also a kind of opt-out choice, or the choice of non-participation on the part of patients; for example, if the patient was not amenable to any of the provider identified options. The opt out choice was not the absence of care, urgent or emergent needs were always addressed, but rather the possibility of referral to other providers who can provide

alternative care options that may represent a better fit for that unique patient at a given time. This was commonly framed in practical terms, as shifting focus to patients who will maximally benefit from the Shared Mental Health Care program, that is, a necessary means of managing a finite amount of resources available within the program.

Reading the Patient

From the provider perspective, delivering patient-centred care within the provider-patient dyad also involved a skilled process of reading the patient. Reading the patient occurred when the individual provider was able to gather information that allowed them to better offer culturally relevant, individualized care that matched the patient's needs, preferences and life situation. In reading the patient, providers felt better equipped to provide patient-centred care by tailoring their approach to the individual's world view, experiences and life situation.

Reading the patient necessitated a skilled process of explicit and implicit information gathering, encompassing everything from considering emotionally where the patient is at, to the patient's values and comfort level with certain treatment options, to social aspects of the individual's life situation that may impact ability to access and participate in mental health care. As explored in focus group one: "...considering patient's comfort level and values when seeking to engage patient in care process, reading the patient trying to figure out best way to engage, and help a person in keeping with their own values and comfort level, meeting the patient where at..." (FG1)

Reading the patient often encompassed an expert process of using provider experience and knowledge to gauge patient preferences, pre-formed ideas about care, particularly mental health care, including amenability to different care options. Providers

talked about the complex interplay of physical and mental wellness suggesting that, particularly in mental healthcare, the patient does not come to clinical encounter as a blank slate but rather with well-formed ideas and preferences regarding care options that are shaped by personal experience as well as by the broader social environment. Patient attitudes about mental health care were sometimes not explicit, necessitating that skilled process of reading the patient that is built over time through experience and relationship development between provider and patient.

For example, patients might have latent or explicit preferences about what they are willing to pursue in terms of intervention and what is a non-option; here there was common reference to pharmacological vs. non-pharmacological treatment of anxiety and depression. In a patient-centred frame, this informed a kind of intentionality around meeting the patient where he or she is at. Reading the patient was also thought to be essential in seeking to best engage the patient, as part of a patient-centred process. In the words of one provider, *"...that's where the money lies, figuring out how the patient feels"* (FG2). In a primary care context, reading the patient was a process that occurred over time, even across the lifespan, working with a patient and building the provider-patient relationship. Reading the patient was situated as a worthwhile time investment in that it carried important implications in terms of working with a particular individual in a way that will maximize active participation, resource use, and ultimately potential outcomes.

Striving for Power Sharing

As providers seeking to offer a patient-centred process, attention to issues of power was identified at the level of individual providers and patients. Striving to share power was characterized by a *valuing of* and *belief in* cultivating awareness of existing

power structures, as well as a kind of intentionality and purpose around the pursuit of power sharing rather than realizing equal per se. In this regard, power differentials were acknowledged to be real-world condition of the system and even broader social climate.

Striving to share power, as a complex process between individual providers and patients, was evident in the subtle communication of power structures imbued in directional language that indicated that - while providers held ultimate sway - there was effort on the part of providers in seeking a more egalitarian approach. As seen in focus groups four, two and one: "letting them [patients] have sort of that informed choice about knowing all of the options and what they'd like to proceed with" (FG4); "...letting [the patient] define…quality of life and what constitutes the good life." (FG2); "... I give responsibility to the client…" (FG1); "...I try [to] incorporate the patient into whatever our plan is." (FG1). Such intentionality on the part of providers was substantiated in the self-correcting, tentative framing used when describing their collaborative decision-making process. As described in focus group one: "So I let the patient. Well let. I, I ask the patient to direct it..." (FG1).

Providers described the need to share power as simply a reality, the understanding that you can't expect patients to go with something they weren't actively involved in developing as one of the conditions of modern practice as distinct from historical models of health care. In an excerpt from focus group three, providers explored patient expectations related to decision-making power in relation to generational differences amongst patient cohorts:

> I think that's how most of my practice probably has gone with, um, I mean that's the patient's expectations nowadays. Except sometimes older patients will still be

about it, will still have the mindset well, where I'll say, you know, what do you want to do. And they'll say, what should I, like you're the doctor, you tell me what to do. Like well, you have a choice, this or this. Well you tell me which. But most of the younger, and I would say, like most, I would say 60 and under, are, are expecting that they're going to make the decision. And they, they're coming in to that, you know, up front about that. [the patient is] expecting that they're going to make the decision. And they, they're coming in to that, you know, up front about that. So, so I don't even know if it's necessarily that you'd be specifically plan it to be patient-centred but that that's just how it is. (FG3)

As individual providers, part of sharing power with the patient was also a reflexive practice of keeping one's self "in-check", hinting at that complexity of achieving a patient-centred process in cases where the patient's ability to engage in care planning may be complicated by her or his healthcare needs (as perceived by the provider). As explored in focus group two, when asked about the role of patient-centred care in particular as related to mental health services, one team described: "And especially when you're dealing with competency issues and psychosis, it's, it's very, very challenging and you try to be patient-centred but it's so hard to kind of keep yourself in check. Uh, huh." (FG2).

The perceived need for reflexivity on the part of the provider emphasized the real-world messiness and complexity of achieving a patient-centred process. That is, patients *expect* and providers *try* to be patient-centred but this is not easy or straightforward, but rather represents what is oftentimes hard work of balancing one's own world view with that of the patient.

Sharing Ownership and Responsibility with the Patient

At the level of individual providers and patients, providers also sought to empower patients to share ownership in the care process, as much as possible (and they acknowledged this was sometimes not possible due to the patient's complex health needs or life situation), distributing the responsibility for care between provider and patient. As described in focus groups one and two: "... one of the values that we try and promote, um, in this clinic is, is, that the clients take a more active leadership in their own care." (FG1); "... we're all very much interested in empowering the client to empower, you know to help themselves...And that's what we try to do is, is to kind of, you know, work together to empower, um, our clients to better take care of themselves." (FG2)

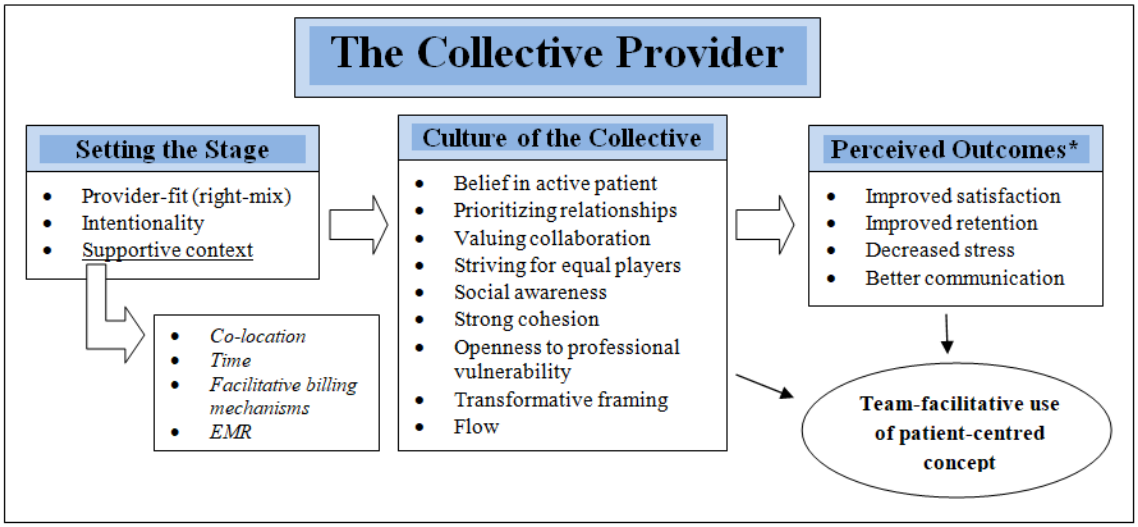
The importance of patient ownership and active participation was framed in the sense that, in the same way providers work within a changing systems context, so too must patients, again emphasizing the complexity and of achieving a patient-centred process. These providers communicated the importance of evaluating "patient engagement" (FG6), the ability of the patient to take responsibility in the care process, alluding to a kind of *patient-fit* in a Shared Mental Health Care context. From the perspective of these providers, good-fit within a Shared Mental Health Care model was realized when patients were considered able to "do the work" (FG1) of the program. Linking the processes of reading the patient with sharing ownership and responsibility, and with that systems lens, determining patient-fit appeared to be an important means of how providers judiciously managed a limited amount of practice resources, including their own time and that of others within the team.

The Collective Provider as a Social Entity

For these providers, well-functioning inter-provider relationships combined with a teamwork-supportive context, created opportunity for the development of a shared provider identity, the Collective Provider. In this section I detail the conceptualization of the Collective Provider inductively derived from these data, with a focus on explicating the conditions and circumstances that appeared to give rise to the Collective identity. I also explore important aspects of the cultural milieu of the Collective Provider that were seen to impact teamwork and patient-centred care. Lastly, I detail the provider-perceived outcomes of the Collective Provider.

Figure 5

The Collective Provider



Defining the Collective Provider

As a team entity, the Collective Provider was characterized by several elements. Broadly, the Collective Provider subsumed a common set of beliefs including: (1) an active patient in the decision-making process; (2) making mutually beneficial inter-provider relationships and working together a priority; and (3) shared interest in coming

together to collaboratively meet the individualized needs of the patient. A central defining feature of the Collective Provider was that inter-provider relationships subsumed within the Collective were thought to create opportunity for delivering the best care possible, as a team, in a way not otherwise possible as individuals.

The Collective Provider was a fluid situated entity, looking somewhat different from team to team. For example, the seeming strength or conspicuousness of a shared identity varied as expressed directly through statements of unity, but also, as substantiated in-directly though social behaviours within the focus groups themselves. In an illustrative excerpt from the fieldnotes for focus group one, which appeared to be an exceptionally cohesive team (with a particularly conspicuous Collective Provider presence), the principal investigator of the primary study reflected on the smoothness of social interactions observed in group:

> The participants' words were very congruent with the way they behaved, the participants took turns and listened to each other. Often one person built on the comments of another person. There was a feeling of ease in the room and comments seemed genuine (Fieldnote 1).

