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Faculty of Health Sciences
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The patient´s role in undergraduate health students' interprofessional clinical placements

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Acknowledgments

Abbreviations

IPE	Interprofessional education
IPCP	Interprofessional collaborative practice
IPECP	Interprofessional education and collaborative practice
IPEC	Interprofessional Education Collaborative Expert Panel
IPL	Interprofessional learning
IPTW	Interprofessional Training Ward

Definitions of central terms and concepts

Interprofessional education
When students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes and services (World Health Organization (WHO), 2010, p. 10).

Interprofessional learning
Learning that "occurs between students or members of two or more professions to enhance knowledge and competence during interprofessional education or informally in educational or practice settings" (Barr & Low, 2013, p. 4).

Interprofessional collaborative practice
When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care (WHO, 2010)

Student
Throughout this thesis, the term student corresponds to *undergraduate students* in health and social professional education. Any deviations from this are specified.

Patient
The term patient is, in this thesis, used in its broadest sense encompassing persons who receive care and treatment from health professionals in clinical settings; patients can elsewhere be termed as clients, users, service-users, residents etc.

List of Papers

The dissertation is based on the following papers:

Paper 1: Jensen, C.B., Norbye, B., Dahlgren, M.A., & Iversen, A. (2022). Patient participation in interprofessional learning and collaboration with undergraduate health professional students in clinical placements: A scoping review. *Journal of Interprofessional Education & Practice.* DOI: 10.1016/j.xjep.2022.100494

Paper 2: Jensen, C.B., Norbye, B., Dahlgren, M.A., & Iversen, A. (2022). Getting real in interprofessional clinical placements: patient-centeredness in student teams' collaborative learning. *Advances in Health Sciences Education.* DOI: 10.1007/s10459-022-10182-y

Paper 3: Jensen, C.B., Norbye, B., Dahlgren, M.A., Tornqvist, T., & Iversen, A. (202X). Students in interprofessional clinical placements: how supervision facilitates patient-centeredness in collaborative learning. *(In revision)*

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Summary in English

The study aims to explore what happens when health professions students undertake an interprofessional clinical placement together and the role of the patient in such a learning arrangement. The organization of healthcare services is currently changing, transitioning from a uniprofessional approach to a team-based approach as the default. An aging population and the increased occurrence of chronic, complex, and non-communicable diseases, combined with decreased access to healthcare providers, create challenges. These must be tackled not only in healthcare services but also in health professions education.

Interprofessional collaborative practice is highlighted as one means of contributing to a more sustainable workforce, which would enhance patient safety and individualized and integrated care and treatment pathways. Higher education institutions are expected to provide opportunities for undergraduate students to engage in collaborative learning throughout their studies in order to ensure a collaboration-ready workforce. Interprofessional clinical placements in healthcare services occur in different settings but have proven challenging to implement. Nevertheless, interprofessional students who encounter people in real-life situations are ideal for developing collaborative skills and learning how to integrate the patient's perspective into teamwork.

Studies that explore students' clinical interprofessional learning (IPL) often include self-reported data (for example, questionnaires or interviews). Calls to use other data generation methods have been made to ensure a deeper understanding of what happens in interprofessional education (IPE). Data for the current Ph.D. project was generated using several methods. In Paper 1, 73 articles on IPE in clinical placements were explored through a scoping review method. In Papers 2 and 3, participant observation inspired by a focused ethnographic approach was conducted in multiple contexts in which interprofessional students engage with patients in clinical placements. Moreover, qualitative interviews (including individual, group, and focus group interviews) were conducted to complement data from the participant observations. Then, the data was analyzed by following the principles of reflexive thematic analysis.

The three papers provide insight into different perspectives on patient involvement in interprofessional education. Paper 1 demonstrates that patients are insufficiently included in research on interprofessional education in clinical placements. Paper 2 shows that patients are the focus of interprofessional student teams' work and learning process. Despite this, patients do not always feel included in encounters with interprofessional student teams. In Paper 3, it was found that supervisors in interprofessional clinical placements are often not present in student teams' interactions with patients. The supervision of interprofessional student teams appears to center on core competencies in IPE, which may overshadow the patient's perspective.

This dissertation provides insight into the involvement of patients in interprofessional clinical placements. The findings suggest that actors (researchers, educators, supervisors, students) involved in interprofessional clinical placements may take the patient somewhat for granted. Higher education institutions should be concerned about facilitating opportunities for students to learn how to involve patients in IPL activities. This also involves ensuring the presence of competent supervisors in interprofessional clinical placements. When facilitating IPL for undergraduate students emphasize, the importance of patients must be emphasized, and that students are supported in how they can enact a patient-centered approach.

Norsk sammendrag

Denne avhandlingen utforsker pasientens rolle i tverrprofesjonelle praksisstudier for studenter i ulike kliniske kontekster.

Vi står midt i en stor omstilling av helsetjenestene globalt og nasjonalt, spesielt knyttet til overgangen fra en særprofesjonell tilnærming til en team-basert tilnærming som standard. En aldrende befolkning, og økt forekomst av kroniske, komplekse, ikke-smittsomme sykdommer kombinert med redusert tilgang til helsepersonell, skaper utfordringer. Dette må håndteres, ikke bare i helse- og omsorgstjenesten, men også i helsevitenskapelige utdanninger.

Tverrprofesjonelt samarbeid fremheves som ett av flere virkemiddel for å bidra til en mer bærekraftig helsetjeneste med økt pasientsikkerhet samt individualiserte og integrerte omsorg- og behandlingsforløp. Utdanningsinstitusjoner forventes å gi muligheter for studenter til å lære sammen gjennom sine studieløp for å sikre samarbeidskompetanse, såkalt tverrprofesjonell samarbeidslæring (TPS). TPS-aktiviteter skjer i dag gjennom teoretisk tilnærming, tverrprofesjonell simulering og i kliniske praksisstudier i helse- og omsorgstjenesten. Det sistnevnte gjennomføres i ulike settinger, men har vist seg utfordrende å implementere. Allikevel, tverrprofesjonelle helsefagstudenters møte med personer i autentiske situasjoner er fruktbare for å lære samarbeid og for å lære å integrere pasientens perspektiv i teamarbeid.

Forskning på TPS i praksisstudier inkluderer ofte selvrapporteringsdata, for eksempel spørreskjemaer eller intervjuer. Det er oppfordret til å bruke andre metoder for å få en dypere forståelse av hva som skjer i TPS. Data for dette Ph.d.-prosjektet ble generert gjennom flere metoder. I artikkel 1 ble 73 artikler om TPS i praksisstudier utforsket gjennom en scoping review-metode. I artikkel 2 og 3 ble deltakende observasjon, inspirert av en fokusert etnografisk tilnærming, gjennomført i flere sammenhenger der tverrprofesjonelle studenter møtte og hadde det daglige ansvaret for pasienter. Kvalitative intervjuer, inkludert individuelle, gruppe- og fokusgruppeintervjuer, supplerte data fra deltakerobservasjonene. Data ble analysert etter prinsippene for refleksiv tematisk analyse.

De tre artiklene gir innsikt i ulike perspektiver på pasientmedvirkning i TPS i praksisstudier. I artikkel 1 viser vi hvordan pasientens rolle i TPS ikke blir tilstrekkelig artikulert i forskning. I artikkel 2 viser våre funn at pasienten står i sentrum for tverrprofesjonelle studentteams arbeids- og læringsprosess, men til tross for dette føler ikke pasientene seg alltid inkludert i møter med studentteamene. Funnene i artikkel 3 viser at praksisveiledere i tverrprofesjonelle praksisstudier holder seg i bakgrunnen og ofte ikke er til stede i studentteamenes samhandling med pasienter. Veiledningen av studentteamene ser ut til å ha fokus på kjernekompetansen i TPS, noe som kan overskygge pasientperspektivet.

Avhandlingen gir nye perspektiver på involvering av pasienter i utdanning og spesifikt i TPS. Våre funn tyder på at pasientperspektivet ofte tas for gitt i TPS, noe som også vises i forskningen på disse læringsaktivitetene. Høyere utdanningsinstitusjoner må være opptatt av å legge til rette for at studenter får møte pasienter og lære seg hvordan å involvere dem i tverrprofesjonelle læringsaktiviteter. Det sistnevnte innebærer også å sørge for kompetente veiledere i tverrprofesjonelle praksisstudier. Involvering av pasienten må vektlegges når tverrprofesjonelle studenter lærer sammen og det blir viktig å støtte dem i å finne gode måter hvordan dette gjennomføres i møter med pasienter.

Foreword

I always wonder
Do you as my healthcare providers see
me –Individually and as a team?
I do not mean literally see me
Through your eyes.
I mean do you see
And understand the whole me?
The person that I am?
The me not through my signs and
symptoms, Blood values or
My condition,
But the me as a mother, wife, nurse,
professor, a global citizen?
The me with my unique background,
culture, language, and experiences?
The me with a history, previous
healthcare interactions, and health
events?

You each assess, question, and probe.
You each expose, poke, and auscultate.
You each palpate, insert, and test.
You each draw-up, scan, and report.
But do you collectively actually see
me?

The me with my own unique meaning
of health,
care preferences, thoughts, and
opinions?
The me with a voice and the desire to
be more
involved in my care?
The me with the knowledge of self?
The me that knows best what is the
most ideal care plan for me?
The me as a human being and not just
as an object to be treated

You consult each other, discuss, and
plan.
You each follow care pathways, best
practice
guidelines, and protocols for care.
You decide.
You then inform me of the treatment
plan that you
collectively develop amongst
yourselves –
For me.

You tell me this is the best option.
You assure me that this is the path,
That there is no other way.
But do you collectively actually see
me?
Do you consider the me you collectively
do not see?

The me you did not get to know? The
social aspects
of me?

My unique social determinants of
health, specific
to me?
The me that is worried the scar your
suggested treatment will leave will
become a new part of my identity?
The me that will have to live with
trying to conceal this revealing aspect
of me.
The me that is considering how the
timing of the medications I need to
take will change my family routine?
The me that will have to transform
how my family interacts with me?
The me that is pondering how the
ongoing monitoring will require
consistent access to technology and
put pressure and onus on me?
The me that will have to deal with not
living carefree?
The me that is thinking how I will have
to limit my social interactions due to
conditions placed on my levels of
activity?
The me that will have to live in further
social isolation?
The me that is aware that I possess
knowledge to be more involved in my
care and want to share another
perspective on your plan for me?
The me that is vocal and opinionated
about me?
The aspects of me that make me ME?

You each act like you listen,
Genuinely care for me,
But when interactions last mere
minutes,
How can you get to know the whole
me?
For there are unspoken aspects of me
that you often do not get to hear
In your individual and collective
discovery.
You each seem like you are looking at
me,
The eye contact is there,
Your observations run deep,
But what exactly do you see when you
look at me?
For my body language often conveys I
need to develop trust to fully reveal the
whole me.

You seem like you feel me and at times
I experience the warmth,
But the emotional connection appears
superficial to me.
For I feel the power you each have over
me, but it is this power that you need
to share not only amongst yourselves,
but with me before I can be
fully me.

In the back of my mind I know –
It's not you, it's the system.
Its how we educate each of you in
silos; Its how we train you.
It's the exhaustion of the pandemic, of
the ongoing
ask, of the limited thanks,
Of being short staffed, of being
underpaid,
Of not having the time to go to the
bathroom, sleep, take a gulp or digest.
The pressures you face,
The responsibilities you are granted,
The expectations are great, and the
fatigue is a given,
But it is my responsibility to share that
there is a me
that you need to collectively see.
The me you need to learn to see can be
a solution for you and me.

The time you spend upfront to share
with me will save the total time you
spend as a team with me.
When you get to know the whole me,
the me feels valued and engaged, and
you get the knowledge you need to
treat me.
You can then take care of me more
effectively.
When you develop treatment plans
with me that work for me, my lifestyle
and family,
Together we can then enhance my
adherence and goal achievability.
When you empower me to be a self-
care manager of my condition in the
community, You minimize my
readmissions, and decrease wait
times for others in society.

I always wonder – Do you as my
healthcare providers understand
The importance of seeing the real me?
I do not mean literally understand,
In your mind.
I mean do you understand
The impact of seeing me can have on
you and me?

When you actually see me collectively,
the whole
me becomes your possibility,
For active partnering and person-
centred care delivery.
It's the me you need to see, the me you
need to include to collaborate
successfully,
To create a future for the healthcare
system where interprofessionally, The
joining of you and me therapeutically
Equates to exceptional healthcare
delivery.

Metersky (2022)

1 Introduction

Imagine a troupe of classically trained actors who enters a national theater, prepared to perform the William Shakespeare tragedy, *Hamlet*. The actors have rehearsed their monologues and lines; they know when to enter and leave the stage. They know who their co-actors are and perceive the act that they dramatize as predictable and something that they are in control of. However, when the actors enter the dress rehearsal, the director informs them that the dramaturgy has changed: the actors are now expected to perform a hip-hop version of the play. In addition, the director expects them to involve the audience in the performance.

Thus, the actors enter the stage in baggy jeans and hoodies. They walk with an attitude and are entirely dependent on their co-actors but alert to who says what and when. They must improvise, perform dance steps that they are unfamiliar with, and try to adapt to what other actors are doing while remembering the essence of their role in the classic piece. All of the actors onstage are simultaneously making the best out of the performance and trying to involve the audience and convince them that they are professionals and know exactly what they are doing.

One can sense a feeling of despair in the performance described above, in which the actors did not have an opportunity to readjust to the director's new demands. Many actors would also argue that rehearsing with their peers enhances the quality of the performance, which also applies to cases in which they must improvise.

Since the late 1980s, there have been numerous calls for change in health professions education to ensure that health professionals adopt a team-based approach to treating patients. With the increased complexity of health issues, due to changing demographics, and fewer healthcare providers to treat and care for patients, major challenges have emerged in healthcare services and health professions education. Interprofessional education and collaborative practice (IPECP) has been emphasized as a key factor in ensuring a sustainable healthcare workforce that can provide high-quality healthcare services that treat the patient as a partner and have the capacity to change when the world changes (World Health Organization (WHO), 1988, 2010, 2016, 2022). Consequently, IPE has become an acknowledged part of many aspects of health professions education, including theoretical studies, simulation training (Paradis & Reeves, 2013; Reeves, Tassone, Parker, Wagner, & Simmons, 2012), and, to some extent, clinical settings (O'Leary, Salmon, Clifford,

O'Donoghue, & Reeves, 2019). Research in the field of IPE is increasing (Khalili et al., 2021), and it has been argued that it is reaching maturity (Xyrichis, 2020). However, researchers, educators and health practitioners are still not on target with IPECP, and gaps related to both research and learning activities that prepare students for future interprofessional collaboration remain (Samarasekera, Nyoni, Amaral, & Grant, 2022).

From a researchers perspective, we are still fumbling around with a mix of classical performance and hip-hop theater. Thus, it is reasonable to explore whether there are any similarities between the actors who must improvise a hip-hop performance of *Hamlet* and interprofessional students who perform "healthcare" with the patient. "To be or not to be?" might be the question.

This thesis aims to explore what happens when health professions students undertake an interprofessional clinical placement together and the role of the patient in this endeavor. Several methods were used to explore the interprofessional clinical placements, including studies on previous research in the field of IPE and observations of interactions between students, patients, and supervisors in interprofessional clinical placements in Norway and Sweden. This knowledge is essential for understanding what happens when undergraduate students learn to engage in interprofessional collaboration in clinical settings and how the patient is involved. It can inform educators about how to design learning arrangements that ensure partnerships with patients, the competencies that supervisors must facilitate, and how to support students' learning process.

1.1 Background

In this section, I provide an overview of publications and policies that have driven the implementation of IPE in health professions education, many of which target healthcare services and have implications for health professions education. I elaborate on what IPE encompasses and describe changes in the patient's role in healthcare, health professions education, and IPE. Finally, I account for aspects related to learning IPE in clinical settings.

My principal worldview is that "everything is connected." From my perspective, it is impossible to consider health professions education without deep insight into healthcare services. Thus, I chose a broad knowledge base when elaborating on the background for the study.

1.1.1 Global policies and strategic incentives for IPE

In this sub-section, I provide an overview of seminal publications and policies that have influenced healthcare over the past decade and strengthened incentives for IPE.

Healthcare systems must contend with an increasing number of individuals with complex health issues and co-morbidities. Some issues are related to an aging population. In addition, chronic disease and mental health issues among patients of all ages, along with an increased prevalence of non-communicable diseases such as cancer, diabetes, cardiovascular disease, and obesity have caused significant challenges for healthcare services and health professionals. Concurrently, there is an ongoing pandemic, and it has been predicted that similar pandemics will occur due to increased globalization.

In 2008, Berwick, Nolan, and Whittington (2008) proposed the "Triple Aim" and suggested three measures to improve healthcare: (1) improving the experience of care, (2) improving the health of populations, and (3) reducing the per capita cost of healthcare (Berwick et al., 2008). According to Berwick et al. (2008), implementing the three measures in parallel could create synergies for improvements to healthcare systems.

A seminal *Lancet* report titled "Health professionals for a new century: transforming education to strengthen health systems in an interdependent world" (Frenk et al., 2010) addressed health professions education issues that are closely connected with the Triple Aim. According to Frenk et al. (2010), health professions education is not keeping pace with the increasing number and complexity of problems in the healthcare system—namely, complex and costly healthcare that demands more from health workers than ever before. The authors highlighted fragmentated, outdated, and static curricula dominated by educators' interests and not by the needs of the healthcare system. This has led modern health professions education to "produce ill-equipped graduates" (Frenk et al., 2010, p. 1923). Systemic problems, such as the "mismatch of competencies to patient and population needs," "poor teamwork," "episodic encounters rather than continuous care," and "predominant hospital orientation at the expense of primary care" were particularly highlighted (Frenk et al., 2010, p. 1923). The Lancet Commission emphasized "people as co-producers and as drivers of needs and demands in both systems" (Frenk et al., 2010, p. 1923). The report also emphasized inequity in healthcare and the distribution of health professions education across the globe. It shared a vision that

> all health professionals in all countries should be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to

participate in patient and population-centered health systems as members of locally responsive and globally connected teams. (Frenk et al., 2010, p. 1924)

In the same year, 2010, World Health Organization (WHO) published the Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010), which acknowledges the role of IPE in health education and the importance of enabling students to engage in collaborative practice. The purpose of the framework is to "provide policy-makers with a broad understanding of how interprofessional education and collaborative practice work in a global context" (WHO, 2010 p. 36). It provides examples of different initiatives in education and healthcare that facilitate IPL and collaborative practice and highlights how these have created synergies at the individual and population level. The framework indicates that collaboration implies more than simply working towards a common goal for patients as individual professionals (WHO, 2010). It adopts a broad perspective on IPECP and specifies that,

> ultimately, interprofessional education and collaborative practice are about people: the health workers who provide services and work together to ensure patients and the community receive the best treatment as efficiently as possible; the educators who understand the importance of bringing together students from a range of disciplines to learn about, from and with one another; the health leaders and policy-makers who strive to ensure there are no barriers to implementing collaborative practice within institutions; and most importantly, the individuals who require and use health-services, trusting that their health workers are working together to provide them with the best service possible. (World Health Organization, 2010, p. 37)

Five years after the *Lancet* report and the WHO framework, Sikka et al. (2015) suggested a fourth aim to add to the Triple Aim (Berwick et al., 2008), and thus renamed it to the Quadruple Aim. Specifically, the fourth aim was to create working conditions that enable health workers to find joy and meaning in their work (Sikka et al., 2015). Sikka et al. (2015) argued that, as "the backbone of any efficient healthcare system," health professionals are critical to transforming and improving healthcare to reach the overarching goals proposed in the Triple Aim. By creating an engaging, inspiring, and meaningful work environment, productivity would increase.

In 2016, WHO published the Framework on Integrated, People-Centered Health Services to intensify the global reorganization and reformation of health services. The framework suggests strategies, policy options, and interventions to meet challenges such as inequity in health, fragmented health services, lack of continuity in care, and the persistent focus on diseases and curative care. WHO (2016) argued that

more integrated people-centered care systems has the potential to generate significant benefits to the health and health care of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction for health workers, improved efficiency of services, and reduced overall costs. (p. 2)

Moreover, WHO (2016, p. 4) proposed five interdependent strategies to develop more effective health services:

1) Empowering and engaging people and communities
2) Strengthening governance and accountability
3) Reorienting the model of care
4) Coordinating services within and across sectors
5) Creating an enabling environment

Healthcare services were suggested by WHO (2016) to be redesigned from a hospital-based inpatient care model to an ambulatory outpatient care model that emphasizes health prevention. This strategy would enable individuals and their families to achieve better clinical outcomes, as they would become active participants in the discussion about their health who are empowered and knowledgeable about their health situation. However, building such healthcare systems requires interprofessional teams "to ensure the provision of comprehensive services for all" (WHO, 2016 p. 7). WHO (2016 p. 8) emphasized coordination of care, which involves close collaboration between healthcare services and the education sector to "align professional curriculum towards new skills needed." To undertake transformational change, the Framework on Integrated, People-Centered Health Services also encompasses the creation of an enabling environment, a complex strategic approach that involves a reorientation of the health workforce. Among other requirements, "health workers must be organized around teams and supported with adequate processes of work, clear roles, and expectations" (WHO, 2016, p. 9).

Moreover, Valentijn et al., (2013) developed a conceptual framework with a close integration with specialized, curative health services from a primary care perspective. Person-focused and population-based care is underlying principles of integrated care. Valentijn et al. (2013, p. 7) defined professional integration as "interprofessional partnerships based on shared competencies, roles, responsibilities, and accountability to deliver a comprehensive continuum of care to a defined population." Shared responsibility is necessary for integrated services to ensure the health and well-being of individuals and populations (Valentijn et al.,

2013). This assumes that health professionals will "let their guard down" and avoid territorial behavior, which can be a barrier to interprofessional collaboration (Axelsson & Axelsson, 2009). Axelsson and Axelsson (2009) called for health professionals to adopt an altruistic stance in which common purpose overrules professional territoriality. This can result in a more holistic approach to individuals and populations. In addition, Axelsson and Axelsson (2009) argued that, by noting the competencies represented in an interprofessional team, professionals can become aware of how they can support each other. For individuals or populations, this interprofessional collaboration can lead to synergies that can accomplish more than if each team member were interacting with the patient on an individual basis (Axelsson & Axelsson, 2009). The understanding of integrated care continues to evolve and has developed into an understanding of "relationship building and the ability to foster an environment where new collaborations and ways of working become accepted as the norm over time" (Goodwin, 2016, p. 2).

The most recent WHO publication to impact health professions education is the Global Competency and Outcomes Framework for Universal Health Coverage (WHO, 2022). This represents another specific yet comprehensive call to enable a collaborative-ready health workforce. The framework aims to ensure universal health coverage, which is closely related to the United Nations Sustainable Development Goals (SDGs)—especially SDGs 3 and 4, ("Good health and well-being" and "Quality education, respectively"; United Nations, 2023). The framework "focuses on the role of health workers in delivering quality health services for which they should be trained" (WHO, 2022, p. 1). It echoes the findings of Frenk et al. (2010) and acknowledges the importance of competency-based education aligned with the population's needs and the demands of the health system. Competency-based education aims to develop individual proficiency through training and experience, including "knowledge, skills, attitudes, and competencies" (WHO, 2022, p. 5).

In line with Frenk et al. (2010), WHO (2022, p. 5) argued that competence must be "defined externally at the level required for graduates, or in the case of healthcare, for practice". The report highlights the core functions of healthcare services and places less emphasis on who should perform them; however, it underlined a team-based, collaborative approach as a key factor in achieving universal health coverage. Moreover, the framework proposes six competency domains to integrate into health workers' practice to ensure quality healthcare and universal health coverage: people-centeredness, decision making, communication, collaboration, evidence-informed practice, and personal conduct. These six competency

domains are all closely connected and interrelated, and the framework argues that they are "relevant to interactions with all people encountered through health services" (WHO, 2022, p. 17). Domains 1 and 4 are most relevant to the dissertation topic and are briefly examined in more detail.

Domain 1 (i.e., people-centeredness) includes "competencies related to the provision of health services that incorporate perspectives of individuals, caregivers, families, and communities as participants in and beneficiaries of health systems" (WHO, 2022, p. 16). It incorporates a holistic view of health that supports and empowers individuals and communities. This involves developing self-reflexivity, sensitivity towards cultural differences, and respect for individual differences, such that people are "at the center of all practice" (WHO, 2022, p. 17).

Domain 4 (i.e., collaboration) involves "collaboration with other health workers, intersectoral collaboration, and collaboration with individuals, caregivers, families, and populations as informed members of the health team" (WHO, 2022, p. 20). Teamwork is promoted as a default mode of work in healthcare. The domain also emphasizes the creation of partnerships with different actors, and the definition of IPE is well-incorporated into the proposed competencies. Developing a self-reflexive attitude is essential, specifically to manage tensions and conflicts within a team (WHO, 2022).

1.1.2 National policies and incentives for IPE

As mentioned, the empirical data for the current study originates from Norway and Sweden. Despite this, I have chosen to concentrate on policies from the Norwegian context, as three out of four contexts in which data was generated were in Norway. Nevertheless, there are many similarities between the management of healthcare and health professions education in Norway and Sweden. For instance, two separate ministries govern the healthcare and education sectors. Official Swedish government reports have pinpointed the need to organize healthcare differently to improve care and continuity for patients and strengthen primary care (The Swedish Ministry of Health and Social Affairs, 2016, 2018). Interprofessional collaborative practice has been emphasized to reach these goals (The Swedish Ministry of Health and Social Affairs, 2018). In the educational sector, legislation regulates expected learning outcomes in health professions education related to IPE (The Swedish Ministry of Education and Research, 1993).

The Norwegian context shares many similarities with the global issues presented in Sub-section 1.1.1. New reforms have been presented and implemented over the past decade. One reform that has significantly impacted health services is the Coordination Reform (Ministry of Health and Care Services, 2009), which emphasizes improved collaborative structures between hospitals and primary health services and focuses on teamwork around patient care. A goal of the reform is to displace healthcare services from the domination of hospital treatment and admissions to primary care. Among other effects, this resulted in the implementation of community health centers to provide intermediate care that does not necessitate hospital delivery to municipality residents.

Moreover, political initiatives in healthcare have significantly impacted the design of health professions education in Norway. This has also been highlighted in education policy documents such as the white papers "Education for Welfare" (Ministry of Education and Research, 2012) and "Quality Culture in Higher Education" (Ministry of Education and Research, 2017), which highlight IPL initiatives as examples of how health education can facilitate learning for the future. Since 2017, major developmental work has been initiated and implemented to ensure that Norwegian health professions education is future-oriented and in line with the needs and demands of health care. This endeavor is part of a new governance system that seeks to increase the influence of healthcare services and patients on education. It has resulted in common legislation for health professions education, which states that students must acquire interprofessional competence through their undergraduate education. An evaluation of this implementation has been initiated to assess its outcomes and how the governance system has enabled connections between the educational and healthcare sectors (Ministry of Education and Research, 2023).

In early February 2023, a commission that was mandated to investigate challenges related to the recruitment of health professionals in Norway up to 2040 presented an official report (Ministry of Health and Care Services, 2023). The latter creates a knowledge base about the demographics associated with access to health professionals in Norway. Among other measures, it emphasizes that educating health professionals to meet future demands in healthcare is crucial. Thus, examining the organization of health professionals' work processes is a prerequisite for ensuring high-quality and effective healthcare services. The report highlighted IPE as a way to enhance health professionals' competence, specifically interprofessional simulation. Moreover, it underlined supervisors' competence in clinical settings as an essential means of action (Ministry of Health and Care Services, 2023).

1.1.3 Interprofessional education and learning

Based on the literature and policies elaborated in section 1.1., a greater focus on IPE in health professions education is warranted. The term IPE refers to an approach in which "students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 10). The crux of IPE is to learn together (Thistlethwaite, 2021), and evidence shows that learning together enhances students´ ability to work together and better care for patients (Reeves, Palaganas, & Zierler, 2017). Thus, learning collaborative skills fulfills the ultimate purpose of IPE: to enhance patient outcomes (Thistlethwaite, 2021).

While IPE can be considered an umbrella term that reflects an overarching educational approach, IPL is related to the micro-learning processes that occur in various learning arrangements (Thistlethwaite & Moran, 2010). Thistlethwaite (2021, p. 211) stressed that "the prepositions "from, with and about' are important as they stress that IPL is interactive and equitable." Moreover, Freeth, Hammick, Reeves, Koppel, and Barr (2005) illustrated that IPL is a process in which students depend on each other and their individual development:

> Where the aim is interprofessional learning, in other words learning with, from, and about each other, it naturally follows that participants are dependent upon each other for at least some of their learning. This does not mean that individually they do not have responsibility for their personal and professional development. Rather, it is the very nature of interprofessional education, to a much greater extent than with other types of learning about professional practice, that the learning emerges from dialogue, discussion and debate within the group. The desired interactive learning may be achieved in a number of different ways. Each places different demands on tutors, facilitators, supervisors and mentors. Staff development to enhance their skills may be necessary. (Freeth et al., 2005, p. 85)

IPE aims to create a solid and integrated health system and reduce the fragmentation of health services (WHO, 2010). Implementing IPE in health professional education is considered key to culture change in health care. As mentioned, IPE is not a specific program but an educational approach and should be seen as "an integral part of all health professional curricula" (Thistlethwaite, 2021, p. 211). Therefore, a strong connection between education and healthcare systems is crucial to succeed with IPE (WHO, 2010).

According to Thistlethwaite (2012), IPE as a phenomenon dates back to the 1960s and was reinforced in the late 1980s through the WHO report "Learning together to work together for health" (WHO, 1988). It proposed that health personnel must learn a team-based approach, as

the sum of their work would result in better-quality care for patients or clients than if each professional worked alone:

> Training in their own profession only does not adequately prepare the members of the different health care professions to apply their different disciplines and competencies; it needs to be supplemented with multiprofessional training so that the different professions become aware of their different ways of thinking and acting and gain experience of coordinated team-work, in which each has an essential role to play. (World Health Organization, 1988, p. 15)

Over the following decades, many initiatives were piloted and implemented (Reeves et al., 2012). Sottas, Kissmann, and Brügger (2016) proposed a classification of IPL arrangements that spanned from theory-based learning, including introductory lectures and practice, in which students are based in clinical settings or other realistic working environments and engage in interprofessional collaboration. Recent reviews have shown that IPE is mainly offered as simulation-based learning and e-learning in undergraduate curricula (Aldriwesh, Alyousif, & Alharbi, 2022; L. Fox et al., 2018; Rutherford-Hemming & Lioce, 2018).

However, Grace (2021) concluded that IPE in clinical placements is becoming a crucial component of an integrated model of IPE. In this model, the learning design aims to facilitate students´ IPL through different phases and developmental stages, where collaborating with patients constitutes the final phase (Grace, 2021). This aligns with a spiral curriculum model in which IPL experiences evolve from classroom-based experiences to interprofessional simulations and clinical settings for senior undergraduate students (Thistlethwaite, 2021). In general, students respond well to IPE, and the evidence suggests that IPL improves the attitudes and perceptions of other professions and enables students to gain knowledge about each other and the skills necessary for collaboration (Reeves, Fletcher, et al., 2016).

Several competency frameworks have been proposed to define interprofessional competencies. Examples include the Interprofessional Capability Framework (United Kingdom), the National Interprofessional Competency Framework (Canada), Curtin University's Interprofessional Capability Framework (Australia), and the Core Competencies for Interprofessional Collaborative Practice (United States; Thistlethwaite et al., 2014). Moreover, a more recent European framework was proposed in 2021, with key competencies for interprofessional collaboration (European Interprofessional Practice & Education Network (EIPEN), 2021). Competency frameworks can provide educators with support in the planning of IPL activities for students (Thistlethwaite et al., 2014).

In the current research, the Core Competencies for Interprofessional Collaborative Practice from the Interprofessional Education Collaborative Expert Panel (2016) informed the sub-studies. The 2016 update is the latest publication[1] and includes four domains (see Figure 1): values/ethics, roles/responsibilities, interprofessional communication, and teams/teamwork. A community and population orientation and a patient- and family-centered approach should feature all domains (Interprofessional Education Collaborative Expert Panel, 2016).
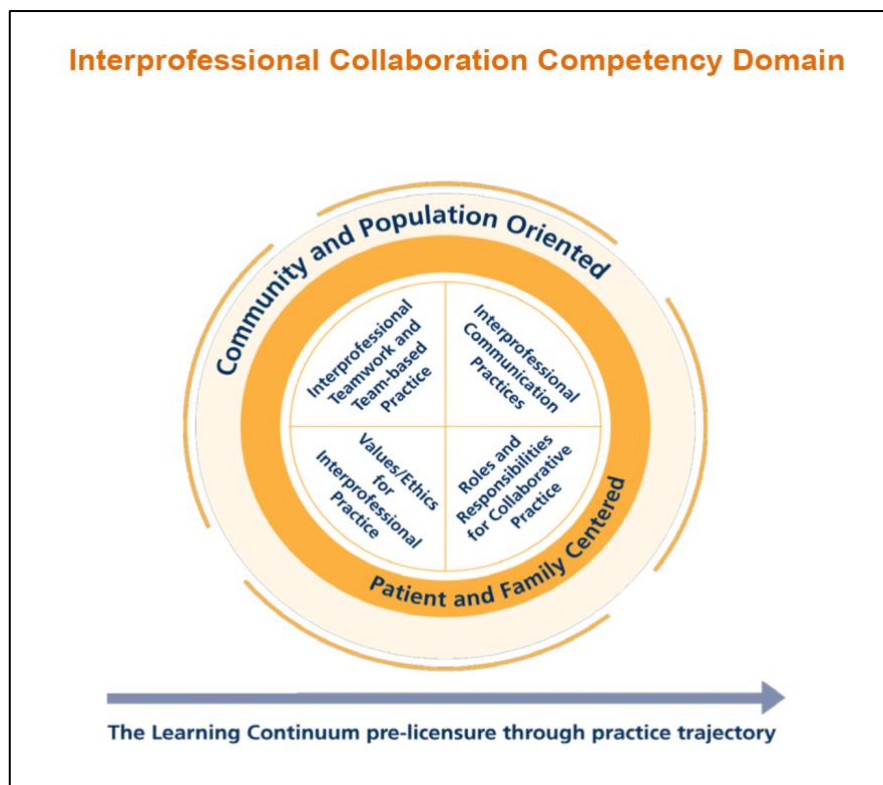
Figure 1. IPEC Interprofessional Collaboration Competency Domains (IPEC, 2016 p. 9)

The core competencies are based on a learning continuum that ranges from undergraduate (pre-licensure) studies to health professionals' practice. The framework explicitly reflects aspects of the Triple Aim (Berwick et al., 2008; IPEC, 2016). Each core competency has a set of eight to 11 sub-competencies that operationalize and specify what the domain includes. Patient- and family-centeredness are critical features across all four domains. For example, in the domain "values/ethics for interprofessional practice," Sub-competency VE5 states that students (or learners) must "work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs" (IPEC, 2016, p. 11). In addition, in the domain "roles/responsibility,"

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[1] A revision of the core competencies is in progress and is expected to be published in Fall 2023 (IPEC, 2023).

Sub-competency RR1 states that team members should "communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals" (IPEC, 2016, p. 12).

1.1.4 The patient's role in healthcare, health professions education, and IPE

The former sections have focused on policies that have influenced health professions education, the rationale for IPE, and IPE as an educational approach. The following two sub-sections delve into what is arguably the objective of everything that we do in healthcare and health professions education: the patient (Engeström, 2000).

The view of the patient in healthcare has evolved from a paternalistic relationship between medical doctors and patients to a more equal relationship (Towle et al., 2016; WHO, 2013). WHO considers patient participation and safety to be "an integral part of patient´s health rights" (WHO, 2013). In many Western countries, legislation regulates the patient's right to be involved in decisions regarding their health issues (WHO, 2013). In Norway, this is regulated through the Norwegian Patient and User Rights Act, in which §3-1 states that "the patient or user has a right to assist in the implementation of health care services" (Ministry of Health and Care Services, 1999). As much as possible, healthcare services should be designed in collaboration with the patient or client. When designing new ways to offer healthcare services, the focus should be on what the patient considers to be essential (Ministry of Health and Care Services, 1999). Sweden has similar patient legislation (The Swedish Ministry of Health and Social Affairs, 2014). Even if the legislation mainly concerns the patient's role in the healthcare system, it is also essential for educators and students in clinical placements.

"Patient-centered care," "patient participation," "person-centered care," and "people-centered care" are all terms that are used to emphasize the importance of involving individuals in decisions and discussions on their health issues. Although they all involve interactions with individuals, their definitions go beyond mere linguistic differences and have implications for practice (Eklund et al., 2019). The term "people-centered" was briefly introduced in Sub-section 1.1.1; I further elaborate on the definitions of the terms "patient-centered" and "patient participation."

Berwick (2009) described his perspective of patient-centeredness as follows:

for better or worse, I have come to believe that we – patients, families, clinicians, and the health care system as a whole – would all be far better off if we professionals recalibrated our work such that we behaved with patients and families, not as hosts in the care system, but as guests in their lives. (p. 559)

Berwick (2009) refers to three maxims that have been a foundation for patient-centeredness: (1) the needs of the patient come first, (2) nothing about me without me, and (3) every patient is the only patient (Berwick, 2009, p. 560). Berwick (2009) proposed a comprehensive definition of patient-centered care as "the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one´s person, circumstances, and relationship in health care" (p. 560). In line with Berwick's (2009) proposition, Epstein and Street's (2011) definition of patient-centeredness states that "patients are known as persons in context of their own social worlds, listened to, informed, respected, and involved in their care – and their wishes are honored (but not mindlessly enacted) during their healthcare journey" (Epstein & Street, 2011, p. 100).

Another concept in patient involvement is patient participation, which means that the patient actively participates and engages in health-related aspects (Eldh, 2019). According to Eldh (2019), "patients advocate a broad conceptualization of patient participation, including aspects such as: sharing information and knowledge, being engaged in self-care, and partnering in a shared decision-making process" (p. 1). Patient participation is considered something more than simply taking part in decisions regarding one's own health issues; Eldh (2019) argued that it is what is vital for the patient in any given situation or context that should be emphasized. In some situations, the most important aspect for the patient may be to be listened to; in others, it may the ability to manage their own healthcare interventions. Thus, Eldh's (2019) work underlines continuous dialogue with the patient on these matters. This dialogue can be supported by the Patient Preferences for Patient Participation (4P) tool that Eldh (2019, p. 2) developed based on empirical evidence collected from over 300 patients. The tool was initially intended for use in care or treatment and as a support for evaluating patient participation throughout or after the process of treatment and care (Eldh, 2019). The 4P tool include 12 items, which are summarized in Table 1.

Table 1. The 12 Items of the Patient Preferences for Patient Participation Tool (Eldh 2019, p. 2)

1) Being listened to (by health care staff)
2) One´s experience being recognized
3) Having the conditions for reciprocal communication
4) Sharing one´s symptoms/issues
5) Having explanations for one´s symptoms/issues
6) Having explanations for what is done (for oneself)
7) Learning about plans
8) Partnering in the planning of care/treatment
9) Phrasing one´s own goals
10) Being able to manage one´s symptoms/issues
11) Managing one's own health care interventions (e.g., medications)
12) Performing self-care (e.g., adjusting one's diet)

Different concepts in patient involvement are part of the curricula in the education of many health professionals, but their operationalization remains inadequate (Towle et al., 2016). In 2015, a statement about the involvement of patients in health and social care education was developed at an international conference in Vancouver, Canada (Towle et al., 2016). The statement "[aimed] to set the direction for patient involvement in education" (Towle et al., 2016, p. 21) and "to promote and ensure that the education of current and future health and social professionals includes the autonomous and authentic voices of patients and their lived experiences so that the care delivered is genuinely patient-centered" (Towle et al., 2016, p. 21). Towle et al. (2016) argued that collaboration with patients in health professions education is essential to ensure that future health professionals are prepared to work in partnership with the patient to

> a) deliver person-centred, relationship-based care; b) engage in shared decision-making; c) support self-care and resilience; d) enhance communication, and emphatic and caring relationships; e) promote patient safety and quality improvement, and f) foster shared values, inclusion, and social justice. (Towle et al., 2016, p. 21)

Patient involvement in healthcare and health professions education can occur at different levels, including the micro, meso, and macro levels (WHO, 2013). Involving patients at a micro level implies direct interactions between healthcare providers (including students) and individuals (Hardyman, Daunt, & Kitchener, 2015; WHO, 2013), while involvement at a meso level implies interactions between (representatives of) patient or interest organizations and the institutions at an organizational level (WHO, 2013), such as a hospital or in an educational context at a university or an educational institution. Finally, involvement at a macro level occurs is related to government authority and may include the proposition and implementation of laws and regulations (WHO, 2013).

The key aspects of healthcare and educational policies described in Sub-sections 1.1.1 and 1.1.2 are also central to IPE. Thistlethwaite and Moran (2010) identified, "The patient" had a central role in IPE and interprofessional learning outcomes. They found that the learning outcomes of IPE include recognizing the patient's needs, understanding the patient's perspective, working in the patient's best interest, ensuring patient safety issues, and including the patient as a partner in interprofessional teams (Thistlethwaite & Moran, 2010). Involving patients "as partners in professional and interprofessional education enhances students´ understanding of their experiences and encourages patient-centred practices" (Barr & Low, 2013, p. 22). Moreover, it has been argued that learning in authentic environments with actual patients is an essential mechanism for students to have positive experiences with IPE (Reeves, Fletcher, et al., 2016). As previously mentioned, the term "patient- and family-centered" in the IPEC core competencies is used to describe a feature of the four core competencies and sub-competencies. Moreover, the Vancouver statement prioritizes patient involvement in IPE to "facilitate a more holistic approach to patient partnerships and teamwork" (Towle et al., 2016, p. 22).

1.1.5 IPE in clinical settings

Clinical placements are ideal for learning collaborative skills (Hilton & Morris, 2001). The purpose of conducting IPL activities in clinical contexts is to provide authentic opportunities for students to practice collaboration and all that this entails. Practicing interprofessional collaboration with patients creates unique situations where the individual patient's needs create an unpredictability that is hard to include in other learning activities. Clinical learning encompasses situations in which students are active, and Thistlethwaite (2021) argues that interprofessional skills should be acquired through active learning. According to Thistlethwaite (2021, p. 220), "active learning occurs through students working in interprofessional teams under the supervision of qualified practitioners in a service-delivery setting."

This can occur through team-based interprofessional clinical placements. Brewer and Barr (2016, p. 747) defined the latter as follows:

> a dedicated and prearranged opportunity for a number of students from health, social care and related professions to learn together for a period of time in the same setting as they perform typical activities of their profession as a team focused on a client-centred approach.

Team-based interprofessional clinical placements is closely connected with what Rowland et al. (2019) described as "bedside learning." Bedside learning occurs when students learn by "being involved in patient care" (Rowland et al., 2019, p. 601). In health professions education, this type of learning has a long history. Still, it has evolved in recent years due to the shifts in healthcare organization, as much patient care now happens in outpatient clinics and ambulatory models (Rowland et al., 2019).

Two of the most important approaches to IPL in clinical settings are interprofessional training wards (IPTWs) and student-run clinics (SRCs; Thistlethwaite, 2021). IPTWs were initiated in the late 1990s in Linköping, Sweden (Dahlberg, Abrandt Dahlgren, Ekstedt, Hammar, & Falk, 2020; Wilhelmsson et al., 2009) and have inspired organizations in many countries to adopt a similar model (Oosterom, Floren, ten Cate, & Westerveld, 2019). An IPTW is defined as "an in-patient clinical ward where students from more than one health care profession (e.g., medical, nursing, physiotherapy, occupational therapy, and pharmacy students) are collaboratively responsible for patient care" (Oosterom et al., 2019, p. 547). Evaluations of learning outcomes from IPTWs have shown that students develop an enhanced understanding of other professions represented in their placement, which lasts several years after the end of the placement (Oosterom et al., 2019).

Like IPTWs, SRCs are designed to provide students with IPL opportunities. Most have been established in primary care contexts in Australia, the United States, and Canada with a dual aim: to supplement ordinary healthcare services and provide IPL opportunities in clinical settings (Kent, Martin, & Keating, 2016). For example, student teams in some SRCs have provided screenings or health assessments and referrals to other health professionals to support recently hospitalized older adults (Kent et al., 2016) or screenings and vaccinations to underserved populations with a high prevalence of Hepatitis B viral infections (Sheu et al., 2011).

IPL in clinical settings can also be pragmatic and opportunistic, pairing students from different professions who are concurrently undertaking professional clinical placements at a ward or healthcare institution (Thistlethwaite, 2021). Many interprofessional clinical placements are unique and based on a pragmatic design, such as those represented in the empirical part of this study (see Sub-section 3.3.2).

In summary, the background for this study demonstrates the diversity and complexity of healthcare, health professions education, and IPE. There are clear political guidelines for the direction that healthcare is headed. Health professions education is expected to be based on the needs of healthcare, populations, and people and thus prepare students to align with the intended direction of the policies. Future health professionals are expected to work in team-based settings and engage in interprofessional collaboration, as tasks may be allocated according to the team's composition and the patient's needs. The latter also provide a central guideline, and it is expected that patients will play a greater role as partners in the healthcare team. In the next section, I provide an overview of research from recent years and try to outline how this aligns with the expectations in the strategic and political discourse.

1.2 Research on IPE in clinical settings

As Section 1.1 reveals, global and national policies have called for health professional education to ensure future health professionals´ ability to concurrently engage in interprofessional collaboration and include the patient as a partner in this collaboration. In this section, I explore recent research on how interprofessional students learn to collaborate in clinical settings and learn to involve the patient in their collaboration.

In general, the research field of IPE is growing (Xyrichis, 2020) and the volume of studies is increasing. While conducting this literature review, I delimited the focus to review studies published within the past five years and standalone studies published between July 2020 and February 2023. The latter delimitation is because, despite a narrower scope, the study reported in the first paper that this dissertation is based on can be considered to cover many essential aspects of interprofessional clinical placements and the patient´s role between 2010 and June 2020.

I synthesized findings from various review studies and single studies on students' learning in interprofessional clinical placements to identify claims made in recent research about learning outcomes for collaboration and patient-centeredness, including partnerships with the patient. While the scope of the review studies was relatively broad, the single studies focused on team-based interprofessional clinical placements, following Brewer and Barr's (2016) definition of the term (see Sub-section 1.1.5). Studies in which students undertook IPE activities, such as shadowing professionals or interviewing team members from other professions, were not reviewed. Studies in which IPL activities were offered on an extracurricular or volunteer basis were also excluded, as these are often not articulated as

clinical placements. I acknowledge that these learning activities can contribute insights on interprofessional collaboration and IPE; however, they fall outside the scope of this literature review (see Table 2 for an overview of the studies reviewed).

The literature search was conducted in the Education Resources Information Center (ERIC) database, Cinahl+, PubMed, Web of Science (WoS), and Google Scholar. A combination of the search terms "interprofessional education," "undergraduate students," and "clinical placements" was used. Several synonymous terms were included in some databases to broaden the search (e.g., "interprofessional education OR IPE OR interdisciplinary education OR interprofessional learning"). In the rest of this section, I summarize the different studies and extract samples and findings that are relevant to the aim and scope of the literature review.

Table 2. Overview of reviewed research

	Inclusion criteria	Exclusion criteria	Reviewed papers (design and methods)
Review studies	Published 2018–2023 Undergraduate students involved in interprofessional clinical placements	Research protocols Studies involving postgraduate students	O´Leary et al. (2019; meta-synthesis) Shakovskoy et al. (2022; narrative scoping review) Mattiazzi et al. (2022; systematic review) Hopkins et al. (2021; rapid review) Walker et al. (2018; integrative literature review) Oosterom et al. (2019; literature review)
Standalone studies	Published July 2020–January 2023 Undergraduate students involved in interprofessional clinical placements, following Brewer and Barr's (2016) definition	Studies in which the main activity was shadowing professionals or interviewing team members from other professions Studies involving postgraduate students Extracurricular or volunteer work in interprofessional settings	Aggar et al. (2020; focus groups) Gudmundsen et al. (2020; ethnographic approach) Mette et al. (2021; quasi-randomized controlled study) Mink et al. (2021; pre, post, and follow-up design) Tong et al. (2021; semi-structured interviews) Beckman et al. (2022; mixed-methods, survey, and individual interviews) Claeys et al. (2022; focus groups) Conte et al. (2022; mixed-convergent parallel design, interviews, and survey) Hood et al. (2022; pre and post surveys) Hatfield et al. (2021; post survey and encounter assessment) McKinlay et al. (2021; mixed methods, pre and post survey, and focus groups) O´Connell et al. (2021; mixed methods, pre and post survey, and focus groups) Kelly et al. (2023; mixed methods, pre and post survey, and individual interviews)

1.2.1 Recent review studies on interprofessional clinical placements

First, with regard to review studies, O'Leary et al.'s (2019) meta-synthesis of challenges in interprofessional placements elucidated the potentially problematic nature of simultaneously focusing on the patient and learning outcomes from the placement. Specially designed training wards (e.g., IPTWs with a straightforward interprofessional design and an organizational infrastructure that supports such an approach) seem to be a success factor for implementing interprofessional clinical placements (O'Leary et al., 2019). Moreover, Shakhovskoy et al. (2022) presented specific recommendations for how to design clinical IPL, such as ensuring a conceptual understanding of interprofessional collaborative care for all actors involved and an adequate duration for the placement and utilizing existing opportunities (e.g., health screening programs) to structure clinical IPE activities.

Studies on IPE interventions in clinical settings have reported positive results for students´ learning outcomes when using Kirkpatrick's evaluation model (Kirkpatrick, 1996). Mattiazzi, Cottrell, Ng & Beckman (2022) revealed that IPE in clinical settings impacts attitudes and perceptions and the acquisition of knowledge and skills; however, only one-fifth of studies reported that learning outcomes impacted patient or client care. Nevertheless, the studies that reported on learning outcomes indicated mostly positive outcomes in areas such as patient experience (Mattiazzi et al., 2022).

Some reviews focused on different clinical learning contexts and clinical placement designs, such as SRC´s (Hopkins, Bacon, & Flynn, 2021), placements in rural areas (Walker, Cross, & Barnett, 2018), and IPTWs (Oosterom et al., 2019). For instance, Hopkins et al. (2021) reported positive learning outcomes for students involved in student-led clinics and addressed findings related to students' perceptions of the impact of patient-centered care. Six of the eleven studies included in Hopkins et al. (2021) rapid review reported changes in students´ ability to provide patient-centered care. The authors emphasized that several studies reported that the interprofessional clinical placement in the SRC´s increased the students' ability to obtain a more holistically patient approach to ensure that their approach suited the patient's needs (Hopkins et al., 2021).

Generally, the review studies noted that significant variation in study designs and methods, which made quality appraisal of the included studies difficult. The field of interprofessional clinical placements is underexplored, and the implementation of IPE in clinical settings remains challenging. Nevertheless, studies on students' experience of interprofessional

clinical placements have argued that their learning outcomes have been primarily positive, students have become more aware of a holistic focus on the patient, and this perspective better accounts for the patient's needs.

1.2.2 Recent standalone studies on interprofessional clinical placements

Standalone studies published within the past 2.5 years were also reviewed. While the number of hits was significantly higher than the ones referred to in this section, an initial screening showed that many studies did not apply Brewer and Barr's (2016) definition of team-based interprofessional clinical placements and were thus excluded. Ultimately, a sample of 13 single studies was reviewed (see Table 2). In line with general findings from the aforementioned review studies, a common thread in the standalone studies was that students learn with, from, and about each other in a variety of interprofessional clinical placements (Aggar et al., 2020; Beckman et al., 2022; Claeys, Dolmans, & de Nooijer, 2022; Conte, Wihlborg, & Lindström, 2022; Gudmundsen, Norbye, Dahlgren, & Obstfelder, 2020; Hatfield, Major, Purkiss, LaCour-Chestnut, & Gill, 2021; Hood, Cross, & Cant, 2022; Kelly, Stephens, Clark, Chesterton, & Hubbard, 2023; Mette, Baur, Hinrichs, & Narciß, 2021; Mink et al., 2021; O'Connell et al., 2021; Tong, Brewer, Flavell, & Roberts, 2021).

Despite positive findings on students' learning with regard to collaboration and harnessing IPE, some studies cautioned that IPE should not be romanticized and that there is no "one size fits all" solution to the design of interprofessional clinical placements; the latter are contextual and must be designed and customized for the contexts in which they will be implemented (Kelly et al., 2023). However, only one study raised doubts about students´ interprofessional learning outcomes (McKinlay, White, Garrett, Gladman, & Pullon, 2021). In the report, clinical supervisors expressed uncertainty about students´ learning outcomes with regard to interprofessional collaboration. They believed that, although the interprofessional students had learned a great deal about the relevant topic (cancer and palliative care), the same was not true of interprofessional collaboration. Interestingly, the students themselves reported positive learning outcomes with regard to the latter (McKinlay et al., 2021).

Some interprofessional students reported learning from listening to their peers' interactions with patients (e.g., through questioning or clinical reasoning; Conte et al., 2022; O'Connell et al., 2021), while others noted how joint documentation of their observations and interactions with patients in electronic health records could be a catalyst for knowledge sharing (Gudmundsen et al., 2020). Some students also became more aware of their own professional

role in collaboration through their clinical placement (Kelly et al., 2023). More positive attitudes towards interprofessional collaboration were reported after undertaking the clinical placements (Aggar et al., 2020; Beckman et al., 2022; Kelly et al., 2023; Mink et al., 2021), and some students reported having a greater ability to work in interprofessional teams (Beckman et al., 2022).

In many studies, students reported an enhanced understanding of the importance of interprofessional collaboration to provide better care and treatment to patients (Aggar et al., 2020; Beckman et al., 2022; Claeys et al., 2022; Gudmundsen et al., 2020; Kelly et al., 2023; McKinlay et al., 2021; Tong et al., 2021) and how care and treatment should follow patients' needs and not the expectations of professionals (Tong et al., 2021). They addressed concepts and terms such as person-centered care (Aggar et al., 2020; Kelly et al., 2023), partnership with the patient (Mink et al., 2021), client-centered care (Beckman et al., 2022), and what matters to the patient (Claeys et al., 2022; McKinlay et al., 2021). Moreover, many students found that interprofessional clinical placements improved their understanding and operationalization of "whole person care" (Kelly et al., 2023) or the holistic nature of IPE (Aggar et al., 2020; Beckman et al., 2022).

Some studies provided insight into how patients or their families interacted with the student team. For example, Conte et al. (2022) conducted a study in which students "invited the patient into discussions by providing medical and caring advice and explanations" in an ambulance service context (Conte et al., 2022, p. 5). In another study, O'Connell et al. (2021) examined how several student teams performed and delivered a medication therapy management review to a patient. Moreover, Kelly et al. (2023, p. 6) demonstrated how an interprofessional initiative influenced staff to encourage more social events and thus patients' mood: "having an interprofessional team of students was key to this as their efforts to work with the residents on different aspects of their well-being helped the staff to overcome barriers they had faced in encouraging sociability."

Of the reviewed studies, Claeys et al. (2022, p. 5) was the only one to explicitly recommend that patients be included in further research on team-based clinical placements "to gain better insight into their perspectives." Beckman et al. (2022) also mentioned that patients can contribute to evaluating the clinical placement model but, from what I can tell, not as a means of enhancing the patient's role. Beckman et al. (2022) attempted to illuminate the patient's

perspective in follow-ups by an interprofessional student team; however, only 5% of patients answered the provided questionnaire. Thus, it is difficult to conclude about the patients view.

Supervision was an essential part of interprofessional clinical placements in several of the studies (Beckman et al., 2022; Claeys et al., 2022; Conte et al., 2022; Hood et al., 2022; O'Connell et al., 2021). Interprofessional students reported that support and supervisor feedback were of great importance to the learning environment (Beckman et al., 2022; Claeys et al., 2022). Students emphasized that level of independence was a catalyst for interprofessional collaboration and that a balance between autonomy and support was vital for enhancing IPL (Claeys et al., 2022; Conte et al., 2022). The nursing students who were interviewed in Conte et al.'s (2022, p. 7) study expressed that "the supervisor´s facilitation skills had a great impact on learning" and emphasized the importance of a supervisor´s ability to take a step back and "let the student team step forward" (Conte et al., 2022, p. 5). In other studies, interprofessional students lacked feedback and support and noted that organizational and contextual factors influence the supervisor´s role in interprofessional clinical placements (Hood et al., 2022; O'Connell et al., 2021).

In line with the scoping review study reported in Paper 1 in this dissertation, IPL in contexts such as IPTWs (Mette et al., 2021; Mink et al., 2021), student-led clinics (Beckman et al., 2022), and primary care (Aggar et al., 2020; Beckman et al., 2022; Gudmundsen et al., 2020; Hatfield et al., 2021) remains a subject of investigation. Nevertheless, a variety of contexts was also represented, including IPE in emergency departments (Hood et al., 2022), IPE in cancer and palliative care (McKinlay et al., 2021), IPE in community pharmacies (O'Connell et al., 2021), and a novel IPE arrangement in an ambulance service (Conte et al., 2022).

The study design and methodological approaches used in the standalone studies greatly varied. This may be one reason for the difficulty of identifying interactions between student teams and patients and learning outcomes related to involving the patient and patient-centeredness. Some studies used a quantitative design, such as a quasi-randomized controlled design (Mette et al., 2021), a pre post follow-up design (Mink et al., 2021), a pre and post survey design (Hood et al., 2022), or a questionnaire and assessment tools (Hatfield et al., 2021) that focused on attitudes and students´ self-perception of IPL and competencies. Mixed-method studies were also represented. Some combined different types of questionnaires with focus group interviews (Beckman et al., 2022; McKinlay et al., 2021; O'Connell et al., 2021), while one study used a mixed convergent parallel design (Conte et al.,

2022) in which nursing students participated in focus groups and medical students answered a questionnaire. Qualitative approaches included individual semi-structured interviews (Tong et al., 2021), focus groups (Aggar et al., 2020; Claeys et al., 2022), and ethnographic approaches (Gudmundsen et al., 2020).

Despite these different designs, studies in which participants—many of whom were themselves undergraduate students—self-reported their learning outcomes and experiences were overrepresented. Of the studies that I reviewed, only Gudmundsen et al. (2020) observed a clinical placement; however, they mainly observed interactions within student teams and, to a lesser extent, their interactions with patients. Therefore, Khalili et al. (2019) recommended that empirical research on IPECP rely more on experiences and observations; although experiences were explored in the reviewed studies, there was a lack of empirical data generated through observations.

The literature review showed that the knowledge base on interprofessional clinical placements is broad. Despite the diverse scope of the reviewed studies, most reported positive outcomes for interprofessional students who participated in clinical placements. The single studies demonstrated that students acquired more positive attitudes towards interprofessional collaboration and perceived that they were better-equipped for collaborative practice after undertaking interprofessional clinical placements. However, single studies remain dominated by self-reported data from students, which were complemented by data from supervisors in some cases.

1.3 Research questions

This thesis explores what happens when health professions students undertake an interprofessional clinical placement together and the role of the patient in such an arrangement. In line with Khalili et al.'s (2019) recommendations, the empirical parts of the study (see Sub-section 3.3.) rely on observations of interprofessional students´ interactions with patients. The overarching research question for the Ph.D. project is as follows:

How is the patient included in students´ interprofessional learning and collaboration in clinical settings?

To answer the overarching research question, the following sub-questions were explored in the three papers encompassed by the dissertation:

1. How is patient participation articulated in research on undergraduate students in interprofessional clinical placements?
2. How do student teams and patients interact in interprofessional clinical placements?
3. How does supervision facilitate and support undergraduate students´ learning about patient-centeredness in interprofessional clinical placements?

2 Theoretical framework

In this chapter, I elaborate on the theoretical framework that has been central to this thesis's empirical parts.

2.1 Micro-social interactions and Goffman's dramaturgy

In Papers 2 and 3, concepts from Erving Goffman´s dramaturgical analysis (Goffman, 1990) informed the analysis of the empirical data. Goffman's work emphasizes micro-social interactions—that is, how individuals interact with each other and construct meaning in everyday life. In general, Goffman was concerned with meetings between individuals and how to characterize them by order of interaction (Aakvaag, 2008, p. 75). According to Aakvaag (2008), Goffman claimed that an order of interaction occurs every time that someone meet other people face-to-face in what he called "encounters." Goffman was concerned with actors in the encounters and how they construct them. In Goffman's sociological thinking, it is primarily in day-to-day life that the order of interaction can be identified, not in politics and other structural factors that other sociologists emphasize (Aakvaag, 2008).

Goffman (1990) used the stage as a metaphor to understand how different people act and interact in everyday life. Activities that individuals participate in for a limited period before a particular set of observers are considered a *performance* (Goffman, 1990). Goffman argued that human interactions in day-to-day life are controlled and staged; people usually strive to make the best possible impression on others. Moreover, individuals assume different roles depending on the context. They strive to be perceived as likable in their various roles and fulfill expectations. When roles deviate from expectations, it may be difficult to properly play one's role (Goffman, 1990).

Individuals use *impression management* to be perceived in the way that they want (Goffman, 1990). Impression management is about presenting oneself to others through behavior. Still, it is closely connected to aspects such as "posture, facial expression, verbal expressions, the volume of speech, tone of voice, clothes, hairstyle, body decorations, how one uses one's gaze, etc." (Aakvaag, 2008, p. 75). For instance, the audience may perceive an actor playing Hamlet in a classical costume differently than an actor playing Hamlet in a hip-hop hoodie, even if the lines that they express are identical. Goffman (1990) also elaborated on the various

roles that individuals possess or enter depending on the situation. A role is a pattern of behavior related to a person's social status in a situation. In interactions, the actors have a shared reality; for example, in an auditorium, some people perform the role of student, while others fulfill the role of professor. If the roles are switched, interactions would be disrupted, and new ways of interacting would form (Goffman, 1990).

According to Goffman's theory, the individual actor is the starting point of his dramaturgy. However, he also demonstrated that individuals are related to each other in a performance. Goffman used the term *team* to refer to "any set of individuals who cooperate in staging a single routine" (Goffman 1990, p. 6). Members of a team are in a critical relationship consisting of two components: reciprocal dependency and reciprocal familiarity. First, each member must rely on their teammates and trust that they will behave in a way that enables the team to achieve its best performance. Second, team members must develop familiarity with each other, which involves allowing the team performance to take precedence over one's individual performance.

In addition, Goffman (1990) distinguished between being frontstage, which entails performing for an audience of at least one other person, and being backstage, where performers can withdraw from the public gaze. Individuals perform frontstage when interacting with others in different settings on a daily basis; it is in this context that impression management takes place. On the frontstage, humans present themselves to others in the way that they want to be perceived depending on the role they have been awarded by the other people in the performance and the context they find themselves in.

It is only when an individual withdraws *backstage* that they can be honest and show who they *really* are (Goffman, 1990). Actors who share a backstage may address each other with different and more casual language or behavior than frontstage. The audience is often not permitted backstage (Goffman, 1990), and active measures are taken to ensure that it does not gain access. Goffman (1990) argued that a backstage is needed as a buffer against all the demands placed on performers frontstage. For a team, the backstage is a place where members can make necessary adjustments and be corrected and where costumes and performance can be examined (Goffman, 1990).

Goffman (1990) provided several examples of the discrepancy between the backstage and the frontstage. Some are related to observations made in restaurants and factories, while others are related to health services. For example, health personnel in a mental health institution want to ensure that patients appear to be in "good condition" when they are visited by relatives. They also provide patients and their families with a nice room to meet in, away from other patients. Goffman (1990) argue that what can be perceived as an excellent standard frontstage sometimes holds a quite different standard backstage. For example, in a restaurant, the area where guests eat can be neat and clean with polite and formal waiters, while the kitchen, which is out of sight from the audience, can be dirty and messy with a harsh tone between the actors. Goffman (1990) provided examples of how a performer can transition from backstage to frontstage in an instant; even those who may behave rudely towards others backstage can be perceived as empathetic and service-minded frontstage.

Interprofessional clinical placements entail a complex performance with many actors involved. Each actor has a frontstage and a backstage, and a team has a common frontstage and backstage (Goffman, 1990). Three groups of actors are central in this study: students, patients, and supervisors. When referring to students´ frontstage and backstage, I mainly talk about the student teams´ common front and backstage, not the individual. I have delimited the students´ frontstage to correspond to encounters between students and patients. Their backstage corresponds to moments when student teams are withdrawn from the patient's gaze, such as in their working area (nurse stations, meeting rooms, etc.) or informal settings, such as lunch or coffee breaks. For supervisors, the frontstage corresponds to occasions where they interact with individual students or student teams, and backstage corresponds to moments when they are withdrawn, e.g., to their office. Supervisors can also be part of formal or informal teams, who, like students, can perform frontstage, withdraw backstage, debrief, and adjust their performance. In this study, however, they are considered on an individual basis. The patient's frontstage corresponds to their performance with students and health practitioners in a healthcare context, and backstage is, for instance, their designated room where they can relax. In cases where patients have family

3 Methodology

The current study originated from a Nordic collaboration between UiT The Arctic University of Norway (UiT) and Linköping University (LiU) in Sweden and a project called "Collaborating to learn and learning to collaborate: Interprofessional education of health professionals for the 21st century." The project comprises three empirical studies—of which this study is one—whose overall aim is to explore how clinical placement arrangements facilitate students´ IPL and collaboration as part of their professional health education.

Originally, this study was planned as an empirical study involving fieldwork in a Norwegian and Swedish context. The initial fieldwork in Norway had already been completed when WHO declared a global pandemic in March 2020 and authorities decided to institute lockdown measures to prevent the spread of Covid-19. While waiting for the restrictions to ease, we were worried that the lockdown would be long-lasting and decided to redesign the study to include a scoping review study. In the fall of 2020, travel between Norway and Sweden remained restricted; thus, we also had to rethink which contexts to conduct fieldwork in. Consequently, two additional Norwegian contexts were included in the project. By contrast, fieldwork in the Swedish context was conducted by a Swedish doctoral candidate named Tove Törnqvist (TT), who further shared data.

As Figure 1 shows, the scoping review study was conducted between the two fieldwork periods, which may have caused it to be influenced by perceptions and initial analysis from the initial fieldwork. Similarly, the second stretch of fieldwork may have been influenced by findings from the scoping review. In the following sections, I elaborate on the epistemological stance adopted in the study, methodological approaches, and the methods used to generate and analyze the data.
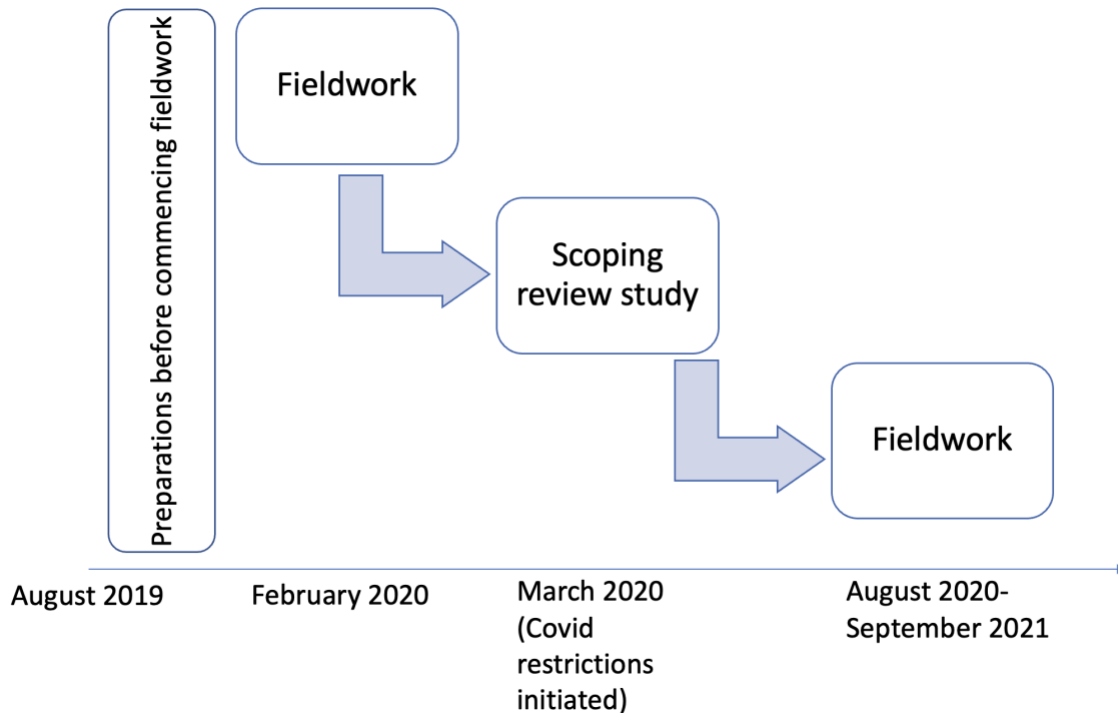
Figure 2. Overarching study design

3.1 Social constructionist perspective

This thesis is positioned within a social constructionist paradigm. This pluralist positioning suggests that "the world is produced and understood through interchanges between people and shared objects and activities" (Savin-Baden & Major, 2013, p. 62). Within this understanding, *reality* is framed as something shared with others, not something that exists independently of human beings (Berger & Luckmann, 2016). Thus, reality is intersubjective and co-created with others. As Berger and Luckmann (2016) claimed, "I cannot exist in everyday life without continually interacting and communicating with others" (p. 112). Under a social constructionist approach, human activity can be the subject of habitualization, as it is often characterized by repetition and routines (Berger & Luckmann, 2016). On the one hand, habitualization is embedded in everyday life as meaningful for the individual. On the other hand, it also leads to a narrowing of choices and "frees the individual from the burden of all [those] decisions" (Berger & Luckmann, 2016, p. 113).

Thus, how interprofessional student teams evolve and their interactions with patients depends on the social interactions between actors. The interprofessional clinical placement becomes highly complex given that the student team's reality with the patient takes place in what could be considered a constructed reality. While each student has their own everyday life, including

their habits and routines, they are also in the process of creating a new reality within their profession. They are further challenged to create a reality of interprofessional teamwork in the specific situation of the clinical placement and bring these initial experiences to other settings with different team constellations.

Consequently, this epistemological stance implies that knowledge is constructed or produced through interactions between different actors, such as the researcher and participant(s) in research. The construction of knowledge is embedded in culture, history, and materiality (Savin-Baden & Major, 2013) through language and discourse. However, some would argue that how individuals embody their lived lives also influences how and what knowledge is constructed (Nightingale & Cromby, 1999).

3.2 Scoping review study

A scoping review study aims to identify, characterize, and map "the available research on a broad topic" (Pham et al., 2014). The most common purpose is to explore the breadth of research or to map existing literature on a topic (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010; Tricco et al., 2016, p. 5). In many cases, scoping reviews are regarded as hypothesis-generating rather than hypothesis-testing, in contrast to, for example, systematic reviews (Tricco et al., 2016).

As described in the previous section, the overall epistemological stance used for the study is a social constructionist perspective. This was also what we set out with when commencing fieldwork in February 2020. A scoping review's epistemology is slightly different from a social constructionist stance. Some argue that scoping reviews can be situated within a subjectivist epistemology (Thomas, Lubarsky, Varpio, Durning, & Young, 2020). However, a social constructionist stance was emphasized when considering the overall findings.

3.2.1 Study protocol

The purpose of the scoping review study reported in Paper 1 was to "summarize and disseminate the body of literature within the field of IPE and patient participation" (Jensen & Iversen, 2020). During preparations for the study, we developed a protocol inspired by Arksey and O'Malley's (2005) seminal paper on scoping reviews and Levac et al.'s (2010) further advancement of the method. The protocol was refined following the Joanna Briggs Institute's guidance on conducting scoping reviews (Peters et al., 2015; Peters et al., 2020).

The protocol included the rationale for the study, a presentation of the tentative review question, inclusion and exclusion criteria, and the search strategy (Jensen & Iversen, 2020).

During the study, some deviations from the protocol were made. As the initial search resulted in a large volume of studies, we limited the timeframe for inclusion to 2010–2020 to ensure a manageable number of articles for screening. We also chose to exclude review studies, as we considered that only primary studies could provide insight into patient participation in interprofessional clinical placements. After the full-text screening and data extraction, we also found that we lacked a tool for identifying patient participation and found support in the previously mentioned 4P tool (see Sub-section 1.1.4).

3.2.2 Identifying potential studies and literature

Search strings were developed, and quality assurance was made in collaboration with a senior research librarian. A literature search was conducted on Cinahl+, PubMed, Scopus, Svemed+, PsycINFO, and Web of Science. Moreover, a search for gray literature was conducted in the OpenGrey database. The hits from the databases were systematized using EndNote X9.3.3 (Clarivate). Then, the web application Rayyan QCRI (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016) was used for the initial screening process (see Paper 1 for more detail).

My main supervisor Anita Iversen (AI) and I reviewed the title and abstracts in the initial screening and decided articles were eligible for full-text screening. I assessed the full-text articles for eligibility and entered them in a Microsoft Excel Spreadsheet. Data related to the research question was extracted from the studies. On several occasions, the entire research team scrutinized the extracted data and decided on a strategy for next steps in the research process.

The analysis of the included papers can be described as an iterative process. For instance, we iterated between software to support the analysis (Microsoft Excel and NVivo12) and between working individually and collectively with the research team. Moreover, iterations between theory and empirical aspects occurred throughout this process.

3.2.3 Methods of analysis

The analysis of the included studies consisted of two stages. First, a descriptive content analysis was conducted, followed by a deductive, reflexive thematic analysis. Dinçer (2018, p. 181) defined descriptive content analysis as "the analysis of previous studies based on specific criteria through frequencies and percentages." During the analysis, we categorized

and summarized several characteristics, including year of publication, country of origin, study design, clinical context, and the professions of the students included in the study. Subsequently, we calculated the frequencies and percentages of these different characteristics.

The second part of the analysis consisted of a deductive reflexive thematic analysis (Braun & Clarke, 2020). This type of analysis is characterized by the use of "existing theoretical constructs, which provide the 'lens' through which to read and code the data" (Braun & Clarke, 2022, p. 10). The 12 items from the 4P tool provided the lens through which we read the articles and thus served as predetermined codes. This enabled the studies to be analyzed through a patient participation perspective. However, at the beginning of the coding process, we found that many studies did not fall under the predetermined codes (i.e., 4P items). Thus, we added a code named "Patient participation not articulated" (Item 0) to indicate that student-patient interactions were not described.