Where there was that robust cohesion characteristic of the Collective Provider, the professional backgrounds of individual speakers were often less apparent. That is, while the focus groups included providers from various professional backgrounds, there was a weighted focus of the collective (we) vs. individual (me). This was seen in the juxtaposition of two of the six focus groups. In one, the roles of individual speakers were more unobtrusive as compared to the other focus group, where the professional affiliation (and often role-specific contribution) of the speaker was often explicitly stated; for

example, the speaker might identify as nurse vs. social worker vs. physician and take time to explain her or his profession-specific contribution.

With enhanced cohesion of the Collective Provider, there was also a propensity towards statements of togetherness, of building up others or acknowledging and validating others, even stepping-in to counter self-effacing or humbling comments during group discussion. As exemplified in one exchange in focus group six.

> I'm embarrassed sometimes like I've seen this person for eight years and you've just spent one hour with them and told me a couple of things that I never knew about them that I probably should have, and I'm like so you know just yeah just you're finding out much more bits and pieces about your patient that you wouldn't have found out otherwise and it helps. A different perspective. Yeah. Yeah. Yeah. Don't be embarrassed, my goodness, you've got so much other things to talk to them about. We, we have that hour to talk about those things, that's the, that's the whole, that's the difference here. (FG6)

The makeup of the Collective Provider differed from focus group to focus group with membership depending on the situated nature of the team and actors therein. This was apparent in the emphasis placed on the importance of certain personnel in the shared team identity in some teams but not others. In many cases, non-direct service providers where included within the Collective Provider, as in the case of certain groups highlighting the importance of key administrative personnel or clinic managers. Focus group three explored the importance of the office manager to overall team functioning, and in focus group two, for example, with every site being "a little bit different" (FG2), the Collective Provider was seen to include a social worker and dietician.

Setting the Stage for the Collective Provider

A kind of recipe for establishing the Collective Provider (setting the stage in Figure 5) was gleaned from these data including the right mix of people or blend of personalities, provider intentionality around working with and getting to know one another, and a practice setting context conducive to collaboration and inter-provider relationship building. These conditional elements appeared to be necessary to the process of establishing a Collective Provider identity.

More specifically, individuals embraced within the Collective Provider appeared to meet certain inter-personal standards conceptualized in this analysis as provider-fit. Fit was broadly defined through preferred inter-personal qualities referred to as a kind of personal "style" (e.g. FG1; FG2; FG5; FG3; FG6), including being respectful, flexible, willing, approachable, reliable, accountable, and generally socially aware rather than "..entitled...demanding... insensitive, and you know kind of [socially] oblivious" (FG6). Provider-fit was not only about demonstrating these team-amenable qualities (and I do mean demonstrating, as these qualities were thought to be observed in the other over time by working together) but was also about jiving-well with the existing group and clinic culture. As described in focus group one:

> Because you can have a really bad blend of personalities and really good intentions and it's not going to work the way it works here. So you have both parts I think. I think you have the good, like the intentionality about making it work and you have the right mix of people now that you've kind of weeded out some of the others that, that work together well, right. (FG1)

For this provider-fit process of purposefully discovering the right blend to occur,

a clinic environment conducive to collaboration was thought to be vital. The providers in these focus groups outlined several important environmental shapers of collaborative relationship development including co-location of providers, protected time for collaboration, supportive billing mechanisms and shared communication tools such as the electronic medical record. Thus, as a context-specific entity, the Collective Provider, developed with particular antecedent conditions such as provider-fit and a facilitative context, establishing a collective identity was not a guarantee. Rather the Collective Provider was a possible outcome of repeated collaborative relationship-building experiences over time in a particular clinic environment and with a particular group of individuals.

The Culture of the Collective Provider

Once established, the Collective Provider was characterized by a particular cultural milieu. Here, I understood culture to be common or shared beliefs, values, and practices of a social group, that are based on implicit knowledge and assumptions members consider legitimate, thus forming the basis of group norms (Kupers et al., 2017, p. 163). In this section, I explore key aspects of the Collective Provider culture as seen in Figure 5.

Perhaps the most defining feature of the Collective Provider was that people embraced or accepted within the collective, within that shared team identity, were perceived to add to rather than detract from the provider experience of Shared Mental Health Care. Simply put, accepted members made patient care better, made work easier, more meaningful. Like patients being able to "do the work" of shared care, providers subsumed within the Collective Provider brought valued work to the table. Members

were able to work well with others, to do the necessary collaborative work of Shared Mental Health Care. With the Collective Provider, working together was made smoother, better, more enjoyable and effective. For example, well-functioning relationships within the Collective Provider were thought to carry benefits for providers in their day-to-day work life such as greater satisfaction with their job, willingness to stick with the job, and decreased stress, while creating opportunity for delivering best care, a better outcome and experience for the patient (albeit from the provider perspective here). By generating such positive perceived outcomes for providers, the Collective Provider was self-reinforcing and continued over time.

Organic language was often used to describe how team functioning was made better by a unified sense of togetherness within the Collective Provider, by virtue of those trusting relationships within the shared team identity. As described in focus group six: "when your relationships go well everything just sort of flows, right."; there is "flow of communication...flow of dialogue"; being together, with that relationship, communication, working together is more "natural" vs. "sterile" (FG2); the team is more "seamless" (FG1); our thinking tends to line up (FG3); [coming together for the patient is] "...like a zipper..." (FG4); "everything is faster...more fun...more satisfying...feels less like work...because we like each other." (FG6). In a negative example of provider-fit, one group explored former "toxic personalities" (FG1) that ultimately weren't able to fit in with the clinic and moved on to another work situations over time, leaving "the blend of personalities that work well together" (FG1). With the absence of the toxic personalities these providers described a shift in the interpersonal milieu, with relationships as energizing rather than "draining", a "palpable difference in the energy, in a positive way"

(FG1).

Where the Collective Provider was well-established, participants alluded to a kind of felt authenticity in which providers got to know one another over time, personally and professionally, in a manner that led to genuine positive regard. As described in focus group one:

> We like each other. Yea. So that's really become something important. Yea. Huge. So, um, as I was mentioning before, I have [#] different clinics, so I get to see a lot of different clinic cultures. And this clinic I can say easily is the most tight, like in terms of them liking each other and working together, like intimately and tightly and truly liking each other. Not that my other clinics don't like each other. They do. But it definitely operates differently here. I think there's a lot more emphasis on team building and making sure that you guys, um, like each other and know each other on a personal level as opposed to just strictly professional. And I, and it's, I think it's just so exciting. Um. And, but we like to have fun too. Uh, huh. No, I can see that. We like each other I think. Yea... (FG1)

Another benefit of the Collective Provider was a kind of transformative framing, the ability of strong inter-provider relationships to shape everyday workplace experiences for providers in teamwork-facilitative ways. As exemplified in focus group six:

> And again because, because the relationships there, it doesn't feel, I'm just having this ah-ha in life lately, but it doesn't really feel like work you know, it's like oh you know if "Name" has a problem with one of her patients well I want to, I want to help and respond to her and it's not, it, it never feels like a burden at all actually. I agree, you want to help right. Right. And that's the whole thing. I: Is

> that the ah-ha. Yeah. Yeah. Well its, the ah-ha is all about how life is all about relationships, that's kind of my ah-ha. (FG6)

Transformative framing was also evident in the posture of providers towards conflict or disagreement. There was a common experience of hesitancy to frame difference of opinion as disagreement or "conflict". Instead, softer terms highlighting a productive function of dissent were used, and the process was thought to (in that shared meaning making sense) affect better overall care. As described in focus group six: "I think we just kind of take each other's perspectives into account right, you just add it into your understanding of the situation, versus you're right and I'm wrong…don't you. Yeah. Yeah, no just more perspective, more info is all I need; I don't think I've felt like there was a conflict" (FG6).

With a deepened sense of togetherness or cohesion within the Collective Provider, achieved over time and with intentionality around getting to know one another, an overarching flavor of comfort and familiarity with working together, of trusting others rather than of being divided or defensive was apparent. As described in focus group five:

> So the longer you work with someone, the more you trust them, the more you trust them, you trust their judgment. So at this point, speaking for myself, my trust level is very, very high because we work together and I trust you guys to make the right decision... (FG5).

Comfort and familiarity within the Collective Provider appeared to enhance providers' willingness to seek out others, creating perceived impact on the overall quality of care by impacting processes such as communication and access. For example, in the context of inter-provider referrals, trusting relationships within the Collective Provider

were thought to shape ready access to providers with whom the referee had an established relationship. As described in one group of providers:

> The other thing I just did as far as relationships go and referrals, one thing that I do know and at least for me is that the referrals that I get, it's not always but often are from the people I have the best relationships with. So it could be a comfort level that they have, they know me, so they'll feel more comfortable referring somebody to me, whereas people I don't have a great relationship with I might not get the same number of referrals. Now there's other factors with that as well…, but just to emphasize how important that relationship is, there's no question the ones that I have the best relationship with I will in general see more of their patients. (FG6)

For those quick, informal, firing off an email or hallway-type communications, with established relationships within the Collective Provider, there was a *could-would* distinction made. Here, the idea was that while you *could* technically consult, say call, a number of different providers for getting a quick bit of in-the-moment guidance, having established, comfortable relationships with other providers shaped the likelihood that providers *would*. The condition of co-location was thought to be important to communication and referrals on a number of levels, by increasing the ability of providers to build those comfortable working relationships that facilitate collaboration but also, in a very practical sense, by making it easier to connect with others, oftentimes in-the-moment. As described in focus groups two, three and six:

> Yea. I would, I would agree with that. I think, I think if you know, if I know the counsellor, know the psychiatrist I'm much more willing to approach them and if

> I don't know them, like in the past when I, you know, we worked on a referral basis and they weren't on site and wasn't collaborative I probably almost never contact a psychiatrist or a counsellor to ask them any questions. We would just kind of go with what's in the report which might be miss, you know, missing things because there are often things in between. But you would, I would, I would almost never call to anybody. I felt kind of uncomfortable to do that. (FG3)

With established relationships within the Collective Provider, these participants also hinted at an openness to showing a kind of professional vulnerability in seeking out the assistance of others team members both in the presence of the patient and other professionals. As described in focus group two:

> ...we're not afraid to say [to the patient], I don't know about that. Have to connect back. I: And might you do that right at the time and then walk down the hall. Sometimes, yea. (I: and get the answer.) Yea, yea, yea. Or if it's not, you know, I'll get back to you... (FG2).

In a negative example, one focus group compared their comfortable, working relationships within the Collective Provider built through experience and face-to-face communication opportunities to the kind of depersonalized consult that occurs when the other provider is not co-located and is unknown. In such situations, the other (with whom the information-seeking provider does not have a history) had the potential to wrongly perceive asking questions as incompetence, creating barriers to collaborative engagement. Being unhampered by such fears, within the Collective Provider, a perceived openness towards seeking out others was realized, further contributing that richness of meaning making not otherwise possible as individuals. As described in one

focus group:

> ... when you're a specialist off site they're kinda, they're sort of anonymous and you sort of, I think you almost have a, as a family doctor, sometimes, for some other thing, did a bit of a, I don't know, like very high regard and then a fear of contacting them that you're going to look like you don't know what you're doing. There's that perception. I don't know. But, uh, you don't feel, you don't have the comfort level I guess to call them. Yea. I think, I think that's a huge part of it. There's probably lots of other parts to. (FG3).

Another team-facilitative feature of relationships within the Collective Provider, was intentionality around power sharing within the team. As perceived by these providers, the conceptualization of team members as "equal players" (FG1) was an important aspect of collaborative relationships. In this regard, the Collective Provider was characterized by intentionality around equally valuing the contributions each member brought to the team. As described in focus group one, "one expertise doesn't trump another" (FG1). The understanding of different members within the Collective as equal players was thought to be cultivated over time and with collaborative relationship development experiences. As explored in focus group five: "…I think that the opportunity to collaborate more means that you do become more equal. Um. I think that that's a natural part of being able to just talk." (FG5)

In integrating complexity, at the same time, individuals within the Collective Provider acknowledged the persistence of power dynamics in the broader health care context within a number of social planes; for example, between professional and non-professional staff and between providers from different professional groups. As described

in focus group one, meaning and value was nonetheless found in demonstrating intentionality and purpose around pursuing the ideal of non-hierarchy, even if a pure kind of non-hierarchy was not necessarily achieved. In this, providers hinted at the notion that certain aspects of the hierarchical environment were out of their control as individuals, and even as a team, for example, broader socially constructed beliefs attributing power and status to those with higher income and education. As seen in focus group one:

> Well that is I think the goal. How folks who typically would not be considered near the higher end of the hierarchy perceive that might be a little bit different because of course there's pay scales...whether they feel it's not hierarchical or just because of tradition that remains entrenched. But I think that the attempt is really ongoing to value their input and to give them, to give all staff the ability to input and, and have effect on the way the clinic functions, um, and what we do as a team....that is. But I do feel like everyone really makes an attempt for there to be, um, you know, certainly quality in and respect and that the respect is. is demanded in a broad based way, not because of your title or your number of letters behind your name or whatever. (FG1)

In another example, family physicians alluded to pervasive attitudes within healthcare towards specialist vs. non-specialist physicians. Here, relationships developed over time were thought to diminish the operational - or in-effect - weight of such disparities by allowing for a focus on collaboration rather than other (potentially conflicting) concerns where there are perceived power disparities such as proving competency:

> It's become a comfort level with, um, the specialist, family doc hierarchy part.

Um. You get different specialists have different viewpoints on that hierarchy and you get comfortable with talking to a specialist. That they know you. They know your capabilities. And maybe they have more, they respect for what, what we do. Uh. So, I think that does make a difference. Sure." (FG5).

Thus, conceptualizing team members as equal players within the Collective Provider had important perceived implications for team functioning. With the acknowledgement of power dynamics, regardless of best efforts, well-functioning relationships within the collective appeared to serve as a buffer against potential hierarchical threats to collaboration and teamwork. Once again drawing on that organic language, with relationships within the Collective Provider, working together was smoother, more natural; potential stumbling blocks such as titles appeared to lose their 'othering' potency:

We all work together. Well these are my colleagues. Like I don't, I don't feel intimidated by [name] because she has an MD degree, an MD by her name and she's a psychiatrist. I don't feel intimidated by [name]. I call her [name], I don't like calling you Dr. [last name]. And you wouldn't want me to. No. No. M: So no, there's that kind of like a level. It's a level playing field. (FG3).

There was also a distinction made between what exists in terms of power disparities, and what is thought to happen or what plays out in an operational sense as a function of inter-provider relationships within the Collective Provider. Focus group five explored the notion that, despite disparities in decision making power between members of different professional groups, within the Collective Provider, what plays out operationally, with those comfortable working relationships is teamwork. In the example

below, a non-physician professional referred to multiple layers of hierarchy stating that in the area of decision-making she would ostensibly be at the bottom, but what happens is that they work together for the patient.

> Well I'm in the bottom in decision-making. I mean that's why I asked what kind of hierarchy. Yea. You know. Even with that though Speaker 1: But I think that if I made a decision, that anybody here could override me. So, I think in terms of decision-making. (Interviewer: What do you think? Is that what happens?) No. (I: Operationally, what happens?) We work together. (FG5)

In striving to be equal players as a Collective Provider, meaningful everyday interpersonal experiences grounded in trust and authentic positive regard for other members, supported a unifying function or cohesion-enhancing function of the patient. In an excerpt from focus group one, comfortable working relationships built with "social history" (FG1) were thought to mitigate conflict and increase comfort with deference to expertise, allowing for decreased conflict or productive conflict and ultimately a unifying focus on the patient and patient needs.

> But I don't think there's ever been really a disagreement about how to go forward from there because it does always involve the patient and their opin [sic]…, and their, um, preferences. And it does also always come from a place of wanting to do the best that we can by that person. And so, it's hard to imagine conflict when you have the same, you know, the same ultimate goal in mind. Uh, huh. Uh, huh. So, it is always a discussion, um, that includes the client as well. And that always leaves a door open to try a different avenue if, it the one that you're trying doesn't pan out the way you think so. (FG1)

Thus, where inter-provider relationships are strong within the Collective Provider, the patient was employed as a means of bringing team members together through a shared sense of purpose.

Understanding Patient-centred Care as a Team (A Collective Provider)

As part of integrating complexity, across focus groups and as the discussion matured, there was a weighted focus on exploring how patient-centred care is delivered by the team, as a Collective Provider. Broadly, delivering patient-centred care as a team involved both human and non-human elements; for example, the different team members as social actors in addition to communication tools such as the electronic medical record. In constructing how care is delivered as a unified group of providers working towards the same overarching goal of patient wellbeing, three key elements were identified from the provider perspective as contributing to the enactment of a patient-centred process as a team including: (1) Conveying the same message to the patient as a Collective Provider; (2) Coming together for a more complete picture; and (3) Managing complexity together.

Conveying the Same Message to the Patient as a Collective Provider

Within the Collective Provider, each provider was thought to contribute valued perspectives and expertise as a result of his or her unique individual relationships with the patient in addition to specialized professional or role-specific knowledge. Patient-centred care as a team involved members coming together, with both complementary and overlapping forms of expertise, and with unique relationships with the patients, to deliver a "same message" (FG3) to the patient. Delivering a unified or same message was made possible through well developed inter-provider relationships built on trust and respect and was characterized by ongoing team communication. As with other processes inductively

derived from these data, co-location played a pivotal role in setting the stage for this aspect of team-delivered patient-centred care. As described in focus group one:

> ...when we are working so closely together and have the chance to collaborate and talk to people. So if [name] sees someone that I've sent to her and she comes to talk to me about it, and then I see that person the next week, we are always giving that person the same message so there's no conflict in what the three of us say. And so you're definitely able to deliver a solid message to a client, um, that doesn't have a lot of room for, you know, alternate interpretation because we're all saying the same thing. (FG1)

In the context of established, trusting inter-provider relationships characteristic of the Collective Provider, where providers were able to deliver the same message, the experience of feeling comfortable backing other team members' care plans (oftentimes in-the-moment) regarding a particular patient was possible. Here, the sentiment was that individual providers within the collective didn't know the patient better or worse, just differently. As described in focus group four, part of delivering a same message also involved validating and building on other team members' work with the patient:

> So, um, [name] has content expertise that I don't have. And I might have some that he doesn't. So we can kind of put those two together to benefit the patient at the end of the day. But it's also the informal but also the shared charting so we can sort of see what, what has been done and then build on that. So, uh, I'll often try and validate with the patient, um, I'm glad you saw [name] and this is sort of what you guys, it looks like you probably, just wrap up what you talked about. And then to build on that... (FG4)

In delivering the same message to the patient, these providers also attended to communicating their collaborative process with patients, the notion that they work together as a team. As described in focus group three:

> And I always let the patients know right up front. This is a team. This is my work, you know I work with these people as a team, you know. We share. What I write goes in the chart. People read it (FG3).

In this quote, and the one immediately above from focus group four, we see the electronic medical record as symbolic representation of teamwork within the Collective Provider. The shared medical chart was explored as an instrument thought to enhance visibility of inter-provider collaborative relationships to patients. As seen in focus group two:

> ... I think the EMR actually the more we talk about it, it's probably another tool that, that the patient sees us using but also knows that we all share this machine and information. And I can look up your labs and let's see what Dr. so and so said this time. So if we use the EMR while they're there too, I think they also recognize that we're collaborating. So I think it's kind of a different type of an operation but I think it, I think they see that we're gathered around this machine and we're all sort of sharing their information so we all have access so it's, it's another component, collaboration that they see that we're putting into this important sacred books and, and we're all sharing it and trying to figure out what's going on. (FG2)

With the co-location of these providers further enhancing the visibility of collaborative relationships within the Collective Provider, the patient experience (albeit

from the provider perspective here) was thought to be impacted by creating a kind of sense of community, in which patients felt cared for, perceived the coming together of a diverse group of providers collectively focused on bettering their life situation. As described in focus group two:

> …we see each other's clientele. And so I think it gives a sense of community. When I see people that I've seen, you know, in the hallway, hi, how's it going, you know. I find I talk to ta lot of people in the hall, you know, whether I'm switching rooms or I'm going to the washroom, out somewhere, or I see them sitting in a lab, you know. And you talk to them. And I think that sense of community within this building really attributes to their mental health. And just allows them to be them, regardless of where they are. I think so. (FG2).