Paragraphs, sentences, or sections in each article were coded. These had either semantic (explicit) or latent (implicit) content that could be understood within the scope of 4P. For instance, if a study explicitly reported that students in an interprofessional team listened to a patient in their clinical placement, this was coded as "being listened to" (Item 1). Latent content that underpinned the same item could be articulated through the authors' writing (e.g., "the student team interviewed patients"). Being interviewed could be identified as a situation in which the patient could have had their experience recognized (Item 2) and, in some cases, could have shared their symptoms or issues (Item 4). It could also be understood as a condition that facilitated the possibility of reciprocal communication (Item 3). Therefore, most articles were coded with multiple items; only five articles were coded with one item.

When the thematic analysis was complete, we plotted the 4P item codes in a Microsoft Excel spreadsheet that also included the studies' characteristics. This enabled the identification of patterns between the unique items (codes) and the characteristics already identified in the descriptive content analysis (e.g., context, study design, country of origin, etc.).

3.2.4 Reporting the study

To ensure transparency, the study was reported following the Preferred Reporting Items for Systematic Reviews and Meta-analysis extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018). The PRISMA-ScR provides guidance on how to report

scoping review studies to improve their reporting and relevance for decision making (Tricco et al., 2018).

3.3 Empirical studies

A focused ethnographic approach (Higginbottom, Pillay, & Boadu, 2013; Wall, 2014) inspired the empirical studies in this dissertation. Focused ethnography is a pragmatic approach in which the subject of interest is often decided before conducting fieldwork. A focused ethnographic approach usually takes place over a limited period, and the research question is often formulated in advance (Higginbottom et al., 2013).

Hammersley and Atkinson (2007, p. 3) claimed that ethnographic work aims to "investigate some aspects of the lives of the people who are being studied, and this includes finding out how these people view the situations they face, how they regard one another and also how they see themselves." By slight contrast, a focused ethnographic approach provides a "pragmatic and efficient way to capture specific cultural perspectives and to make practical use of that understanding" (Wall, 2014, p. 4). Thus, Higginbottom et al. (2013) argue that focused ethnography is especially suitable for exploring health professions education (Higginbottom et al., 2013). In the empirical studies of this Ph.D. project, the aim was to explore interprofessional students' interactions with each other and patients; thus, there was no option to be in the field for an extended period, as the students were only present in these types of placements for a limited time. Therefore, a focused ethnographic approach was considered to be especially suitable for achieving the aim of the study.

3.3.1 Study design

The empirical part of this study was designed as a collective case study (Kekeya, 2021). A case study can be defined as "an empirical inquiry that investigates a contemporary phenomenon (the 'case') in depth and within its real world-context, especially when the boundaries between phenomenon and context may not be clearly evident" (Yin, 2014, p. 16). A collective case study encompasses the definition of a case study but includes "multiple case studies which are undertaken in one or single research, to gain in-depth insights of the research topic" (Kekeya, 2021, p. 35).

3.3.2 Study contexts

The study contexts consisted of four interprofessional clinical placements involving health and social professions students with the common intention to learn about, from, and with each

other (WHO, 2010) in a clinical setting. Three placements were based in various healthcare institutions, which are hereafter referred to as "the health center," "the rehab," and "the IPTW." The fourth placement, hereafter known as "the online encounter," was digitally hosted. This placement was originally designed to take place in person, but it was adapted into an online arrangement due to the Covid-19 pandemic. After Covid-19 restrictions were lifted, students could choose whether to attend the placement online or in person. An overview of the study contexts is provided in Table 3.

Table 3. Overview of study contexts

Contexts	"The health center" (Norway)	"The rehab" (Norway)	"The online encounter" (Norway)	"The IPTW" (Sweden)
Length	Two- or four days (day shifts)	Five days (day shifts)	Eight hours	10 days (day and night shifts)
Health services provided	Intermediate care, mainly for older adults with complex health issues. Patients were admitted from a regional hospital or from home, either with a plan to return home or await long-term care at a nursing home.	Interprofessional rehabilitation for patients with complex functional impairments following illness or injury	Specialized hospital treatment Home care in an assisted living facility	Interprofessional training ward located in an orthopedic hospital ward that provides pre- and post-operative care for patients with different orthopedic issues
Patients encountered by student teams	Two to three older patients with complex health issues and either a plan to return home or await long-term care	Two middle-aged patients with acute injuries who have been in rehabilitation for a limited time	Two older patients: one in a hospital ward and one in an assisted living facility	A variation of six patients (mostly older adults) who were admitted to the ward for orthopedic issues
Instructions for students	Collaborate interprofessionally with each other when encountering and providing daily follow-up and care to patients in the ward. Write an interprofessional journal summary, including observations and suggestions for further care.	Collaborate interprofessionally with help from a detailed timetable, which shows a variety of activities for the different students to attend and take responsibility for (e.g., physiotherapy sessions, morning routines, etc.)	Familiarize oneself with the team and interprofessional work and screening and agree on what tasks to accomplish before meetings with the patient or user. Conduct an interprofessional screening with a patient or user and emphasize what is important to them. Write a proposal for an interprofessional care plan for the healthcare facility. This plan will be submitted for grading, along with an assessment of the teamwork.	The interprofessional student team oversees the daily care, mobilization, and rehabilitation of patients/ Daily activities are displayed in a timetable, including morning routines, rounds, patient meals, supervision, lunch, etc.
Participating student professions	Students from • Nursing (final year) • Medicine (final year) • Physiotherapy (final year) • Occupational therapy (final year) • Pharmacy (first year, master's level)	Students from • Nursing (second year) • Occupational therapy (final year) • Physiotherapy (final year)	Final-year students from • Nursing • Occupational therapy • Physiotherapy • Biomedical laboratory science • Social work	Final-year students from • Nursing • Medicine • Occupational therapy • Physiotherapy
Team size	Five to six students	Five students	Four to six students	Five to six students
Supervisors	Supervisors with a professional backgrounds as a - Physiotherapist - Nurse - Medical doctor	Supervisors with a professional backgrounds as a - Physiotherapist - Nurse - Occupational therapist	N/A	Supervisors with a professional backgrounds as a - Physiotherapist - Nurse - Occupational therapist - Medical doctor - Assistant nurse
Structure of interprofessional supervision	Scheduled time for interprofessional reflection ("reflection hour"; one to two hours per period)	Scheduled interprofessional supervision (three one-hour sessions)	N/A	Scheduled time for interprofessional reflection (one to two hours at the end of a day shift)

The first of three in-person interprofessional clinical placements took place at the health center, a newly established Norwegian community health center that provides intermediate care for patients admitted from the regional hospital or from home, often via the municipality's after-hours medical service. The admitted patients were often—but not

exclusively—older adults with complex health problems and a plan to either return home or await long-term care (e.g., at a nursing home). The clinical placement arrangement was recently initiated and includes health professions students who are mainly in their final year. It lasted two to four days and involved multiple student teams of five to six students, respectively two and three teams in each clinical placement period.

During the first observation period, nursing students attended uniprofessional clinical placements in the ward for two weeks and knew each other and the patients. They did not know the other team members. Team composition varied, as only nursing students who were present on day shifts were included in the teams. Each team oversaw two or three patients, for a total of six patients per period. The students provided daily care to patients, including comprehensive health assessments and different types of consultations. The teams worked concurrently and had access to designated rooms for preparations, post-encounter discussions, and consultation of the patient´s electronic health records. In the health center, clinical supervisors with interprofessional backgrounds alternated between different student teams and were mainly present in the student team´s workspace. Uniprofessional supervision was provided on request. Moreover, all students occasionally attended a supervision session to reflect on their experiences with the interprofessional placement.

The second of three in-person interprofessional clinical placements took place at the rehab, a specialized Norwegian rehabilitation institution that offers rehabilitation services to people with severe illness or injury. Patients are referred from regional hospitals and admitted for a limited time. Their age range varies, but complex functional impairments are common among admitted patients. Interprofessional placements occur annually for final-year students and last one week; there were five students in the interprofessional student team, which oversaw the treatment of two patients. The students provided daily care, physiotherapy, and occupational therapy to patients. They alternated between different rooms at the institution to prepare their encounters with the patients, hold post-encounter discussions, access patients' electronic health records, and participate in supervision sessions. A registered nurse was available in the ward to answer (practical) questions about patients, and the supervisor responsible for coordinating the interprofessional placement[2] supervised the student team at scheduled times

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[2] The supervisor had a professional background as physiotherapist.

but was not with the team during patient encounters or at other times. An occupational therapist supervisor was also available for the only occupational therapy student in the team.

The third in-person study context, the IPTW, was a well-established Swedish interprofessional training ward located within an orthopedic ward at a regional hospital. The clinical placement was compulsory for final-year students and lasted two weeks. The students alternated between day and night shifts, with five to six students per shift. The IPTW featured six beds, and the admitted patients varied as some patients were discharged and new ones were admitted. Patients were admitted acutely and electively. During the observation period, most were older adults. The student teams provided daily care, including pre- and post-operative procedures, follow-up on medical issues, and initial rehabilitation measures. Supervisors were present throughout the shift and available for questions. At the end of each day shift, the student team and the responsible supervisor conducted a supervision session, with a scheduled theme as a starting point. Themes included "my role," "the team," "the patient," and "different health professions."

Finally, in the online encounter, patients were recruited from two clinical settings, a hospital ward and an assisted living facility. Patients from both settings were older adults with comorbidities. The interprofessional team consisted of four to six health and social professional students, and the placement was estimated to last eight hours (one day). To ensure social distancing, encounters with patients occurred entirely via the Zoom video conferencing platform (Zoom Video Communications Inc, 2023). However, one student team was invited to send two team members to be physically present with the patient; thus, a hybrid encounter took place. The students were instructed to perform a comprehensive interprofessional screening based on the question, "What matters to you?" They met online to prepare for the encounter, then met the patients. Information obtained in the conversations informed the student team's design of an interprofessional care plan for the patient. Subsequently, a lecturer assessed the care plan based on a pass/fail grading scheme. No supervision was provided.

3.3.3 Involving stakeholders

Khalili et al. (2021) argued that research in the field of IPECP should "strive for the inclusion of learners, facilitators, service users, community members, and civil society as partners (e.g., as informants, data interpreters, knowledge translators)" (p. 6). Patient and public involvement in research (PPI; Staley, 2015) inspired the involvement of students in this study.

The purpose of PPI is to ensure that stakeholders "have a say in the decisions made about the research so that the methods and outcomes are more appropriate to research participants and patients" (National Institute for Health Research (NHS), 2010, p. 1). This principle was considered transferable to the involvement of students in educational research.

While preparing the fieldwork and interviews, I consulted students in two ways. First, I contacted a group of nursing students who undertook their clinical placement at the health center. They had recently completed an interprofessional clinical placement and shared their experiences of conducting the placement. This provided an initial picture of the clinical placement and how I could "fit in" as a researcher. Second, I invited interprofessional undergraduate students to join me for a coffee. To be eligible, they had to have completed an interprofessional clinical placement. Three meetings were held in an informal setting (i.e., a local university coffee shop) with two pharmacy students, three nursing students, and a recently graduated nurse. In each meeting, the preliminary project plan was presented, and participants were invited to reflect on the following questions:

- How do you perceive the focus of the project?
- How should we organize the project with the planned methods?
- What questions may be essential to ask in interviews with students, patients, and supervisors?
- What should the researcher bear in mind when conducting fieldwork?
- What are your thoughts on recruiting participants for this project?

The students were optimistic about the project's thematic approach and purpose. They provided input on when and how the researcher´s presence could be enacted (e.g., interprofessional rounds as a fruitful setting for observation or when to ask questions). Some participants problematized involvement in research as yet another task to fulfill within a clinical placement, as they perceived that placements were already "packed" with to-do lists. They also shared their perspectives on recruiting student participants, including providing information through e-mail and having clinical coordinators repeat it before the first placement day (also known as the introductory day). Participants also expressed concerns about patient participation in the clinical placements and discussed how to ensure that patients were aware of the interprofessional clinical placement happening in the ward. Their input on interview questions for different participants was incorporated into the various interview guides.

After completing the fieldwork, dialogue and analysis seminars were initiated in the health center and the rehab. Each seminar lasted one and a half to two hours and took place in the institution's meeting facilities or online. Clinical coordinators invited participating health professionals and leaders to join. The seminars included a presentation of preliminary findings from the research team´s analysis and a discussion on the healthcare practitioners and research team's perceptions of these. The seminars provided inputs to the analysis process for the research team. In addition, a brainstorming session was undertaken to assess how the interprofessional placements could proceed and progress and which foci may warrant a closer examination. During the IPTW, TT and her supervisors had similar meetings with staff at the training ward.

3.3.4 Preparations and familiarization with the field

In the health center, a clinical coordinator supported the research team in distributing information about the study to the students, the ward personnel, and patients and their families. In the rehab, an educator connected to the healthcare facility provided stakeholders with an orientation about the research project and distributed related information to leaders and staff members. For instance, they disseminated a poster with information about myself and the research project to inform inpatients and their families about the research and the reason for my presence (see Appendix 1). The tentative schedules that were designed to guide students during the placement period were helpful for planning the fieldwork (e.g., what time interviews could be conducted, or which plenary sessions could be important to observe). In the weeks before the beginning of fieldwork, several short, ad hoc meetings were held to sort out practical issues. In the online study context, a project leader with a position in the affiliated university provided an orientation about the interprofessional clinical placement. In addition, a website with information aimed at students, patients, and placement sites clarified its design and organization.

3.3.5 Participants and recruitment

Participants were recruited from three groups: patients, students, and supervisors. In the Swedish context, only students and supervisors were recruited. The only inclusion criterion was participation in an interprofessional clinical placement.

Department leaders and ward personnel recruited patient participants in different contexts. While I had control over the information provided on consent forms and documents distributed to these stakeholders (Appendix 2), the same could not be said of the oral

information provided to participants. The inclusion criteria for patient participants were good cognitive health and the ability to understand information provided about the study. The ward personnel were well-informed about the inclusion criteria to ensure a common understanding of who was eligible for the study. As an additional measure, a simplified information sheet about the study was made available to ensure that patients understood what they were consenting to (see Appendix 3); this was added to the regular consent form.

Students at the in-person placements were recruited with support from clinical coordinators. Before the introductory day, they received information about the study via e-mail, including the consent form (see Appendix 4). At the beginning of the introductory day, I provided information about the study and distributed consent forms. The students could ask questions about the study, which some did. In the Norwegian study contexts, consent from students who were not present at the introductory day was obtained via e-mail. For students in the online context, all consent forms were sent via e-mail and returned as either a scanned copy or a written text stating their consent. One of the two student teams that I observed in the online context allowed me to observe their encounters with patients, but they did not return the consent forms and declined my invitation to participate in the focus group interviews due to exams; thus, data from the observation was excluded and deleted. However, the patient from this encounter participated in an individual interview.

Supervisors were informed about the study before the beginning of the clinical placements. Most of them were also present with students on the introductory day and received verbal and written information about the study (Appendix 5). I sought out supervisors who were not present, either in person or via e-mail, to obtain written consent.

3.3.6 Generating empirical data

The empirical data for Papers 2 and 3 was generated through a focused ethnographic approach in which participant observations, including informal conversations and semi-structured qualitative interviews, constituted the main research method.

3.3.6.1 Participant observation

Throughout the interprofessional clinical placements, I participated in the students, patients, and supervisors´ interactions in daily activities in various healthcare contexts. This follows DeWalt and DeWalt's (2011, p. 1) definition of participant observation: "participant observation is a method in which a researcher takes part in the daily activities, rituals,

interactions, and events of a group of people as one of the means of learning the explicit and tacit aspects of their life routines and their culture." What was unique about the different clinical placements that I observed is that they can be considered situated and constructed (Lave & Wenger, 1991). Thus, there may not be an established life routine or culture among participants, at least not that they were aware of. From a social constructionist perspective, I believe that the participants constructed daily routines, rituals, interactions, and culture by interweaving former experiences in a similar but new healthcare context, which resulted in a "new" interprofessional interaction. In this construction, I acknowledge that my presence as a participant observer also influenced what the participants established as their work environment and routines and how they spoke about the interprofessional clinical placement with myself and each other.

Participant observation is contextually dependent. Thus, I aimed to adapt my presence to the context, activities, and actors involved in the different settings. Consequently, I made several methodological choices during each period of fieldwork. For instance, I alternated between several teams at the health center in each placement period. My priority with the teams was to participate in patient encounters with patients who consented to participate in the study. Despite preparing a tentative observation plan (see Appendix 6), my participant observations also had an intuitive character. That is, I made choices about my presence in situations that I had not prepared for and did not know the consequences that these would have for the data.

During the participant observations, I took notes in a pocket notebook as a research method. The purpose of taking notes was to support the fieldwork by enabling me to recall what had happened in a situation and develop a comprehensive text for analysis (Emerson, Fretz, & Shaw, 2011). Notes varied from detailed dialogues or single words to drawings or sketches of a situation. In this study, notes were sometimes written in situ; other times, I retreated from the situation and quickly jotted down some notes during a break from the observations. In some cases, I wrote field notes about detailed dialogue between the participants; in others, I immediately wrote a comprehensive report of what had happened in the encounter. In retrospect, I was more focused on dialogue and details during the first fieldwork period than in the later ones, in which I adopted a broader approach. I strove to be discrete while jotting down my observations and was conscious of not taking any obvious notes if an unexpected event occurred. I was also concerned about not making participants aware of my reactions to a situation and thus make them uncomfortable with my presence.

After the fieldwork, I rewrote my notes into comprehensive field notes, which are more detailed and provide thicker descriptions of a situation. The comprehensive field notes were more standardized, including metadata (e.g., time and length, place, which team was involved, and participants), observation notes, theoretical considerations, and methodological considerations. When possible, I began working on the comprehensive field notes at the end of each observation day to ensure that my memories of different situations were fresh. However, this was not always possible; thus, in many cases, I had to rewrite the notes into comprehensive notes after the fieldwork had already ended.

3.3.6.2 Informal conversations

Whenever possible, I held informal conversations with different participants. Informal conversations are common in ethnographic studies and can be used to better understand a phenomenon in the observations (Fangen, 2010; Forsey, 2010). Informal conversations occurred with all participants and often took place naturally, without any prompting on my part. Sometimes, I asked to speak with a student or a supervisor who could not attend interviews because I had unanswered questions about their relationship with the teams or patients. After the informal conversations, I jotted down what I perceived as the essence of the conversation and my impression of what had been said. In cases in which I specifically asked to speak to a participant, we found a space where we could briefly speak undisturbed. I did not take notes in informal conversations during coffee or lunch breaks, which I emphasized to participants when I provided them with information about my approach to the fieldwork. In all settings, the informal conversations allowed me to form relationships with various participants.

3.3.6.3 Qualitative interviews

Several interviews were conducted for the study, including individual, focus group, and group interviews. The group interviews had fewer participants but was inspired by the organization of a focus group, intending to let the participants drive the discussion. My role as an interviewer was to moderate participation, introduce new themes, and facilitate discussions (Krueger & Casey, 2015). Each interview depended on access to participants, the time available to participants, and available physical space (Savin-Baden & Major, 2013). Consequently, each interview was unique; the only commonality between them was my presence as an interviewer. A breakdown of the different interviews and number of participants is presented in Table 4, Row 3.

The interviews were semi-structured. A semi-structured interview implies that the researcher follows a set of pre-developed questions but also asks additional questions in response to participants' comments (Savin-Baden & Major, 2013). In the current research, pre-developed interview guides contained open-ended questions and indicated themes of interest; however, reflections and discussions about encounters between students and patients constituted the basis for the interviews. Thus, I addressed situations or actions that I had reacted to or questioned during the observations to understand participants' views on them better (see Appendices 7, 8, and 9 for the interview guides).

In general, the interviews were conducted immediately after the fieldwork. This was considered most appropriate, as the aim of the interviews was to reflect the fieldwork and the participants' memories of the patient encounters were still fresh at this point. In some cases, this led to the somewhat hasty recruitment of participants (especially student participants) to ensure they could attend the interviews. Some students could not attend the interviews due to conflicts with other planned activities. Some patients were interviewed during the placement period, either because it was considered most appropriate, or they could not participate in an interview at the end of the placement. The time point of the interview with patients was also a time priority that needed to be considered, as I could only interview a sample of participants on the last day of the placement period and wanted to ensure that I generated as many perspectives as possible when I had in-context access to participants.

First, individual interviews with patients were conducted either in the patient's room or at their home, which I considered to be more comfortable for them. Four interviews were conducted in person and two were conducted via telephone. For the telephone interviews, both patients were at home when we spoke. All inpatients had private rooms, which allowed us to speak undisturbed; the two patients who gave telephone interviews stated that they were alone during our conversation and were thus undisturbed.

Then, focus group interviews were conducted with students in meeting rooms at the healthcare facilities (respectively at the health center and at the rehab), which they were already familiar with. In total, four focus groups were conducted: two with six students each, one with three students, and one with four students. Coffee, tea, snacks, and pizza were served to make the atmosphere informal, and oval tables ensured that all participants could interact. The focus groups began with an informal introductory question, which allowed the students to "warm up." Subsequently, I aimed to introduce questions or a theme during the moderated

discussion, then allow the students to drive the conversation, as suggested by Krueger and Casey (2015). In some focus groups, I was more active if the conversation ran dry and prompted students to elaborate on topics that they had mentioned. My general perception of the four focus groups is that the discussions had good flow, but with few disagreements between the participants.

Finally, two group interviews were held with supervisors. The first group interview was conducted in a small office space at the health center, while the other was held on Microsoft Teams with the supervisors from the rehab-context. The office space allowed all participants to face each other without being separated by a table, but it felt a bit crowded. By comparison, conducting a group interview online resulted in more turn-taking and fewer free associations. This may have been caused by the difficulty of reading each other's body language and interacting as naturally as one would in a physical space. On Microsoft Teams, the "raise hand" function was liberally used; I moderated the different participants and allowed them to speak in turn.

AI was an assistant moderator in the focus group interviews at the health center and the online group interview with supervisors at the rehab. Sometimes, the assistant moderator's role is to summarize the main points of the discussion (Krueger & Casey, 2015). In this study, AI asked some follow-up questions, summarized the discussion, and took notes that were available for support during the analysis process.

Table 4. Overview of generated empirical data

Data sources	Generated data					
	Dataset A	**Dataset B**	**Dataset C**	**Dataset D**	**Dataset E**	**Dataset F**
	Used for Papers 2 and 3	Used for Papers 2 and 3	Used for Paper 2	Used for Paper 2	Used for Paper 3	Used for Paper 3
	Intermediate community health center (four-day clinical placement)	Intermediate community health center (two-day clinical placement)	Online patient encounter (20 minutes)	Hybrid patient encounter (2.5 hours)	Rehabilitation hospital (five-day clinical placement)	Interprofessional Training ward (two-week clinical placement)
Observation of interactions between students, patients, and supervisors	Field notes about team activities, patient encounters, and supervision	Field notes about team activities, patient encounters, and supervision		Field notes about patient encounter and team meeting	Field notes about team activities, patient encounters, and supervision	Field notes about team activities, patient encounters, and supervision
	Two teams Two patients Six supervisors	Three teams Two patients Five supervisors	One team One patient 0 supervisors	One team One patient 0 supervisors	One team Two patients Four supervisors	Two teams A variety of six patients Eight supervisors
(Length)	(28 hours)	(15 hours)	(20 minutes)	(2.5 hours)	(32 hours)	(70 hours)
Semi-structured interviews	Audio-recorded focus group interview with six students	Audio-recorded focus group interview with six students	Audio-recorded individual interview with one patient	Audio-recorded focus group interview with three students	Audio-recorded focus group interview with four students	Informal conversations with students and supervisors
	Audio-recorded individual interviews with one patient	Audio-recorded individual interview with one patient		Audio-recorded individual interview with one patient	Audio-recorded individual interviews with two patients	
	Audio-recorded group interview with three supervisors				Audio-recorded group interview with three supervisors	
	(Three hours)	(1 hour 45 minutes)	(33 minutes)	(1 hour 30 minutes)	(Four hours)	
Supplementary data	Documents for students about the clinical placement	Observation of evaluation meeting	Website with information about the arrangement	Website with information about the arrangement	Documents for students about IP clinical placement	Documents for students about clinical placement
						Photos of information posters displayed in the ward

3.3.7 Preparing data for analysis

All participants' names were excluded from the field notes to ensure anonymity and discretion. Anonymization was performed using several measures and discretionary

assessments. For instance, each participant was assigned an identification code[3] in the transcripts or field notes; different students were identified by the Norwegian abbreviation for their profession and a number. Thus, a nursing student could be represented in the fieldnotes as SPL1, SPL2, SPL3, SPL4, etc.[4] When rewriting the notes into comprehensive field notes, several choices were made to ensure participants´ confidentiality in addition to the identification codes, especially with regard to patient information. In some cases, the patient's gender was changed, and details about diseases, illnesses, or specialized medications were replaced by generic descriptions (Braun & Clarke, 2013). Statements made by patients, students or supervisors that could be traced back to the individual were either excluded or replaced with a generic description to ensure discretion. In Dataset F, similar measures were taken with Swedish abbreviations to represent the different participants and their professional association. The identification key was unavailable to me, as this was stored by TT.

The interview data was transcribed verbatim using the data management software NVivo (QSR International, 1999) or Microsoft Word. Field notes and transcripts were written in Norwegian to ensure proximity to the data throughout the analysis. When reporting the results of the studies, excerpts were translated into English.

3.3.8 Data analysis

While data analysis is presented as a stage that occurs *after* data is generated, it is important to acknowledge that many analytical directions are provided earlier in the research process. From a social constructionist perspective, examples include proposal writing, in which the applicants background influences choices, the selection of methodology and methods, and the iterating process between different researchers in a project.

For Papers 2 and 3, a five-step reflexive thematic analysis (TA; Braun & Clarke, 2022) was performed. TA offers the flexibility to capture both semantic and latent patterns in the data. A flexible approach was necessary for the complex data generated. The first phase of TA is immersion within the datasets to gain a deep familiarity with the content (Braun & Clarke, 2022). I was already familiar with the data generated at the health center, the rehab, and the online encounter. However, I was unfamiliar with data from the IPTW, which was generated

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[3] The identification key was stored separately from the data.
[4] "SPL" is the Norwegian abbreviation for the word "*sykepleier*," which means "nurse" (or, in this case, "nursing student").

by TT. Consequently, I paid closer attention to the familiarization process for this dataset and held several meetings and conversations with TT to ensure a shared understanding of the field notes. Nevertheless, the familiarization process was necessary for immersion within all datasets, as some time elapsed between the fieldwork and interviews and the beginning of the formal analysis process.

At the beginning of the data analysis, I re-read the field notes and interview transcripts and carefully listened to the interview recordings. The latter helped me to recall the atmosphere of the interviews and complemented the written transcripts. As a part of the analysis for Paper 2, an online data analysis workshop was arranged with people from our Nordic research collaboration, between UiT and Linköping university, on IPE. During the workshop, excerpts from the field notes and interviews were presented, scrutinized, and discussed. This catalyzed the analysis process, as it contributed to several different perspectives on the data and possible interpretations of them. A similar approach was undertaken for the dataset from the IPTW, in which my Nordic research partner and I held a thorough workshop on the data after the initial reading.

After the initial naïve reading of all the datasets, the material was re-read with more critical engagement to reflect on the different data. During this process, I made annotations about questions and comments that the material triggered. Some preliminary notions and reflections were shared with the supervisor team and further discussed.

In TA, codes are the smallest units of analysis (Braun & Clarke, 2022, p. 52). According to Braun and Clarke (2022), the coding process is an "organic and evolving process" (p. 54) and occurs without any preparations besides the research question that guides the analysis. Coding is an iterative process, which means that the researcher is forced to move back and forth in the coding process when new codes that might adjust or apply to previous data that has already been coded are generated (Braun & Clarke, 2022). As shown in Table 5, a code can be a single word or a short sentence.

Table 5. Examples of data excerpts, themes, and codes

Data extract (field note or interview, participant, context, and dataset)	Theme	Code
When we were reading and preparing for the first day and reading medical records and stuff, we got a picture of what the patient was like and their condition. (Pharmacy student, the health center, Dataset B)	Student preparations and planning	Getting to know patients
A nursing student, a pharmacy student, and an occupation therapy student are sitting around a large table. Due to a lack of space, the medical students sit a bit off to their side. The mood seems tense; the students are quiet. They don't talk to each other. The supervisor asks the group about the purpose of students being together in clinical placement. She asks, "Is it effective to do it this way? Why should we collaborate?" A student responds after some silence (maybe around 10 seconds): "it may be the best thing for the patient." (Field note, the health center, Dataset B)	Adjusting to the patient´s situation	Plenary session Better for the patient Collaboration beneficial for the patient
I feel that, for me as a nursing student, it was obvious [what to do], but she [the biomedical laboratory science student] is only in the lab and takes a lot of blood samples. They have not had any proper interaction with the patient or screening or … they analyze the [different patient] samples, so she could have had a little more supervision in advance. "What exactly are we going to do?" (Nursing student, the online encounter, Dataset C)	Need for supervision	The supervisor could make students´ roles visible Expectations of independence

The research questions for Papers 2 and 3 led to variations in the systematic coding process despite the data for both studies consisting of field notes and interview transcripts. For Paper 2, data was inductively and semantically coded with data-driven codes (Braun & Clarke, 2022; Braun, Clarke, Hayfield, & Terry, 2019). For Paper 3, a combination of data-derived (semantic) and researcher-derived (latent) codes was applied. The interview data, which consisted of statements made by students and supervisors, was characterized with semantic coding, while field notes, which often included narrative reports from the researcher's perspective, were coded with latent codes. After coding across all datasets, the supervisors' interactions with students and patients were extracted.

After the datasets were coded, an initial clustering of codes was performed to perceive the contours of a possible theme. The purpose was "to cluster codes into broader patterns that are coherent and meaningfully tell you something important and relevant in relation to your research question" (Braun & Clarke, 2022, p. 80). In this study, a theme was considered an overarching interpretation of codes with a shared meaning. The further analysis for Papers 2 and 3 was characterized by creative processes that alternated between codes and themes, mind maps, and written text. Tools such as colored markers and whiteboards were also used to stimulate creativity. In meetings with the supervisor team, the proposed themes were presented, scrutinized, revised, and refined. In fact, themes were refined and renamed throughout the writing of the papers to ensure that the final themes mirrored their content (see Table 5 for examples).

3.4 Reflexivity

Reflexivity concerns a researcher's self-appraisal (Berger, 2013) and, metaphorically speaking, what they carry in their backpack that may influence the research. According to Berger (2013), reflexivity means the

> turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation. As such, the idea of reflexivity challenges the view of knowledge production as independent of the researcher producing it and of knowledge as objective. (R. Berger, 2013, p. 220)

The term "reflexivity" is often associated in line with the abovementioned definition. However, reflexivity can, in addition to the researcher's *personal* reflexivity, encompass *functional* reflexivity, including how the methods and study design influence knowledge production, and *disciplinary* reflexivity, which involves turning the lens towards how academic disciplines shape knowledge production (Wilkinson, 1988). That being said, Wilkinson (1988) claimed that personal and functional reflexivity are often interwoven, as the researcher's values, attitudes, and interests often influence the topics under study, methodological choices, and study design.

From the beginning of this doctoral project, I strove to adopt a reflexive stance to raise a critical view of my role as a researcher, what I brought with me into the research, and how my values, attitudes, former knowledge, relationships with participants, and presence in the field influenced the project. Throughout the latter, I maintained a reflexive diary on different topics. Initially, it reflected my thoughts on my pre-existing relationship with one of the study contexts (the health center), where I had previously played different roles. Thus, I had to reflect on how this might have influenced the research process. In later stages, I wrote reflexive notes about the methodological choices that I made and my perceptions of how my presence as a researcher influenced participants.

I have had to be reflexive about how I gained access to the field and my professional background as both a registered nurse and nurse educator may have influenced participants in different contexts. For instance, in interviews with patients, I was invited into my interlocutors' lives on a much broader basis than in their meetings with the student teams. In many cases, patients were more concerned with speaking about their lives and health issues than reflecting with me on the students´ learning and how they perceived their encounters with interprofessional teams. The patients talked about their families, homes, occupations, experiences of being sick, and details about their health issues. Although they reflected on their encounters with students, it often struck me that the statements they shared with me did not always correspond to what they shared with the student teams. I am unsure what caused this, but it has been eye-opening to see how my position as a researcher—and perhaps an RN—involved so much essential trust. I reflected on how important it is for me to manage this trust in the best possible way on behalf of the Ph.D. project, the research community, and my profession.

The final issue that I want to address is one that I frequently reflected on with my supervisors and peers: the relationship between being or becoming a researcher and taking on or playing an activist role. I have been made aware by my supervisors of how the activist in me can influence my research perspective and had to work on this, especially when writing the research reports. As an RN, I have been trained to advocate for the patient. "You are the patient´s advocate" was repeated numerous times throughout my undergraduate studies and is a legacy that I continue to impart to colleagues in clinical settings and nursing students in training. Some may consider these to be idle words. However, I strive to practice what I preach, and this study is also a testament to this. Becoming a qualitative researcher is about positioning oneself and being transparent about one's identity, as the most critical tool in one's research is oneself. I have aspired to make this visible in the dissemination of my work. I do not think of my activist position as having negative connotations. Still, I acknowledge that it can interfere with my research position and that I must act wisely to ensure that my research is trustworthy.

3.5 Combining different methods

In this study, different qualitative methods were combined to generate and analyze data. Combining methods is often related to a mix of quantitative and qualitative methods, which is known as a mixed-methods study design (Pritchard, 2012). By contrast, the combination of qualitative methods has been less explored, often due to insecurity related to ontological and epistemological inadequacy, which "requires a strong sense of reflexive engagement throughout the research process" (Pritchard, 2012, p. 133). In some sense, this study can be considered a bricolage, which refers to a "construction (as of a sculpture or a structure of ideas) achieved by using whatever comes to hand" or "something constructed in this way" (Merriam-Webster Dictionary, 2023). A bricolage is multifaceted and implies research that gathers theories and approaches from different disciplines (Warne & McAndrew, 2009). A bricoleur can enhance understanding of complexity within a field or at least "move beyond the blinds of particular disciplines" (Warne & McAndrew, 2009, p. 855).

This study was initially planned as a straightforward focused ethnographic study in two clinical contexts. However, its forced redesign due to the Covid-19 pandemic led to a greater combination of methods in multiple clinical contexts. In these contexts, healthcare and education are intertwined and resulted in a more complex study of the patient's role in interprofessional education.

3.6 Ethics

Initially, the Regional Ethical Committee (REK Nord) was approached for an initial evaluation of the project (No. 55397). REK Nord stated that the latter was not subject to a presentation ("Ikke fremleggspliktig"), as it was not regulated by the Norwegian Act on Medical and Health-related Research (The Health Research Act). Subsequently, the Norwegian Centre for Research Data (No. 831589) and the Swedish Ethical Review Authority (No. 2018/46-31) approved the study (see Appendices 10 and 11, respectively). The latter approval was applicable to the data generated in the IPTW, while the former approval was applicable to the data generated in the Norwegian contexts. When we redesigned the study, a notification of change was sent to the Norwegian Centre for Research Data and approved (Appendix 12). Moreover, all data was generated following the Helsinki Declaration (World Medical Association, 2020) and the Ethical Guidelines for Educational Research (British Educational Research Association, 2018). As mentioned in Sub-section 3.3.7, confidentiality was ensured through several measures.

Initially, the data was stored in Services for Sensitive Data (TSD), a password-protected cloud service that only my main supervisor, the project leader, and I could access. However, after re-assessing the data classification, we revised our data management plan and migrated the data to a library on the cloud service Microsoft SharePoint[5] in the spring of 2022. The comprehensive field notes and interview files were encrypted to prevent access by unauthorized users. The participant key was stored on an encrypted external hard disk. Consent forms and the notebooks used for note-taking during fieldwork were stored in a locked cabinet at my office and secured with an admission card. As mentioned, the notes did not include sensitive information about participants, such as name, age, patients' health issues or diagnoses, etc.

Participants provided written consent before the data was generated and were informed that they could withdraw from the study at any time. They could provide consent for two issues: for the researcher to be present as a participant observer and for participation in interviews.

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[5] This software is recommended by the information technology department at UiT The Arctic University of Norway for storing research data that is not classified as sensitive (UiT The Arctic University of Norway, 2022).

All participants consented to take part in the observations, while some student participants and supervisors declined to participate in interviews.

At the health center, interprofessional student teams oversaw patients other than the ones recruited for this study. To ensure the discretion of other patients, my presence was coordinated in collaboration with the student teams (e.g., they invited me into the meeting room when they discussed patients who had consented to participate). When they discussed other patients´ cases, I either left the room or students anonymized the patient by giving them a fictional name and consciously omitting identifiable details about their health history; in some cases, I entered the room after the student teams had completed their review of the patient's health issues and diagnosis and began to plan their approach to the patient. At the rehab, the student team oversaw only two patients, both of whom consented to participate in the study. This allowed me to participate in all activities with the patient when appropriate.

Conducting research at a healthcare institution with patients in vulnerable situations is ethically challenging. Throughout the fieldwork, I continuously performed discretionary assessments to ensure that neither patients nor students were bothered by my presence. For instance, I did not participate in patients' morning routines to ensure their privacy. This may be a blind spot in my role as a researcher, as many interactions happen in such situations; however, I believe that I obtained insight on the latter through subsequent interviews with students and patients. From my professional perspective as a nurse, I was sometimes a bit apprehensive about some participants' cognitive status, such as older adult patients. Since I did not have first-hand information about the state of their health, they may have had issues such as hearing impairments or minor memory issues that created the perception that they were not well-informed about the study. Therefore, information about the project and their right to withdraw at any time was repeated before and throughout the interviews. However, all patients were competent to consent according to Norwegian legislation (Ministry of Health and Care Services, 1999).