Cultivating a sense of community for the patient was thought to be particularly important in a Shared Care context where health issues spanned mental and physical wellbeing, and in a context where broader stigmatizing attitudes regarding mental health may be at play:

> I think they do know at least a little bit because we have a thing where, let's say I want a nurse to come and give an injection. We send a very urgent task to the nurses saying, you know, patient is in 22, please give B12, whatever. Um. And so I'll say, I'm just going to send a note to the nurses to come and see you. And then a nurse shows up after I'd done that. So I think they do have a, a lot of them have a sense of that. And they have a sense of the mental health information is kept within their own. Yea. (FG2)

In respecting the expertise of other providers and in communicating a "unified

front" (FG4), any concerns regarding intervention between providers preserved attention to conveying the same message within the Collective Provider-patient dynamic. Here, the improved teamwork characteristic of the Collective Provider is apparent. As described in focus group three:

> And I think being, you know, being careful to present to patients that it's a team and I'm not, you know, if there was anything that I had disagreed about, I would never be saying to the patient, well I think that's wrong what [name] said to you or some...if you had any concern, you'd be asking, you know, asking them in private to clarify something but you'd never be telling the patient that you disagreed with something or they did something wrong...(FG3)

Again, nodding to the complexity of realizing a patient-centred process, conveying a same message to the patient was thought to be particularly important where ethical dilemmas arose in the delivery of patient-centred care, that is when the provider and patient agenda may differ; for example, when providers feel the patient is choosing an unsafe path. Focus group three explored the complexities of cases where the patient is pursuing a course that is concerning to providers:

> I'm hoping, I'm hoping that we're all going to be approaching this patient in the same way. Uh, huh. We're all going to be saying, listen, we all know what's going on here. Listen. We're concerned about this. Listen, these are some of your options. You know, we're not here to, you know, scold you, lecture you, tell you what to do. We're concerned. I'm concerned. [name]'s concerned. [other name]'s concerned. Yea. You know we don't want anything to happen to you. Uh, huh... (FG3)

From the provider perspective, delivering a unified or same message was thought to carry important implications for the patient experience of Shared Mental Health Care. As described in focus group one: "...And particularly when people are needing support over an issue that they're struggling with. Hearing the same message every time I think is really important." (FG1).

Coming Together as a Collective Provider for a More Complete Picture

Within the Collective Provider, each member was thought to have unique relationships with patient and therefore access to different pieces of the patient's (often complex) overall story. Here, inter-provider relationships that created space for appreciating new or different angles afforded providers access to a kind of collective meaning making that would not otherwise be possible when working with patients as individuals. This ability to gain new perspective as a unified team of providers was embodied in the words of one provider, who suggested that through engaging with other providers in the context of comfortable, established relationships "... we can, I guess, jointly see...the impact of those interventions in that person's life...." (FG4). For these providers, the unique perspectives that different members brought were not viewed as more or less valuable than one another but rather "just different" (FG4).

Improved understanding of the patient's story accompanying the Collective Provider was apparent in an example from focus group one where participants explored inter-provider relationships as an asset during assessment:

> And same with, you know, when there's an assessment, you know...it's really nice when I'm in there with [name] because I take a back seat approach and so she conducts the, the assessment but that allows me time to kind of reflect on what

> I'm hearing. And, you know, if I'm hearing something that I'm thinking, hmm, you know I want to explore this. Then she, you know, invites my participation and, and so we work together in that regards. (FG1)

Emphasizing the importance of having a supportive clinic context, being co-located, inter-provider relationships could support a better understanding of the complete picture through opportunistic involvement of other providers, oftentimes, in-the-moment. Here, being together and collaborating created opportunity for meaning making as a Collective Provider that might be otherwise lost without that timely access to other providers as a kind of sounding board.

> Speaker 1:...because I think both of us have, we have different relationships with the patients we see. So if I have an idea and I've talked to the patient about it, and they're in agreement or maybe they seem like they're in agreement, I'll pull one of the providers aside and I'll just say, listen, this is what's going on. I talked about this, I'm making this referral and, uh, if they know something that I don't know, a lot of times their information can be quite helpful because sometimes they'll say, that's a good idea and sometimes they'll say, you know, no, they're just, they're just saying they're going to do this and they have a history of not showing up so you're kind of wasting your time. (Interviewer: So you use that idea that the primary care providers might know them.) Speaker 1: They know them differently. (FG4)

Piecing together the different pieces of the patient's story (as uniquely gleaned from different members within the Collective Provider) was thought to be particularly important when working through complex cases together. As described in focus group

one:

> I think my experience with that has been if, if I'm, if I have a theory about something and then whoever is the kind of referral person has a theory about something, then we will talk about how do we tease out, you know, what our thoughts are. And so then it just involves, okay, well I'm going to take this approach with this client and we'll see where that gets me. And then, you know, they'll say, okay, and I'm going to be doing, asking this or investigating this or exploring this. And we usually come together again and, you know, we'll talk about it. We'll talk about There's always a way to kind of unpackage something if they're, if they're questions and that's usually what it is. We have different questions. But the questions are all relevant and it's like let's tease out. (FG1)

In complex cases, the shared understanding of the patient resulting from the Collective Provider appeared to serve as a buffer against potential threats to teamwork such as team splitting. "splitting", a term commonly associated with patients diagnosed with cluster B personality disorders (e.g., Borderline Personality Disorder), is defined as situations where a patient's different behaviours towards different team members (commonly arising from the perception of the different members as all good or bad) becomes a source of staff team disagreement or conflict (Green, 2018). This was explored in relation to a situation described by providers in focus group two:

> She's [the patient's] not necessarily split per se but I think she's good at keeping us on our toes though... Um. And essentially, um, yea, she'll tell me diff…, not, just different angle of things than she might tell [name]. So I think the first time that I kind of clued in, I was, might have been a little bit late about that. Uh. But

then we kinda got on the same page and realized, okay, um, and you still want patient-centred so you want her at the end of the day to get services that she needs in the right way or right time. Um. But also not to, um, I think, to avoid that whole splitting idea. So I don't think it actually necessarily happened but I think it No. It could have. It could have. It could have. It could have. Yea. I know I found it very helpful when you and I had the discussion about [describes a procedure] Yea. Because I know you had been up front with, with her about that but it was kinda, Yea. it was kinda like she didn't really want to hear that. I think so. But then when I said the same thing to her a week later, and I could, I don't know if she actually said to me, you know [name] said that to me last week. So, but she could kind of tell, you know, we're both coming across with The same message. with the same message here. And, you know, and it, and it's not a, you know it's not a mean message or anything like that. It's, you know, we understand, Yea. you know, what's going on here so. I, I found it quite helpful having that conv…. Yea. I do remember us having that conversation so we do. Yea.: Uh, huh. Because I mean she, she has a bit of a tendency to, um, to think other people don't understand or aren't helping her because she had a run-in with a few [providers in the past] Yea. Yea. So. So I think it was, it was very important you and I talked... (FG2)

Thus strong relationships characteristic of the Collective Provider were thought to allow for greater focus on the patient while simultaneously improving teamwork.

Managing Complexity Together

Relationships within the Collective Provider, made work better, easier, more

meaningful. In terms of relationship development, needing help from other providers to manage the different aspects of patient centred-care was part of the impetus for initially engaging other providers. Once relationships were established, providers were able to meaningfully support each other in managing the complexity of care in a variety of ways, leading to a collaborative and self-reinforcing cycle of continuing to value and seek out others as part of delivering patient-centred care. Thus, another key feature of delivering patient-centred care as a Collective Provider involved providers supporting each other in managing the complexity of patient-centred care as a function of those strong inter-provider relationships.

These providers often talked about how work can "get overwhelming sometimes" (FG5), and that as a group:

> ... you own the patient together then instead of saying, run away. And I think that's happened in practice, in consults. You send the consult, send it back, it's over and there's no. And it just, I think it fosters the [inter-provider] relationship so that if there's problems down the road you can just continue to talk. (FG2).

By meeting the needs of other providers, members within the Collective Provider perceived greater shared ability to meet the individualized needs of patients in a timely manner as part of a patient-centred process: "So if I have somebody in my office who's really struggling at that exact moment [name] is very giving of herself and of her time to come help me in that moment." (FG1).

Within the Collective Provider, managing complexity together involved sharing expertise with one another to help each other manage particularly challenging patient situations. By working together through difficult cases, work was made smoother and less

stressful. For example, one focus group explored the challenges around engaging patients with cluster B diagnoses (e.g. Borderline Personality Disorder), with mental health specialists supported other providers in identifying how to best approach the individual in a way that the patient would be empowered, to maximally engage in a patient-centred process.

> Well, again, you know, the Shared Care program tries to do and what I definitely try to do is, like for instance, our, you know, Cluster B clients. You know I will try and provide some recommendations as to how to approach this client, you know. Like how to kind of, you know, talk to them again in a way that's going to lead to them feeling more empowered to take care of their life rather than them needing to show up here, you know, a hundred times because they're, they're feeling that their needs aren't met. So that's another piece that I try and do as much as possible is, you know, if somebody is seeing somebody, you know, who's more Cluster B, I'll say, you know, you might want to take this approach when you're talking with them in your office and try and, you know, really be kind of highlight, you know, what they're doing well. How they, you know, what they're doing, you know, that's making them feel good and again like really use the strength-based model and so on. I try and teach that to the care providers so that they can use that approach with, you know, all their Cluster B clients because that makes it, that makes their time with them a lot more successful I think. So that's, that's what I try and do. And that's, I think that's what we both try and do is, is empower our providers to be able to feel more comfortable to deal with these situations that they encounter on a regular basis in their office. But give them

more tools to, to deal with that. That's been very helpful. We've had lots of conversations with those where it's not so much consult because it's how would be the best way to approach this. And that has been very valuable. (FG1)

Managing complexity together also included sharing decision-making in complex cases, for example, where there might be immediate safety concerns. As described in focus group two:

> Other times, it's a decision I don't want to make. So I have someone in my office who is making, you know, passive statements of thoughts of self harm but, you know, how concerned am I. Is this person safe to go. Should they be going to hospital. Uh. You know there's some psychosis as well and I don't, you know, and then I don't want to make that decision. So then it's either ask a doc to come in or if [Shared Care Counsellor]'s here, you know, ask him to come and see because this person's really pretty sick and I'm not sure they should be going home. So I think, I make the decision, what decisions I make in a way. Yea. Yea. (FG2).