To ensure that students felt comfortable with my presence, I repeatedly asked for permission to attend their encounters with patients. I also stated that my observations would not influence their grading for the clinical placement or other issues related to their professional studies. I concluded all interviews with a question about how participants perceived my presence; the overall response was that they perceived it as unproblematic and positive.

4 Methodological considerations

Methodological considerations imply a critical examination of aspects that influence different stages of the research process and outcomes (Reynolds et al., 2011; Tracy, 2010). Quality assurance in qualitative studies has been and continues to be a topic of discussion for several decades (Tracy, 2010). A review of the discourse on this matter shows that two narratives dominate: an output-oriented approach and a process-oriented approach (Reynolds et al., 2011). Tracy (2010) proposed an expansive model of quality in qualitative research that includes both approaches and suggested eight universal markers of good quality in qualitative studies: (a) a worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence (Tracy, 2010, p. 839). This model was central to considerations about the quality of this study.

4.1 Worthy topic

According to Tracy (2010, p. 840) "good qualitative research is relevant, timely, significant, interesting or evocative". As Chapter 1 of this thesis shows, the topic of this study is highly relevant for current times. A call to action was made many years ago by WHO (2010); it was followed by the Framework on integrated and people-centered health services in 2016 (WHO, 2016) and further emphasized in 2022 (WHO, 2022). These global developments demonstrate interest in collaborative care in healthcare services and its close relationship with the education of health professionals. However, the fact that this call to action remains relevant shows that change takes time. At a micro level, the current study demonstrates that much works remains to be done to facilitate a focus on the patient in IPE. Even if students and supervisors have the best intentions in interactions with patients, patients may not have as much involvement as they can and would like to.

4.2 Rich rigor

The concept of rich rigor refers to a study's requisite variety (Tracy, 2010) and "the need for a tool or instrument to be *at least as* complex, flexible, and multifaceted as the phenomena being studied" (Tracy, 2010, p. 841). Rich rigor is not a requirement for high-quality qualitative research, but it increases the likelihood of good quality (Tracy, 2010). Undoubtedly, the bricolage approach proposed for this study (see Sub-section 3.5) increased the complexity of the study and the number of perspectives on the patient's role. This may have in turn increased the richness and quality of the study. In retrospect, the scoping review

constituted an important basis for the empirical studies; however, it may also have influenced the data analysis.

4.3 Sincerity

Tracy (2010) emphasized sincerity as an end goal for a study. "Self-reflexivity, vulnerability, honesty, transparency, and data auditing" (Tracy, 2010, p. 841) all contribute to a study's sincerity. I argue that these aspects were accounted for throughout this dissertation by focusing on my role as a researcher, both as a novice researcher and a professional nurse, and how this influenced my relationships and interactions with participants. We strove for sincerity in the three papers by being transparent about the research processes and the researchers' roles.

4.4 Credibility

Credibility is a term that has been discussed by many qualitative scholars (Frambach, Van Der Vleuten, & Durning, 2013; Krefting, 1991; Tracy, 2010) and refers to the trustworthiness of the research findings. According to Geertz (1973; quoted in Tracy, 2010, p. 843), thick descriptions are obtained when "the researcher accounts for the complex specificity and circumstantiality of their data." In the empirical papers and this dissertation, I sought to illuminate the specificity of each research context and the circumstances in which data was generated. When reporting findings from the studies, many trade-offs were made regarding which data would best show rather than tell what happened in different contexts (Tracy, 2010). This was challenging, especially since many data extracts could be interesting to readers but scientific journals provide limited space for dissemination of findings. Thus, publishing studies with complex data in ordinary scientific journals arguably forces the researcher to bow to things bigger than them, which could have implications for credibility.

The concept of crystallization also contributes to a study's credibility and "encourages researchers to gather multiple types of data and employ various methods, multiple researchers, and numerous theoretical frameworks" (Tracy, 2010, p. 844). I consider crystallization to be a strength of this study. We gathered multiple types of data through a variety of methods in the sub-studies. Our research team had an interprofessional composition and consisted of researchers with various professional backgrounds and experience with various research methods. This contributed multiple perspectives on the data and the reporting of the findings.

Cross-checking or member-checking is often reported as a characteristic of rigor and quality in qualitative research (Frambach et al., 2013). This is also emphasized as a means of increasing a study's credibility. However, Tracy (2010 uses the term "member reflections," which implies that the researcher "allows for sharing and dialoguing with participants about the study´s findings, and providing opportunities for questions, critique, feedback, affirmation, and even collaboration" (p. 844). In the current study, member reflections occurred partly through the fieldwork and partly through the dialogue seminars described in Sub-section 3.3.3.

In the fieldwork, I strove to encourage member reflections but found this to be challenging. For instance, when observing interactions between participants that did not align with my professional values, it was challenging to reflectively and inquisitively discuss this with them, not impose my views as a critique. Member reflections is also related to building rapport with participants, which Paradis and Sutkin (2017) proposed in ethnographic approaches. As different actors in the interprofessional clinical placements had different tasks or activities that they were expected to undertake, I also had to ensure that I did not interfere. Consequently, I could not always directly discuss and reflect on events I was curious about with participants following situations that I had observed. Nevertheless, the interviews provided a unique opportunity to discuss different observations.

As mentioned in Chapter 3, TT and I generated the data for the empirical parts of the study. Therefore, I cannot explain in detail how all the fieldwork was conducted and how choices were made, which may cause some challenges. Sharing data is considered a political and strategic investment and is encouraged (UiT The Arctic University of Norway, 2021). We had an opportunity to engage in reciprocal data sharing because of the established collaboration between UiT and LiU, which was very valuable when the Covid-19-pandemic emerged. However, the importance of maintaining an ongoing conversation between the researcher who conducted the fieldwork (TT, in this case) and the researcher with whom the field notes are shared (myself, in this case) must be emphasized. There were occasions when we became aware of the importance of tacit aspects of observation, which must not be undermined in interpretation and analysis. This may be especially evident when the researchers are novices, which may decrease the quality of the field notes (e.g., whether we described smells, sounds, perceptions of atmosphere, etc.).

4.5 Resonance

Resonance is created through "aesthetic merit, evocative writing, and formal generalizations as well as transferability" (Tracy, 2010, p. 844). From a researcher's perspective, it is challenging to judge whether the reporting of a study resonates with readers. However, I have been concerned with telling a story rather than reporting a study throughout the writing process for the sub-studies and this dissertation; this approach was heavily inspired by Lingard and Watling (2016). The empirical part of the study was conducted in different contexts; thus, transferability is embedded in the study. However, there are contextual differences in findings from the different sub-studies. In the dissemination of the findings, I have maintained clarity and humility about their cultural and historical situatedness within the context of the fieldwork and the generated data and the fact that they may not be applicable to all settings. If the study were to be repeated, other findings may emerge as these interprofessional clinical placement arrangements evolve; moreover, the actors involved—both old and new—may contribute cultural variety.

4.6 Significant contributions

The findings from the study highlight important aspects of health professions education and the patient's role in interprofessional students´ learning, specifically for IPE. The study's contributions may not have theoretical significance for the scholarly community per se (Tracy, 2010) but rather a more heuristic significance and move people to "further explore research, or act on the research in the future" (Tracy, 2010, p. 846). A piece of informal feedback given by the research community during the revision process and dissemination of the findings in scientific forums is that the topic and findings are essential for designing specific IPE arrangements on a micro level. They may also be significant in discussions of IPE on a macro level (e.g., definitions of IPE). In addition, the study may contribute to learning content for faculty development in higher education institutions and healthcare services. Finally, I believe that the knowledge generated in this study has some practical significance (Tracy, 2010), as it may catalyze some reflections on the patient´s role for researchers, educators, or (clinical) supervisor in interprofessional clinical placements.

4.7 Ethical considerations

Ethical issues have thoroughly considered in this study, including procedural ethics, situational ethics, relational ethics, and exiting ethics (Tracy, 2010). Procedural ethics—that is, the procedures necessary to conduct research in specific contexts (Tracy, 2010)—are

examined in Section 3.5 and in the different papers. Moreover, the section on reflexivity (see Section 3.4) provides examples of situational and relational ethics and how these were enacted, especially during the fieldwork and interviews. Exiting ethics, including how the study is reported, are closely interwoven with resonance (see Section 5.5). Within the research team, ongoing discussions have been held on how to ensure the integrity of participants; at the same time, our studies have raised some critique on interactions and the inclusion of patients that may not always be thoughtfully enacted or of the best standards.

4.8 Meaningful coherence

A coherent study achieves the stated purpose and accomplish what it is meant to be about. It also uses methods and practices that are in line with theories and the paradigm that the study is positioned within (Tracy, 2010). Finally, it interconnects the "literature reviewed with research foci, methods, and findings" (Tracy, 2010, p. 848).

This study aimed to explore what happens when interprofessional undergraduate students undertake a clinical placement together and the role of the patient in such arrangements. At first, the study may seem messy, and coherence may not be apparent. Still, considering the study overall, I believe that there are connections between the different parts of the study. For instance, the coherence between the research focus, the broad literature base, and the various methods that complement each other in generating data partner well with each other.

Throughout the research process, I have also been aware of my positioning within social constructivism and how this influenced all stages of the research process, from the development of research question(s) to back-and-forth exchanges with my supervisors, my presence in the field, and how the participants and I co-constructed a reality for the placements, the analysis process within the research team and in dialogue with several of the participating sites, and the final writing of the papers. Throughout its different stages, the study has been dynamic and "alive."

However, coherence could have been strengthened by spending more time on the theoretical approach in the preparatory phase. Nevertheless, the somewhat complicated procedure of the study generated important knowledge for the IPE field to work on. Moreover, I believe that the study accomplished its aims. The close examination of interprofessional students' interactions with patients and how they are supported in their learning process is crucial. It

may contribute to the re-arrangement of interprofessional clinical placements and result in a more reflective approach to how patients are involved in such arrangements.

5 Results

In the current chapter, I summarize the main findings from the three papers on which this thesis is based. An overview of the papers is presented in Table 6. The results were used to answer the overarching research question: "How is the patient included in students´ interprofessional learning and collaboration in clinical settings?"

Table 6. Overview of the different studies

	Paper 1	**Paper 2**	**Paper 3**
Aim	To explore how patients' participation is articulated in research involving interprofessional undergraduate students who engage in collaborative learning in clinical settings	To explore interactions between interprofessional student teams and patients in clinical learning arrangements	To better understand how supervision facilitates and supports undergraduate students´ learning about patient-centeredness in interprofessional clinical placements
Type of data	73 research papers	Empirical data Datasets A, B, C, and D	Empirical data Datasets A, B, E, and F
Analytical concepts	The Patient Preferences for Patient Participation (4P) tool	Goffman´s dramaturgy	Goffman´s dramaturgy
Main findings	Significant variation in country of origin, study design, and education programs featured. Variation in context of learning arrangements: hospitals, primary care settings, and various learning arrangements specifically designed for interprofessional learning (IPL). Variation in articulation of patient participation, but lack of articulation in nearly half of studies (especially in contexts with learning arrangements specifically designed for IPL)	Patients are not always the focal point of the learning process of interprofessional students; nevertheless, they are a catalyst for the teams' work process, and interactions with patients later facilitated knowledge sharing in the student teams.	Preliminary findings showed that supervisors spend time recruiting suitable patients for IPL, but a patient focus is barely thematized during the placement. Supervisors rarely joined student teams' interactions with patients. In planned supervision, the learning process and interactions between students were scrutinized, but a patient focus was seldom considered.
Contributions to the thesis	Illuminated how patient participation is articulated in research on IPE and that it needs to be articulated to a greater extent in research on learning arrangements in which patients are essential	Student teams' interactions with patients was central to their collaborative processes and interactions. There is potential to involve patients more in the teamwork.	Supervisors are central to the development of IPL opportunities before and during placements. Valuable information and insights that support reflection and learning may be lost when supervisors only interact with students. Students lack support and feedback from supervisors on patient interactions.

5.1.1 Paper 1

The aim of Paper 1 was to explore how patient participation was articulated in research involving interprofessional undergraduate students who engage in collaborative learning in clinical settings. The results showed that the reviewed papers originated from 11 countries, with the most papers originating from the United States ($n = 23$), Sweden ($n = 13$), and Australia ($n = 12$). The methods used and study designs varied; quantitative studies were represented in 32 papers, qualitative studies were represented in 33 papers, and mixed-methods studies were represented in the remaining eight papers. Twenty-five education programs were featured in the studies, which most frequently involved medical students, nursing students, physiotherapy students, and occupational therapy students. One-third of studies were conducted at hospitals, most often within IPTWs. Another third of studies were conducted in municipal healthcare settings (e.g., home visits or nursing home facilities). The remaining third of studies were performed in various settings (e.g., SRCs, charitable community clinics, schools, etc.).

Papers that were eligible for review were deductively coded using the 12 items from the 4P tool (Eldh, 2019). Overall, 42% of studies ($n = 32$) did not articulate patient participation following the items in the 4P tool. In approximately 40% of papers, we identified descriptions of aspects related to recognizing the patient (Items 1–4). Approximately one fifth of the studies articulated how interprofessional student teams informed and explained health concerns or their action plan to patients. However, few studies noted that patients were partners in planning their care and treatment (Item 9) or actively involved in their care and treatment (Items 10 and 11). Finally, none of the studies articulated students' interactions with patients to support them in performing self-care (Item 12).

When these findings were combined with those from the descriptive content analysis with deductive TA, some unexpected results emerged. In 19 out of 73 papers, studies conducted in contexts specifically designed for IPL activities (e.g., IPTWs or SRCs) did not articulate patient participation. By contrast, studies conducted in a community health services setting seemed to provide more information about interactions between student teams and patients and thus how patients may have participated in conversations about own health issues.

5.1.1.1 Contributions of Paper 1

In terms of contributions to the field, the findings presented in Paper 1 demonstrate how patient participation is articulated in research on IPE and that it needs to be articulated in a

greater extent in research on interprofessional clinical placements in which patients are essential. We found that, in studies published between 2010 and 2020, it is sometimes difficult to gain insight into the interaction between students and patients in interprofessional clinical placements. Thus, Paper 1 highlights the need to explore interactions between students and patients in interprofessional clinical placements to a greater extent, as this has been rarely documented. These findings contribute to the discussion on the role of patients in IPL arrangements and how to raise the visibility of research on this topic, and whether interactions with patients should be more emphasized by, for example, editors of journals in the field of IPE.

5.1.2 Paper 2

The aim of Paper 2 was to explore interactions between interprofessional student teams and patients in clinical learning arrangements. Specifically, it examines how interactions between students and patients could be considered patient-centered. Comprehensive field notes, focus group interviews with students, and individual interviews with patients at the health center and the online encounter were analyzed. Drawing on Goffman's dramaturgical terms *impression management*, *backstage*, *frontstage*, *team*, and *performance,* the thematic analysis resulted in three overarching themes: (1) preparing safe and comfortable encounters with the patient, (2) including and excluding the patient in an encounter, and (3) adjusting to the patient's situation.

5.1.2.1 Preparing safe and comfortable encounters with the patient

During the students' initial preparations backstage, they were interested in each other's perspectives and connected by a shared focus on the patient. The patient played a role in the students' preparations, even when they were not physically present. The students behaved and spoke respectfully to each other and about the patient; they maintained a professional demeanor while preparing to perform frontstage with the patient. By coordinating their questions and repeating their plans, they ensured that all team members knew how to at least begin the performance. The student teams were concerned with preparing for safe and comfortable encounters with patients, regardless of information obtained about each patient.

5.1.2.2 Including and excluding the patient in the encounter

In encounters between student teams and patients, the patient was always the center of attention. They contributed to the frontstage performance by answering a series of questions from different team members during the encounter. These questions mainly focused on the

patient's medical or physical health issues. Despite the student teams' attentiveness to the patient, some patients missed the opportunity to share their concerns with the student teams. This perception also resonated with some students, who perceived that some patients seemingly felt pressured to provide "the right answers" to their questions. Surprisingly, the question "What matters to you?" was the starting point for several encounters. However, some student teams felt that it was difficult to operationalize the answers provided by patients.

5.1.2.3 Adjusting to the patient´s situation

After encounters with patients, the student teams retreated to the backstage and interactions between team members often adjusted their plan, their interaction with each other or the approach to the patient. Despite some patients' perception that they were not invited to share their story, meetings with patients influenced aspects such as the team's work process. Team members expressed different views on a patient's situation after meeting the patient than the preconception they had when preparing; nevertheless, the patient's health issues remained the focus of the students´ conversation. Moreover, team members suggested and shared different measures to improve or maintain the patient's health status. The post-encounter meetings typically had a more informal atmosphere than the preparatory meetings, and students seemed to be more relaxed.

5.1.2.4 Contributions of Paper 2

Regarding contributions to the field, the student teams' interactions with patients were central to their collaborative processes and how students interacted with each other and the patient. The students were concerned with patients' health issues and attentive to patients as recipients of treatment and care. Patients were given a role that they were both aware and not aware of, and students seemed to have intentions to pursue a patient-centered approach. However, some patients did not have an opportunity to share their personal story with the students teams, which must be addressed when learning how to engage in teamwork in clinical settings. Therefore, Paper 2 identified a potential for greater patient involvement in interprofessional clinical placements.

5.1.3 Paper 3

In Paper 3[6], the aim was to better understand how supervision facilitates and supports undergraduate students´ learning about patient-centeredness in interprofessional clinical placements. To this end, data from the participant observations and interviews with students and supervisors at the health center, the rehab, and the IPTW was analyzed. The terms *backstage* and *frontstage* from Goffman's dramaturgy informed the interpretation and analysis of the data. The TA resulted four overarching themes: setting the agenda; alternating roles, presence, and positioning; illuminating interprofessional learning opportunities; and facilitating trust and independence.

5.1.3.1 Setting the agenda

The preliminary findings showed that supervisors were central to setting the agenda for learning activities and supervision in clinical placements. Moreover, they were essential in planning and scheduling; many students used schedules as important guides in their placement. Selecting suitable patients for the interprofessional student teams was perceived by the supervisors to be essential in contexts that were specifically designed for IPL. Patients' suitability was related to the complexity of their health issues, which supervisors expressed should facilitate different students' professional perspectives to be made visible to peers. Often, the patient's perspective was not subject to supervision and scrutiny.

5.1.3.2 Alternating roles, presence, and positioning

In many observed cases, supervision occurred in the students' backstage settings, where supervisors moved in and out of the workspaces designated for student teams. In one case, the supervisors responsible for the interprofessional placement were only present at set times. In the Swedish context, supervisors went frontstage with students, but their presence frontstage was rare in other contexts. Consequently, many supervisors had limited insight on students' frontstage performance. Nevertheless, their presence backstage attracted enquiries from students, often regarding practicalities and routines. Supervisors varied their roles and presence during the shifts, from sitting in the background to overseeing supervision and reflection sessions.

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[6] In revision as of February 24th 2023.

5.1.3.3 Illuminating interprofessional learning opportunities

When supervisors were present with student teams, they pursued to illuminate opportunities for students to share knowledge and engage in IPL. Supervisors asked questions, gave examples of how an interprofessional collaboration could look like, and facilitated activities that could enhance IPL either backstage or frontstage. Some questions were directed at individual students to prompt knowledge sharing with the team, while others were addressed to the team as a whole and related to the team's work process.

5.1.3.4 Giving trust and independence

An underlying principle across the different contexts was that supervisors trusted student teams to oversee their work and work process. Thus, there were many situations in which supervisors stepped back and allowed students to reach joint decisions about plans and measures for patients. They also granted trust and independence to students for frontstage performances. Supervisors were reluctant to observe (or take control of) interactions between students and patients.

5.1.3.5 Contributions of Paper 3

In terms of contributions to the field, Paper 3 offers a perspective on how supervisors can support and facilitate students' learning about patient-centered care. Supervisors were central in developing IPL opportunities before and during placements. However, by almost exclusively working behind the scenes, they also missed out on valuable information and insights that could trigger reflection and learning with and about the patient. Although the supervisors' interactions with student teams backstage contributed to patient-centeredness, there is still potential to increase patient focus in supervision for IPL.

5.1.4 Findings revisited

The three studies conducted for this thesis view the patient in interprofessional clinical placements through various lenses: the 4P tool (Eldh, 2019), patient-centered care, or central concepts in Goffman's (1990) dramaturgy. The first paper provides insight on the discourse in the IPE research community. By contrast, the second and third papers illuminate micro-interactions between students and patients and students and supervisors. Although the use of these theoretical and analytical concepts is helpful, it may be productive to examine the overall findings from a bird's eye perspective and assess their contributions from a broader perspective.

Despite a critical view of IPL, patient participation, and patient-centeredness in the studies, I would first like to emphasize that researchers (in Paper 1), students, and supervisors (in Papers 2 and 3) all seemed to have good intentions with respect to their reporting research and their performance with the patients. None of the findings revealed any unethical aspects with the participating patients; nevertheless, some patients mentioned room for improvement, which must be carefully considered. The findings raise the question of unconsciousness in organizing and conducting interprofessional clinical placements and what I term the *taken-for-grantedness* of the patient. This may be related to the discourse within the IPE community and a perception of researchers and educators that it is obvious what happens when students and patients interact; I return to these points in Chapter 6.

The interactions between health professions students and patients took place at a micro level, which Goffman´s (1990) theory also illuminated. Paper 2 provides empirical insights on how patients are included in interprofessional clinical placements at a micro level; this is also true of Paper 1, which demonstrates the diversity of patients' participation in clinical placements involving interprofessional undergraduate students. For all the papers, it is reasonable to suggest that there is potential for greater micro-level inclusion when interprofessional student teams work with patients on supervision and research (e.g., by involving them as users or co-researchers in research on interprofessional education featuring patients).

Synthesizing findings from the three papers formed a picture of the complexity of interprofessional clinical placements. While Paper 1 provides insights on an overarching perspective of how patients' roles and participation are articulated in research on IPE, Paper 2 yielded contributions on direct interactions between students and patients, which could be considered a dyadic approach. Finally, Paper 3 clarifies relationships between students, patients, and supervisors and shows the triadic relationship between these three types of actors.

6 Discussion

This study´s purpose was to explore how different student teams interacted with each other and patients in various clinical contexts while learning interprofessional collaborative care. Patient participation and patient-centeredness were central in the three papers, while Goffman's dramaturgy informed the analysis in Papers 2 and 3. Using a scoping review method and participant observations, we generated knowledge that was not previously presented in many studies and enhanced understanding of what happens in interprofessional clinical placements.

The study generated many findings that are worth discussing. In this chapter, I focus on two of the most critical findings: (1) students´ interprofessional learning must also include the patient's perspective and partnerships with patients and (2) the supervisor plays a crucial role in supporting students´ learning about patient-centered interprofessional collaboration. I discuss these findings in light of recent research in the field of IPE, expectations on healthcare and health professions education in global and national policies, and implications for future organization of health professions education, specifically IPE.

6.1 Main findings

Throughout the three sub-studies, we identified examples of how different actors enacted patient participation and patient-centeredness. As emphasized in Chapter 4, patients and interprofessional student teams interacted in various ways. However, it seems evident that students interacted with the patient to a certain extent, then withdrew to "make up their minds" about them. Their intentions and conversations about patients were empathetic and respectful, but the patients were not included as partners within the teams. The three papers generated discussions about how health professions students can learn to involve patients in interprofessional clinical placements.

6.1.1 Learning to collaborate *and* create partnerships with the patient

The overall findings from this study suggest that students in interprofessional clinical placements play the lead role and focus on "learning about, from, and with each other" about teamwork, different roles and responsibilities, interprofessional communication, and interactions. This is positive and reflects what has been called for by strategic and political documents (Frenk et al., 2010; Ministry of Education and Research, 2012, 2017; Ministry of Health and Care Services, 2009; WHO, 2010, 2016, 2022). Even if IPL is seen as a micro

learning process (Thistlethwaite & Moran, 2010), it is also a part of an overall learning process in which it may be difficult to tell when learning outcomes come into play.

In clinical settings, IPL requires an interactive learning approach (Freeth et al., 2005), which Thistlethwaite (2021) also emphasized. The studies reviewed in Section 1.2 show that interprofessional clinical placements are designed with the concept of activity between students to ensure that they learn about, from, and with each other. The findings from this dissertation complement this result and demonstrate that student teams are eager to share knowledge and learn more about each other's professions. This implies that IPE in clinical placements leads to learning that, for instance, "emerges from dialogue, discussion and debate within the group" (Freeth et al., 2005, p. 85). However, our findings show that there may be a need to rethink who is *within* the group and potential learning outcomes if the group was expanded. Policies and strategies emphasize the patient's role and the need for them to occupy greater space in decisions about their own health issues (Ministry of Health and Care Services, 2009, 2014; WHO, 2010, 2016, 2022). In this study, students or supervisors rarely problematized the patient's perspective and role within the team, even if partnering with the patient is a central learning outcome (Thistlethwaite, 2021; Thistlethwaite & Moran, 2010).

In Papers 2 and 3 (and, to some extent, the review of the research in Paper 1), we found that patients often played a supporting role in the interprofessional clinical placement, while students occupied the lead role. This was also identified in many recent studies, see Section 1.2 (Aggar et al., 2020; Claeys et al., 2022; Conte et al., 2022; Gudmundsen et al., 2020; Hood et al., 2022; McKinlay et al., 2021; Mette et al., 2021; Mink et al., 2021; O'Connell et al., 2021; Tong et al., 2021). This confirms that it is challenging to design interprofessional clinical placements that include both a learning perspective and a patient perspective (O'Leary et al., 2019). While interacting with patients was a central component of interprofessional students´ learning process in all the standalone studies presented in Section 1.2, only a few studies explored the patient's perspective (Beckman et al., 2022; Kelly et al., 2023). That being said, students in many studies reported benefiting from learning about interprofessional collaboration with patients, which we also found in Paper 2. Still, students´ collaborative learning remained the focus of many reviewed studies (see Section 1.2) without studying what happens in the clinical setting for example, through observations.

In clinical learning activities, it is justifiable that students play a lead role. However, when learning in virtue of patient care (Hilton & Morris, 2001), the patient's needs are the source of

students' learning and they must at least *share* the spotlight with students. In interactions with patients, who are often in vulnerable situations, their views and perspectives must dominate. Many studies—as well as the current study—have shown that students become aware of this perspective through their interprofessional clinical placements, at least in theory (Aggar et al., 2020; Beckman et al., 2022; Claeys et al., 2022; Conte et al., 2022; Kelly et al., 2023). However, the findings from this thesis highlight suggest that more space must be made for the patient and that they must be invited into discussions about their own health issues. Some patients may be uninterested in or incapable of significant involvement, perhaps due to cognitive impairments or other issues, which is acceptable. I do not intend to push responsibility for care and treatment onto patients, as A. Fox and Reeves (2015) suggested might happen. However, the opportunity to be involved should always be given; if the patient cannot participate, there may be family or friends who can advocate for them within the team.

A study by Cheema et al. (2022) illustrated how patients can be involved in students learning. In their study, patients joined a case conference traditionally only attended by students and supervisors. Consequently, students and supervisors had to adjust their performance in discussions of patients' health issues in terms of how information was communicated and who was the focal point of the discussion. Students and supervisors reported mild discomfort with discussing issues such as differential diagnoses or substance abuse with patients present. However, the patients themselves perceived their presence as valuable and instructive and emphasized the opportunity to make clarifying comments to students (Cheema et al., 2022). This is an important lesson, as patients "owned" their health problems, demonstrated that they were experts on their own lives, and had a say in the discussion. Health profession students must practice interactions with patients not only as individual professionals but also as a team, with all the attendant challenges and benefits (e.g., communication between members of the team and patients). During this practice, feedback and support from supervisors can contribute to ensuring safe clinical placements that include space for learning (Hallin & Kiessling, 2016). This leads to another crucial actor in interprofessional clinical placements: supervisors.

6.1.2 Supervisors' crucial role in interprofessional education

This study and many others (Beckman et al., 2022; Freeth et al., 2005; Marshall & Gordon, 2005, 2010; Reeves, Pelone, et al., 2016) emphasize that supervisors play a crucial role in IPE. However, Thistlethwaite, Gilbert & Anderson (2022) argue that shortcomings in IPE are related to a failure to train clinical educators as interprofessional educators. As highlighted in

Paper 3, supervisors contribute to the design, coordination, and organization of interprofessional clinical placements. They are also essential supporters of students' learning process. However, as we found, the supervisors may have undermined how vital their role is for IPL. As Goffman (1990) claimed, a role refers to patterns of behavior in certain situations and is associated with expectations from actors in a performance. This is an important reminder of the supervisor's role in interprofessional placements. First, this is a role that many supervisors are unfamiliar with and may feel uncomfortable in and unprepared for (O'Leary et al., 2019). However, for interprofessional students, the supervisors role in IPL is an unfamiliar role and they may not know what to expect of it. Thus, this could be seen as a double challenge for supervisors who are assigned this role; as O'Leary et al. (2019) argued, they may "bump along" and metaphorically create a path as they walk.

The findings from this study show that, as Bleakley and Bligh (2008) suggested, supervisors in the interprofessional clinical placements ensured interactions between students and patients, with the educators serving as a support and resource. Their presence varied, and the students' independence level could be considered high, as most interactions between interprofessional students and patients occurred without the supervisor present. Moreover, thus, the interprofessional clinical placements follow the suggestion about using the "patients as the primary source for learning" (Bleakley & Bligh, 2008, p. 90). As illustrated in the subsection 6.1.1., learning in interprofessional clinical placements is a highly complex activity. Not only does it focus on learning with, from, and about different professions, which is a new experience for many students, it also involves learning with, from, and about the patient (Bleakley, 2014). This puts interprofessional students in situations and positions that they may have never experienced. Some students desire more autonomy (Claeys et al., 2022) and appreciate independence (Conte et al., 2022; Hood et al., 2022), while others crave more feedback (O'Connell et al., 2021). As Goffman claimed, being present in the background or backstage can make it difficult for supervisors to grasp student teams and individual students´ need for supervision on many aspects related to interactions with patients. By implication, supervision may become superficial and not delve into core matters in interprofessional collaboration or patients' issues. Although our findings suggest that patients are somewhat taken for granted, it also seems that supervisors in this study also took students' need for support for granted. This may be caused by the notion that team members support each other, supervisors would interfere with their work with each other and the patient, or expectations due to the students' status as seniors. The supervisors' low profile in interactions with teams

at the health center and the rehab may support such an interpretation. However, students in both contexts lacked feedback and support; in line with O'Connell et al.'s (2021) findings, they desired closer follow-up by supervisors.

The recent WHO framework on universal health coverage argues that "supportive supervision is one key to the success of the implementation of the framework – effective supervision requires that those engaging in supervision have achieved competence in the practice activity to be supervised as well as the practice activity of supervision" (WHO, 2022 p. 12). This statement is worth dwelling on. When considering the education of professionals who play a supervisory role, it is relevant to ask how, for instance, interprofessional collaboration and patient-centeredness were incorporated into the curriculum and how supervisors emphasize these aspects when providing healthcare themselves. From my perspective, it may be unrealistic to believe that supervisors should emphasize patient-centeredness in IPE and support students´ learning on this topic in the interprofessional teams if this mindset is not central to them. Different professions may highlight patient-centeredness in different ways even if it was part of their curriculum and in turn influence what is emphasized in the supervision of students. Moreover, patient-centeredness may not have been the focus of supervisors who participated in this study and thus not a topic that they explored in their supervision of interprofessional student teams. However, a vital starting point is for supervisors to be more involved with students and patients frontstage, both to provide support and to gain insight into interactions between students and patients.

A recent consensus study on educating educators in IPE emphasize patients' place in health professions education (Browne et al., 2021). Participants commented on a current "lack of involvement of patients or service users in health education" (Browne et al., 2021, p. 8) and linked this to the "changing expectations of service users" (Browne et al., 2021, p. 8), which requires a change in the supervision of students. Thus, supervisors in interprofessional clinical placements must adopt a multifocal view of the learning process. They can facilitate learning with patients by balancing students´ need for autonomy and support (Claeys et al., 2022). However, supervisors must also facilitate the patient's inclusion in students´ learning process by reminding them of why their team was constructed in the first place—the objective of healthcare is the patient, as Engeström (2000) argued—and centering the patient in teamwork.

Faculty development is considered crucial for the delivery of effective IPE (Reeves, Fletcher, et al., 2016). Supervisors' knowledge and attitude towards interprofessional collaboration and

patient-centered care may influence how they emphasize the patient's role in their supervision. It may be idealistic to believe that every supervisor will equally emphasize the patient's role. However, this must be highlighted as an important learning outcome (Thistlethwaite & Moran, 2010), as a central feature of the IPEC core competencies, and a guiding principle in the education of interprofessional supervisors. The latter may also be the core issue, as not all supervisors who interact with students in interprofessional clinical placements have had formal education as interprofessional supervisors. They may have been recruited to their supervisor role due to an interest in supervising students, but they may not be aware of the knowledge base for IPE and expected learning outcomes.

6.2 Implications of the findings

The findings from this study have important implications for the design of interprofessional clinical placements and the education of future health professionals. Over the long term, they may also have implications for the students the future ability to deliver effective healthcare services that improve health outcomes for individuals and populations, which is discussed in the following sub-section.

6.2.1 Becoming part of an enabling environment or creating it?

One of the strategies proposed in the WHO framework for integrated care is to build a more sustainable and effective healthcare system by "creating an enabling environment" (WHO, 2016, p. 9), which, among other requirements, implies a reorientation of the health workforce. An enabling environment is a complex term that involves engaging people and communities, strengthening governance and accountability, reorientating the model of care, and coordinating healthcare services around the individual's needs and demands (WHO, 2016). The term "transformational" has been used in relation to the concept of enabling environments; it is considered a complex task that involves numerous means of action. IPE can be one of the pieces that contributes to solving the puzzle and creating an enabling environment.

Frenk et al. (2010) claimed in the *Lancet* report, introduced in Sub-section 1.1.1. that universities and higher education institutions, "through their educational function, produce professionals who can implement change in the organizations in which they work" (p. 1928). This implies that the interprofessional students who participated in this study become part of an enabling environment; they may even contribute to and create enabling environments and cultures within their organizations. If this argument is valid, it provides yet another reason to

ensure that these individuals can work in interprofessional constellations, partner with patients, and be co-creators of an enabling environment for the health workforce *and* patients.

However, one may not be able to imagine what this enabling environment should include in the future. As Thistlethwaite and Xyrichis (2022) suggested in their forecast of IPE,

> [h]ealth professional students of the future may find themselves working in new kinds of teams where previously established ways of working no longer apply. Indeed, they may find themselves needing to engage in a process of reprofessionalization: re-think, reestablish, and re-assert their professional identities and roles within new kinds of teams. (Thistlethwaite & Xyrichis, 2022, p. 166)

In other words, educators and healthcare professionals must prepare for the unpreparable. This is closely related to what Binkley et al. (2012) defined as 21st-century skills. The overlap between core competencies in IPE and some of these proposed skills is clear, especially skills related to "ways of working" and "living in the world." In the first group, communication and collaboration and teamwork are emphasized by Binkley et.al (2012) as skills that are crucial for the future. In the latter, democracy and basic values such as respect, acceptance of human rights and equality, and "willingness to participate in democratic decision making on all levels" (Binkley et al., 2012, p. 55) are examples of what 21st-century skills may incorporate. In healthcare, the health issues of populations and patients will still drive developments in healthcare and health education curricula (Thistlethwaite & Xyrichis, 2022). Learning how to include the patient as a partner in teamwork, which our study showed was a challenge, may contribute to the ability of future health professionals to involve other types of team members in the future and the more significant development of 21st-century skills.

Professional educators' leadership and ownership of health professions education and interprofessional education may still be key factors in advancing health education (Frenk et al., 2010). The current official report on recruitment of health professionals by the Norwegian Ministry of Health and Care Services (2023) is a testament to this. This means that students and young professionals, which Frenk et al. (2010) highlighted as stakeholders with an essential role, must not only be willing to change but also have the capacity and competence to change. IPE is a key means of contributing to a more collaborative-ready workforce, and the findings from this study support the idea that having opportunities to practice collaboration in clinical settings is fruitful for developing skills that are conducive to collaborative practice (Hilton & Morris, 2001) and provides a different view of collaborative

practice than theoretical approaches or interprofessional simulation. By learning with, from, and about each other and the patient, future professionals may be knowledgeable and aware of each other and thus administer care and treatment for patients with the right level of care and competency, which may lead to a more sustainable organization of healthcare in the future. From the discussion in this subsection, I deduct that IPE—in both the broadest sense and specifically in relation to patients—can open students' eyes to the health system that they are part of, how they can ensure a democratic healthcare system for individual patients as teams and team members, and create an enabling environment for health professionals, patients and others involved in healthcare.

6.2.2 Mind the gap: IPE for integrated care and universal health coverage

The initial example of the classically trained actors in section 1.1 reflects a constructed situation pushed to extremes. However, it stimulates the imagination about how scenes from *Hamlet* could be enacted in a hip-hop style. While health professions education may not be as extreme, we should still be concerned about expectations in healthcare services that health professionals should have good collaborative skills and that patient-centeredness should permeate interactions between professionals and patients and their family. In higher education, we are well on our way to implementing IPE; there are numerous learning arrangements, theoretical and practical, that provide hope for a future in which collaborative practice and patient-centeredness form the backbone of services provided by health professionals. However, as the findings from both previous research and this dissertation show, there is room for improvement and conscious action in IPE in clinical settings.