In helping each other out within the Collective Provider, in a way that improved the provider experience, a debriefing process between providers regarding particularly complex cases was also apparent. Here, the common experience of frustration helped to add a sense of universality, further enhancing cohesion within the team. At the same time within the Collective Provider, different members were able to share specialized knowledge with others that made work easier, feel more manageable. As explored in focus group six:

> There's also, there's a difficult family, I think we were talking about them earlier

today that I have a really hard time managing and I think I would have beaten my head against the wall a long time ago if I didn't have the insight and perspective that I'm getting from everyone in Shared Care, like "Name" the other counsellor sat down with this family or the parents anyways and came and said to me, like there is clearly some marriage issues going on here and that is going to totally make this a very difficult thing, situation for you to treat their son. Uh-huh, you know I'm like really, I never, that never occurred to me and probably should have and I'm glad she said that because now I don't feel quite as frustrated that I feel like I'm getting nowhere, you know and like somebody just sort of validated that yeah there's, there's a lot more going on and it's going to be a battle you know. So it just, job satisfaction like I can, I can deal with it a bit better there. (FG6)

The value of debriefing as part of managing complexity together is seen in another passage from focus group one:

The other thing that co-location offers is an opportunity to support each other, you know, because there's more than once that, you know, um, I have needed to kind of debrief about a client that I've seen somebody and just having, you know, [name], can I just talk about, you know, what's happened in the session or [name]. Yea. Speaker 1: And, and because [name] knows the players here, also the other thing that has worked really well is the willingness to just accept phone calls. You know, because she knows who we are and how we work. You know she can accept a phone call by me, make a recommendation for meds, you know, over the phone and then we can kind of talk about, you know, kind of proceeding in that way. That would not happen if co-loca…, if we didn't get to know each other as

well as we do and how we work, you know. So I think not only, you know, that professional debriefing but just, just kind of on a more personal level, just needing to, you know, somebody to, to be there for us if, you know, we have a difficult kind of. A therapist needing a therapist. Speaker 1: Yea. Speaker 2: Yes. Speaker 1: A therapist. It's really important. You know. Or to say, you know I just met with this client and it's like ah, you know. Yea, yea. So. And it came back to this morning's case. Just having both of u…, like because we're in the same space at the same time with this difficult case, I think it made it easier for us individually to kind of handle it Yea. as opposed if we would have been seeing this person in isolation. Absolutely, would have been. It helps so. Never mind the resource of, say, that's like But this is a different issue having the built-in support so. (FG1)

Lastly, managing complexity together as part of patient-centred care was not only described in direct concrete terms such as sharing workloads, but also in the sense of a more intangible symbolic kind of sharing - to paraphrase - the feeling that we've got each other's backs, that we're in this together. With the Collective Provider, the "we" identity in terms of managing complexity together in particular was thought to contribute to job satisfaction. As described in focus group four: "…nobody will hold all the answers. So if you're able to, um, have an environment where you can have support to, to get those answers, um, it's just a lot easier and your satisfaction I think with your role increases." (FG4)

Chapter 9: Discussion

In this study, I found that providers constructed initial understandings of patient-centred care at the level of the provider-patient dyad. As aspects of patient-centred care, the elements of structuring choice, striving for power sharing, and sharing responsibility and ownership with the patient inductively derived from these data bear resemblance to existing literature. Other authors have identified similar constituent elements of a patient-centred approach including active patient participation (Kitson et al., 2012) shared decision making and choice (Ripat, 2017; Stewart et al., 2014; van Mossel, Alford & Watson, 2011; Zucca, Sanson-Fisher, Walker, & Carey, 2014), and sharing power and responsibility (Asimakopoulou & Scambler, 2013; Fix et al., 2018; Mead & Bower, 2000; Ripat, 2017; Sharma et al., 2015). The re-identification of core features of patient-centred care, although in a Shared Mental Health Care context, is perhaps less remarkable; however, as I employed a constructivist lens, an examination of how these participants gained momentum in articulating their collective understanding of patient-centred care points to an interesting thread of tension that trickled throughout this analysis.

In generating the data set, Wener and Woodgate (2016) used a semi-structured focus group guide that incorporated a prompt to open up potential dialogue regarding patient-centred care. Immediately following this prompt, participants tended to employ familiar renderings of patient-centred care, at least in terms of language, seemingly from broader healthcare rhetoric. For example, patient-centred care was initially framed using common discourses such as shared decision making, adopting a posture of humility, respecting and learning from the client, focusing on developing partnerships and adopting

a strengths-based lens that incorporates belief in and a valuing of patient involvement. In adopting my particular epistemological lens, many of these initial descriptive renderings of patient-centred care were ultimately set aside in an effort to focus on the meaning making processes of participants as social beings. Still, that more descriptive, and in a sense, familiar or recognizable articulations of patient-centred care were present at the outset, is nonetheless noteworthy; in particular, when considering how the definition of patient-centred care was transformed though talk as participants integrated the complexities of seeking a patient-centred process in relation to the everyday realities of their unique team, patients and clinic environments.

More specifically, in exploring the meaning of patient-centred care early renderings, in addition to being broad and straightforward, also tended to have a moralistic flavor, that is, patient-centred care as a deeply felt belief system, a kind of *right way* of doing things. Over the course of discussion, these providers seemed to progressively reframe the concept through talk using a kind of pragmatic logic to reflect a more nuanced definition that accounted for the complexities of making patient-centred care actionable within the privileges and constraints of their immediate practice environments and even the Shared Mental Health Care model itself. This overarching meaning making process of reframing was embodied in the core category of integrating complexity: defining and re-defining patient-centred care. Reframing or movement towards that balanced or tempered understanding of patient-centred care was commonly initiated in the form of *but* statements, and in that exploration of what it patient-centred care *is not.* For example, patient-centred care involves valuing an active patient *but* this does not presume a passive provider; patient-centred care involves valuing and soliciting

patient preferences *but* is not just offering or going with any option, that's not using provider expertise, that is not reciprocal respect for expertise; patient-centred care involves valuing providers as equal players and sharing power with the patient, but power structures (which are at play in ways that are beyond immediate provider control) exist and so meaning is found in intentionality related to non-hierarchy, and so forth. The pivoting point for reframing ("but"...) using that pragmatic or real-world, experience-focused reasoning, commonly included reference to health? systems, ethical and/or professional constraints. Thus, an overarching process of rationalization was identified with tensions between patient-centred care as established rhetoric, and in some cases as a kind of valorized belief (or at least in some broadly articulated form as is often put forth in patient-centred discourse) with a situated understanding of patient-centred care that accommodated certain aspects of existing patient-centred discourse that were seen to be achievable, for both providers and patients in a Shared Mental Health Care context.

In seeking to understand this progressive pattern of rationalization, I suggest that Berger's concept of "ideological work" (1981) has analytic utility. In his study of counterculture communes in rural California, Berger developed the term "ideological work" to describe how communards engaged in a process of intellectual maneuvering to manage discrepancies between their beliefs and the realities of communal life that constrained the enactment of those beliefs. Berger explains that while it is generally difficult to change one's circumstances, it is comparatively easier to re-frame or modify one's beliefs. In understanding a particular group's ideological work, Berger suggests that inquirers seek to examine how different lines of argument (1) "legitimate [a particular] course of action" and (2) function to "confer some honour or dignity on the actors who

formulate and adhere to them" (Berger, 1985, p. 80).

That patient-centred care has been embraced in the broader healthcare domain is apparent in the rhetoric of major policy documents and profession-specific position statements internationally including Canada (Herbert, 2005), the United States (IOM, 2001), the United Kingdom (Health Foundation, 2015) and Australia (ACSQHC, 2011). This is certainly the case in primary care, where patient-centred care is considered to be a major philosophical pillar (College of Family Physicians of Canada, 2019). The argument is readily made that according to the dominant culture of primary care, a patient-centred approach in which the patient is an active participant in choice and decision-making is - for the most part in the contemporary climate - socially expected both from the perspective of service providers (who are necessarily socialized into their professions and roles) and from the perspective of patients as consumers. Indeed, this is sometimes put forth as a matter of near-religious conviction or as described by Stewart et al. (2014), as "moral imperative". Yet, as critically put by one UK journalist (Hawkes, 2015), "patient-centred care has many evangelists but few practitioners". Nowadays the felt culture says that providers must value and incorporate a patient-centred approach, however very real stumbling blocks abound. Providers in this study hinted at these stumbling blocks when exploring the challenges of patient-centred care. Patient-centred care was important to them, was valued, but at the same time fundamentally constrained in a myriad of ways by provider, patient and systems limitations. For example, limits on the amount of time and resources providers are able to dedicate to any one patient and patient willingness and ability to participate in a patient-centred process.

In seeking to navigate barriers to a patient-centred process or "structural

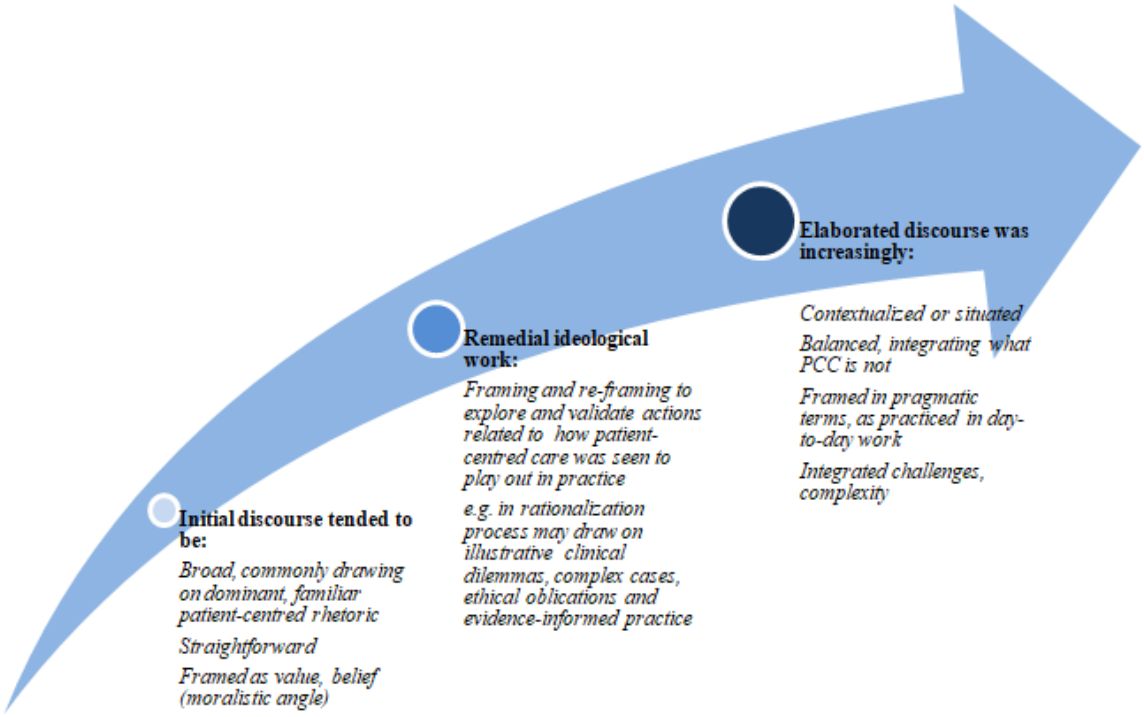
constraints" using Berger's language, providers do not always have the "requisite resources" to enact and sustain a patient-centred process in an idealistic sense, or at least in some generically prescribed format, as is a common criticism of the patient-centred movement as more rhetoric than practice (e.g. Whalley Hammell, 2013). Moreover for these providers, patient-centred care was not as straightforward as a broad conceptualizations might imply (or at least those conceptualizations that do not account for the team context in which patient-centred care is commonly delivered). Participants explored challenges such as when patient and provider agendas differ; when the patient chooses an unsafe path; when competency is a concern or when the patient is not in a position to take an active rather than passive role; cases where patients might be attempting to take advantage of the system (however unintentionally); and when there are disparities between what the patient wants, say the number of counselling sessions, and what providers are able to offer as - to paraphrase these participants- as not a disagreement with what the patient needs but rather constraints on what the system can provide, and so forth.