Health professions education is required to keep pace with continuous change and challenges in healthcare services (WHO, 2010, 2016, 2022). A shift in how health professions education is delivered should be prioritized to ensure that health professionals are flexible and able to adjust to each other while providing patient with opportunities to be involved in their own healthcare (Frenk et al., 2010). Providing opportunities for undergraduate students to familiarize themselves with their own profession, other professions, and their relationships with each other; train in teams and identify the potential benefits and challenges of these arrangements for themselves and patients; become aware of the value of interprofessional work, similarities and differences between professions, and how all the aforementioned aspects are enacted within teams and with patients; and communicate and discover adjustments that must be made between different actors involved in healthcare prepares future

health professionals to be collaborative-ready from the day that they graduate (Barr, 2000; Frenk et al., 2010). In addition, providing opportunities for IPE in undergraduate education contributes to better-integrated healthcare services (Valentijn et al., 2013). However, for better integrated healthcare to happen, patients' taken-for-grantedness in IPE must be reduced.

As previously mentioned, enhancing patient outcomes is the ultimate aim of IPE (Thistlethwaite, 2021). The WHO framework on integrated care (WHO, 2016) and current framework on universal health coverage (WHO, 2022) were developed to enhance patient outcomes and experiences. Therefore, it is important for the design and activities of IPL to be aligned with expectations. Furthermore, IPE for integrated care should take place in clinical settings with students, and it is emphasized by Thistlethwaite (2022) that the patient's voice is crucial "in planning and delivering education".

Throughout this Ph.D. project, I became increasingly aware of the terminology used in IPE, specifically regarding patients. The IPEC (2016) core competencies advocate for patient- and family-centeredness, other central documents advocate for person-centeredness (Khalili et al., 2019), and the recent WHO framework proposes the term "people-centeredness" (WHO, 2022). As a result, there is significant confusion about the use of terminology; there does not seem to be coherence between terms used in IPE and terms used in healthcare policy documents that advocate for IPE in health professions education. In research, there may be challenges in synthesizing and comparing IPL activities to understand and enhance patient-centered, person-centered, or people-centered care. For students, confusing terminology may cause problems in understanding how to operationalize the type of care that the terms imply. This was also reported by student participants in Claeys et al.'s (2022) study, in which students problematized that learning (theory) about patient-centered care and enacting it to actual patients are two very different approaches. Finally, with regard to patients, there is a need to identify implications for the individual when terms such as "patient-centered," "person-centered," or "people-centered" care are used in IPE. It may be necessary to include all terms, but this should be reflected in central competency frameworks and problematized in faculty development and education for supervisors in clinical settings.

WHO (2022, p. 5) has been clear about this matter and argues that, by "defining a shared set of expectations and a common language, outcomes defined at the level of competence can offer increased accountability between education and employment." In the fall of 2023, an

updated version of the IPEC core competencies is expected to be released (IPEC, 2023). It will be interesting to see if the working groups succeeded in harmonizing the language of global healthcare or health education policies and competency descriptions for IPE. Currently, the IPEC core competencies are featured by a patient- and family-centered approach, but this does not explicitly involve partnering with patients and their families.

The findings from this study imply that, by continuing to design clinical placements such as the ones highlighted in this dissertation, health professionals will be collaborative-ready and able to contribute to a collaborative-ready workforce (WHO, 2010, 2016, 2022) but are still unlikely to significantly include patients in this collaboration. I share this concern with Thistlethwaite et al. (2022, p. 585), who claimed that "many health and social care professionals graduate without the requisite capabilities to work within contemporary health services that require interprofessional collaborative practice" in a letter to the editor of the scientific journal *Medical Education*. I believe that students should include the patient in collaboration under supervision and that a supervisor should support and facilitate their reflections about how and when to involve patients. However, one reason why this does not frequently occur is related to the competence of educators from both higher education and clinical settings. On the one hand, educators may remain in their "profession-specific comfort zone" (Thistlethwaite et al., 2022, p. 585). On the other hand, they may have more or less of a focus on patient-centeredness. Without practicing involvement of patient during IPL, initiating collaboration with, and including patients is much more challenging for new graduates who are entering health services. This may also have implications for future health professionals who will supervise the next generation of health professionals.

6.3 Limitations

This study focused on highly complex interprofessional clinical placements involving many actors, as it aimed to explore how interprofessional student teams interact with each other and patients. However, many perspectives were not included, such as those of other actors in the clinical settings. For example, leaders or other employees' perspectives on IPE and the patient's role in IPL could have generated fruitful insights and contributed to a better understanding of how and why the clinical placements unfolded in a certain way. Moreover, aspects such as organizational culture (e.g., "authentic" collaborative practice in which students are not present or patient-centered practice) could have informed the study.

The patient's role in IPE were very central to this study. However, there was relatively little interview data from patients.[7] Nevertheless, most of the observations that took place in the Norwegian context included patients. Before adjustments had to be made for Covid-19, all data generation had been planned for a compressed period in the initial design of the study, which could have strengthened the study´s data on the patient's perspective. That being said, the Covid-19 restrictions forced us to contemplate other contexts that we had not previously considered and made the data more diverse than originally planned. Future studies may benefit from a study design that generates more data from the patient's perspective (e.g., their perceptions of involvement in IPE). In this study, the maxim "every patient is the only patient" was applied. Although interviews with patients were relatively brief and few, their unique perspectives must be acknowledged as essential contributions to understanding involvement of patients in interprofessional clinical placements.

The theoretical concept that I chose may have limited my analytical perspective, and I acknowledge that other theories and ideas could have resulted in different interpretations. Several theoretical frameworks were considered initially in the research process (for example Cultural-Historical Activity Theory (Engeström, 2000) and Landscapes of Practices (Wenger-Trayner, 2015), but were disregarded.

7 Concluding remarks

In this thesis, I explore how interprofessional student teams interact with each other and patients in various clinical contexts. We gained insight into what happens in interprofessional clinical placements in diverse settings; some were in their infancy, while others were more established. The methods used to generate data provided opportunities to identify what happens in interprofessional clinical placements and when reporting research on these placements. The findings from this study show that students' collaborative learning is the focus of interprofessional clinical placements and that patients may be taken for granted. The preliminary findings from Paper 3 also enhance understanding of the supervisor's role in interprofessional clinical placements and how it is enacted with patients.

As argued, there is room for greater awareness of including the patient and their perspective in IPE. IPE and interprofessional clinical placements can significantly contribute to a

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[7] Two interviews from the rehab remains to be analyzed for a planned Fourth paper.

collaborative-ready workforce. This learning arrangement can also ensure that future health professionals are familiar with team-based approaches and better-integrated care for patients. Interprofessional clinical placements can strengthen students' future ability to be co-creators of enabling environments in healthcare; thus, working with other professionals and patients in partnerships is crucial. Moreover, it is essential to provide opportunities to practice interprofessional collaboration with supervision and support to enable students to determine where and what to further develop.

Interprofessional clinical placements are diverse and, in many cases, in their infancy. Students are unfamiliar with the learning environment, supervisors are unfamiliar with their role, and patients are used to being approached by one professional at a time. This creates complex challenges for the design of interprofessional clinical placements. One aspect concerns the space given to patients in interactions with students; another is the supervisor's competency and ability to show students how to work patient-centered. Both of these aspects generate new research questions to explore in the future.

I acknowledge that many healthcare and health professions education processes exist simultaneously. These shifts cause great demands for students, supervisors, and patients, and it is essential to accept that implementing IPECP is a work in progress and that we need to take one step at a time. Preparing health professionals for the future is an issue for healthcare services and health professions education to collaborate on. To be or not to be, was the question asked in the introduction. Through this thesis I have argued that IPE and the partnership with the patient is what needs *to be* in the future. I have a strong belief that educators and clinicians will step up and prepare future health professionals for a knowledge and skills base in collaborative practice where they can tackle whatever genres they are confronted with.

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Papers 1-3

Paper 1

Jensen, C.B., Norbye, B., Dahlgren, M.A., & Iversen, A. (2022). Patient participation in interprofessional learning and collaboration with undergraduate health professional students in clinical placements: A scoping review. *Journal of Interprofessional Education & Practice*. DOI: 10.1016/j.xjep.2022.100494

Review

Patient participation in interprofessional learning and collaboration with undergraduate health professional students in clinical placements: A scoping review

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ARTICLE INFO

ABSTRACT

Undergraduate students obtaining interprofessional education (IPE) in clinical placements are expected to develop patient- and family-centered competencies; however, the patients' role in IPE requires attention. We explored how patient participation was articulated in the IPE research and literature from 2010 to 2020. 73 articles were eligible for inclusion and were subjected to a two-folded analysis. Characteristics included publication year, country of origin, study design, and varied contexts. Studies were conducted in hospitals, primary care, or a variety of settings (one-third each) and 25 different education programs were represented; however, students from medicine, nursing, physiotherapy, and occupational therapy were on the healthcare teams most often. In 42% (n = 32) of the studies, patient participation was not articulated. Most studies articulating patient participation showed partial participation; for example, how interprofessional students recognized and informed patients. Few studies described extensive patient participation; however, some noted patients' active participation in care planning and treatment and the student–patient relationship. This review provides novel insight into how patients' participation in interprofessional clinical learning is articulated. We believe that acknowledging patients' role in IPE is necessary to improve the provision of healthcare services and to promote IPE as a patient- and family-centered practice. Our results may contribute as an input into the academic discourse in IPE and have implications for future publications within the research field.

1. Background

A variety of Interprofessional Education (IPE) initiatives have been implemented to prepare undergraduate students for interprofessional teamwork. Learning arrangements such as case-based interprofessional discussions in small groups, large group lectures, simulation training, online learning activities,[1] and interprofessional student teamwork in clinical placements[2–4] have been explored.

The different arrangements can enhance students' understanding of their role and the roles of other professionals in relation to themselves, as well as challenge their beliefs and attitudes regarding interprofessional collaboration. While some learning outcomes of IPE can be addressed through learning arrangements based within higher education institutions, e.g., lectures or simulation, others must be addressed in clinical workplaces. Learning in clinical settings with authentic patients may be "the ideal learning environment for developing skills conducive to collaborative practice"[5]; p. 173). Meeting patients with varied needs and expressions can affect both team dynamics and emotions,[2] thus contributing to learning. Previous research has synthesized six learning outcomes for IPE[6]— teamwork, roles/responsibilities, communication, learning/reflection, the patient, and ethics/attitudes.

Learning outcomes related to "the patient[1]" encompass "the patient's central role in interprofessional care (patient-focused and patient-centered care); understanding of the service user's perspective (family/carers); working together and cooperatively in the best interests of the patient; patient safety issues; recognition of patient's needs, and patient as a partner within the team"[6]; p. 511).

Different frameworks support educators in planning how students

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[1] In this study, "patient" is used in its broadest sense to refer to patients, clients, users, and/or family caregivers.

can "develop the attributes required for them to be effective members of healthcare teams in their future practices"[7]; p. 873). As illustrated in Fig. 1, the IPEC expert panel[8] suggested four competency domains that were embraced from a community- and population-oriented approach with a patient- and family-centered focus. The patient- and family-centered aspect is implemented in all domains. However, "values/ethics for interprofessional practice" emphasize patients' cultural diversity, interests, cooperation, and the provider–patient relationship as central.

1.1. Patient-centered care and patient participation

There are multiple definitions of patient-centered care. Epstein and Street[9] constructed the definitions as follows:

"Deep respect for patients as unique living beings, and the obligations to care for them on their terms. Thus, patients are known as persons in context of their own social worlds, listened to, informed, respected, and involved in their care – and their wishes are honored (but not mindlessly enacted) during their health care" (p. 100).

According to Epstein and Street[9]; patients should be invited to become active participating partners in consultations and meetings regarding their healthcare. Consequently, patients and health professionals can create a personal and individualized care and treatment path. Eldh et al.[10] argued that an invitation to participate is insufficient and emphasized that true patient participation is present when health professionals "recognize each patient's unique knowledge and respect the individual's description of [their] situation." (p. 503). When exploring this from a patient perspective, interviewed patients claimed that it is important for them to be actively involved, that health personnel are attentive, and that there is a connectedness between them and care providers.[11]

Eldh[12] developed a clinical tool— Patient Preferences for Patient Participation (4P)— based on patients' views of what they considered participation to be. The 4P-tool was meant to be used for conversations between health professionals and patients so that planning, follow-ups, and evaluating healthcare interventions supported patients' participation.[12] The 4P-tool includes 12 items:

(1) Being listened to (by healthcare staff)
(2) One's experience being recognized
(3) Having conditions for reciprocal communication
(4) Sharing one's symptoms/issues
(5) Having explanations for one's symptoms/issues
(6) Having explanations for what is done (for oneself)
(7) Learning about plans
(8) Partnering in planning of care/treatment
(9) Phrasing one's own goals
(10) Being able to manage one's symptoms/issues
(11) Managing healthcare interventions oneself (such as medications)
(12) Performing self-care (e.g., adjusting diet)

1.2. Aim of this scoping review

We aimed to gain insight into how patients participate when they meet interprofessional undergraduates who undertake learning in clinical settings. The following question was investigated— how is patient participation articulated in research on undergraduate students taking part in IPE in clinical placements? The responses to this question will inform how patient participation can be identified in varied IPE research. This coincides with the global research priorities within the field of Interprofessional Education and Collaborative Practice (IPECP), which calls for a continuous evaluation and integration of "the perspectives and expectations of patients, clients, and caregivers related to IPECP"[13]; p.14).

2. Methods

2.1. Protocol

The study protocol was initially inspired by Arksey and O'Malley's[14] framework for scoping reviews and Levac et al.'s[15] recommendations concerning methodology advancement. It was further refined according to the guidance for scoping reviews from the Joanna Briggs Institute.[16,17] The draft protocol was revised by our research team, including two health educators and researchers in the IPE field. A final version was registered in Open Science Frameworks repository on July 2, 2020.[18]

2.2. Eligibility criteria

We considered peer-reviewed primary studies with both quantitative and qualitative methodologies and gray literature. Eligible works had to be written in English or Scandinavian (Norwegian, Swedish, or Danish) and describe an interprofessional learning arrangement in which undergraduate students interacted with patients. This review followed the Preferred Reporting Items for Systematic Reviews and Meta-analysis extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco, 2018).

2.3. Search strategy

The first author (CBJ) conducted the searches in accordance with the search strategy protocol. The initial and limited search for articles was carried out on the Cinahl+, PubMed, and Scopus databases to identify eligible search terms. Index terms in the different databases were identified and an article on search strategy[19] inspired certain text word terms identified as most used for IPE.

The main search for literature commenced in May 2020 in seven databases— Cinahl+, PubMed, Scopus, Svemed+, PsycINFO, and Web of Science (Appendix 1); further, OpenGrey was used to search for gray literature. A senior research librarian was consulted on several occasions to help validate the quality of the search string. The final search was conducted on June 8, 2020, which resulted in 4903 articles and 44 gray literature items were identified. These were imported to the citation management system, EndNote X9.3.3 (Clarivate), where de-duplication was performed and articles/literature in languages other than English or Scandinavian were removed. Articles outside the time frame (2010–2020) were removed. A total of 2503 papers were included after the screening and selection process.
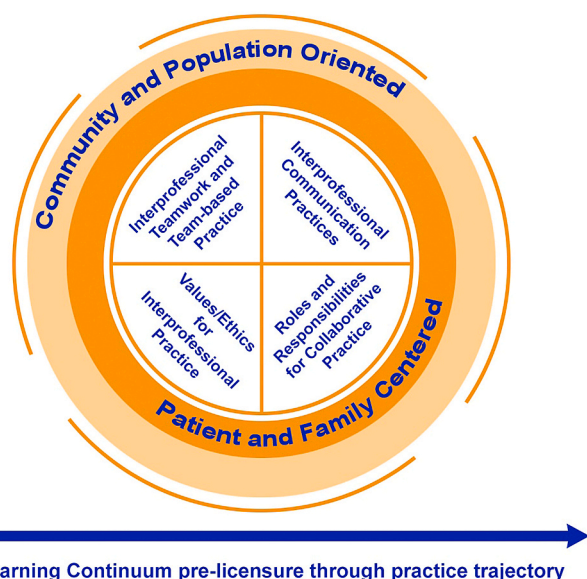

The Learning Continuum pre-licensure through practice trajectory

Fig. 1. Interprofessional collaborative practice domains.[8]

2.4. Identification of potential studies and literature

References from articles were exported by EndNote X9.3.3 (Clarivate) to the web application for systematic reviews, Rayyan QCRI.[20] Two reviewers (CBJ and AI) blindly screened titles and abstracts in Rayyan QCRI. Reviewers had three planned meetings during the screening process to discuss nuances in the inclusion and exclusion criteria and to synchronize labeling of excluded articles. In cases where abstracts were unavailable in Rayyan QCRI or the scope of study was unclear, full-text papers were retrieved in Google Scholar and skimmed to deduce their eligibility. This screening yielded 49 articles. Minor differences in reviewers' interpretations of article content were resolved through discussion until consensus was reached.

Full-text articles were then assessed for eligibility. Data extraction was performed parallelly with the eligibility assessment. CBJ and AI examined a random sample of five papers to pilot the data extraction form. The remaining articles were screened by one reviewer and data were charted in a Microsoft Excel spreadsheet[2] that included author name, title, year, country of origin, aim/purpose, population, method/methodology, context, description of student preparation, description of learning arrangement, patient/client/user characteristics, patient participation described (Yes/No), education programs involved, if it was eligible for inclusion (Yes/No), and the reason for exclusion (if not eligible). The extracted data were scrutinized by the research team. Exclusion was owing to one of the following reasons:

- Students did not interact with patients/clients/users
- Patients' encounters or characteristics were not described
- The interprofessional team included postgraduate students or students in continuing education programs
- Could not obtain full-text

Reference lists of eligible peer-reviewed studies were examined to identify literature that had not been included in the main search results. Only titles of gray literature items were screened. We did not examine reference lists for gray literature. Peer-recommended articles were also screened. Finally, 73 articles were included for review. The search process is shown in Fig. 2.

2.5. Deviation from the study protocol

Two deviations were made from the study protocol[18] because of the large volume of initial hits— 1) the time frame was limited to 2010–2020 to ensure that studies published after the strengthened global policies on Interprofessional Education[98] were included; and 2) all types of review articles were excluded as we wanted to explore primary studies. Review articles obtained in the initial search (n = 136) were briefly examined to ensure that the topic of our scope was not previously explored.

After full-text screening and data extraction, many of the included studies either lacked or had scarce descriptions of how the patient or family participated in the IPE arrangement. We therefore needed a set of tools to understand what patient participation in IPE could be and how it was elucidated. This gave us the opportunity to look at the studies from a different perspective than the original researchers.

2.6. Analysis of extracted data and full-text items

CBJ acted as the main investigator throughout the analysis process and met the research team once or twice per month during the review period to scrutinize and discuss process and preliminary findings. The process was iterative, and we analyzed extracted data in multiple rounds. We iterated between individual and collective work, between the different software for analysis (Microsoft Excel and QSR International's NVivo12), and between former theoretical knowledge and the present empirical aspects.

The original data extraction spreadsheet was reduced to a less-detailed version[3] including author names, year of publication, country of origin, study design, clinical context, and health education programs. This constituted the basis for a descriptive content analysis where the different characteristics were quantified. The characteristics were selected as they were considered the most relevant to answer our research question.

After quantification, full-text PDF files of included studies were imported to NVivo12[22] where a deductive reflexive thematic analysis[23] was conducted. To capture the patients' perspective, the 12 items from the 4P-tool constituted the predetermined codes. An additional item was constructed and labeled item 0— "patient participation not articulated"— which indicated that student-patient interaction was not described.

In the deductive reflexive thematic analysis, paragraphs, sentences, or sections in each article were coded. These had either semantic (explicit) or latent (implicit) content that could be understood within the purview of 4P. For example, if a study explicitly expressed that students listened to a patient in a learning arrangement, this was coded as "being listened to" (item 1). Latent content that underpinned the same item could be articulated through the authors' writing, for instance, that "the student team interviewed patients." Being interviewed could be identified as a situation in which it was possible for the patient to have their experience recognized (item 2) and in some cases, have the opportunity to share their symptoms or issues (item 4). It could also be understood as a condition that facilitated the possibility for reciprocal communication (item 3). Therefore, most articles were coded with multiple items (i.e., only five were coded with a single one).

After conducting thematic analysis, the codes identified in each article from the 4P items were plotted into the Microsoft Excel spreadsheet which made it possible to identify patterns between the unique items (codes) and the characteristics already identified in the descriptive content analysis.

3. Results

3.1. Search results

The searches from the seven electronic databases (including OpenGrey) yielded 4947 records— 2503 titles and abstracts were screened. Then, 2340 articles and 5 gray literature items were excluded in accordance with the eligibility criteria. Next, 158 articles were retrieved in full-text. Of these, 93 articles were excluded. This resulted in 65 potential articles relevant to our scoping review. Subsequently, their reference lists were scanned for articles missed through the search, which yielded 42 potential articles; however, 11 were duplicates and were thus excluded. Thirty-one articles remained after de-duplication, which were assessed for eligibility, out of which 24 were excluded, and seven met the inclusion criteria. One additional article was obtained from a peer recommendation. Therefore, 73 articles were analyzed.

3.2. Characteristics of included studies

Included studies were published between 2010 and 2020 (Table 1). Among the studies, 59% were published between 2016 and 2020. The remaining 41% were evenly spread out over the first five years of the decade.

The 73 included items originated from 11 countries. One-third were published in the US (n = 23), followed by Sweden (n = 13) and Australia (n = 12). The remaining items originated from the UK (n = 6), Norway (n = 6), Denmark (n = 5), Brazil (n = 2), Canada (n = 2), Germany (n =

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[2] Available on request from the corresponding author

[3] Available on request from the corresponding author
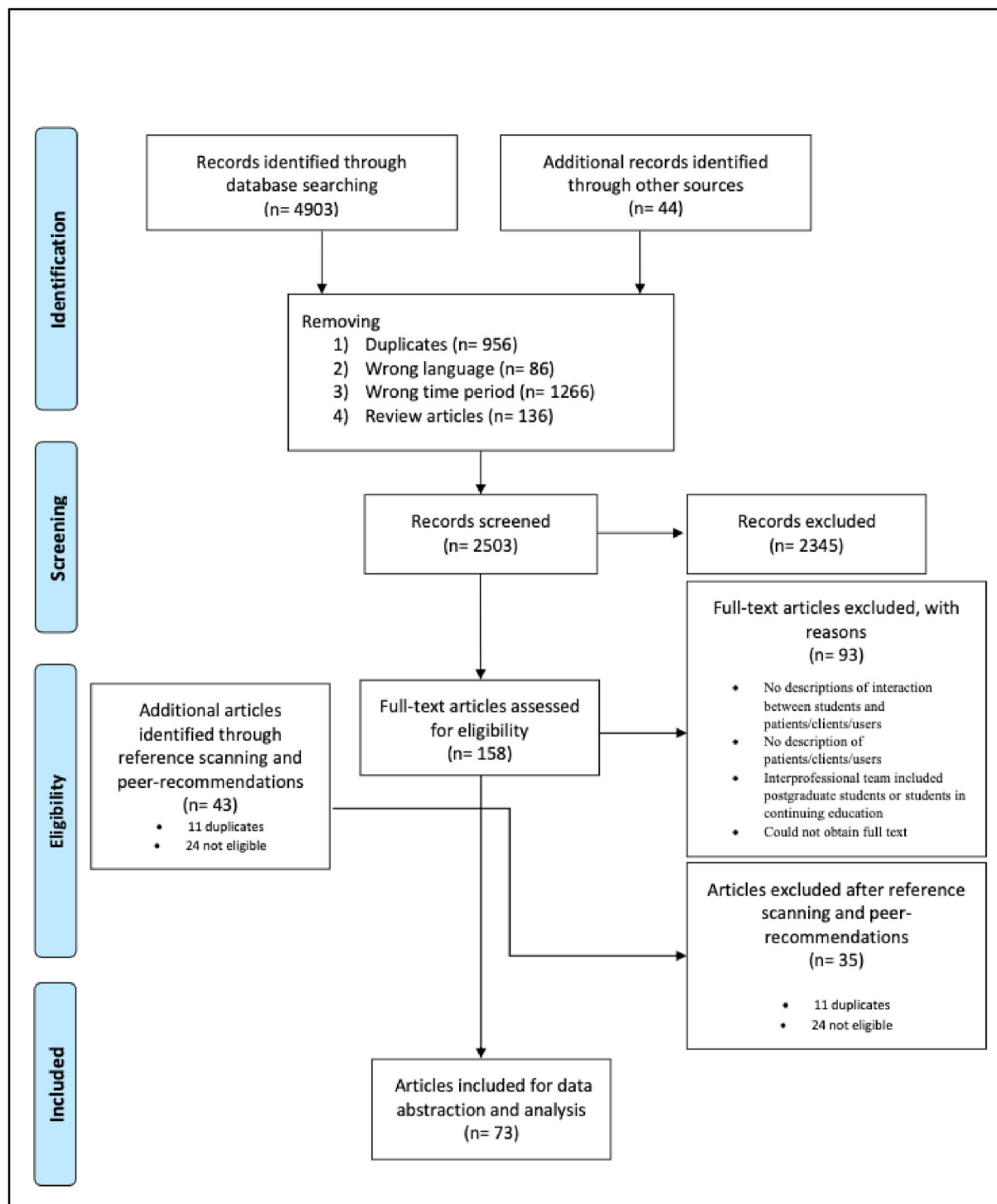
Fig. 2. PRISMA Flow diagram for study selection.[21]

2), New Zealand (*n* = 1), and South Africa (*n* = 1).

3.2.1. Types of methods and study design

Three types of study designs were utilized— 32 items used quantitative methods including validated questionnaires like the Readiness for Interprofessional Learning Scale, Interprofessional Attitudes Scale and/ or Collaborative Healthcare Interdisciplinary Relationship Planning to measure (changes in) students' attitudes or questionnaires or registered data to investigate patients' outcomes or students/patients' perceptions of an IPE intervention; 33 used qualitative methods including focus groups, ethnographic approaches and case study designs (8 of these

were labeled as "descriptive reports"); and 8 used mixed-methods including the abovementioned questionnaires combined with focus groups.

3.2.2. Education programs involved in the clinical learning arrangements

In all, 25 different education programs were represented in the included studies (Table 2)[4]. Members of the interprofessional student

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[4] Other students included: Early childhood education, Pedagogy, Child and youth care, Bachelor in Interprofessional Healthcare, and Osteopathic medicine.

Table 1
Overview of year of publication.

Year	Number of publications
2010	6
2011	8
2012	3
2013	5
2014	7
2015	1
2016	12
2017	3
2018	12
2019	8
2020	8

Table 2
Frequency and percent of professional students included in the reviewed literature (2010–2020; n = 73).

Health profession	Frequency	Percentage
Medicine	53	72.6
Nursing	49	67.1
Physiotherapy	38	52.0
Occupational therapy	29	39.7
Pharmacy	19	25.7
Social work	13	17.6
Speech and language pathology	9	12.2
Nutrition/dietetics	9	12.2
Other students	8	10.8
Exercise physiology	6	8.1
Physician assistant	6	8.1
Psychology	5	6.8
Public health	5	6.8
Podiatry	4	5.4
Dentistry	4	5.4
Bio-analytics	3	4.1
Dental hygiene	2	2.7
Dental therapy	1	1.35
Paramedic	1	1.35
Radiation therapy	1	1.35

teams were typically medical (*n* = 53) or nursing (*n* = 49) students. Physiotherapy students (*n* = 38) and occupational therapy students (*n* = 29) were also commonly represented. Other students included those studying pharmacy (*n* = 19), social work (*n* = 13), speech and language pathology (*n* = 9), and nutrition (*n* = 9).

3.2.3. Context of studies

Included articles presented studies from a variety of settings. Approximately one-third (34%) of the included studies were conducted in a hospital setting. Most were interprofessional learning arrangements organized as interprofessional training wards (IPTW), often in orthopedics. Other studies in hospital settings were conducted within the context of acute care, pediatrics, or psychiatry.

One-third (34%) of the studies were conducted in primary care settings; for example, in-home visits or interprofessional arrangements in nursing home facilities. The remaining 31% were conducted in a variety of settings, such as interprofessional student clinics or charitable community clinics, schools, or low-security residential institutions.

3.3. Patient participation identified with the 4P-tool

The most striking result to emerge from the data was that patient participation was not articulated in 42% of the studies (*n* = 32). However, 40% of the studies did describe aspects related to recognition of the patient (items 1–4). One-fifth of the studies articulated situations in which interprofessional student teams informed and explained issues or their plan of action to the patients. Table 3 illustrates what studies were related to which 4P-item(s), including the constructed item 0. As

Table 3
Patient participation in interprofessional learning arrangements through the lens of 4P.[12]

Item number and description	Studies in which item was identified	Representative examples from included studies
0. Patient participation not articulated	[24–55] (*n* = 32)	"The dental student identifies tobacco users, advises the tobacco users to quit, and connects them with a pharmacy student in the clinic who provides tobacco cessation education, including education on medication options."[45]; p. 54) "Student clinicians are expected to lead the patient care visits by reviewing the patient's medical history, discuss an appropriate plan of care with the licensed healthcare supervisor, provide the direct patient care and document all relevant information after the medical or therapy patient visit."[51]; p. 560)
1. Being listened to (by healthcare staff)	[2,3,56–78] (*n* = 24)	"All responding patients were very satisfied with the visits and felt that they had been listened to and treated with respect by the students."[76]; p. 4) "The team listened to her discuss her pain and asked relevant questions. The team asked her to rate her pain and emphasized the importance of being honest, according to the nursing student's instructions. The patient rated her pain as 10, meaning the 'worst possible pain.'"[2]
2. One's experience being recognized	[2,3,56–77,79–84] (*n* = 29)	"Participants also had the opportunity to explain why they might, or might not, consider a change in lifestyle, eating, or activity. This dialogue provided students with valuable education and practice in therapeutic communication."[71]; p. 127) "One thing we did well was listening to her and letting her speak whatever was on her mind and using an open-ended question, so she could talk about what she wanted."[67]; p. 4)
3. Having conditions for reciprocal communication	[2,3,56–77,79–85] (*n* = 30)	"The patients tells the students what they have never told us"[59]; p. 499) "I learned that it is not always about coming up with the best pharmacological recommendations, but sometimes all it takes is talking to the participant

Table 3 (*continued*)

Item number and description	Studies in which item was identified	Representative examples from included studies
		to figure out what really is best for them."[63]; p. 319)
4. Sharing one's symptoms/ issues	2,3,56–59,61,62,65–73,75,79,80,82–84 (*n* = 22)	"Students screened each patient using a semi-structured interview covering mobility, diet, function, continence, falls, mental health, social status, and foot care."[71]; p. 124)
5. Receiving explanations about what is done	56,58,61,66,69,71,80,81,86–88 (*n* = 11)	"IP teams showed admirable creativity in communicating therapeutic, diagnostic and rehabilitative procedures to patients and their families. For example, IPTW teams started to write short-discharge reports in lay language for patients and their families besides the usual medical discharge report to enable patients to better understand their hospitalization, surgery, planned adjuvant treatment and rehabilitation."[88]; p. 7) "Patient care included repeat clinical assessments, making and enacting management and disposition plans, including either making specialty unit referrals, with the lodging of inpatient or SSU bed requests for patients being admitted, or delivering appropriate information to those being discharged."[87]; p. 428)
6. Receiving explanations about one's symptoms/ issues	56,61,63,66,71,72,78,80,87–89 (*n* = 11)	"The 60-min student consultations were appreciated by patients. The extended consultation provided opportunities to ask students for information about existing conditions and discuss management options."[71]; p. 127) "By adding all this information together and by providing the pharmacy information it really helped the participant have a big picture of their disease state as well as their improvements in their physical activities."[63]; p. 319)
7. Learning about plans	56,61,66,71,81,88,90 (*n* = 7)	"Weekly conferences were held with each team to ensure that the care and treatment were well planned and well coordinated. To further support this aim, the conferences were attended

Table 3 (*continued*)

Item number and description	Studies in which item was identified	Representative examples from included studies
		by permanent staff, the patient, and his or her family during hospitalization"[81]; p. 3) "During the spring semester the teams present their projects to the family, and the last home visit is to determine the effectiveness or acceptability of the project from the family's perspective."[61]; p. 5)
8. Partnering in care/treatment planning	61,67,70–73,81,84,91–95 (*n* = 13)	"The student teams worked with patients to set goals at each encounter and modified the plan longitudinally as needed on subsequent visits."[92]; p. 3) "All of the patients noted improvement in the goals they set with the team"[67]; p. 5)
9. Phrasing one's own goals	67,96,83,92 (*n* = 4)	"The collaborative work process was then activated for the construction of the diagnosis and of the integrated care plan to be developed with the family or a specific member of it. This plan was reviewed every two weeks by the student team together with the family/ individual."[96]
10. Managing one's symptoms/ issues	70,89 (*n* = 2)	"Translated comments from the patients included the following: 'Now, I know why my teeth bleed;' 'No more sugared gum;' 'Great talk;' 'I received information to prevent cavities;' 'It was helpful and educational;' 'I appreciated it;' 'I would come again to hear it;' 'Information was helpful;' 'It is better to teach people how to protect their teeth;' 'I understood what I was told;' 'I learned that our teeth need to be clean;' and 'Keep taking care of people; keep teaching people how to take care of their teeth.'"[89]; p. 1095)
11. Managing healthcare interventions independently	59,89 (*n* = 2)	"Asks about how the patient monitors her blood sugar levels. Satisfied with the answer the patient demonstrates the use of the blood testing home kit. The student then asks about compliance with medications and is satisfied."[59]; p. 500)
12. Performing self-care	None	None
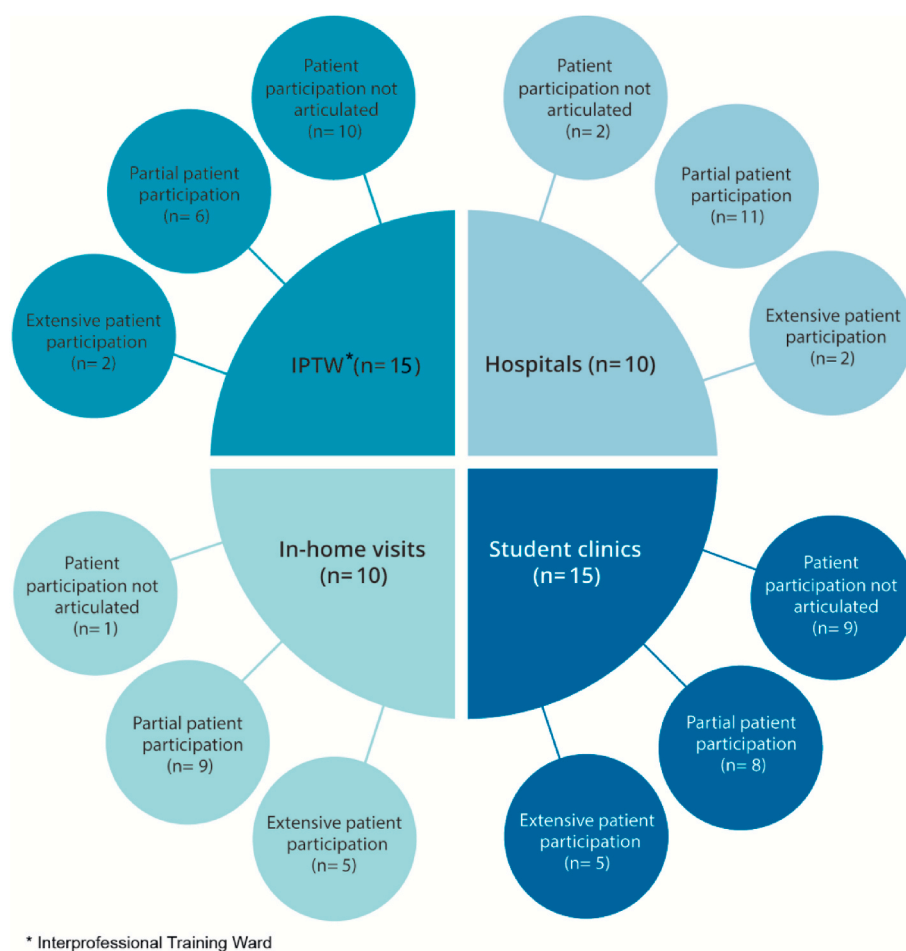
Fig. 3. Patient participation in the four dominating contexts.[5]

illustrated in the bottom part of Table 3, few studies articulated how patients were actively involved in their care and treatment (items 10 and 11) or planning with students (item 9). None of the included studies articulated how students interacted with patients to perform self-care (item 12). Taken together, these findings show a variation from not articulating patient participation through partial patient participation to more extensive patient participation.

3.4. Patient participation in different learning contexts

As mentioned above, the different interprofessional learning arrangements occurred in a variety of contexts, including IPTWs, student clinics, hospital settings, and in-home visits. In 19 studies in which learning arrangements took place in the context of either an IPTW or student clinic, patient participation was not articulated (Fig. 3); 14 studies articulated how patients were recognized and informed by students; and 7 studies articulated how patients took part in planning. In learning arrangements within the hospital setting that were not organized as IPTWs, only two studies did not articulate patient participation. In the latter context, most studies described patients being recognized or informed by students. For in-home visits, recognition of and informing the patient was recurring. In this context, patients seemed to participate

more in planning or goalsetting with student teams than in the other contexts.

3.4.1. Patient participation in the three dominating countries of origin

The US ($n = 24$), Sweden ($n = 13$), and Australia ($n = 11$) were the most represented countries in our review. Almost half of the studies ($n = 11$) from the US did not articulate patient participation; this also applied to studies from Australia ($n = 5$). Of the articles originating from Sweden, 75% ($n = 9$) did not articulate patient participation.

In summary, findings from the descriptive content analysis showed that included studies were published throughout the whole decade (2010–2020), with a slight predominance between 2016 and 2020. There were variations in country of origin, study design, and students' discipline. In 42% of the included studies, patient participation was not articulated. Of the studies that articulated patient participation, most described how interprofessional students recognized and informed patients while some studies showed how the patients participated in planning of treatment. Only two studies gave example of how patients were an active part in care and treatment.

4. Discussion

The aim of this scoping review was to answer the question "How is patient participation articulated in research on undergraduate students taking part in IPE in clinical placements?" The results showed a variation in year of publication, country of origin, research methods used,

and interprofessional learning context. Our findings revealed that research within this field, despite strategic calls,[97,98] was not patient-focused. Nearly half of the included studies did not provide insight into how patients participated in interactions with interprofessional students. The studies that did provide insight articulated how student teams recognized the patient but rarely noted student-patient partnerships concerning goal setting and health management. The results also showed that certain contexts like IPTWs and student clinics were less likely to articulate patient participation than others.

4.1. Extent of patient participation

Patient-centered care and patient participation are two closely related concepts. Both include deep respect for patients, caring for patients on their own terms, recognizing patients' wishes in a responsible manner, and considering patients as resourceful individuals.[9,10] The 4P-tool originally illustrates different patient preferences for participation in example being listened to, sharing ones symptoms or being empowered to take control over one's own healthcare.[12] In some of the articles, it was articulated how students listened to patients telling their "stories" (e.g., items 1–4). Other examples showed how they involved the patient in care conferences or in managing their own healthcare interventions (items 7 and 11, respectively). Whether this was in accordance with the patients' preferences in the interprofessional learning arrangements are yet to be explored.

In our study, we used the 4P-tool analytically and thereby considered the items as a continuum that progresses from *non-participation* to *partial participation* to *extensive participation*. In the studies that articulated patient participation, students listened to patients, recognized their health issues, and explained these issues in detail. In some cases, patients articulated their own goals; however, overall, more extensive participation was required. We recognize that what was articulated does not necessarily represent the whole picture of what happened in the learning arrangements; but these findings suggest that IPE researchers focus on other aspects than patients' presence when writing up their research. Nevertheless, we found it uplifting that we could identify patient participation, even if only partially; however, the lack of more extensive participation is a bit worrisome, especially since both are expected learning outcomes of IPE.[6]

4.2. Variation in articulated patient participation in different contexts

Here, the term "context" was understood as the different settings in which interprofessional learning arrangements occur. Interprofessional learning arrangements happen in a variety of clinical contexts, which may imply that there is a potential for interprofessional learning in many settings. Some contexts already have an established collaborative practice (e.g., primary care teams), while others are specifically constructed with a purpose to promote learning about interprofessional collaboration (e.g., in-home visits or IPTWs). Four contexts— IPTWs, student clinics, other hospital sites and in-home visits— dominated the included articles. The differences in how patient participation was described in these contexts was interesting and unexpected. We wish to elaborate on the unanticipated finding that articles originating from certain contexts seemed to articulate interactions with patients to a lesser extent than their counterparts. This especially applied to the contexts of IPTWs and student clinics.

IPTWs were created to enhance the opportunity for interprofessional learning and "collaborative and interprofessional competences in a realistic milieu"[99]; p. 127. Student clinics were also established to benefit interprofessional students with "an increased understanding of both their own and other professionals' roles in an interprofessional

team, how to practice within that team, improved patient-centered care, and individual benefits to the students such as improved communication skil.[100] A recent review on IPTW suggested that the goals of establishing these learning arrangements have been reached and that both student learning and patient outcomes were enhanced by this organization.[4] It is therefore surprising and striking that articles regarding IPTW paid so little attention to the nature of interaction between students and patients. In both contexts, patients were only briefly mentioned— often related to diagnosis and not how the interprofessional students interacted with them.[25,28,34,38–41,43,48,79,85,88]

There are several possible reasons for this. One could be that authors expect readers to know what traditional treatment and care represents and that students and patients obviously interact. However, the conditions for patients admitted to, for example, an orthopedic ward, may vary. A patient could be a young man with a complex injury from a motorcycle accident or an elderly lady who fractured her hip by falling out of bed in her nursing home. This would force different approaches from the interprofessional student teams and challenge how patient participation was enacted in the given situation, thus making articulating this information important.

We recognize that many contextual factors may play a role in the interactions between students and patients. For instance, patient participation is sometimes not possible or even wanted by the patient. There also might be practical or logistical issues for not inviting the patient to participate. However, such factors would be interesting to read more about in IPE research and could give a fuller picture of the complexity that students are facing in interprofessional clinical learning, regardless of context.

4.3. Implications for educational design

Our findings raise questions that have implications for how educators design learning arrangements for interprofessional students.

"The object of medical work is the patient, with his or her health problem or illness. This is what in the end gives rise to continuity and coherence to both the actions and the scripts. Without the patients the activity would cease"[101]; p. 964.

The patient is the overarching reason interprofessional skills and competencies need to be addressed, improved, and disseminated throughout the course of a healthcare education. Health educators are responsible for ensuring that students see patients as complex beings rather than just subjects.[102]

Our findings suggest that researchers and educators need to have two thoughts in mind concurrently. First, it is fully understandable and still necessary that IPE focuses on students' learning— how they learn about each other's professions, how team members communicate with each other, and how the different health professionals complement each other's competencies.[103] Second, it is necessary to document how interprofessional student teams experience, reflect on, and learn how to create partnerships with patients. Patients provide key information for healthcare providers and express a distinct point of view and thus should be involved in decision-making. This shift in mindset may create care provision that is patient-focused and closely intertwined with IPE learning objectives.

We also believe that a more conscious and active inclusion of patients in IPE coincides with the issues raised in the quadruple aim.[104] These issues are actions to improve individuals' care experiences, improve the health of populations, reducing healthcare costs, and ensure a sustainable work life for healthcare providers. More attentive and approachable interprofessional students may lead to greater satisfaction among

patients and their families. Improved patient outcomes may also improve students' satisfaction and facilitate further collaboration with other professionals and patients. Health educators need to prepare future professionals on how to collaborate and have positive patient encounters, as opposed to what was noted two decades ago: "too often, caring for chronic illness features an uninformed passive patient interacting with an unprepared practice team, resulting in frustrating, inadequate encounters"[105]; p. 1775). This can and should be addressed in profession-specific programs, but we believe there is added value in promoting this in multidisciplinary contexts.

4.4. Implications for future research

Our findings raise questions concerning what researchers tend to focus on in IPE research, on what competencies health educators provide future practitioners with, and thereby also the quality of IPE. Paradis and Reeves (2013) found that the term "patient" was increasingly used in IPE research. This was linked to the rising trend in healthcare related to patient-centered care, user involvement, shared decision-making etc. However, from our understanding, this tells us nothing more than the frequency of the term used in research articles. Our findings showed that even if the patient was mentioned and somewhat described, this did not always provide a base for understanding how he or she was actually a part of IPE. One could go as far as asking if just by mentioning the term "patient," authors succeed in ticking off the box on a checklist. Meanwhile, is the patient actually considered the object of health education, treatment, and care, like Engeström[101] claimed? When research concerning IPE in clinical settings omits a patient-centered focus, we must investigate what short- and long-term consequences this could have.

Lastly, from our experience, the publication norm within a research field constitutes how studies are being written. To have an article accepted, the author must, in many cases, "slavishly follow the demands formulated"[106]; p. 206. Researchers lean on historical elements; for example, how former articles in their field are structured or what terminology is used, to adapt to the academic discourse in the field. The "academic discourse is not just an entity but a social, cognitive, and rhetorical process and an accomplishment, a form of enculturation, social practice, positioning, representation, and stance-taking". We recognize that adapting to the academic discourse in many ways is necessary to become a member of the research community; however, this adaption may be a way to preserve a certain mindset. If publishers accept publications because they fall within the norms, they may also contribute to preserve the focus of the research that is being conducted. Our findings raise intriguing questions regarding the nature and extent of patient participation in IPE, but they also raise questions concerning publication norms and who holds the power to change directions and the discourse within our research field.

We anticipate that by encouraging more focus on patients and patients' role in IPE research, the knowledge base can expand and possibly lead to innovative developments in interprofessional clinical learning arrangements in the future. By giving more space to patient-student interactions, researchers may contribute to a necessary development

for better quality in both IPE and future healthcare services.

5. Study strengths and limitations

This scoping review was based on 73 articles that described patients' interactions with undergraduate students in interprofessional clinical placements; thus, not all student-patient interactions were included. We are aware that our search was not exhaustive; however, through reference list screenings and peer-recommendations, we strived to fill possible gaps. Moreover, studies were not examined for methodological rigor; however, we followed the framework of the Joanna Briggs Institute. The main part of the analysis was conducted by one reviewer; however, the research team was closely involved throughout the whole process and contributed to a great extent in interpreting and scrutinizing the findings. The 4P-tool that was used for analysis was originally developed to thematize interactions between health professionals and patients and not between patients and students. Our use of 4P as an analytical tool is a development of the intended use with patients. One might assume that patients would have different expectations when interacting with students than professionals; however, using this tool may represent a new and innovative approach for understanding patient participation in IPE. Nevertheless, the aim of this review was to offer initial insight into patient participation in IPE and outline possible ways forward for research and practice.

6. Conclusion

This review was undertaken to show how patient participation was articulated in research on interprofessional learning arrangements for undergraduate students. The key findings from the thematic analysis showed that patient participation was not articulated in almost half of the included studies. When articulated, students only facilitated partial patient participation in which patients were recognized and listened to; but they were invited to participate more extensively only to a small extent. We also found that studies performed in specially designed environments like IPTWs and student clinics articulated patient participation less often than those in other settings.

We argue that a greater focus on patients' role in research on IPE is necessary. We also reflect on how the patient dimension is thematized in clinical interprofessional learning arrangements. IPE researchers must be conscious about how patient participation is articulated to ensure the evolution of a solid knowledge base. This could lead to the creation of innovative learning arrangements in which patients have a central role. In the long run, this could contribute to fulfilling the quadruple aim.

Acknowledgments

Appendix 1

Example of Search strategy CINAHL (EBSCO)

1	N interprofessional N3 education OR N interprofessional N3 learning OR N interprofessional N3 training OR N interprofessional N3 attitudes OR N interprofessional N3 studies OR N interdisciplinary N3 studies OR N interdisciplinary N3 education OR N interdisciplinary N3 learning OR N interdisciplinary N3 training OR N multiprofessional N3 learning OR N multiprofessional N3 learning OR N multiprofessional N3 training
2	N multiprofessional N3 training OR N multidisciplinary N3 education OR N multidisciplinary N3 studies OR N multidisciplinary N3 learning OR N multidisciplinary N3 training OR team* OR N collaborative N3 studies OR N collaborative N3 practice OR peer-learning OR professional learning OR joint learning OR joint training
3	shared learning OR shared training OR MW education, interdisciplinary
4	1 or 2 or 3

(continued)

5	N clinical N3 placement OR N clinical N3 education OR placement OR N student N3 placement OR N clinical N3 training OR ward
6	(MH "Student Placement")
7	5 or 6
8	health professional student* OR health professions education OR professional students OR undergraduate* OR health occupation students OR student AND health
9	(MH "Students, Health Occupations+")
10	8 or 9
11	4 and 7 and 10

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Paper 2

Getting real in interprofessional clinical placements: patient-centeredness in student teams' collaborative learning

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Abstract

Collaboration between healthcare providers helps tackle the increasing complexity of healthcare. When learning teamwork, interprofessional students are expected to work patient-centered; recognizing the patient's expertise and partnering with them. Research on interprofessional education (IPE) for undergraduates has illuminated learning outcomes, organization of learning activities, change in attitudes, etc. But, we know little about the interaction between patients and interprofessional student teams. This study aimed to explore how interprofessional student teams and patients interact in interprofessional clinical placements. With a focused ethnographic approach, participant observation and qualitative interviews were conducted in two contexts; a physical and an online arrangement. Central ideas in Goffman's dramaturgy constituted a theoretical lens. A reflexive thematic analysis generated three themes: (1) Preparing safe and comfortable encounters with patients, (2) Including and excluding the patient in the encounter, and (3) Adjusting to the patient's situation. We identified students' intentions of patient-centeredness when preparing encounters, but patients did not always feel included and listened to in encounters. After encountering patients, student teams adjusted their teamwork, by changing the team composition or the planned clinical interventions to better meet the patients' needs. Notably, team-based patient encounters led to a different view of the patient, their health issues, and how to collaborate. Our findings can inform educators of the importance of addressing patient-centered care in interprofessional learning arrangements. Today, clinical interprofessional placements may not exploit the potential for learning about patient-centeredness. A thematization of this, e.g., in supervision in future clinical placements can ensure an enhanced focus on this in interprofessional teamwork.

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Introduction

Health professionals are expected to work interprofessionally with their peer providers as they are confronted with complex patients that require integrated, long-term care and treatment (World Health Organization (WHO), 2010, 2016). Professional health education is encouraged to train future healthcare providers on individuals' varied healthcare needs (Frenk et al., 2010; WHO, 2010). To tackle the complex challenges that aging, chronic diseases, mental health issues, and non-communicable diseases, e.g., cancer, cardiovascular disease, and diabetes, can cause, health professionals need to be educated and prepared differently. A recent WHO-competency framework on universal health coverage accounts for competencies within six domains, including people-centeredness, decision-making, communication, collaboration, evidence-informed practice, and personal conduct (WHO, 2022). The goal is to guide the standards for education and practice to achieve a better quality of health care services, especially in primary care, where an increasing part of health care will be delivered in the future (WHO, 2022).

Interprofessional education (IPE) and collaborative practice are recognized as potential routes for improving the quality of healthcare service delivery (Berwick et al., 2008). IPE occurs when workers or students from two or more professions learn with, from, and about each other to improve collaboration and the quality of care and services (Centre for the Advancement of IPE, 2016). In Norway and many other European and western countries, legislation regarding healthcare services, patients' rights to be involved in decisions concerning their care, and treatment in healthcare services have been claimed. However, this has not been dealt with thoroughly in health professional education. The 2015 Vancouver statement on "The patient´s voice in health and social care professional education" has emphasized the importance of this issue in education. The statement aims to enhance patient involvement not only in a uni-professional manner but also in interprofessional learning, as "opportunities are often missed to expand patient involvement in education beyond individual professional programs to promote team-based education and care" (Towle et al., 2016, p. 21). One priority was to "facilitate a more holistic approach to patient partnerships and teamwork" (Towle et al., 2016, p. 22). This study explores this by delving into undergraduates' collaborative learning with patients in interprofessional clinical placements (Fig. 1).

Fig. 1 Competency domains within the Global Competency and Outcomes Framework for UHC (WHO, 2022 p. 13)

Clinical placements are "the ideal learning environment for developing skills conducive to collaborative practice" (Hilton & Morris, 2001, p. 173). In the clinical setting, patients who have sought care may be "participating in learning by virtue of student participation in those care relationships" (Rowland et al., 2019, p. 606). Interprofessional clinical placements for undergraduates were initiated two decades ago in Linköping, Sweden (Dahlberg et al., 2020; Wilhelmsson et al., 2009). A similar organization (Oosterom et al., 2019) and numerous unique arrangements in communities and hospitals worldwide (Jensen, et al., 2022) is also found. Interprofessional clinical placements enable learning not only between interprofessional students but also between the interprofessional students and patients (Bleakley & Bligh, 2008; Rowland et al., 2019). Clinical placements allow patients in various settings with different experiences to contribute to students' professional and interprofessional development (Rowland et al., 2019).

Thistlethwaite and Moran (2010) showed how "the patient" is central to learning outcomes for IPE. Recognizing patients' needs, understanding the patient perspective, and including the patient as a partner within interprofessional teams were some of the themes identified (Thistlethwaite and Moran, 2010). These are all part of patient-centered care (PCC), which represents the transition from a paternalistic relationship between a doctor and a patient to an equal relationship in which the patient holds expert knowledge of their own life and health situation (Berwick, 2009). Ideally, patients will have more agency in what healthcare interventions should be implemented for their concerns. Consequently, patients and health professionals can create personal and individualized care and treatment paths (Berwick, 2009) in which the patient's wishes are honored but not mindlessly enacted (Epstein & Street, 2011). The goal of PCC is to contribute to "a functional life for the patient" (Eklund et al., 2019 p. 8) through building emphatic and respectful relationships where the health practitioner facilitates shared decision making and a holistic focus for the individual (Eklund et al., 2019).

Studies on IPE in clinical placements where patients are included are numerous. However, the interaction between students and patients, including the patients´ role, has not been explored sufficiently (Jensen et al., 2022). Examples are studies that refer only to the patient's diagnosis (e.g., "orthopedic patients"; Hallin & Kiessling, 2016) or in more general terms (e.g., "nursing home patients"; Baerheim & Raaheim, 2020). Some studies describe the interaction between patients and interprofessional student teams (Damsgård et al., 2018; Kent et al., 2016a, 2016b), while others have provided a more detailed description of the content in meetings between interprofessional students and service users (Ciccone et al., 2013). More extensive insight into patient and interprofessional students' interactions is however needed. An interesting aspect of said interaction is an exploration of how the placements can promote students' interprofessional learning and collaboration, and patient-centeredness. The latter is considered a feature of all learning domains in competency frameworks on IPE (Interprofessional Education Collaborative Expert Panel (IPEC), 2016).

This study aimed to explore interprofessional student teams and patients' interactions in clinical learning arrangements.

Theoretical framework

The study's theoretical framework draws on concepts from Erving Goffman´s dramaturgical analysis (Goffman, 1990). Goffman's work emphasizes micro-social interaction, that is, how individuals interact with each other and construct meaning in everyday life. An

analytical focus on micro-social interaction allows a new gaze on what goes on in interprofessional clinical placement between students and patients in different contexts.

Goffman argues that human interaction in day-to-day life is controlled and staged, so we always strive to make the best possible impression on others. He puts this in parallel with actors on a stage and claims that humans continuously use impression management to be perceived the way they want (Goffman, 1990). As humans, we enter various *roles* depending on the situation in which we find ourselves. A role is a pattern of behavior related to a person's social status in a situation. When interacting, there is a shared reality between the actors; for example, in a classroom, some perform in student roles, and some serve in the teacher role. If roles are switched, the interaction would probably be disturbed, and new ways of interacting would be formed (Goffman, 1990).

Activities that individuals participate in during a limited period before a particular set of observers are considered a *performance* (Goffman, 1990). According to Goffman (1990), performances are controlled and staged to manage the impressions that the performer wants the audience (one or several persons) to perceive. This type of performance happens in what he calls *frontstage*. In our case, this would correspond to the phase where students deliver interprofessional collaboration with the patient. At the frontstage, an individual will present himself following the expectations of the situation and try to live up to their role.

Backstage, the performer retreats from the audience and public gaze and can lower their shoulders and not be on display (Goffman, 1990). Moreover, backstage would, in our case, correspond to moments where students meet and reflect, formal or informal, either before a frontstage performance or after. Backstage performers may address each other in a different and more casual language or behavior than frontstage performers. Backstage is often where the audience is not permitted (Goffman, 1990).

In Goffman's theory, the individual is the starting point, but he also shows how individuals are related to each other in a performance. Through the term *team,* he refers to "any set of individuals who cooperate in staging a single routine" (Goffman, 1990, p. 6). Members of the team are in a critical relationship consisting of two components: reciprocal dependency and reciprocal familiarity: First, each member must rely on their teammates and trust that they will behave to achieve the team's best performance. Second, team members need to develop familiarity with each other, which includes letting the team performance take precedence over the individual frontstage performance. The italicized terms above will further inform our analysis.

Methodology

The study is designed as a qualitative collective case study; it includes multiple cases and focuses both within each case and across cases (Kekeya, 2021 p. 35). The common methodology of the case studies is a focused ethnographic approach inspired by Andreassen et.al. (2020) and Higginbottom et.al. (2013). This approach is well-suited for research on health professional education, and a focus on particular issues in learning arrangements can be expedient (Andreassen et al., 2020). Beyond this, focused ethnography is pragmatic, as topics are often pre-selected, and data generation is conducted within a given timeframe or event (Higginbottom et al., 2013). The decisions to focus on students´ interaction with patients in interprofessional learning arrangements were decided before the empirical studies.

Study contexts

The study contexts comprise two different arrangements for students' interprofessional learning. Common for the contexts is interprofessional undergraduate students encounters with patients in clinical settings.

The first learning arrangement is physical, situated at a community health center, where students do their clinical placement. The second learning arrangement is students' online encounters with patients in different clinical settings, such as a hospital ward and an assisted-living facility (see Table 1). The online arrangement was initially physical but was digitalized due to the Covid-19-pandemic; however, after Covid restrictions ceased, the arrangement is offered either physically or digitally, by the student's choice.

In the community health center, patients were admitted from a regional hospital or their homes, either with a plan to return home or await long-term care, e.g., in a nursing home. Interprofessional students participated in learning arrangements for two to four days in their final year. Multiple student teams consisted of 5–6 students; in the first observation period, nursing students in the teams shifted after two days. Nevertheless, each team oversaw 2–3 elderly patients with complex and chronic health issues. Student teams were encouraged to collaborate interprofessionally by providing daily care for patients, conducting holistic health assessments, and different kinds of consultations. The teams worked concurrently and had their workspace for preparations and debriefings. Students were expected to write a collective interprofessional journal summary, including their observations and suggestions for further care. Interprofessional supervisors were present in many teams´ preparations and post-encounter meetings. Uniprofessional supervision was provided if needed.

In the online encounter, the interprofessional student teams consisted of 4–6 students. Each team met one patient in a different clinical setting. The learning arrangement was estimated to last approximately eight hours. One team met a patient living in an assisted-living facility, and the other met a patient admitted to a local hospital due to an infection. Health

Table 1 Overview of the multiple sources in our data material

	Length	Health care context	Sample	Method for generating data
Physical arrangements	28 h	Community Health center	Students; Patients	Participant observation
	1 h 10 min	Community Health center	Students	Focus group interview
	25 min	Community Health center	Patient 1	Individual interview
	14 h	Community Health center	Students; Patients	Participant observation
	1 h 20 min	Community Health center	Students	Focus group interview
	33 min	Community Health center	Patient 2	Individual interview
Online arrangements	20 min	Assisted-living facility	Patient 3	Participant observation
	25 min	Assisted-living facility	Patient 3	Individual interview
	1 h 15 min	Hospital ward	Students, Patient 4	Participant observation
	34 min	Hospital ward	Patient 4	Individual interview
	1 h 8 min	Hospital ward	Students	Focus group interview

professionals on site preselected patients. As a starting point, students were instructed to conduct an interprofessional screening with the standardized question, "What matters to you?" (Barry & Edgman-Levitan, 2012). Subsequently, they co-wrote an interprofessional care plan to be assessed by a lecturer with a pass/fail grading. The team also had to include an evaluation of the team's work process. Arrangements in this context were intended to be carried out entirely digitally; however, in one of the two observed cases, the clinical coordinator invited a couple of students to be physically present at the hospital while the rest of the team was present online. Supervision was not provided.

In both contexts, the teams independently planned and structured meeting(s) with the patients and did not follow any procedure to organize the encounter.

Participants and recruitment

Participants were recruited by purposeful sampling (Patton, 2002) either from being a student in an interprofessional team ($n=37$) or a patient ($n=5$) interacting with interprofessional student teams. A breakdown of the different students´ professions is shown in Table 2. Coordinators of the learning arrangement recruited students based on who was attending the clinical placement at the specific period of observation. Health personnel employed at the healthcare facility recruited patients based on their suitability for the student teams to learn from (e.g., health complexity, issues for all professions to grasp) and their ability to understand participation in the research.

The student team that met Patient 3 (see Table 1) declined the invitation to participate in a focus group interview because of exams. Consent to use field notes from the observation of the team was not obtained; thus, the observational data were excluded. Nevertheless, Patient 3 participated in a telephone interview and expressed his views on the encounter.

In the community health center, a purposive sample of students representing a diversity of professional programs across the teams was interviewed. In the online encounter context, the whole team was interviewed except for two students who could not attend.

Empirical studies

Data was generated through participant observation and interviews with students and patients (See Table 1). The first author (CBJ; Ph.D. student, RN) conducted observations and interviews in both contexts.

Table 2 Breakdown of student teams´ professional composition

	Physical arrangements					Online arrangements	
	Team 1	Team 2	Team 1	Team 2	Team 3	Team 1*	Team 2
Nursing	$n=3$	$n=2$	$n=3$	$n=3$	$n=2$		$n=1$
Medicine	$n=1$	$n=1$	$n=1$	$n=1$	$n=1$		–
Physiotherapy	$n=1$	$n=1$	–	–	$n=1$		$n=1$
Occupational therapy	–	–	–	$n=1$	–		$n=1$
Pharmacy	$n=1$	$n=1$	$n=2$	$n=1$	$n=1$		–
Social work	–	–	–	–	–		$n=1$
Biomedical lab.sci	–	–	–	–	–		$n=1$

In the community health center, team meetings, encounters with patients, and interprofessional supervision sessions were observed. When appropriate, CBJ asked students to elaborate on their actions to understand the different situations better.

In the online encounter, CBJ joined the students on Zoom and observed the interprofessional student teams´ encounters with patients and their subsequent team meetings. CBJ had her web camera turned on but did not ask elaborate questions during the online sessions. Here the interviews were used to gain a better understanding.

Semi-structured qualitative interviews were conducted after participant observations. Focus groups with students were conducted physically and through Microsoft Teams (See Table 3). Patients participated in individual interviews, either physically or via telephone. Interview guides were developed to indicate the themes of interest. The interaction between interprofessional students and patients constituted the starting point of the interviews.

Data analysis

As our study included diverse datasets from different contexts, we found that reflexive thematic analysis (TA) allowed for a flexible cross-case approach that made it possible to identify themes and patterns across the datasets.

Comprehensive field notes and interview transcripts were imported into the qualitative data analysis software NVivo (QSR International, 1999).

A six-phase TA process (Braun & Clarke, 2020, 2022) commenced about six months after finalizing the data generation. TA was conducted with an inductive approach guided by Braun & Clarke´s (2020) understanding of this as identifying meaning "grounded in the data, rather than pure induction" (p. 331). During analysis, we iterated between the different phases and between the field notes, interview data, and theory.

Jot notes from fieldwork were rewritten into comprehensive field notes (Emerson et al., 2011) and interviews were transcribed verbatim. As part of the familiarization process, the first phase in TA, CBJ immersed herself in interviews and field notes within each case. A data analysis workshop with an extended international research group was also conducted to kick-start the analysis process with different perspectives.

The data were subsequently coded inductively and semantically with participant-driven codes to capture the participants´ explicit meaning (Braun & Clarke, 2019, 2022). Initially, field notes, transcripts from focus groups, and individual interviews across cases were grouped and coded. Candidate themes were developed, reviewed, and refined through a creative process in the research team. Patterns related to happenings in the student teams and happenings in the patient encounters were identified. At this point in the analysis, it became apparent that the patterns we found could be understood considering Goffman's dramaturgy. We used Goffman to understand how and when patient focus occurred and how this influenced the team members´ interaction with each other and the patient. Further analyses generated three overarching themes: (1) preparing safe and comfortable encounters with patients, (2) including and excluding the patient in the encounter, and (3) adjusting to the patient's situation (see Table 4).

Table 3 Breakdown of health professional students within the different focus groups

Physical arrangements	2 medical, 2 nursing, 1 pharmacy, 1 physiotherapy
	1 medical, 2 pharmacy, 3 nursing
Online arrangement	1 occupational therapy, 1 social work, 1 nursing

Excerpts from field notes and interviews are highlighted in the findings by citation marks or with a block quote.

Ethics

This study was approved by the Norwegian Centre for Research Data (no. 831589). All data were collected following the Declaration of Helsinki (World Medical Association, 2020) and the Ethical Guidelines for Educational Research (British Educational Research Association, 2018). Participants provided written consent before data generation and could withdraw from the study at any time.

Findings

In our analysis, we have focused on two actors; patients and students. We have assumed that the student teams were already established when using Goffman as our lens to understand the interactions. Consequently, the analysis did not focus on the students' interactions when establishing their teams.

We found that student teams develop a joint backstage when focusing on one or several patients. When teams encounter patients, they perform frontstage *together* with the patient. When ending the encounter, the patient, and the team withdraw to their backstage. This movement between front and backstage could either happen as a unique episode (in the digital context) or multiple times (in the physical context).

In the following section, we provide empirical examples from our analysis and show how Goffman's dramaturgy can shed light on how interprofessional student teams and patients interact.

Preparing safe and comfortable encounters with patients

Across contexts, students were instructed to prepare for encounters with one or several patients. When preparing, students were initially interested in each other's professional perspectives. Still, they switched focus from themselves to the patient and their health issues, and the students different professional views were integrated into their talk about the patient.

The teams had a respectful tone when talking about the patient and upheld their professional roles, even if they, at this point, did not interact directly with the patient. Information obtained from the electronic health records (EHRs) about patients' goals and wishes was repeatedly discussed during preparation. Despite the patient not being physically present backstage, they became present through the students' interactions with each other and the her and the information visible on "the widescreen". The patient played a role backstage without being aware of it.

In the community health center, students asked questions like "What is the plan now?" "Can we call this a plan?" and "Can we take a recap of what we agreed on?" in several cases. The teams agreed on what they would do, who was asking questions, what questions each professional student needed answers to, how many would see each patient, and what professions would be favorable to have in the meeting. They agreed on who would play what role in the performance that would take place frontstage with the patient. This was also reported by students in the online arrangement, talking about how they juxta

Table 4 Examples of data extract, data source, codes, subthemes, and overarching themes

Data extract (data source)	Codes	Subthemes	Overarching theme
"It was reassuring that the nursing students were familiar with the facility and electronic patient record system, and also knew the patients a bit" (Focus group)	Nursing students' familiarity was reassuring; Spent time exploring the patient's health issues	Student preparations and planning	Preparing safe and comfortable encounters with patients
Members from team 1 are standing a bit spread in the corridor after their preparation-meeting. The medical student signals that they are going to see one of their patients. CBJ asks to tag along with the team. The medical student knocks the patient's door and goes in, we can hear that she asks if it is okay for the patient that the entire team and the researcher comes to see her. The patient answers that it is ok. (Field notes)	Relationship with the patient; Interaction between students and patient; Facilitating a comfortable encounter; Respect for the patient	Ensuring safety and comfort for the patient	Preparing safe and comfortable encounters with patients
"I want students to be curious, that they listen. And the ones I met were inquisitive, they were very nice people" (Individual interview)	Positive aspects of the encounter; Students listened to patient	Patients' expectations and experience	Including and excluding the patient in the encounter
"We did become aware of, at least that one time, that we asked many closed-ended questions to the patient and that we may have to focus a bit more on open-ended questions" (Focus group)	Interaction between students and patient; Asking patient's questions; Patient encounter	Questions-inclusive and exclusive	Including and excluding the patient in the encounter
"When I participated in the morning routine, I see that it takes time, it is not given that the patient wants to get up, so there is more to the picture than just what I think about" (Focus group)	Patient encounter, Picture of patient is different after encounter, Positive aspects of IPE	Students experience of encounters	Adjusting to the patients' situation

positioned their questions to structure the meeting. However, the students in the online arrangement felt it challenging to prepare the encounter as they had no information about the patient besides where they were located. The nursing student even talked about how their team prepared to improvise: "We improvised a bit, as our goal was to find out what mattered to her and what was important for her, we felt that we could follow up on what she said [and make her elaborate on those things]".

Including and excluding the patient in the encounter

In several observed encounters in the community health center, students obtained consent and provided information about the student team before entering the patient's room. This was reported to provide safety and ensure a comfortable encounter for the patient. Through this action, the students invited the patient to play a part in directing the encounter. It also made it possible for the patient to prepare in their backstage before the student team entered.

The patients were the center of attention in all encounters across contexts. The students often prepared and asked the patient a series of questions. Questions mainly had a medical (or bodily) focus, relating to the patient's perception of their health condition and health-related issues. Patients answered accordingly but expressed in interviews that these kinds of questions did not always invite them to tell what was important to them. Two patients reported that they felt there were many unnecessary questions and few questions regarding their background and history. Both expressed a wish to ask questions themselves but did not get an opportunity to do so. The patient who met the student team entirely digitally felt that he did not have the chance to tell the student team about his pre-function and repeated this several times throughout the interview with CBJ.

One focus group participant expressed concerns that patients felt pressured to give "the right answers" to the student's questions. She also characterized many questions as leading and not open for the patient to tell their own story or reflect. One team in the physical context asked a patient, "What matters to you?" but the medical student involved in the encounter expressed that it was difficult to grasp the answer as the patient talked about other issues. This question was also central in the assignment for encounters in the online arrangement; the perception of having the chance to speak about themselves varied between the two patients. One felt that she got a chance to tell the student team "everything", while the other patient, as already mentioned, thought he did not have the opportunity to tell them what was important to him.

Adjusting to the patients' situations

After meeting the patient, the teams adjusted in several ways: They adapted to the patient's issues and the team's professional composition when possible. Plans were changed according to the information the students obtained in the patient encounter, and the preconceived pictures that some students expressed they had of the patients were adjusted.

When returning backstage to their meeting location (either physical or online), team members shared their perceptions and observations of the patients. Each team member and the team were somewhat forced to explicate the competencies they possessed and what they lacked concerning the patients' goals and wishes. The student team adjusted their work processes following their encounters with the patients. In the community health center, student teams on several occasions requested help from other teams with a different

professional composition that could contribute to a broader understanding of the patient; for example, when a pharmacy student contributed to a comprehensive drug review for one patient, or when a physiotherapy student contributed to the physical assessment of a patient with members from the student team. In contrast to the online arrangements, the teams in the community health center encountered patients several times during their placement which made the adjustments in the team composition possible.

Patients' health issues were still the main focus of the teams and the central point of discussion. Students thoroughly assessed patients' situations after encounters, and some expressed that meeting patients also led to adjustments in their preconceived picture. A pharmacy student claimed,

> "(…) When we sat down to read and prepare the first day and read medical records and such, then we got a picture of how the patient was, the condition … But when we visited them [the patients] then, it was like, 'Okay, that's not true'—what we had imagined. So, the whole picture must be included for the best possible treatment."

Students suggested different measures to improve patients' health status, including specific examinations, health screening, or more abstract measures, such as identity preservation. Student teams in the physical context revisited the EHR to confirm patients' statements during the encounters. Students in the digital context continued their interaction online but were forced to repeat and recall what the patient had expressed in the frontstage performance without accessing the patient's EHR.

Students seemed to become more aware of their peers' knowledge and perspectives after meeting the patient and similarities or differences compared to their roles. Some students with limited clinical experience expressed gratitude to fellow students (on several occasions, nursing students) who helped them feel safe with the patient. Nevertheless, as uncomfortable as it may have been, the frontstage performance was expressed as necessary to gain insight into the different patients' spheres and learn to adjust to them.

The post-encounter meetings contrasted with the initial team interaction. After the frontstage performance, the student team could "relax." The backstage setting now allowed for a different kind of openness where students were more open about their uncertainties when returning backstage. Sharing this uncertainty and lack of knowledge with each other could imply a more laid-back backstage, where the team members were allowed to reveal their knowledge gaps openly.

Discussion

The purpose of this study was to gain a better understanding of how interprofessional student teams interact with patients in interprofessional clinical placements.

Across cases and contexts, our findings indicate that patients are central to the teams' collaborative processes; however, patients are not always sufficiently included in team-based encounters.

Undergraduate students in interprofessional learning arrangements change their attitudes and gain knowledge about other health professions (Barr et al., 2006). Reeves et al. (2012) found that undergraduates often reported changes in beliefs, knowledge, attitudes, and collaborative care after IP arrangements. Re-organization of practice and improvements in care delivery were less reported at an undergraduate level than in postgraduate studies (Reeves et al., 2012).

This study shows that interprofessional clinical arrangements enable students to learn with, from, and about each other. Students also learn that the patient encounter impacts their practice with the patient and within the team. When considering the expected learning outcomes for IPE on "the patient" (Thistlethwaite & Moran, 2010), students recognize that the patient's health issues and perspectives are also considered; however, partnering with the patient is not identified to a great extent. We believe the latter is an essential finding, especially considering that students were in their final undergraduate year, some only months away from graduating. One explanation may be related to the students´ traditional training, including mainly one-to-one interactions in uni-professional arrangements and interprofessional team-based encounters that were unfamiliar to the students. Thus, the students´ former experiences may have impacted how they interacted with each other and the patient. It is necessary to question if we would identify a more inclusive interaction with the patient if team-based encounters were the norm and the students were trained for this at an earlier point or on several occasions in their education.

The different interprofessional clinical arrangements where student teams interact with patients have the potential to train PCC. However, our study indicates that there is a potential for more explicitly talking about PCC both backstage and frontstage, with and without the patient. We consider the patient and their story central when students learn interprofessional collaboration because the patient is the outspring of the teams' agendas and actions. We argue that students' learning outcomes on collaboration would be impaired if the patient was lacking as the patient encounter in many cases triggered, e.g., professional knowledge sharing between students. Our analysis shows how adjusting preconceived pictures of patients helped the students express what competence was needed and showed how flexibility played a part in the learning arrangements. Findings from other studies on clinical placements support this finding and address the flexibility concerning how interprofessional students learn to communicate with each other (Howell et al., 2012). Even in the digital context, where teams were set and did not have the flexibility to invite other professions into their teamwork, the students discussed and problematized how their different professions could contribute to the patient's situation.