A possible explanation for this progressive re-framing of patient-centred care in the course of focus group discussion from idealistic to pragmatic or achievable terms, is ideological work or maneuvering. As these providers generated momentum in meaning making, they appeared to progressively elaborate their definition of patient-centred care in a situated manner, perhaps as part of seeking to reconcile ideological conflict between patient-centred care as put forth in rhetoric and patient-centred care as it was seen to play out in their day-to-day work life. A balanced understanding that accommodated real-world structural constraints while legitimating their work, supported providers in feeling

satisfied in their roles as providers and as a team.

Figure 6

Integrating Complexity: Patient-centred Care as Ideological Work



The example of structured choice in this analysis is particularly illustrative when applying the concept of ideological work. The reader might have understandably balked at the seemingly oxymoronic notion of *structuring* choice. How can authentic choice making arise from a constrained number of options and in a manner structured by another? These providers offered a compelling line of reasoning (which, for myself, as a provider-researcher who experiences the challenges of delivering a patient-centred process first hand, seemed particularly reasonable, precipitating my own kind struggle with ideological work but that's another story). Specifically, these providers suggested

that if it were open, totally free choice process, that would not be respecting provider expertise and so would not be in keeping with the active patient *and provider* aspect of patient-centred care; to paraphrase, as one team succinctly described, otherwise why are we here? Furthermore, surely providers, with ethical obligations around beneficence and non-maleficence, must offer some direction grounded in their unique expertise to encourage positive health outcomes?

Montague et al. (2017) looked at the definition of patient-centred care as perceived by the public vs. healthcare professionals. Interestingly, the definitions from these groups largely overlapped, with the exception of professionals adding the importance of expert judgment and evidence-base. In this study, providers clearly subscribed to the patient-centred philosophy (as they indicated in those early articulations of patient-centred care) but also (they later remind us) to evidence-informed care planning. The linking of patient-centred care and evidence-informed practice in the form of structuring choice, in a way that accommodated an active patient and provider, may represent a kind of "remedial ideological work" (Berger, 1981). Here, structured choice, in addition to referencing systems constraints, was validated by links to evidence-based motives. Whether patient-centred care and evidence-based practice work in harmony or opposition remains a point of contention in existing literature (Alford & Watson, 2011; Stewart et al., 2014 vs. van Mossel). That evidence informed practice was used as to justify structuring choice in constructing an understanding of patient-centred care may hint at a polarized view, that is, at least at a practice rather than theoretical level; however, this remains unclear from this analysis. Regardless, as an example of ideological work we see how the practice of choice within a patient-centred frame in the

form of *structured choice* was situated in a way that providers were able to uphold in day-to-day life and within the constraints of their setting and mandated roles.

Other authors have questioned the veracity of choice within a patient-centred frame as played out in the everyday practices of frontline clinicians, suggesting that choice in patient-centred context may be more akin to decision-making rather than choice-making. In their study on the challenges of patient-centred oncology care as practice or rhetoric, van Mossel et al. (2011) talked about how, when describing their approach, providers almost uniformly used a particular aspect of patient-centred care "in the launch of their accounts" (p. 281), bearing striking resemblance to the initial description process gleaned in this analysis. These authors go on to argue that with further description, a reasoning process was revealed whereby choice and decision somehow became merged, when what occurred was that providers provided options and patients then make a decision, with the authors questioning whether the patient exercises choice or if there is merely the "semblance of choice" (p. 282). These authors cite the work of Argyris and Schon (1974), suggesting there may be a gap between claimed or "espoused theory" and what providers actually do. They proposed that, rather than suggesting an intentional deviation from patient-centred values on that part of providers, that the concept itself is dubiously achievable; that patient-centred care is "contentious, and integrating the principles into day-to-day practice is difficult, particularly when treatment options are complex and their impact on people's lives are significant, and in many situations, risky" (p. 286). Similar tensions between patient-centred care as ideal and as an approach used in practice have been identified as a developmental struggle that occupational therapy students must manage when transitioning to practice (Ripat, Wener,

& Dobinson, 2013). As aptly put by Orchard and Bainbridge (2015), while the majority of healthcare establishments purport to be client-centred, at the end of the day these institutions favor a systems focus in which the onus is on the client to fit it with the practices, including schedules, procedures, and structures, of the healthcare organization. In light of this analysis, I draw attention to the distinction between patient-centred care as rhetoric and as an achievable, situated, practice that adequately captures the complexity of operating within the culture of a contemporary health care system as requiring further research attention.

In considering the ideological work of the providers in this study, I also highlight the dilemma of specification. If the patient-centred concept is defined in an overly complicated manner , it may be rendered unusable, yet if it is too generic it lends itself to misunderstanding or even appropriation (Hodgkin & Taylor, 2013). Other authors have drawn attention to this dilemma, for example, Fix et al, (2018) have referred to the challenge of healthcare employees conceptualizing patient-centred care as "… being so nebulous that it encompasses everything" (p. 304) and in a way that might "water down" the understanding of patient-centred care, hampering its potential for realization. These authors compare this to an overly specific or narrowed understanding that is limited to the clinical encounter between provider and patient, and so does not take into account important organizational and cultural factors that constrain the potential for meaningful change.

As seen in this study, in a situated manner, as part of remedial ideological work providers may reasonably be expected to define and re-define patient centred care as they manage the complexities of their daily practice. In light of this process, it may be that

providers are not be best served by idealistic formulations of patient-centred care, or at least ones that are oversimplified or overlook the structural obstacles to achieving a patient-centred process in practice settings *as they are* so to speak - that is - in a packaging that may be unattainable (in an orthodox sense) in providers' immediate circumstances. Indeed, according to Berger, a kind of ideological work is also done when researchers tailor their findings to a particular audience, that writers must make ideological choices about how they render their research to avoid being ignored (p. 92). It is interesting that, when asked directly about the meaning of patient-centred care, what was most accessible, and what was first rendered by these participants, was patient-centred care as conceptualized in broad, rhetorical, terms and at the individual level.

The packaging of the patient-centred message is no small challenge given that patient-centred care is commonly enacted by teams and so must be delivered to an audience of stakeholders from different backgrounds, socialized into different traditions, with different (oftentimes implicit) philosophical allegiances. Perhaps this accounts for pervasiveness of the siloed study of patient-centred care, in that different professional groups must engage in ideological maneuvering to render their material palatable to an in-group audience. After all, you want the material to meaningfully resonate with knowledge users, you want them to buy what you're selling. In any case, the nuances in how patient-centred message is packaged and distributed carries important implications, and this study would suggest, that where allegiances may differ amongst providers, a focus on inter-provider relationships might represent a possible solution (at least worth exploring in an immediate sense) to what are more deeply rooted systems paradoxes. Providers are (I think) most often looking to do the best they can with what they have,

and yet patient-centred care remains elusive in that rhetoric vs. everyday practice sense (Frampton et al,2013; Hodgkin & Taylor, 2013; van Mossel et al., 2011; Whalley Hammel, 2014). As satirically described in an editorial by Delamonthe (2013) following his suggestion that the very notion of centrality of the patient may lend itself to ideological crimes, "the next iteration of reform needs to focus on the whole people, not body parts...In the meantime, the queue of specialist nurses for single diseases will see you now." (p. 1). A focus on inter-provider relationships may represent a viable solution, at least, for now.

Ideological dilemmas and systems issues aside, as a secondary analysis, I must also explore links to the primary study by Wener and Woodgate (2016). In situating my findings, I suggest that establishing the Collective Provider identity is a possible outcome of the Interprofessional Collaborative Relationship Building Process. While "patient-focus" is an important underlying element of inter-provider relationship development, I argue that this is distinct from patient-centred care, with a positive, team-facilitative, understanding and mobilization of the patient-centred concept (as intended in patient-centred rhetoric) as a possible outcome of well-functioning inter-provider relationships. My findings would otherwise appear to align well with those of Wener and Woodgate (2016). For example, these authors described how the onus was on providers new to an existing team to "fit-in" with the established group and clinic culture, which, in that situated manner, differed from setting to setting. This is not unlike the conceptualization of "provider-fit" in the present analysis as the alignment of the individual personally, professionally, and socially with the current team to which she or he was seeking entry, with the potential for achieving that "right blend", characteristic of the Collective

Provider, as a possible outcome rather than guarantee. Similar to Wener and Woodgate (2016), I also found several features of the built and organizational environment to be essential in creating opportunity for providers to develop well-functioning inter-provider relationships, including co-location of providers, shared communication tools such as the electronic-medical record, facilitative billing mechanisms (salaried vs. fee-for-service) and a clinic culture that valued team building and encouraged protected time for collaborative activities. The benefits of co-location to provider outcomes have been explored by researchers in primary care such as Bonciani, Schafer, Barsanti, Heinemann, and Groenewegen (2018), although these authors suggest that this may not translate to positive patient experiences. Other identified factors within the Collective Provider are likewise consistent with existing literature including the link between cohesion and team performance (Salas, Grossman, Hughes, & Coultas, 2015). As I employed a constructivist lens, I do not suggest validation in identifying similarities to Wener and Woodgate's (2016) analysis, but rather that these analytic similarities would argue for analytic richness and depth of the primary investigation and ask the question - so what's new?