Meeting patients forces adjustments in interprofessional students' novice collaborative practices. In slight contrast to Reeves et al. (2012), our study shows a potential ability for undergraduates to re-organize and improve their care-delivery plans at least on a micro level, for the individual. We consider patient encounters a key for interprofessional student teams to learn with, from, and about each other and the patient as the meetings expand their perspectives on each other as professionals and their perspective on the patient.

Our study identified that patients were given space and a role by the interprofessional student teams; however, they still did not get the space they potentially could have had. As initially introduced, PCC includes patients' holding expert knowledge of their own lives and health situations (Berwick, 2009). By involving the patient, personalized care and treatment can be obtained. Respect for the patients, caring for them on their terms, and being listened to, informed, and involved are emphasized (Epstein & Street, 2011). Including the patient as a partner can achieve democratic encounters that can contribute to better experiences, better diagnostic practice, and enhanced patient safety (Bleakley, 2014). Patients also find it positive to be present in teaching and supervision arrangements of health professional students where their own health concerns are addressed (Cheema et al., 2022).

Fox and Reeves (2015) argue that patient-centeredness may not favor all patients. They point to patients' socio-economic status and how some patients may not be able to or even want to be partners in their healthcare decisions. They also exemplify how

patients have been reprimanded by physicians when trying to take on the expert role and obtain more knowledge about their health issues. Our study shows that the patients' narratives were not always heard and appreciated by the students. Some patients expressed in interviews that they did not feel they had the opportunity to tell their stories to the interprofessional students. Through an explicit focus on PCC in clinical IPE for undergraduates, a thematization of practical communication issues, power distribution between health professionals, and power distribution between health professionals and patients can occur.

Bleakley and Bligh (2008) claimed that modern medical education seems to refuse "the deliberate use of patients as the primary source for learning" (p. 90). They argue that educators still need a reminder that the patient is the primary concern of health and medical work (Bleakley & Bligh, 2008). Paradoxically, patient-centeredness is learned through the language and eyes of professional educators (doctors, nurses, etc.) and not from the patient (Bleakley & Bligh, 2008). In our study, the interactions between students and patients occurred mainly without supervisors. Where supervisors are available, they function as support and not gatekeepers for students' interaction with patients. This is in accordance with what Bleakley and Bligh (2008) claimed as the optimal interaction between students and patients for learning patient-centeredness. However, patient-centeredness was not thematized directly in the student teams or by supervisors in our study; thus, we question whether students are aware of this aspect of learning in the IPE arrangement and if the thematization of patient-centeredness would cause other forms of interaction with the patients.

It may also be necessary for learning patient-centeredness that the patients were aware of the learning aspect; they may have "cut some slack" to the students, acknowledging that they were in a learning process and not fully trained. Marshall et al. (2012) explored patients' views on PCC. They reported that being actively involved, health personnel being attentive, and feeling a connectedness between themselves and their care providers were important for patient-centeredness. Our findings show students' attempts to actively involve the patient and attentiveness toward health aspects; however, the patient feeling connected may not be as evident.

As Kent et al. (2016b) found, there may be tension between students' objectives of learning to become a health practitioner and learning teamwork and the patient's needs for a health consultation. For the patient, it may also become an internal tension of being an educator and a health care receiver. In our study, the patients expressed their views on the encounters based on their experience of receiving health care and being assessed; we interpret that they did not identify themselves as educators. This may have something to do with how patients are prepared for their encounter(s) with student teams and how they have been empowered to take a role as an educator, or at least reflected on what the students can learn from the unique meeting. It is reason to argue that patients must be empowered to request a patient-centered approach from healthcare providers and educate students about this, including what PCC means for them as individuals. Accordingly, students can incorporate this knowledge about the patient into their collaborative training.

Finally, the different experiences in clinical learning arrangements can be used as a momentum to trigger students' reflection and to explore further what PCC might be in the various settings in which students and patients perform and interact. Patient-centeredness in interprofessional learning arrangements and interprofessional practice may be thematized with the patient in both the backstage and frontstage. Educators must encourage students to discuss this matter with patients, supervisors, and each other. And not least, patients must be empowered to participate in the PCC discussion and how this can be understood in the individual's context.

These findings help clarify the interactions between interprofessional student teams and patients in clinical placements. We must explore how patients can contribute to educating students on interprofessional collaboration and patient-centeredness. Both a strength and limitation of this study are how the participant observation has a holistic approach; on one side the complexity of different encounters are captured, on the other side details may have been overseen. A more in-depth analysis of the discourse between students and patients may help elucidate this interaction. A second limitation is a minor focus on the supervisor's role. While this study enhances our understanding of interprofessional student teams and patient-centeredness in patient interaction, further studies regarding supervision in such interprofessional clinical placements would be worthwhile.

Reflexivity

The first author, CBJ, can serve as a researcher, educator, and registered nurse to hold both an emic and an etic position. For instance, CBJ had a prior relationship as a former nurse educator with some of the students in the first observation period. The research team balanced the possible emic view with an etic consideration of the data. Reflections on "participant reactivity" (Paradis & Sutkin, 2017), that is how a researcher´s presence impacts participants natural performance, were addressed by the research team. Participants reported in interviews that they mostly did not take notice of the researcher´s presence. We believe that using multiple data sources and reflecting together with participants about their interaction with each other strengthens the credibility of our study (Frambach et al. 2013).

Data availability Research data are confidential and not accessible.

Declarations

Conflict of interest All authors have declared that they have no conflict of interest.

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Paper 3

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The patient's role in interprofessional education is fundamental but has received insufficient attention previously. This study explored how supervision facilitates and supports undergraduate students' learning of patient-centeredness in interprofessional clinical placements. Data were generated in three clinical contexts inspired by focused ethnography. We found that supervisors are important actors in preparatory tasks to facilitate interprofessional learning. They are engaged in student teams' learning, however often in their preparations or debriefings and seldomly in encounters with patients. In planned supervision sessions the patient perspective is also less frequently scrutinized. Nevertheless, clinical settings provide numerous opportunities that may be exploited further.

Keywords: supervision; clinical supervision; interprofessional education; patient-centered care; health occupations students; medical students

Introduction

Interprofessional education (IPE) occurs when "students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (World Health Organization, 2010, p. 10). Learning outcomes from IPE are often considered generic or "soft" (Thistlethwaite & Moran, 2010) and comprise skills, attitudes, and knowledge applicable to all health professions. Students are expected to learn about professional roles, teamwork, communication. The patient is central (Thistlethwaite & Moran, 2010). The latter implies that students learn to perform patient-centered work by including the patient in the team, striving to understand the patient's perspective, and recognizing patient needs while working in their best interest and ensuring patient safety (Thistlethwaite & Moran, 2010, p. 511). Competency frameworks such as the IPEC Core Competencies (Interprofessional Education Collaborative Expert Panel, 2016) suggest patient-centeredness as an overarching feature of the core competencies.[1] Not only is this optimal, but it also resonates with legislation in countries such as Norway, Sweden, and the United Kingdom, where patients and service users are entitled to involvement in decisions concerning their health and well-being (Government of the United Kingdom, 2012; The Norwegian Ministry of Health and Care Services, 1999; The Swedish Ministry of Health and Social Affairs, 2014).

Clinical placements for interprofessional students are ideal for learning collaborative practice with the patient (Hilton & Morris, 2001). Bleakley and Bligh (2008) suggested that clinical learning should happen with and from patients and that

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[1] Values/ethics; roles/responsibility; interprofessional communication; and teams/teamwork

students can only learn patient-centeredness *with* the patient, not through educators; instead, educators must facilitate this learning. Further, Bleakley (2014) has encouraged interprofessional learning comprising "learning to think (*with*) patients in mind" (p. 13).

Supervision is central in interprofessional learning arrangements, and in clinical settings, the supervisor plays a critical role (Davys et al., 2021; Ericson et al., 2012). In this paper, we use "supervisor" to refer to one or several persons (often health practitioners) as facilitators and supporters for interprofessional student teams in their clinical placement. However, many terms, including mentor, facilitator, clinical teacher, clinical supervisor, and placement teacher, are used to name the same role (Marshall & Gordon, 2005). Generically, clinical, or professional supervision is qualified health practitioners' formal supervision through intensive relationship-based education and training that are case-focused and support, direct, and guide supervisees' work (Milne, 2007, p. 440). Supervision can be considered intersubjective mutual dialogue, where the supervisor and supervisee construct the agenda *together* (Herron & Teitelbaum, 2001).

In contrast to professional supervision, the interprofessional context implies that the supervisor and supervisee do not necessarily share a professional background. Thus, interprofessional supervision focuses less on the professional aspect and more on the process and relations between supervisees (Davys et al., 2021). Differing experiences with providing and participating in supervision activities among supervisors and supervisees with different backgrounds add to the complexity (Davys et al., 2021). Nevertheless, in some cases, support and facilitation from supervisors can be hands-on and occur bedside with students and patients. However, it can also be considered a formal, relational, and case-focused activity (Milne, 2007) that implies a cognitive, constructive, and collaborative process between the supervisor and supervisee (Herron & Teitelbaum, 2001). Norwegian scholar Sidsel Tveiten (2019) described supervision

as a spontaneous and integrated part of everyday practice or a planned and structured event with an essential relational aspect.

Research on interprofessional supervision of undergraduates in clinical settings has emphasized educators', supervisors', and students' perspectives. The experience of supervising interprofessional student teams (Chipchase et al., 2012; O'Leary et al., 2019) and how supervisors' own experiences with and attitudes toward interprofessional practice impact supervision and the initiation of formal and informal learning opportunities and activities (Marshall & Gordon, 2010; Reeves et al., 2016) have been elucidated. Studies have provided insight into how the specialized preparation and training of interprofessional supervisors are key to their becoming more comfortable in their role (Kristensen & Flo, 2014; O'Brien et al., 2019; O'Leary et al., 2019; Yang et al., 2017), as well as the ability of preparation to promote more positive student outcomes (Kent et al., 2017). While some studies have addressed patients' essential role in collaborative practice learning (Marshall & Gordon, 2005, 2010), few have provided insight into patients' role and perspective in interprofessional learning activities and supervision. Echoing O'Leary et al. (2019), Jensen et al. (2022a) have argued that the patient's role has been insufficiently articulated in research on IPE for undergraduates in clinical placements, and this topic needs to be explored further (Reeves et al., 2016).

Therefore, this study aimed to understand better how supervision facilitates and supports undergraduate students' learning of patient-centeredness in interprofessional clinical placements.

Theoretical underpinnings

This article draws on concepts from Erving Goffman's dramaturgical analysis. Goffman (1990) uses the (social) stage as a metaphor to understand how different persons act and

interact in everyday life, which he calls performance. According to Goffman (1990), humans assume different roles depending on the context. People strive to be perceived as likable in their various roles and fulfill expectations. When roles deviate from expectations, playing one's role properly may be hard.

Goffman (1990) distinguishes between being frontstage, which entails performing for an audience (of at least one other person), and being backstage, where performers can withdraw from the public gaze. Individuals perform frontstage daily when interacting with others in different settings. Only when someone withdraws backstage can they be honest and show who they are (Goffman, 1990). In his work, Goffman (1990) exemplifies several cases where there is a clear distinguishment between the interaction (attitude, language, manners, etc.) backstage compared to the frontstage. He illustrates how people can transition backstage to frontstage in seconds and "mask up" for their audience.

Interprofessional clinical placements, with all their actors, entail a complex performance where each actor has frontstage and backstage, and the team has a common frontstage and backstage. For students, the frontstage corresponds to encounters between student teams and patients. Backstage corresponds to moments when student teams are withdrawn, such as to their working area (nurse station, meeting rooms, etc.) or in informal settings such as breaks. For supervisors, the frontstage corresponds to occasions where they interact with individual students or student teams, and backstage corresponds to moments when they are withdrawn, for example, to their office. The patient's frontstage corresponds to their performance in front of students and health practitioners in a health care context, and backstage is, for instance, their designated room where they can relax.

Methodology

This study is part of a Nordic research collaboration between UiT The Arctic University of Norway, and Linköping University in Sweden through the project "Collaborating to learn and learning to collaborate: Interprofessional Education of health professionals for the 21st century". The aim is to explore interprofessional education (IPE) in clinical placements.

The research is positioned within a social constructionist perspective where "the world is produced and understood through interchanges between people and shared objects and activities" (Savin-Baden & Major, 2013, p. 62).

This study adopted a focused ethnographic approach (Andreassen et al., 2020) and is a collective case study (Kekeya, 2021). Focused ethnography is pragmatic and suitable for research on health professional education; topics are often pre-selected, and fieldwork is conducted within a particular timeframe or localized to an event (Higginbottom et al., 2013).

Two researchers generated data using multiple methods, including participant observation, semi-structured interviews, and informal conversations with interprofessional students, their supervisors, and patients in three contexts. Fieldwork began in February 2020 and concluded in September/October 2021. Data were subsequently analyzed within and across cases to understand patient-centeredness in the supervision of interprofessional students (Kekeya, 2021).

Study contexts

The study contexts were a Norwegian community health center ("the health center"), a Norwegian rehabilitation facility ("the rehab"), and a Swedish interprofessional training ward ("the IPTW").

The health center provides intermediate care, mainly for older patients with complex health issues. Patients are admitted from a regional hospital or their homes, planning to return home or proceed to long-term care in a nursing home. Multiple student teams oversaw 2-3 patients' daily follow-ups during placements.

The rehab provides specialized interprofessional rehabilitation of patients with complex functional impairment following illness or injury. During the placement, the student team oversaw the daily follow-up of two patients.

The IPTW is located within an orthopedic hospital ward providing pre-and postoperative patient care. Student teams oversaw a variation of six patients during the placements, both admitting and discharging patient underway.

[Table 1 near here]

The supervisors in the three contexts were clinicians responsible for supervising students from their profession and interprofessional teams. On a day-to-day basis, the supervisors provide health care from their different professions, and in periods with students on placement, they also supervise students. The supervision task is a part of their job description and not something they were hired to do specifically. The only exception was the supervisor in the rehab, who did not have a clinical position.

Participants and recruitment

Study participants were recruited via purposeful sampling (Patton, 2002). On-site personnel supported recruitment by providing oral and written information about the study before placements started. Posters were hung up in the ward to inform about the researcher's presence and agenda. When meeting participants in person, information was repeated.

47 students, 19 supervisors, and six patients gave written consent to participate in the study. All participants were recruited for participant observation, but a sample was invited to give interviews in the two Norwegian contexts. Where there were multiple teams, a selection of students was invited. We aimed for heterogeneous groups representing a broad experience base (Krueger & Casey, 2015). Thus, the selection was performed such that variation in professions, team affiliation, and, to the extent possible, gender could be attained. Interviewees were twelve students from the health center and four from the rehab.

All participating supervisors in the Norwegian context were invited to join group interviews, and three from each accepted the invitation.

A study regarding the interaction between the participating students and patients has been published elsewhere (Jensen et al., 2022b).

Empirical studies

Participant observation

The first author (CBJ, Ph.D. student, RN) conducted participant observations at the health center and the rehab, and co-author TT (Ph.D. student, Reg. OT) at the IPTW. Observations included student team meetings, interaction amongst team members, supervisors' interaction with student teams, and supervision sessions. An example of the observation protocol from the Norwegian context is provided in Appendix 1.

The health center observations were conducted in two separate periods with multiple student teams (two and three teams). CBJ rotated to the different teams' meetings as they prepared for patient encounters, undertook patient encounters, or during debriefing afterward.

At the rehab, observation occurred in the patient´s room or physiotherapy or occupational therapy facilities. Meetings exclusively with students and interaction

between the students and the supervisors were observed.

At the IPTW, TT alternated between day and night shifts. Observations occurred at the nurse station and during rounds and other scheduled meetings.

Jot notes were written during or immediately following participant observations. Depending on the situation, some notes generally focused on actions and interactions, while others referred to participant dialogue. Jottings were rewritten as comprehensive fieldnotes (Emerson et al., 2011).

Qualitative interviews and informal conversations

Focus group interviews (Krueger & Casey, 2015) were conducted with Norwegian students and supervisors. Interview guides comprising open-ended questions were developed to indicate the themes of interest (Appendix 2). Specific events from observations were central to the discussion in many interviews. Interviews were conducted face-to-face or on Microsoft Teams. CBJ moderated interviews, with AI as a co-moderator. Interviews were transcribed verbatim.

At the IPTW, TT had informal conversations with the participants when appropriate and invited them to elaborate on their perceptions of the clinical placement and their interactions with other team members, supervisors, and patients. Summary notes were then written.

Data analysis

CBJ performed a five-step reflexive thematic analysis (TA) (Braun & Clarke, 2022). TA offered flexibility to capture both semantic and latent patterns in the data. This supported our exploration of how interprofessional supervision is enacted in different contexts and how the patient perspective is thematized in supervision sessions.

Data were imported into NVivo (QSR International, 1999). At step one of the

TA, CBJ immersed in data by transcribing and re-reading the field notes. The first impression of the data was discussed with the research team. Further, codes were generated through a combination of data-derived (semantic) and researcher-derived (latent) codes (Braun & Clarke, 2013, 2020, 2022). Single words, sentences, or sections in interview transcriptions or field notes were the units of analysis. The coding of the interview data was mainly semantic, while the coding of the field notes was mainly latent.

Nevertheless, the field notes that cited dialogue between supervisors and students were coded semantically using participants' own words. After coding the entire dataset, the focus was narrowed to supervisors' interactions with students and patients. Themes were developed through a creative process alternating between codes and themes and between mind maps and written text. In research team meetings, proposed themes were scrutinized, revised, and refined. The analysis generated four themes: setting the agenda; alternating roles, presence, and positioning; illuminating interprofessional learning opportunities; and giving trust and independence.

Reflexivity

Reflexivity concerns turning the lens toward oneself as a researcher, which is essential in qualitative research to understand the researcher's role in generating knowledge (Berger, 2013). For instance, the research team scrutinizes CBJ´s positioning considering her professional background and experience from supervision in education and clinical settings. Here, the interprofessional composition of the research team promotes alternative perspectives to CBJ´s position, e.g., in data analysis. With the social constructivism underpinning the study, we acknowledge that the study's data generation, analysis, and reporting is a social construct and may have looked differently if other researchers were to conduct a similar study in the same context.

Ethics

The Norwegian Centre for Research Data (no. 831589) and The Swedish Ethical Review Authority (no. 2018/46-31) approved the study. All data were collected following the Helsinki Declaration and the Ethical Guidelines for Educational Research (British Educational Research Association, 2018). Participants provided written consent before data collection and could withdraw from the study anytime.

Results

Our findings show how interprofessional supervisors interacted with students and approached them in different roles and positions depending on their learning agenda. A key result is that supervisors were involved with student teams mainly in their backstage, not when the teams interacted with patients frontstage. Inclusion of the patient in supervision happened through questions illuminating interprofessional learning opportunities. However, our findings show that student teams' patient interaction was not scrutinized.

In the following subsections, we will provide empirical examples under the four themes the thematic analysis generated and interpret them through the lens of Goffman's dramaturgy.

Setting the agenda

Supervisors in interprofessional clinical placements play a crucial role in setting the agenda for student learning and collaboration. They direct what will happen through planning and organizing before students arrive and assume an active role through daily interactions with student teams.

Supervisors provide pre-planned schedules for students with fixed times for different activities. The schedule was described in more detail at the health center in the

first observation period than in the second. The supervisors reported that their need for a more rigid schedule decreased as they gained more organizational experience. At the rehab and the IPTW, schedules were detailed, with set times for different patient activities (e.g., morning routines, meals, pre-rounds, physical therapy, etc.) and student activities (e.g., supervision sessions, lunch, professional supervision). At the rehab, supervisors emphasized that the schedule is flexible and meant only to guide the students; however, students tended to perceive the schedule as fixed and followed it slavishly.

At the health center and the rehab, selecting appropriate patients is an essential preparatory task. Supervisors set the agenda by constructing collaborative learning opportunities for students. Supervisors reported that finding "suitable" patients for learning arrangements in these contexts is time-consuming. "Suitable" patients need to be complex to allow all student team members to identify their roles and undertake professional tasks. One supervisor reported that the selection process is sometimes characterized by last-minute decisions that disturb the learning process when it becomes evident that the patient may not be appropriate. The statement below illustrates such an experience.

> It is crucial which patients are chosen, and what amazes me – because this happens again and again – is that no one knows [the answer to the question] "Who decided on these patients?" and [then they ask] "Should we not do it together?" or [they say] "Oh, the placement starts on Monday, and we have not found any patients yet." And I think putting a little effort into finding patients will make the placement flow much better.

A supervisor from a different context echoed this and added another aspect from the patient's perspective.

> […] it's good to have patients where there is a bit [for the students] to grasp and where there are some health issues to assess and that we also link it to the professions we know will attend the IP placement. It could, for instance, be a drug review that may be

relevant or functional assessments […] also the patient must be interested in participating, which is very important, and preferably [the patient] himself or herself considers it beneficial to participate.

At the IPTW, setting the agenda for collaborative learning with patients is more organic, as the learning arrangement is more extended, and student teams oversee the admitted patients. Throughout placements, patients change several times, and supervisors do not fully control patient suitability, even if some ward admission criteria are provided. Our interpretation is that supervisors at the IPTW must be prepared to improvise and cannot shape the agenda as much as in the constructed arrangements the other contexts represent. Nevertheless, across all contexts, supervisors set the stage for students to identify their role backstage during teamwork and frontstage when interacting with the patient. Whereas the backstage setting is more controlled, with plans and objectives for student team meetings, the frontstage setting with patients is, in all contexts, largely outside the supervisor's control; that is, supervisors cannot strictly plan performance in this setting.

Another aspect of setting the agenda became apparent through observation of what we considered planned supervision sessions across all contexts. In two contexts, supervisors reported having a "cheat sheet" for support during interprofessional supervising sessions. Many observed sessions were characterized by turn-taking, where students speak in turns, often about their different roles and how they can learn from each other. Supervisors leading the sessions had predetermined questions that pinpointed conversation topics, including student experiences such as patient encounters and teamwork. Supervisors acknowledged students' statements regarding different issues but occasionally scrutinized them further. When student teams initiated discussions about patient issues, supervisors even prompted them "to move the focus from the patient to themselves," a direction with which the students complied.

Alternating roles, presence, and positioning

Supervisors in two of the three contexts constantly moved in and out of the student teams backstage. At the IPTW, this movement happened in and out of the nurse station and in patient rooms, entailing supervisors working in proximity to the students and patients. Hence, supervisors were available throughout the day, and students actively approached them about theoretical and practical issues, while questions about collaboration and teamwork were rarely posed. Supervisors also moved in and out of the students' designated work area at the health center but kept a low profile when entering and leaving. Specifically, they sometimes whispered to each other if more than one supervisor was present. Here, supervisors observed and listened to student teams' conversations from a distance, for example, while sitting behind team members.

Nevertheless, supervisors' presence with student teams backstage facilitates reciprocal communication, where students can ask supervisors questions. At the rehab, the supervisor was only present with the team at set times and did not come and go. In the rehab, supervisors scheduled supervision sessions with student teams and did not observe or approach teams unannounced.

Supervisors' frontstage presence varied greatly in this study. At the health center, two occasions where a supervisor joined the student team when encountering a patient were observed. On the first occasion, the supervisor introduced the students to the patient and then left the room. On the second occasion, the supervisor was present to ensure proper handling of a medical device the patient needed. Beyond such situations, supervisors at the health center and the rehab did not interact with patients or observe student teams interacting with patients frontstage. In contrast, supervisors at the IPTW were always present, during both day and evening shifts. Their presence is characterized by working shoulder-by-shoulder with student teams and having knowledge about and relations with both students and patients. On several occasions, students approached the

supervisors with specific patient problems, and the supervisor responded immediately, sometimes going frontstage to interact with patients alongside students. At the IPTW, students were not explicitly instructed to interact with patients in teams; thus, on many occasions, students met with patients one on one.

Besides varying their presence, supervisors also changed roles depending on the agenda and the learning activity. For example, a supervisor at the IPTW changed roles every few hours: a colleague (working shoulder to shoulder) during morning routines, a background observer during rounds, and presiding over students' reflections in the afternoon. Supervisors at the health center alternated between being observers giving prompts from the background and presiding over supervision sessions. The rehab was unique in that the supervisor had the established role of leading the interprofessional supervision sessions.

Illuminating interprofessional learning opportunities

Across all contexts, supervisors illuminated opportunities for students to share learning experiences. This happened backstage through questioning, exemplifying, and facilitating activities that students could accomplish together with patients frontstage. Supervisors prompted student teams using questions and comments with various characteristics, including concerning the patient, the process, and theory or students' knowledge.

Patient-related questions were generic, for example, "What it´s like to be a patient for a day?" or specific to particular patient, such as "Have you asked her what she wants?" Some patient-related questions also concerned students' knowledge of a particular treatment; for instance, a supervisor said: "I ask out of curiosity, has anyone tried to find out why the patient is itching? Maybe you could involve the pharmacy

student from the other team?" Some questions were theoretical to force students to assume a professional role and explicate professional theoretical knowledge.

Across all contexts, teams were prompted on their teamwork and process; however, prompts were not always about the patient's situation. At the health center, this happened while teams were working together to prepare or during post-encounter meetings and planned supervision sessions. The example below shows how a supervisor at the health center tried to prompt a student team to reflect on their work process to facilitate more interprofessional collaboration among the students.

> A team comprising three nursing students, two pharmacy students, and a medical student was mapping one of their patient's health issues. The team decided to split up to work on different tasks; the nursing students met with the patient, while the other students remained at their workstations to peruse the electronic health record (EHR). After returning from seeing the patient, the three nursing students sat together discussing the encounter and reading the EHR on a widescreen. The medical and pharmacy students were working on three computers facing away from the nursing students.
>
> The supervisor entered the room and immediately reacted upon seeing the students. Standing between the students, she asked them to kindly stop what they are doing and said, in a calm and curious tone, "Can you tell me what I am looking at right now?" The pharmacy and medical students turned around and replied, "We have split up. We are perusing the information from each profession's point of view." The IP supervisor responded, "How about processing this information together?" Before anyone answered, she continued by giving an example of the difference between multidisciplinary and interprofessional collaboration: "What does it take to have good interprofessional collaboration versus multidisciplinary work? Is this what is happening here now? You are sitting in the same room, but are you taking advantage of that?"

At the rehab, the student team spent most of their time working with each other and with patients without supervisors present. This resulted in few prompts or interruptions to their backstage teamwork and frontstage interaction with patients.

Facilitating trust and independence

The final theme describes how supervisors trust student teams in patient interaction and how independent teamwork is emphasized as an essential principle in clinical learning arrangements.

Independence was an underlying principle across all contexts. It may be related to the point in the educational process where most students are situated and the expectations of students who are almost finished their professional training. It seems that supervisors expected students to handle frontstage performances with patients independently; hence, supervisors did not need to play a role in this performance. Supervisors seemed to trust students to make independent professional choices regarding the measures and actions in the patients' interest.

Across all contexts, supervisors emphasized how they let student teams work toward a joint decision regarding patients. One supervisor said that it is necessary "to manage to sit on one's hands" and elaborated that supervisors often feel the urge to help student teams by providing answers and suggestions regarding their plans and actions involving patients frontstage but actively refrain from intervening to allow the team generates their course of action. In her words: "Several times this morning, I wanted to say, 'Have you thought about this or that?' but they eventually reach an answer, even if it takes a while […]." Another supervisor also exemplified this, as follows:

> Today, they [the student team] were going to see a patient with cognitive impairment, and my immediate thought was, "Oh, the whole team should not go in," but I managed to hold back while they discussed and shared a bit about what a cognitive impairment is. They eventually realized after a while that only two [students] should see that patient. Then, I realized that teams will eventually find the answer, but I want to make sure they get there, and I may have to intervene as a supervisor if I see that they don't, but it was an excellent experience for me [to see that they did].

Both excerpts show how supervisors suppressed their immediate instinct to guide student teams with questions and comments in favor of letting the students play leading roles in their teamwork.

As previously mentioned, in two of the three contexts, supervisors did not observe or assume a role frontstage; instead, they oversaw the student teams' preparations and finishing work and received briefings in supervision sessions on how the team interacted with patients. Several students recognized the principle of becoming independent but sometimes missed the supervisor's presence in patient encounters frontstage and when working backstage with the student team. A medical student at the health center said:

> We were a large team in the patient room, but if a supervisor had been present, they could have given us some feedback, which would have been helpful. Because we don't know, I mean, the patient seemed positive and happy, but it would be nice if someone with an outsider's perspective had observed the encounter.

A nursing student at the rehab commented as follows regarding backstage preparations before meeting a patient for the first time:

> I almost felt a kind of lack of a supervisor or [a] superior, not management but someone who has some idea of what we are meant to do. I somehow did not quite know what it was, what the intention was, so we had to find out a bit of it ourselves together […] We did not get any feedback on whether it [the preparations, interactions with patients, etc.] was done right, so that caused some uncertainty (laughs a little).

Despite these experiences, none of the students expressed these feelings to the supervisors during the interprofessional supervision sessions or on other occasions that involved interacting with supervisors. Moreover, the supervisors did not ask about students' thoughts on this matter.

Discussion

This study explored how supervisors include the patient and stimulate a patient-centered approach when supervising undergraduate students in interprofessional clinical placements. Our findings are diverse but tell an overarching story of when, when not, and how the patient was involved. A patient focus was integrated into some supervision. However, the interaction between student teams and supervisors seemed to address practical issues or competencies such as understanding each other's roles, team collaboration, and work processes. Looking through Goffman's (1990) lens, it was an unexpected finding that supervisors mainly situated themselves with student teams backstage is interesting.

Integrated and spontaneous supervision, following Tveiten (2019) definition, occurred when supervisors were present with interprofessional student teams during preparation for or processing patient encounters. Supervisors' presence facilitated reciprocal dialogue characterized by questions and prompts. The conversation was based on what are regarded as core competencies in interprofessional education, for instance, the domains that IPEC (2016) has proposed. On the other hand, students approached supervisors with many practical issues related to pending patient procedures or about where to find appropriate equipment; few, if any, questions were identified that were rooted in interprofessional core competencies or considerations regarding student teamwork or teams' encounters with patients.

The terms "reflection" or "reflection hour" were used in student schedules to denote supervisors' conversations with students in two of the contexts (see Table 1). Reflection is a central part of supervision, which was essential to our study's supervisors. Reflection aims to return to an experience or event and think about and analyze it to develop competencies and future practice (Schön, 1987). At the IPTW,

"reflection" denote a planned daily event involving the student team and the supervisor during the day shift.

From our point of view, these daily reflection sessions fall within the frame of planned and structured supervision, with a reflective learning model as the basis for the session. Davys et al. (2021) also found that supervisors emphasized reflective learning models in interprofessional supervision and considered it more important to use such an approach when dealing with various professional backgrounds. The supervisors seem to consider incorporating reflective approaches in interprofessional clinical placements meaningful, for example, through their questions or prompts. Nevertheless, planned supervision sessions across contexts were characterized by turn-taking, which aimed to include everyone and ensure that each person had the chance to participate. This technique may help supervisors decide which path to follow in subsequent supervision (Tveiten, 2019). However, across the cases in our study, a fresh round often continued with a new question from the agenda and thus did not inform a specific supervision direction. Our findings show few instances of deep exploration of students' issues; although supervisors acknowledged what was said, they did not scrutinize the content. Even when students were explicitly invited to reflect on experiences after a shift, there were few cases of a true exploration of what was said and how related matters affected student team members' interactions with each other and patients. It is paradoxical that the supervisors emphasize the importance of choosing suitable patients for interprofessional teamwork learning but do not use the patient as outspring for reflection and, thereby, learning. Learning in clinical settings must be "initiated by the learner's needs, goals, and interests" (Ramani & Leinster, 2008, p. 349).

Supervisors' frontstage presence was rare in two of the contexts examined in this study, and what happened in that setting went unthematized in the planned supervision

sessions. From a researcher's perspective, the supervisors' frontstage presence was often related to specific and practical issues and not focused on gaining insight into patient encounters. Some students reported missing the supervisor's presence and the opportunity for feedback and support on their team's interaction with patients. On the one hand, this could be the supervisors' way of "sitting on their hands" to endow the student teams with trust and encourage independence, thereby facilitating greater student ownership in frontstage performance. This technique is supported by other studies that have described students' positive perceptions of taking an active role with patients. However, the same study also reported some criticism from students regarding supervision and how it was organized (Ericson et al., 2012). Claeys et al. (2022) noted that students need a balance between autonomy and supervisory support, while Ramani and Leinster (2008) underlined that directly observing the learner–patient interaction can be "very illuminating" (p. 353) and helpful in planning future learning activities. They also emphasized that directly observing students is crucial to giving appropriate feedback (Ramani & Leinster, 2008). Feedback can be highly beneficial to students, as it can help them better understand their performance, why they may have performed in a certain way, and how they can improve (Wisniewski et al., 2020). From our perspective, the supervisors' emphasis on backstage presence in interprofessional placements was partly in line with Bleakley and Bligh (2008), who called for medical educators to assume a more withdrawn and facilitating role. However, it is unclear whether Bleakley and Bligh's (2008) suggestion of stepping aside was meant to be taken literally to the extent identified in our data. As researchers, we believe feedback on students' interprofessional collaboration during patient encounters can highlight important learning aspects related to patient-centeredness and the core competencies students are expected to develop.

Cheema et al. (2022) addressed issues related to the supervision of medical students and the influence of patient presence in supervision sessions on students' and supervisors' patient-centeredness, for instance, how they speak about the patient. Those scholars also referenced backstage and frontstage (Goffman, 1990) in the discussion of their findings, especially role disturbance due to patient presence in areas previously reserved for supervisors and students. Like in the interprofessional placements, the supervisor was not present with students during the initial patient encounter Cheema et al. (2022). Traditionally, students' backstage is the exclusive locale of supervision. However, backstage becomes frontstage when the patient is present, thus another location where students must perform. Students and supervisors have perceived this new organization as challenging, but patients have reported that it helped them better understand their diagnosis and health issues. Patients felt empowered to correct students' perceptions of issues raised during encounters (Cheema et al., 2022). It is heartening to have studies such as Cheema et al. (2022) reporting innovative initiatives in clinical learning activities; it may represent a giant stride in supervising interprofessional student teams. Patient- and family-centeredness are emphasized in supervising and supporting collaborative learning (Marshall & Gordon, 2005, 2010), but interprofessional supervision is complex and challenging (Marshall & Gordon, 2005; Reeves et al., 2016). Even if learning about and improving collaboration in patients' interests (Marshall & Gordon, 2005) are the main focus, it may be a giant leap—at this point—to include the patient in supervision sessions, as in Cheema et al. (2022). As researchers and educators, we propose starting with an enhanced and more conscious patient focus in dialogue and reflections in integrated and planned supervision. Hence, the patient perspective will constitute the basis for interprofessional learning in clinical settings, and we can realize the potential for enhancing patient-centeredness in IPE.

Across the contexts in our study, supervisors in interprofessional clinical placements enable students to learn with, from, and about each other. Our findings also suggest that supervisors competently support students in identifying how this happens in their interactions, demonstrating supervisors' awareness of the (first part of the) definition of IPE. However, patients' unique perspective on what good quality of care and services entail is less scrutinized. Moreover, across all contexts, there are multiple opportunities for dialoguing about and exploration of interprofessional (student) teams' experiences with patients. Nevertheless, as researchers we question whether, for instance, the predetermined questions that supervisors often use as support do more harm than good, especially regarding the theme of patient-centeredness. When interpreting the data, it may seem that predetermined questions hinder supervisors from delving into spontaneous dialogue about patient encounters and, to use a metaphor, may thus imprison supervisors within the confines of the agenda.

The interprofessional clinical placements observed in our study can be gold mines for authentic interprofessional collaboration learning with patients as a starting point. Supervisors know the need to facilitate and support student learning with, from, and about each other. However, the patient-centered focus is casual and does not permeate discussions on other core competency aspects. Supervisors' approach to students is incongruent with our understanding of supervision in clinical settings. Researchers and educators have been shaped by their own experiences of being supervised and supervise (Davys et al., 2021). This study does not explore how each supervisor perceives and understands what supervision is for them. However, if our understanding is prevalent, this implies that higher education institutions offering formal and informal courses for supervisors in interprofessional clinical placements have some work to do. This work includes facilitating development in organizing the

supervision of interprofessional teams and inclusion of the patient, who is always the object of health care (Engeström, 2000), whether professional or interprofessional. Specifically, this entails enabling and empowering supervisors and their competencies and confidence in allowing interprofessional students to learn from the patient and strengthening their ability to invite unforeseen themes (about patient encounters) in supervision. The latter can be seen as an extension of the supervisory principle of fostering independence by "sitting on one's hands," as it may invite students to decide what their subject of scrutiny includes.

Although the findings in this paper are reported by distinguishing between different contexts or connecting them, an explicit discussion on how contextual factors influence supervision is not performed. Some of our findings suggest that the context in which supervision is enacted influences how and when supervision occurs (or does not) and how the patient-centered focus is included. A greater focus on the context in future studies could generate interesting findings that further account for the impact of context on supervision and the facilitation of patient-centeredness.

Strengths and limitations
It is important to highlight that this is a study of undergraduate health professional students, in two high-income Scandinavian countries with well-adapted welfare systems. The transferability to other contexts must be carefully considered.

By generating data in various contexts, we adopted a holistic focus, striving to capture the complexity of our observations. In this study, supervisors' actions and interactions are considered a part of the big picture. A holistic focus may be a strength as supervisors' practice may be considered organic and naturally enacted with student teams. However, in the IPTW, we were unable to observe frontstage due to Covid-19

restrictions. Future research in IPTWs would benefit from gaining more insight into this.

It can be considered both a strength and a weakness that not all authors had first-hand knowledge of the data and the different contexts, as only one researcher in each context generated data. However, the research team extensively discussed data generation, analysis, and possible interpretations. The different perspectives and combination of the researchers' insider and outsider perspectives are considered essential to the study's quality.

Given the focus of this paper—how supervisors facilitate undergraduate students´ learning of patient-centeredness—another limitation is the lack of involvement of patients as e.g., contributers in designing the study or co-researchers.

Conclusion

Notwithstanding these limitations, this study highlights when, when not, and how supervisors in different Nordic contexts support student learning in interprofessional clinical placements and how they include the patient in their supervision practice. Our study shows that supervisors are excelling at highlighting the teamwork aspect of interprofessional student teams but may benefit from more explicit awareness of the patient-centered part. By doing so, they can support and facilitate students' learning and enactment of patient-centered care in interprofessional care provision. We have suggested some specific focus areas that can contribute to developing future education for clinical supervisors of interprofessional student teams through building competencies that engender their confidence to step outside of set agendas and engage with unforeseen events that patients may introduce to learning interprofessional teamwork.

Declaration of interest
We report no conflict of interest.

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Table 1. A comprehensive overview of the contexts.

Contexts	The health center (Norway)	The rehab (Norway)	The IPTW (Sweden)
Length	2-4 days (day shifts)	5 days (day shifts)	10 days (day and night shifts)
Instructions for students	Engage in interprofessional collaboration when encountering, performing daily follow-up with, and providing care for patients in the ward. Keep an interprofessional journal, including observations and suggestions for further care.	Engage in interprofessional collaboration according to the detailed timetable (showing a variety of activities for students to undertake, e.g., physiotherapy sessions, morning routines, etc.).	Work as part of an interprofessional student team to oversee the daily care, mobilization, and rehabilitation of patients. Daily holding points are displayed on a timetable, including morning routines, rounds, patient meals, supervision, lunchtime, etc.
Participating students' professions	Final-year students from: Nursing (n = 17) Medicine (n = 5) Physiotherapy (n = 3) Occupational therapy (n = 1) Pharmacy (n = 6)	Second- and final-year students from: Nursing (2nd year) (n = 3) Occupational therapy (n = 1) Physiotherapy (n = 1)	Final-year students from: Nursing (n = 5) Medicine (n = 3) Occupational therapy (n = 1) Physiotherapy (n = 1)
Team size	5-6 students	5 students	5-6 students
Participating supervisor´s professions	RN (n = 4) Medical doctor (n = 1) Physiotherapist (n = 1) Pharmacist (n = 1)	RN (n = 1) Physiotherapist (n = 2) Occupational therapist (n = 1)	RN (n = 3) Medical doctor (n = 1) Physiotherapist (n = 1) Occupational therapist (n = 1)
Structure of interprofessional supervision	Scheduled time for interprofessional reflection (reflection hour; 1-2 h each period)	Scheduled interprofessional supervision (3 1-hour sessions)	Scheduled time for interprofessional reflection (1-2 h at the end of the day shift)

Appendices 1-12

Appendix 1 – Information about the researcher´s presence in the ward

Appendix 2 – Standard information letter to patients with consent form

Appendix 3 – Simplified information letter to patients

Appendix 4 – Standard information letter to students with consent form

Appendix 5 - Standard information letter to supervisors with consent form

Appendix 6 – Observation Protocol

Appendix 7 – Interview guide Focus Groups (students)

Appendix 8 – Interview guide individual interviews (patients)

Appendix 9 – Interview guide group interviews (supervisors)

Appendix 10 – Original approval from Norwegian Centre for Research Data

Appendix 11 – Approval from The Swedish Ethical Review Authorities

Appendix 12 – Approval of notification of change from Norwegian Centre for Research Data

Appendix 1

Information about the researcher´s presence in the ward

Informasjon om forskning ved avdelingen

Jeg heter Catrine Buck Jensen og er doktorgradsstipendiat ved Det helsevitenskapelige fakultet ved UiT Norges arktiske universitet. Jeg er utdannet sykepleier og pedagog og har min arbeidsbakgrunn fra akutt geriatri, hjemmetjeneste samt som lærer på sykepleierutdanningen ved UiT.

Avdelingen du er pasient eller pårørende ved deltar i et forskningsprosjekt med tittel "Pasientens rolle og inkludering i tverrprofesjonell studentpraksis". Jeg vil i den forbindelse oppholde meg som forsker ved Sunnaas i en periode sammen med studenter fra ulike helsefagutdanninger.

Dagene forskningen pågår er mandag til fredag i uke 39 (27.september til 1.oktober)

Forskningen har til hensikt å gi kunnskap om hvordan pasienten inkluderes når helseprofesjonsstudenter skal lære å samarbeide med hverandre i sine praksisstudier.

Avdelingen har i forkant av forskningsperiodens oppstart avklart med de pasienter og evt. pårørende som studentene arbeider med, at de har samtykket til mitt nærvær i pleie- og behandlingssituasjoner. For forskningen vil det være av interesse at forsker følger studentene i aktiviteter knyttet til planlegging, gjennomføring og vurdering av eget tverrprofesjonelle samarbeid. Forskningen vil derfor ha nytte av at forsker får følge studentene inn i deres arbeid med pasienter, for å se hvordan de løser sitt samarbeide i pasientpleie og behandling. Dersom du er pasient eller pårørende som har samtykket til at forsker deltar i pleie og behandlingssituasjoner vil jeg informere om at du på et hvert tidspunkt har rett til å trekke deg og reservere deg mot at jeg som forsker følger studentene i den videre pleien og behandlingen. Ta kontakt med leder ved avdelingen dersom du ønsker å trekke tilbake samtykket.

Skulle du ha noen spørsmål knyttet til prosjektet er det bare å ta kontakt med meg når du ser meg i avdelingen, eller sende meg en e-post på catrine.b.jensen@uit.no

For andre spørsmål knyttet til avdelingens deltakelse i prosjektet eller tilbaketrekking av samtykke kan du kontakte leder ved avdelingen.

Vennlig hilsen Catrine Buck Jensen, doktorgradsstipendiat

Appendix 2

Standard information letter to patients with informed consent form

Vil du delta i forskningsprosjektet
"Pasientens rolle og inkludering i tverrprofesjonell studentpraksis"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske hvordan pasienter inkluderes i situasjoner hvor studenter fra ulike helsefagprofesjoner møtes i klinisk praksis for å øve på ferdigheter i tverrprofesjonelt samarbeid, såkalt tverrprofesjonell samarbeidslæring. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Dette er en doktorgradsstudie hvor vi ønsker å utforske hvordan pasienter inkluderes i situasjoner hvor studenter fra ulike helsefagprofesjoner møtes i klinisk praksis for å øve på ferdigheter i tverrprofesjonelt samarbeid. Med tverrprofesjonell samarbeidslæring (TPS) mener vi læresituasjoner hvor studenter fra to eller flere profesjoner lærer *med, fra og om hverandre* for å forbedre samarbeidet for pasientens beste.

Tidligere forskning på TPS har i liten grad vært fokusert direkte på pasientens rolle i slike læresituasjoner. I mange studier kommer det indirekte fram at TPS skal være pasientsentrert, men fokuset i forskningen har først og fremst vært på hvordan TPS gjennomføres, hva studenter lærer fra dette og hvordan det oppleves å samarbeide med andre studenter. Derfor ønsker vi å utforske hvordan pasienten blir inkludert når helsefagstudenter møtes for å lære tverrprofesjonelt samarbeid i kliniske praksisstudier.

Det overordnede spørsmålet som studien ønsker å besvare er; Hvordan inkluderes pasienten i helsefagstudenters tverrprofesjonelle læring og samarbeid?

Hvem er ansvarlig for forskningsprosjektet?
UiT Norges arktiske universitet er ansvarlig for prosjektet. UiT samarbeider med Linköpings universitet for å realisere prosjektet.

Hvorfor får du spørsmål om å delta?
Du får forespørsel om å delta fordi du har sagt ja til å møte og snakke med en gruppe helsefagstudenter tilknyttet NTNU.

Hva innebærer det for deg å delta?
Hvis du velger å delta i prosjektet, innebærer det at en forsker deltar og observere i det digitale møtet mellom deg og studentgruppen. Forskeren vil ta notater underveis og kanskje også stille utdypende spørsmål dersom situasjonen tillater det.

Etterpå inviteres du til et digitalt intervju eller telefonintervju (etter hva som passer best for deg) hvor du får anledning til å fortelle forskeren om ditt møte med studentene. Intervjuet vil vare ca. 30-45 minutter. Det vil bli gjort lydopptak og skrevet notater i intervjuet.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert.

Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt forhold til studentene, NTNU eller den eventuelle helseinstitusjonen du er tilknyttet vil ikke under noen omstendigheter bli påvirket av om du deltar eller ikke.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

Ved UiT Norges arktiske universitet vil det kun være prosjektgruppen for doktorgradsstudiet som har tilgang til dine opplysninger. Navn og kontaktopplysninger vil erstattes med en kode som lagres på egen navneliste adskilt fra notater og intervjudata. Datamaterialet vil lagres på en godkjent forskningsserver og krypteres slik at informasjonen ikke kan forstås av andre.

Catrine Buck Jensen (doktorgradsstudent) vil være den som samler inn, bearbeider og lagrer data.

Prosjektleder Bente Norbye og veiledere i doktorgradsprosjektet Anita Iversen (hovedveileder), Madeleine Abrandt Dahlgren (biveileder) vil ha tilgang til anonymiserte data for å kunne bidra i analysering av disse.

Alle publikasjoner fra prosjektet, f.eks artikler, konferansepresentasjoner o.l. vil være anonymiserte og det vil ikke være mulig å gjenkjenne deg i disse.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Prosjektet skal etter planen avsluttes 14.08.2025. Personopplysninger og opptak slettes ved prosjektslutt.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:
- innsyn i hvilke personopplysninger som er registrert om deg
- å få rettet personopplysninger om deg
- få slettet personopplysninger om deg
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra UiT Norges arktiske universitet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:
UiT Norges arktiske universitet ved

- Prosjektansvarlig Bente Norbye på e-post (bente.norbye@uit.no) eller telefon: 776 25154
- Doktorgradsstipendiat Catrine Buck Jensen på e-post (catrine.b.jensen@uit.no) eller telefon: 776 20958
- Vårt personvernombud: Joakim Bakkevold på e-post (personvernombud@uit.no) eller telefon: 776 46322
- NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Bente Norbye   Catrine Buck Jensen
Prosjektansvarlig/   Doktorgradsstudent
biveileder

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet **Pasientens rolle og inkludering i tverrprofesjonell studentpraksis** og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ☐ at forskeren kan delta som observatør i det digitale møtet jeg har med helsefagstudenter fra NTNU
- ☐ å delta i et intervju så snart det passer, dersom det blir aktuelt
- ☐ at forskeren kan være til stede dersom helsefagstudenter (evt. sammen med veiledere) har faglige samtaler og diskusjoner om meg som pasient

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca.14.08.2025

(Signert av prosjektdeltaker, dato)

Vil du delta i forskningsprosjektet
"Pasientens rolle og inkludering i tverrprofesjonell studentpraksis"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske hvordan pasienter inkluderes i situasjoner hvor studenter fra ulike helsefagprofesjoner møtes i klinisk praksis for å øve på ferdigheter i tverrprofesjonelt samarbeid, såkalt tverrprofesjonell samarbeidslæring. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Dette er en doktorgradsstudie hvor vi ønsker å utforske hvordan pasienter inkluderes i situasjoner hvor studenter fra ulike helsefagprofesjoner møtes i klinisk praksis for å øve på ferdigheter i tverrprofesjonelt samarbeid. Med tverrprofesjonell samarbeidslæring (TPS) mener vi læresituasjoner hvor studenter fra to eller flere profesjoner lærer *med, fra og om hverandre* for å forbedre samarbeidet for pasientens beste.

Tidligere forskning på TPS har i liten grad vært fokusert direkte på pasientens rolle i slike læresituasjoner. I mange studier kommer det indirekte fram at TPS skal være pasientsentrert, men fokuset i forskning har først og fremst vært på hvordan TPS gjennomføres, hva studenter lærer fra dette og hvordan det oppleves å samarbeide med andre studenter. Derfor ønsker vi å utforske hvordan pasienten blir inkludert når helsefagstudenter møtes for å lære tverrprofesjonelt samarbeid i kliniske praksisstudier.

Det overordnede spørsmålet som studien ønsker å besvare er; Hvordan inkluderes pasienten i helsefagstudenters tverrprofesjonelle læring og samarbeid?

Hvem er ansvarlig for forskningsprosjektet?
UiT Norges arktiske universitet er ansvarlig for prosjektet. UiT samarbeider med Linköpings universitet for å realisere prosjektet.

Hvorfor får du spørsmål om å delta?
Du får forespørsel om å delta fordi du er pasient ved Sunnaas sykehus HF og innlagt på en avdeling hvor en tverrprofesjonell studentgruppe har sin praksis.

Hva innebærer det for deg å delta?
Hvis du velger å delta i prosjektet, innebærer det at en forsker kan delta og observere i situasjoner hvor du og studentene møtes. Forskeren vil ta notater underveis og kanskje også stille utdypende spørsmål dersom situasjonen tillater det.

Etterpå inviteres du til et intervju hvor du får anledning til å fortelle forskeren om ditt møte med studentene. Intervjuet vil ta ca. 30-45 minutter. Det vil bli gjort lydopptak og skrevet notater i intervjuet.

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Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert.

Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt forhold til studentene, Sunnaas sykehus eller helsepersonellet som arbeider der vil ikke under noen omstendigheter bli påvirket av om du deltar eller ikke.

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Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Prosjektet skal etter planen avsluttes 14.08.2025. Personopplysninger og opptak slettes ved prosjektslutt.

Dine rettigheter
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Med vennlig hilsen

Bente Norbye   Catrine Buck Jensen
Prosjektansvarlig/   Doktorgradsstudent
biveileder

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet **Pasientens rolle og inkludering i tverrprofesjonell studentpraksis** og har fått anledning til å stille spørsmål. Jeg samtykker til:

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Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca.14.08.2025

(Signert av prosjektdeltaker, dato)

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Med vennlig hilsen

Bente Norbye   Catrine Buck Jensen
Prosjektansvarlig/   Doktorgradsstudent
biveileder

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet **Pasientens rolle og inkludering i tverrprofesjonell studentpraksis** og har fått anledning til å stille spørsmål. Jeg samtykker til:

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Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca.14.08.2025

(Signert av prosjektdeltaker, dato)

Appendix 3

Simplified information letter to patients

Informasjon om forskning ved avdelingen

Jeg heter Catrine Buck Jensen og er doktorgradsstipendiat ved Det helsevitenskapelige fakultet ved UiT Norges arktiske universitet. Jeg er utdannet sykepleier og pedagog og har min arbeidsbakgrunn fra akutt geriatri, hjemmetjeneste samt som lærer på sykepleierutdanningen ved UiT.

Avdelingen du er pasient eller pårørende ved deltar i et forskningsprosjekt med tittel "Pasientens rolle og inkludering i tverrprofesjonell studentpraksis". Jeg vil i den forbindelse oppholde meg som forsker ved avdelingen i en fire-dagers periode sammen med studenter fra ulike helsefagutdanninger.

Dagene forskningen pågår er mandag, tirsdag, onsdag og torsdag i uke 8 (17.-20.februar 2020)

Forskningen har til hensikt å gi kunnskap om hvordan pasienten inkluderes når helseprofesjonsstudenter samarbeider tverrprofesjonelt i sine praksisstudier.

Avdelingssykepleier har i forkant av forskningsperiodens oppstart avklart med de pasienter og pårørende som studentene arbeider med, at de har samtykket til mitt nærvær i pleie- og behandlingssituasjoner. For forskningen vil det være av interesse at forsker følger studentene i aktiviteter knyttet til planlegging, gjennomføring og vurdering av eget tverrprofesjonelle samarbeid. Forskningen vil derfor ha nytte av at forsker får følge studentene inn i deres arbeid med pasienter, for å se hvordan de løser sitt samarbeide i pasientpleie og behandling. Dersom du er pasient eller pårørende som har samtykket til at forsker deltar i pleie og behandlingssituasjoner vil jeg informere om at du på et hvert tidspunkt har rett til å trekke deg og reservere deg mot at jeg som forsker følger studentene i den videre pleien og behandlingen. Ta kontakt med avdelingssykepleier ved avdelingen dersom du ønsker å trekke tilbake samtykket.

Skulle du ha noen spørsmål knyttet til prosjektet er det bare å ta kontakt med meg når du ser meg i avdelingen, eller sende meg en e-post på catrine.b.jensen@uit.no

For andre spørsmål knyttet til avdelingens deltakelse i prosjektet eller tilbaketrekking av samtykke kan du kontakte avdelingssykepleier ved avdelingen.

Vennlig hilsen,

Catrine Buck Jensen, stipendiat

Appendix 4

Standard information letter to students with consent form

Vil du delta i forskningsprosjektet

"Pasientens rolle og inkludering i tverrprofesjonell studentpraksis"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske hvordan pasienter inkluderes i situasjoner hvor studenter fra ulike helsefagprofesjoner møtes i klinisk praksis for å øve på ferdigheter i tverrprofesjonelt samarbeid, såkalt tverrprofesjonell samarbeidslæring I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

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Tidligere forskning på TPS har i liten grad vært fokusert direkte på pasientens rolle i slike læresituasjoner. I mange studier kommer det implisitt fram at TPS skal være pasientsentrert, men fokuset i forskningen har først og fremst vært på hvordan TPS gjennomføres, hva studenter lærer fra dette og hvordan det oppleves å samarbeide med andre profesjonsstudenter. Dette til tross for at lovverket gir klare føringer for at pasienter skal involveres og medvirke i avgjørelser knyttet til egen helse samt utvikling av helsetjenester og helsetjenestetilbud (Pasient- og brukerrettighetsloven, 1999). Denne studien søker derfor å utforske hvordan pasienten blir inkludert når helsefagstudenter møtes for å lære tverrprofesjonelt samarbeid i kliniske praksisstudier.

Det overordnede spørsmålet som vi ønsker å besvare er; Hvordan inkluderes pasienten i helsefagstudenters tverrprofesjonelle læring og samarbeid?

Hvem er ansvarlig for forskningsprosjektet?
UiT Norges arktiske universitet er ansvarlig for prosjektet. UiT samarbeider med Linköpings universitet for å realisere prosjektet.

Hvorfor får du spørsmål om å delta?
Du får forespørsel om å delta fordi du gjennomfører tverrprofesjonell samarbeidslæring i praksis (TverrPraks) i regi av NTNU og skal delta læringsaktiviteter hvor TPS er i fokus.

Hva innebærer det for deg å delta?
Hvis du velger å delta i prosjektet, innebærer det at en forsker vil delta og observere i situasjoner hvor du og dine medstudenter på en digital plattform: 1) Forbereder møte med pasient 2) Møter pasient 3) Gjennomfører evt etterarbeid/refleksjoner etter møte med pasient. Forskeren vil ta notater underveis og kanskje også stille utdypende spørsmål dersom situasjonen tillater det.

Deretter inviteres du til enten et individuelt intervju eller et fokusgruppeintervju sammen med dine medstudenter hvor du/dere kan utdype det forskeren har observert. Individuelt intervju vil ta ca. 30-45 minutter, fokusgruppeintervju vil ta ca 90 minutter. Begge deler vil skje i Microsoft Teams. Det vil bli gjort lydopptak og skrevet notater i intervjuet.

I forbindelse med prosjektet vil forskeren også invitere pasienter som studentene har vært i kontakt med til intervju. Disse vil i få anledning til å fortelle om sin opplevelse av studentgruppas TPS-møter utfra sitt perspektiv.

Det er frivillig å delta

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Ditt forhold til praksisplassen eller universitetet vil ikke i under noen omstendigheter bli påvirket av om du deltar eller ikke.

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- ☐ At forskeren deltar som deltakende observatør i de ulike situasjonene skissert over
- ☐ å delta i intervju, enten i gruppe eller individuelt

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca.14.08.2025

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Appendix 5

Standard information letter to supervisors with consent form

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Hvis du velger å delta i prosjektet, innebærer det at en forsker vil delta og observere i situasjoner hvor du og studentgruppen: 1) Forbereder møte med pasient 2) Møter pasient 3) Gjennomfører evt etterarbeid/refleksjoner etter møte med pasient. Forskeren vil ta notater underveis og kanskje også stille utdypende spørsmål dersom situasjonen tillater det.

Deretter inviteres du til intervju (enten individuelt eller med andre veiledere) hvor dere kan utdype det forskeren har observert. Intervjuet vil ta ca. 45 minutter. Det vil bli gjort lydopptak og skrevet notater i intervjuet.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt forhold til arbeidsplassen eller universitetet vil ikke i under noen omstendigheter bli påvirket av om du deltar eller ikke.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

Ved UiT Norges arktiske universitet vil det kun være prosjektgruppen for doktorgradsstudiet som har tilgang til dine opplysninger. Navn og kontaktopplysninger vil erstattes med en kode som lagres på egen navneliste adskilt fra notater eller intervjudata. Datamaterialet vil lagres på en godkjent forskningsserver og krypteres.

Catrine Buck Jensen (doktorgradsstipendiat) vil være den som samler inn, bearbeider og lagrer data.

Prosjektleder Bente Norbye og veiledere i doktorgradsprosjektet Anita Iversen (hovedveileder), Madeleine Abrandt Dahlgren (biveileder) vil ha tilgang til anonymiserte data for å kunne bidra i analysering av disse.

Alle publikasjoner fra prosjektet, f.eks artikler, konferansepresentasjoner o.l. vil være anonymiserte og det vil ikke være mulig å gjenkjenne deg i disse.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Prosjektet skal etter planen avsluttes 14.08.2025. Personopplysninger og opptak slettes ved prosjektslutt.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:
  - innsyn i hvilke personopplysninger som er registrert om deg,
  - å få rettet personopplysninger om deg,
  - få slettet personopplysninger om deg,
  - få utlevert en kopi av dine personopplysninger (dataportabilitet), og
  - å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra UiT Norges arktiske universitet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:
UiT Norges arktiske universitet ved

  • Prosjektansvarlig Bente Norbye på e-post (bente.norbye@uit.no) eller telefon: 776 25154

- Doktorgradsstipendiat Catrine Buck Jensen på e-post (catrine.b.jensen@uit.no) eller telefon: 900 522 94
- Vårt personvernombud: Joakim Bakkevold på e-post (personvernombud@uit.no) eller telefon: 776 46322
- NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Bente Norbye   Catrine Buck Jensen
Prosjektansvarlig/   Doktorgradsstipendiat
biveileder

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet **Pasientens rolle og inkludering i tverrprofesjonell studentpraksis** og har fått anledning til å stille spørsmål. Jeg samtykker til:

☐ At forskeren deltar som deltakende observatør i de ulike situasjonene skissert over
☐ å delta i intervju, enten individuelt eller i gruppe

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca.14.08.2025.

(Signert av prosjektdeltaker, dato)

Appendix 6

Observation Protocol

Observation protocol

WHEN	Date/Time
WHAT	What type of activity is going on? What do participants do? What do the participants say?
HOW	How is the activity performed? What do participants do? Body language/gestures/mood How do they sit/position themselves? How do they dress?
WHO	Who/which people are involved? Who talks to whom?
WHERE	Where does the activity take place? What does the physical environment look like? DRAW THE ROOM/PEOPLE'S LOCATION/IMPORTANT ITEMS
QUESTION	Current follow-up questions – to whom
PARTICIPANT REACTIVITY	Inquiries to the researcher from participants Could some of the behaviour be due to the researcher's presence? Could some of the behaviour be due to the research question and focus of the research project?

- What are your first impressions of the situation?
- What do you experience/react to/ are significant or not expected in the situation? How do people in the group react to this?
- Is there anything the people in the group react to otherwise?

TIPS for jottings;

1. Write down details of critical components (observed situations, interactions)
2. Write down sensory details (about the room, nonverbal expressions, colors, and shapes)
3. Write down what is being said, not your interpretation of it. Write down individual words that can help you remember the dialogue.
4. Write down emotional expressions.
5. Write down general impressions and feelings you get.

Appendix 7

Interview guide Focus Groups (students)

Interview guide - focus groups with interprofessional students

Interviews with the students is based on 1) The researcher's observation of the students 2) Aspects the researcher has not observed

Theme	Featured Questions (key questions marked with bold font)
Background	Which study programme do you belong to?
	What academic year are you in now?
Introduction	
	Welcome
	information about what the interview entails.
	The purpose and framework for focus group interviews
	- The purpose of the interview is to get an elaboration on what I have observed during the interprofessional placement and to shed light on it from the student's perspective
	- Talk to *each other* about the questions being asked/the topic
	- Say your honest opinion of what is being discussed, it is allowed to disagree – none of what is brought up may affect the practice assessment or similar
	- If the discussion in the group is about patients who have not consented to be part of the study, I will stop the discussion and move on to a new topic.
	- The interview is recorded on an audio recorder and I may take some notes along the way to keep in mind things that I want to follow up on/ask you questions about later in the interview.
	- Duration approx. 60-90 minutes
	- Please turn off your mobile phone or other things that may cause disturbances during the interview
	Can you confirm that you have consented to participate in the interview?
Opening sequence	
Opening question	Tell us your name, what study program you are from, and what you most like to do when you are not studying.
Transitional issues	Think back to when you first heard about IPE in clinical placements – what were your first thoughts on this?
Key topic: About the student's understanding of TPS practice with patients	
	Talk a little about the purpose of interprofessional clinical placements
	What is the reason why you will meet other students in clinical placements?
	Talk about how you prepared the collaboration around the patient

	What happened in the meeting between the students?
	What were you talking about?
	Who talked about what?
	How did you take advantage of each other's presence?
	Where do you obtain the information about the patient?
Keytopic: About patient encounters	
	What happened when you met the patient?
	How did you talk to the patient?
	What did you do with the patient? How do you ensure that the patient understands what is happening?
	How did you plan the division of labour?
	Are there rules for who should do what?
	Who decides the rules?
Alternatively	*Tell us about the assessments you made in order not to go in to the patient*
	How did you arrive at this decision?
	If you had met the patient, how do you think it would affect the interprofessional work?
Key topic: On reflection on interprofessional placements and the patient's role	
	Talk about what happened when you met in the reflection meeting with your supervisor
	How did the reflection meetings influence your thoughts and views on the patient's role?
	If you had the opportunity to redo the interprofessional placement, what would you do differently?
Ending	
	Summary of the interview (ass moderator) possibly elaborate on certain questions
	What has it been like to have a researcher with you throughout the day?
	How have you experienced participating in a focus group interview?
	Is there anything that you think should have been done differently?
	At the very end; What do you think is the most important thing you have discussed today?
	Thanks for participating!

Situations from the week that may be relevant to point back to:

Appendix 8

Interview guide individual interviews (patients)

Interview guide - patients

Tema	Featured Questions
Introduction/interview framework	Welcome/thank you for allowing me to come
	The purpose of the interview is to deepen the students' work in what we call interprofessional collaborative learning. I want to shed light on this from the patient's perspective, as well as the students and their supervisors. This type of practice is primarily about the students learning from, about and with each other in their encounters with the patient. I am here to see how the students work together with the patient when they "learn" in the ward
	To get the best possible interview: - Be honest about what you mean; everything said today is treated with confidentiality and will not be traced back to you. It will have no consequences on care and treatment here or elsewhere. - The interview is recorded on an audio recorder, and I may take some notes along the way to help me keep in mind things that I want to follow up on/ask you questions about later in the interview. - Duration approx. 30-45 minutes - Please turn off your mobile phone if necessary. Other things that may cause disturbances during the interview
	Can you confirm that you have consented to participate in the interview? Inform about the possibility of withdrawing consent or request access to what concerns you in the data material
Aperture	I would like to talk to you about the meeting you had with the health science students today/this morning. I would like to talk to you about meeting students from different health science educations when they are in practice
The patient's understanding of the students' encounter with it	
	Can you start by talking about the meeting you had with the health science students today?
	What was the reason these students came here?
	What students were here?
	How did they talk to you?
	Who was talking?
	What did they do to you?
	What did you say to them?
	What did you do?
The patient's expectations of meetings with interprofessional students	

	If you were to imagine the most ideal way to meet a group of health professional students, what would this meeting look like?
	What do you think students could learn from this meeting?
	What do you want to be able to contribute when it comes to your own health situation?
	(What did you get to contribute to the meeting today?)
	Can you tell me a little bit about how you would like to be met by students from different health professional educations?
	(How do your wishes match the meeting today?)
Ending	Summary of the interview
	What has it been like to have a researcher present?
	How have you experienced being interviewed?
	Is there anything that you think should have been done differently?
	What's the most important thing you think we've talked about in the interview?
	Is there anything you'd like to say that we haven't talked about?
	Thanks for participating!

Appendix 9

Interview guide group interviews (supervisors)

Interview guide - supervisors for interprofessional student groups

Interviews with supervisors are based on 1) The researcher's observation of supervisors in interaction with the students/patient and 2) Aspects that the researcher has not observed.

Theme	Featured Questions
Introduction	Welcome Information about what the interview entails - The purpose of the interview is to elaborate on what I have observed during the interprofessional placement and to shed light on it from the supervisor's perspective. - Be honest about what you mean; everything said today is treated with confidentiality and will not be traced back to you. - The interview is recorded on an audio recorder, and I may take some notes along the way to keep in mind things that I will follow up on/ask you questions about later in the interview. - Duration approx. 40-60 minutes - Please turn off your mobile phone or other things that may cause disturbances during the interview. Can you confirm that you consented to participate in the interview? Inform about the possibility of withdrawing consent or requesting access to what concerns the participant in the data material
Supervisor's background/context	
	Tell us about your practice as a health practitioner and supervisor for students
	How long is your professional practice?
	How long have you supervised students in clinical placements?
	How long have you been supervising interprofessional groups?
	Can you think back to when you first heard about interprofessional collaborative learning taking place in clinical placements, what did you think about that?
Key topic: About the supervisor's understanding of interprofessional placements with patients	
	What is the purpose of interprofessional collaborative learning in clinical placements?
	How is it organized here with you?
	Who is involved?
	What do you want to achieve?
Key topic: About the supervisor's preparations for the interprofessional placement	
	What preparations do you make before the placement period?

	What role does the supervisor have in this?
	How does the selection of relevant patients take place?
	What is the selection based on?
	How are patients prepared?
	What is your role in relation with the patient?
Key topic: Supervision of the interprofessional students during the placement and the patient's role	
	Tell us about how you follow up the group during the day/week?
	What did you do as a supervisor?
	Who does what?
	What happened when the students met the patient?
	Alternatively: What were the reasons why the students did not meet the patient?
	What do you think a patient meeting could have contributed with?
Key topic: On reflections on interprofessional learning and the patient's role	
	What happened when the students met for the reflection meeting?
	What did you do as a supervisor?
	What did you emphasize in the supervision?
	What guides the emphasized topics in the supervision sessions?
	What happens to the students' view/understanding of (own role in relations to the patient/patient's role) through the reflection meeting?
Ending	
	Summary of the interview
	What has it been like to have a researcher with you this day/week?
	How has the interview been?
	Is there anything that you think should have been done differently?
	What do you think is the most important thing we've talked about in the interview?
	Thanks for participating!

Situations from the past week which may be relevant to elaborate on:

Appendix 10

Original approval from Norwegian Centre for Research Data

Sikt

Vurdering av behandling av personopplysninger

Referansenummer
831589

Vurderingstype
Standard

Dato
11.12.2019

Prosjekttittel
Pasientens rolle og inkludering i tverrprofesjonell studentpraksis/Including the patient in Interprofessional learning and collaboration

Behandlingsansvarlig institusjon
UiT Norges Arktiske Universitet / Det helsevitenskapelige fakultet / Institutt for helse- og omsorgsfag

Prosjektansvarlig
Bente Norbye

Prosjektperiode
15.08.2019 - 14.08.2025

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 14.08.2025.

[Meldeskjema ↗](#)

Kommentar
BAKGRUNN
Prosjektet er vurdert av REK til å falle utenfor helseforskningslovens virkeområde (REK sin ref: 55397).

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 11.12.2019 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde: https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html

Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle særlige kategorier av personopplysninger om helseforhold og alminnelige kategorier av personopplysninger frem til 15.08.2025.

INFORMASJONSSKRIVET TIL UTVALG 3
Dersom dere skal delta på møter der studenter/veiledere diskuterer/reflekterer rundt møtet med pasienter må dere innhente eksplisitt samtykke fra pasientene til dette. Du må derfor legge til informasjon om dette i informasjonsskrivet til pasientene.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp

til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a, jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER

NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

– lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
– formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER

NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

TSD er databehandler i prosjektet. NSD legger til grunn at behandlingen oppfyller kravene til bruk av databehandler, jf. art 28 og 29.

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET

NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/ pågår i tråd med den behandlingen som er dokumentert.

Lykke til med prosjektet!

Kontaktperson hos NSD: Lise A. Haveraaen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Appendix 11

Approval from The Swedish Ethical Review Authorities

Regionala etikprövningsnämnden PROTOKOLLsutdrag 1(1)
i Linköping
Avdelningen för prövning av övrig
forskning

Sammanträdesdatum
2018-04-17   kl. 13:15-16:40
Plats: Konferensrummet, Medfaks kansli

Närvarande:

Ledamöter:
Owe Horned, f.d. lagman, ordförande
Åsa Nilsson Dahlström, universitetslektor, *(socialantropologi, kulturarv)*
vetenskaplig sekreterare
Gerhard Andersson, professor *(klinisk psykologi)*
Motzi Eklöf, docent *(hälsa-samhälle/vård- medicinhistoria)*
Katarina Eriksson Barajas, professor *(pedagogik)* ersätter Lars Björklund
Kristina Gustafsson, docent *(socialt arbete, etnologi)* deltar ej vid p 7, 9, 22, 23
Maria Gustavsson, professor *(pedagogik i arbetslivet)* deltar ej vid p 8
Mikael Heimann, professor *(utvecklingspsykologi)*
Ulf Melin, professor, *(informatik)*
Elin Palm, universitetslektor *(tillämpad etik)* deltar ej vid p 6
Lars Witell, professor *(företagsekonomi)*

Ledamöter som företräder allmänna intressen:
Örjan Albihn, studievägledare
Linnéa Darell, fd riksdagsledamot
Madeleine Johansson, företagare

Övriga:
Maria Hoffstedt, adm sekr

PUNKT	ÄRENDE	BESLUT

8. Komplettering av ansökan om etikprövning
    Forskningshuvudman: Linköpings universitet
    Forskare: Madeleine Abrandt Dahlgren, Inst. för medicin och hälsa, Linköpings universitet
    Projekt: Interprofessionellt lärande i praktiken: Studenters samarbete och samverkan med
    patienter i olika arrangemang för klinisk verksamhetsförlagd utbildning inom hälso- och
    sjukvård.
    Dnr **2018/46-31**
    Föredragande: Motzi Eklöf

    Nämnden har den 23 mars 2018 erhållit komplettering i ärendet. Nämnden godkänner
    ansökan.

    Maria Gustavsson anmäler jäv och närvarar inte vid beslutet.

Vid protokollet   Justeras

Åsa Nilsson Dahlström   Owe Horned

Att utdraget överensstämmer med originalet intygar:

Anna Alexandersson
Administrativ sekreterare

Beslutet expedierat till behörig företrädare och forskare

Appendix 12

Approval of notification of change from Norwegian Centre for Research Data

Vurdering av behandling av personopplysninger

Referansenummer	**Vurderingstype**	**Dato**
831589	Standard	26.11.2020

Prosjekttittel
Pasientens rolle og inkludering i tverrprofesjonell studentpraksis/Including the patient in Interprofessional learning and collaboration

Behandlingsansvarlig institusjon
UiT Norges Arktiske Universitet / Det helsevitenskapelige fakultet / Institutt for helse- og omsorgsfag

Prosjektansvarlig
Bente Norbye

Prosjektperiode
15.08.2019 - 14.08.2025

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 14.08.2025.

Meldeskjema ↗

Kommentar
NSD har vurdert endringen registrert 06.11.2020.

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg den 26.11.2020. Behandlingen kan fortsette.

Endringene gjelder at tre nye utdanningsinstitusjoner blir inkludert i prosjektet. Det skal gjøres feltarbeid av tverrprofesjonelle studenters møter med pasienter. Dette innebærer at det skal gjennomføres observasjon av møtet mellom student og pasient. Ved én institusjon gjennomføres møtene digitalt, og forskerne vil delta i det digitale møterommet.

Intervju med studenter i etterkant av observasjon vil gjennomføres via Microsoft Teams. Microsoft Teams vil dermed være databehandler i prosjektet. NSD legger til grunn at behandlingen oppfyller kravene til bruk av databehandler, jf. art 28 og 29.

LOVLIG GRUNNLAG
Det innhentes informert samtykke til deltakelse fra samtlige registrerte. Vår vurdering er at det legges opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a, jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Lykke til videre med prosjektet!

Kontaktperson hos NSD: Lise A. Haveraaen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)