In narrowing the analytic focus to patient-centred care, this study adds the implication that by shaping the quality of inter-provider relationships, these features so too contributed to the potential for achieving a patient-centred process as a Collective Provider. The joining of inter-provider relationships with the ability of providers to deliver a patient-centred process in a team-based environment would suggest that any effort to close the gap between rhetoric and practice in the area of patient-centred care, at least in team-based healthcare settings, must - in part - include attention to the quality of inter-provider relationships. Where historically the focus has been on the micro-sphere of

the provider-patient dyad in seeking to advance patient-centred care, I suggest that we must widen our gaze to meaningfully look at the quality of relationships within the team. Indeed, D'Amour, Ferrada-Videla, San Martin Rodriguez and Beaulieu (2005), have referred to teamwork as a *sine qua non* (p. 119) that is, an essential element of successful practice in healthcare, and that teamwork is the commonest circumstance in which patient-centred care is delivered. Likewise, Reeves, van Soeren, MacMillan and Zwarenstein (2013) have argued that the reality that no one profession can meet the increasingly complex health care needs of patients and the corresponding shift towards a unifying focus on the patient fundamentally ties patient-centred care to the question of how to achieve interprofessional collaboration. Thus, I echo a resounding "yes" to calls amongst researchers that investigations of patient-centred care in healthcare settings so too must examine interprofessional collaboration and collaborative relationships. It would seem (perhaps unsurprisingly) that the fates of patient-centred care and interprofessional collaboration are somewhat intertwined.

In this study, I also highlighted the conceptualization of patient-centred care in a Shared Mental Health Care setting from two distinct viewpoints, as individual providers and, for these established teams, as a unified group of providers, termed the Collective Provider. The conceptualization of care beyond the individual, at the level of the healthcare team, is gaining momentum amongst researchers seeking to address the issue of quality in a modern healthcare context in which increasingly complex care requires the coming together of a breadth of highly specialized providers. Although not specific to patient-centred care, Lingard (2016), for example, has brought critical attention to conceptualization of "competence" in healthcare as an individualistic vs. collective

phenomenon, arguing that while individual providers may be competent in what they do as professionals, in a real-world setting where providers must come together as a group to deliver services, individual competence does not necessarily ensure competence as a group. Lingard introduced the term “collective competence” to describe a “distributed capacity of a system, an evolving, relational phenomenon that emerges from the resources and constraints of particular context" (2016; p. S19). Similar to aspects of patient-centred care inductively derived from the data in this study, in this definition, she highlights a dynamic understanding of competence as a fluid (ongoing rather than as end-point) and inherently situated process that is played out, by necessity, in a relational sense.

The pitfalls of an individualist orientation as such may have parallels to the collective realization of patient-centred care, that is - to the actualization of patient-centred care in team-based healthcare environments. Like Lingard's concept of Collective competency, in a contradictory sense, it may be that providers who are individually competent in providing patient-centred care, may not be able to meaningfully do so as a group without attention to building effective inter-provider relationships. This may be a possible explanation for the often seen “paradoxical co-existence” (Bilodeau, Dubois, & Pepin, 2015) or seeming “antithetical” (Nembhard, Singer, Shortell, Rittenhouse & Casaline, 2012) presence of patient-centred care with seemingly opposing paradigms such as profession-centred or physician-centred practice. In a variety of healthcare settings, different paradigms may be simultaneously operating while vying for dominance with varying levels of success depending on the group (or team) and context. In situating my findings, I argue the distinction between patient-centred care as individual vs.

collective endeavor so too merits further investigation.

Patient-centred care as collective endeavor becomes particularly important when considering how the patient-centred concept may be used by individuals in different ways in team settings. For the providers in this study, where inter-provider relationships were well-established, based on that genuine positive regard that comes from knowing and caring about other providers, the concept of patient-centred care tended to be used in a unifying or teamwork facilitative rather than dissenting manner within the Collective Provider. This positive mobilization of the patient-centred concept made working together *for the* patient easier, better, and more satisfying. Indeed, the practice of using patient-centred care as a means of bringing providers together is threaded throughout the larger portion of healthcare team rhetoric. Different authors have referred to being patient-centred as the impetus for engagement or involvement with other professions (Croker, Fiser, & Smith, 2015) and as a means supporting providers in bonding around their "shared mission of patient-centered care" (Bennett et al., 2015, p. 203), and so forth. The assumption is often made (in general terms or in the form of those common-sense links) that patient-centred care improves teamwork; although similar to this study, some authors have suggested how patient-centred care may influence interprofessional collaboration by influencing inter-provider relationship dynamics in particular.

In their discussion of "interprofessionality", a frame of reference for conceptualizing cohesive practice among groups comprised of different professionals, D'Amour and Oandasan (2005) conceptualized patient-centred care as addressing the wishes and needs of the patient including an awareness of the patient’s willingness and readiness to collaborate in their care (p. 11). Stating that a focus on the patient is required

but not sufficient (p. 16), these authors suggested a shared focus on the client would improve team collaboration within the team by shifting motivation away from professional turf management amongst team members towards shared patient-oriented goals and shared professional territories. Similar links have been drawn by other authors such as Mitchell, Parker, Giles, and Boyle (2014) in their argument that a focus on common beliefs, including patient-centred values, may represent an important way of addressing dysfunctional dynamics within the interprofessional team. Building on the work of D'Amour et al., Mior et al. (2010) proposed a framework for interprofessional collaboration between chiropractors and physicians in community-based primary care that relies on "trusting relationships" and "patient centredness" as a foundational context for interprofessional collaboration. Mior et al. employed the term "patient-centered focus" positioning patient-centred care, much like D'Amour and Oandasan, as a means of bringing providers together in a way that shifts the focus away from the personal or professional preferences of providers that may hinder collaboration.

In their qualitative exploration of nursing and medical student education in a Norwegian context, Aase et al. (2016) found that the theme of the patient-centred perspective, conceptualized as "looking at interprofessional teamwork through the eyes of the patient" (p. 113), must be considered for successful interprofessional collaborative training. These authors pointed to the work of Menzies-Lyth (1970, as cited in Aase et al. 2016), who suggested that "under stress, health care team members may - mostly unconsciously - direct their attention away from the patient and towards maintaining team relations" (p. 114), concluding that effective teamwork is dependent on a determined effort on the part of providers to incorporate patient-centred perspectives. Another

possible link has been offered by Bennett et al. (2015) who found that the practice of sharing clinical stories among providers helped to develop a connection around their shared objective of providing patient-centred care, enhancing key aspects of team effectiveness such as communication, conflict resolution and supportive inter-provider relationships.

On the other hand, despite its intended purpose, patient-centred care may be used by providers in a way that disrupts teamwork and instigates conflict. Indeed, the examination of patient-centred care as individual vs. collective practice becomes particularly important in view of recent critical accounts of how patient-centred care can be mobilized within teams as a product of issues of power and control. In the social circumstances of healthcare teams, power, like any other finite commodity, may be seen as something to be gained or lost amongst individuals or groups, including between providers and with patients. For example, authors such as Fox and Reeves (2015) have suggested that the concept of patient-centred care may be used by providers in a process of solidifying professional power and control of the patient, effectively reinforcing or even extending conventional medical dominance. They present the idea that patients' self-directed care decisions may only be viable in so far as they reflect the "right" decision in the eyes of medicine, whose professional reach has now been extended under the auspices of patient-centred care and interprofessional collaboration, to include the broader interprofessional team. Raising similar concerns, Papadimitriou and Cott (2014) have suggested that good teamwork does not necessarily lead to improved patient-centred practice, but rather intentional strategies are needed to avoid reinforcing professional power and control of the patient. In a multiple case study by Bilodeau et al. (2015),

providers welcomed patients as unique individuals, wished to empower them and to invite participation, but with the ultimate expectation of compliance, that patients would "follow the rules" (p. 112). In another qualitative study in stroke rehabilitation, Levack, Gerard Dean, Siegert and McPherson (2011) found that despite the labeling of goal setting as patient-centred, certain types of goals - goals that aligned with the interests of professionals rather than patients - were "privileged", with the authors questioning whether patient-centred goals were in fact at all possible given that, regardless of patient involvement, at the end of the day goals continued to be dictated by organizational drivers such as health system and funding models (p. 206).

Still other teamwork disruptive manifestations of patient-centred care have been suggested. For example, Kriendler (2012) has argued that within the social context of teams and groups, the very idea of patient-centred care can be maneuvered to fuel inter-group conflict. She described how nursing scholars may draw on patient-centred care as "ammunition in the fight against medicine" referring to a process of establishing in-group "superiority" and "advantage" (p. 1144). Kriendler has also problematized the rhetoric of patient-organizations, arguing that in their efforts to reclaim control, responsibility and decision-making power in the care process by moving away from the passive term of "patient" towards "people", patient-organizations may be othering vulnerable patients for whom that degree of autonomy would be otherwise undesirable or unattainable. Using a phenomenological approach, Gachoud, Albert, Kuper, Stroud, and Reeves (2012) have similarly identified that that patient-centred practice, while ostensibly benefiting the patient and serving as a key driver of collaboration, may negatively impact team dynamics when used by providers to engage in boundary work with the aim of

establishing hierarchical superiority over other professional groups. Drawing on Gieryn's sociology of science, "boundary work approach" (p. 488). Gachoud et al. (2012) explains boundary work as occurring when scientists establish and defend legitimacy of their field by drawing lines of authority, sometimes seeking to expand that authority into areas historically claimed by others. Applying the boundary work approach to the study of patient-centred practice in a team setting that incorporated social work, nursing and medicine, these authors suggested that nurses and social workers used patient-centred practice to establish a kind of hierarchy in which they occupied a dominant position to medicine, that is were more patient-centred, and so were in a position to claim greater symbolic and/or financial status.

The use of patient-centred care as a tool of dissension is markedly different from what was gleaned in this study. It is possible that where there are good inter-provider relationships grounded in that authentic positive regard, providers are more likely to make decisions collaboratively, to meaningfully take into account the perspectives of other team members rather than enforcing a profession-based hierarchy of decision making that persists in contemporary healthcare structures. In any case, the potentially mitigating effects of positive inter-provider relationships merits further exploration.

As described by Papadimitriou and Cott (2014), patient-centred care does not occur in a vacuum. In the situated, social and organizational conditions of the interprofessional team, patient-centred care may be defined, understood, valued, and mobilized in different ways by different individuals and groups. Existing literature examining the links between patient-centred care and interprofessional collaboration, relationships, and teamwork focus on the common purpose of supporting the patient, but

is also peppered with the language of power and conflict. As a unifying theme, as was the case for the Collective Provider in this study, patient-centred care can be used to build team cohesion, a sense of shared purpose and meaning in working towards the best interests of the patient. However, this may not be the case in many teams that do not have access to the same facilitative inter-provider relationship building context as these Shared Mental Health Care teams. As seen in a growing body of critical work, for others, despite best-laid plans, patient-centred care may be used as a combative tool between individuals and groups, as a means of advancing professional interests or of garnering improved status and other social rewards. Still further, patient-centred care has the potential to be used as a means of extending provider control over the patient under the guise of power-sharing. While these certainly represent extreme views, further research is needed directly examining the interplay of patient-centred care and interprofessional collaborative relationships in diverse interprofessional team settings, and in particular, the study of patient-centred care as individual vs. collective practice.

Chapter 10: Limitations

This study had several limitations. Firstly, secondary analysis carries the risk of misrepresentation when the analysis takes place in a context removed from the primary study (Funk, Stajduhar & Outcalt, 2015). In such cases, risk may be allayed by the involvement of a researcher who is richly familiar with the primary study. In this project, the principal and co-investigator of the primary study were involved. Specifically, Dr. Wener, oversaw the analysis as my academic advisor and Dr. Woodgate was involved as one of my committee members. Secondly, in retrieving the original raw data I did not have access to audio recordings but rather transcripts and related documents alone. As a result, nuances in meaning making may have been lost that would have added to the richness of the analysis. For future studies, ideally taking this a step further by filming of the focus groups might allow me to construct potentially even greater subtleties of meaning making. A third limitation is that of the six focus groups, focus group one was the largest and lengthiest session. This group also represented the most longstanding team with the seemingly strongest level of cohesion. Although the categories derived from these data held up to constant comparison across groups and incidents, and negative case examination, there is a slight weighted representation of selected quotes in the findings towards focus group one as containing the most exemplary and evocatively impactful articulations. Also worth mentioning, is that this analysis was very much based on exemplar teams and so the findings may be markedly different from how patient-centred care is used by providers in newly established teams, or where there are significant individual and/or contextual barriers to team maturation and development. Finally, it is

with a sense of irony I acknowledge that these data were collected from the provider perspective alone rather than patient perspective, an acknowledged gap in the study of patient-centred care (e.g. Marshall, Kitson & Zeitz, 2012). Thus, while this study offers meaningful contribution to the study of patient-centred care in teams, future research should seek to incorporate the patient perspective on how patient-centred care and interprofessional collaborative relationships and teamwork are related rather than the *patient-as-perceived-by-provider* perspective so common to the study of patient-centred care.

Chapter 11: Knowledge Mobilization

As a new researcher, my plan for knowledge mobilization is focused on dissemination activities. Findings will be presented in a public forum at my thesis defense in 2020 as well as submitted to appropriate conferences and peer reviewed journals for presentation and publication. A poster of this project as research-in-progress was presented at the 2018 Helen Glass Research Symposium and the 2019 international North American Primary Care Research Group (NAPCRG) primary care conference. The project will be presented at the upcoming 2020 Canadian Association of Occupational Therapists (CAOT) annual conference. A summary of findings will be shared with the primary care community through the continuation of a newsletter originally developed by Wener and Woodgate to share the results of the primary study. I will also report findings to my funders, the Canadian Occupational Therapy Foundation and the Manitoba Graduate Scholarship at the University of Manitoba, by way of study reports.

Chapter 12: Conclusions, Implications for Practice and Future Research

In this study, where providers were able to come together as a Collective Provider, patient-centred care served a cohesion-enhancing function that was perceived to allow for collaborative work and ultimately better care, despite the existence of barriers to teamwork such as hierarchy. It may be that in a contemporary context where barriers to both patient-centred care and interprofessional collaboration persist, well-functioning inter-provider relationships have the potential to mitigate the detrimental effects of hierarchy and other team disruptive processes in primary care teams. In exploring the relationship between my findings and extant literature, I argued that the potential for patient-centred care to be mobilized in a harmonizing or combative manner in a team-based Shared Care setting, may be linked to the quality of inter-provider relationships. I therefore suggest that interventions targeting enhanced patient-centred care where the approach is delivered by teams rather than individual providers should account for the importance of the quality of inter-provider relationships in realizing this approach. Stakeholders interested in advancing patient-centred care in team-based settings should thus consider how patient-centred care is played out as a *collective* in addition to *individual* endeavor. In considering patient-centred care as a collective practice, antecedent conditions that support inter-provider relationships as outlined in the Interprofessional Collaborative Relationship Building Model (Wener & Woodgate, 2016) and in Figure 5: The Collective Provider, should be considered.

What remains unclear from this analysis, is the question of whether or not the patient is meaningfully considered a part of the healthcare team and what the patient

understanding, rather than the - as perceived by providers - patient understanding of what patient-centred care is, and its relationship to team relationship dynamics. Thus, future research should examine the patient-perspective along with if and how the patient is actionably situated within the interprofessional team as part of a patient-centred process.

Appendix A Positionality

Introduction

This memo was written early on in my research process at the time of constructing and defending my project proposal in 2018, and is therefore framed in an anticipatory sense.

Positionality of the Researcher Memo

The world view and assumptions I bring to this study are perhaps most meaningfully related to my experiences, training and socialization as a rehabilitation professional, specifically as an occupational therapist. As a values-based profession of philosophy, occupational therapists are deeply invested in the advancement of client-centred care. A core belief in the profession is that disability and disease are inherently as perceived by the client and that clients are experts in their own lives. Therapists bring their own expertise and knowledge to the therapeutic relationship, but remain both leaders and followers in the process, albeit to the degree that this aligns with the participant's world view.

Critical evaluations in occupational therapy have identified a gap between rhetoric and practice in the area of client-centred practice (Whalley Hammel, 2014). This is most commonly argued to the case in more medically-oriented environments, and some researchers have suggested that for client-centred practice to be meaningfully implemented it must be endorsed by all stratifications of an organization including client, family, provider, management and policy levels. I am cognizant that demonstrating the value of client-centred practice or a facilitative role of client-centred practice in the interprofessional collaborative process, certainly in environments such as primary care

where the role for occupational therapists is currently expanding, may support occupational therapists in solidifying their position in primary care as well as furthering our aim of moving the philosophy from rhetoric to actualization.

I also come to the study of patient-centred care as a practicing occupational therapist working at a community-based day program for young adults with social, intellectual and developmental disabilities. Working in this unique cultural environment, grounded in a community-practice paradigm, I subscribe to the importance of striving for a person-centred process and in accompanying rather than doing for participants as much as possible as they journey towards their personal goals, commonly related to community living.

I also acknowledge that, as an occupational therapist, I am invested in expanding efforts to enhance interprofessional collaborative structures in healthcare, which by definition, require favorable conditions for my profession such as flattened hierarchy. Negotiating interprofessional power would seem to be a zero-sum game, and for one profession to gain power, another must lose. Medicine is well established at the top of the food chain in primary care settings, and structuring services around the family physician in many ways makes practical sense, with general practitioners as gatekeepers to the system. In my role as a tutor in occupational therapy, I also see that medicine is seemingly at the top of a kind of (implicit) epistemological ranking system where the scientific method and so-called hard science is held above other forms, oftentimes deemed lesser, forms of inquiry. Even among the allied health professions it would seem that those that align more closely with the medical model tend to be more readily understood and utilized to full scope, and typically, this does not include occupational

therapy.

In Manitoba, regional leaders have demonstrated their belief in the emerging value of interprofessional collaboration by creating co-located interprofessional collaborative teams in community access centres (Wener, 2016). Advancing interprofessional collaboration and the building of integrated teams could expand the potential role for occupational therapy in addition to garnering greater professional power in primary care settings and perhaps more broadly. Thus in undertaking my study, I will need to be mindful of these allegiances. This could, for example, push a favored view of client-centred practice as a facilitator to the collaborative process or cause me to overlook barriers identified or problems I may encounter with the core of "patient-focus" within the ICRB model. As a result I will need to reflect upon and journal my thoughts throughout the life of my project.

At a more practical level, my statement of objectives and design decisions are similarly influenced by my profession, namely in my efforts to target a rehabilitation audience of reviewers, funders (COTF) and knowledge users. In rehabilitation, there seems to be a weighted use of methodologies on the descriptive as opposed to interpretive end of the spectrum of qualitative inquiry. From a learning outcomes perspective, I have come to realize that I have a distinct cognitive preference for grappling with topics that are perhaps more theoretically than practically driven. Through the challenge of writing this proposal, I have also come to realize that (in true novice fashion) I tend towards a more black and white understanding of methodology. As such, I will need to be mindful that within applied sciences such as healthcare, I may need to adapt a more flexible understanding of grounded theory techniques.

A final consideration suggesting the need for reflexivity is related to my relationship with the creator of the Interprofessional Collaborative Relationship Building model (ICRB), who is an occupational therapist as well as my academic advisor and mentor. I will have to remain open to the potential for contradictory or problematic discoveries relating to her data and the model itself. In a related manner, and acknowledging where I am at both developmentally as a new researcher and with respect to confidence in my work, I will have to be cautious of seeing what I want to see as related to the ICRB. However paradigmatically unsound (and much to my dismay) in a student frame of mind, I often still find myself looking for that "right answer". This is cause for concern in a secondary qualitative analysis. Thus in my analytic process, at the outset, I will plan to delay looking at memos from primary study that are specifically analytic in nature, until I have reasonably determined (however provisional) a core analytic direction based on my own reading of the data.

Appendix B Focus Group Guide

Primary Health Care Provider & Mental Health Care Providers Focus Group Interview Guide

The following interview questions are intended to answer the research questions 2-3.

2. To identify how the individual (micro), professional and team (meso), and systemic (macro) conditions and interrelationships influence the interprofessional collaboration process that occurs in the context of shared mental health care.
3. To identify the opportunities and challenges of the interprofessional collaboration process in the context of shared mental health care.

Some of you have already participated in individual interviews however, during this group interview we will focus more on how the team works to provide mental health services in primary care. Specifically, we will focus on the interprofessional collaboration process that you use to provide mental health services to patients.

1. Who is involved in the interprofessional collaboration process? physicians, nurse practitioners, mental health counselors, psychiatrists, patients, families, others?
2. What kinds of mental health concerns do patients or primary care providers present?
3. How is the interprofessional collaboration initiated?
4. Once the referral to Shared Care is made:
    a. What is the role of the primary care physician/nurse practitioner
    b. What is the role of the shared care counselor/psychiatrist

    c. What is the role of the patient/family/others
    d. Who makes the final decision about the plan of action?
5. How do the roles vary depending on the services requested or required?
6. How are decisions made? What happens if there is disagreement?
7. How are conflicts resolved?
8. How is information communicated between health care providers?
9. What role does the patient play in the interprofessional collaboration process?
10. How are the unique circumstances of a given patient considered in the interprofessional collaboration process?
11. What do you see as your team's strengths?
12. What would make your team better?
13. What does the primary care program or the mental health program have in place that encourages or facilitates collaborative practice?
14. What have been your biggest challenges collaborating ?
15. What could the program or the WRHA do to enhance interprofessional collaboration?
16. What have been the opportunities/strengths of interprofessional collaboration for your shared patients with mental health concerns?

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