PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Changing relationships: How does patient involvement transform professional identity? An ethnographic study
AUTHORS	Codsi, Marie-Pierre; Karazivan, Philippe; Rouly, Ghislaine; Leclaire, Marie; Boivin, A

VERSION 1 – REVIEW

REVIEWER	Dr Jess Drinkwater Leeds Institute of Health Sciences, University of Leeds UK
REVIEW RETURNED	16-Nov-2020

GENERAL COMMENTS	This is an important and well-conceived addition to the literature on PPI in health service improvement and should be published. The study focuses on the identity of professional partners in patient-partnering work which is an overlooked topic. However, there is detail missing in the methods, and the focus of the results and discussion slips toward patient partners' identities rather than professional partners' identities. Methods I would like more detail or a reference to explain what the authors mean by "Participatory ethnographic study". There is a wide literature on participant and non-participant observation in ethnography that could be used. I would like more detail on the study context. How many patients and staff does the family medicine clinic have? How often did the committee meet? How long were meetings? Were observations made opportunistically between meetings, or were observations limited to the meetings and time around the meetings? How were the ethical issues of participant observation addressed? There are 12 committee participants and only 9 interviews, but this is described as 100%. I'm assuming the participant observers weren't therefore interview, but this needs clarity as does the role of the participant observers. Data collection: Who conducted the interviews? Was each person interviewed once or more than once, and at what time points in the process were they interviewed? How many meetings, or hours of observation, were conducted? Data analysis: I am not sure what "analysis by conceptualising categories" means. The authors' state the coding was "entirely revised by ML" - was this a second analysis or a second coder? It would be nice to have more discussion of reflexivity in relation to the data collection and analysis. Particularly as observations were conducted by multiple observers, with different identities, of the same meeting – which is a strength. Results I would be interested to know whether there were differences in the

different professionals' identities. Particularly if there were differences between the clinical professionals and the secretary, receptionist, and manager who I assume do not have a clinical professional-patient relationship/identity. This is important as much of the discussion is related to professionals' clinical identities.

The first two sections of the results (stories and ideals), clearly focus on the findings related to the professionals' identity. The last three sections (balance, categorisation, and symbols) switch between professionals' identities and professionals' perceptions of patient partners' identities. I think the paper would have a greater impact if the focus remained on professionals' identities. I accept professionals' identities are influenced by patient identities, but this could be described more clearly.

For example:

P16 line 13-20 it could be argued professionals struggled to balance their identity of carer and partner, and as a result project vulnerability onto patients even when they are in a partner role.

P16 line 31-42 I know representation is a big issue, but I'm not sure it adds to this paper. Unless, the issue is professionals struggling to balance their own identities, because they are in flux with patients' identities. This is described in the next section (p16 line 45-55) – the patient switching identities forces the professional to confront their identity. Rather than reflecting on their own identity, they reflect on the patient identity and project a lack of legitimacy onto the patient.

P17 line 8-21 focuses on the definition of the patient partners' role. I am more interested in the discussion of the professionals' patient identity. I would focus this section on the professionals struggling with their multiple identities, including as patient. Therefore they project their identity issues onto patient partners which is my understanding of quote 1.4.b.

Section five needs to be clearer how remuneration effects professionals' identity (for the record I agree it does). Do professionals' question why they are being paid for improvement work and what I assume is a differential pay structure amongst different members of staff?

P16 line 26 – I think "morally reprehensible" is a bit strong. Professionals do confront patients on many issues (eg weight, drug use etc), therefore it's not "morally reprehensible", it's just uncomfortable and no one likes it.

Discussion

As with the results the discussion slips into discussing professionals perceptions' of patient partners' identity rather than focusing on professionals' identity and the implications for partnership work. For me the message in the data is that professionals struggle trying to be both carer and colleague. They then impose this confusion on patients, and blame them, rather than acknowledging that they need to do the work to become comfortable with both identities. For example p19 lines 10-14 are currently written as the patient needs to do the identity work, but actually it might be the professional being unable to shed their carer identity and projecting a patient role onto the patient.

I think the final paragraph of the conclusion could be clearer.

Language and references

The manuscript needs proof reading as there are a few small typos regarding tenses and multiples - especially the summary box, abstract, and article summary.

The PP acronym is not explained.

The text could be de-gendered by using their/they rather than he/him

	(see p16 line 33 'himself' and 'him', p19 line 10 for example – but other examples too). P9 line 54-56 – I think this sentence needs rephrasing particularly ending on 'the traditional way of doing' P10 line 5 – I think it should be 'business literature' rather than 'business sector' P12 line 35 should be "at the same level of the other co-researchers" The references need checking – references 17-19 don't appear to be used and P20 line 9 references 33-36 don't appear to be the right ones.

REVIEWER	Prof. Ida Gremyr Chalmers University of Technology Sweden
REVIEW RETURNED	17-Nov-2020

GENERAL COMMENTS	Dear authors, Thank you for the opportunity to read your manuscript. The topic is interesting, and it is in my view important to touch upon topics that address some of the challenges with patient involvement as a means to support further implementations of such initiatives. In the following I have chosen to organize my comments per section of the manuscript. Introduction In following a common introduction model, the research area that will be contributed to is expected to be established in the introduction. As your introduction reads now there is a lack of mentioning of models/theories about identity. This is very central in your work, at least the Ghadiri model, so it should be mentioned already in the introduction. I would also expect some problematizing on the choice of model for the reader to understand why this model is the best choice for your study. There are some sentences about studies on identity tensions in the business sector that are mentioned in the last paragraph of the introduction. These needs more elaborations so that the reader can see what you bring from these studies into your own study. Later in the manuscript, see e.g. comment on methodology, it is clear that you in this study focus identity of the professionals. This choice of perspective should be made even clearer in the introduction, alongside a motivation of this choice of perspective. Methodology The format of the Methodology section is similar to a structured abstract and is a bit hard to read, I'd prefer regular paragraphs. In the section about the chosen conceptual model there is a lack of motivation of the choice of model, as well as a lack of use of complementary references, which leaves a core concept – the identity model – relying only on one reference and not properly anchored/motivated with a basis in your specific purpose. When discussing the study context there is no mentioning of the content of the work that the improvement committee carried out, some details are needed for a reader to eb able to judge e.g. transferability to other settings.

	In Data collection there are no examples of exact interview questions, please add. As this manuscript focus identity tensions arising in new ways of interacting with patients it is beneficial to add information on when the interviews were carried out – at the start of the new way of working? Only at the end? Both? Etc. further the number and length of interviews should be stated. Further, for the findings section to be easier to access identifiers of interview persons would be beneficial, as it stands now a reader cannot know if all quotes just reflect one interviewee or if you have a balanced use of your data. When you discuss data analysis, please clarify what data you worked with – only interview data analyzed in this way, or also data from the observations? Results As above, the style is similar to a structured abstract and is a bit hard to read, I'd prefer headings and paragraphs. Regarding Table 1, the comment above on adding identifiers to interviewees (e.g. I1, I2 etc) is related to this table and the trustworthiness in showing that the empirical examples used are emanating from various "data sources". Discussion Table 2 could be enhanced and clarified by adding a column to the right of the characteristic labels (e.g. Identity of physician) with a concise description of what you mean by the labels. As it stands now, especially the last one "Responsibility" is unclear as it has not been clarified what type of responsibility this concerns. Overall, could the contributions to theory bee more explicitly stated in the discussion? Strengths, limitations, and future research Also, in the last paragraph of the discussion you mention "initial interviewees" and this time aspect could be interesting to exploit further in the discussion (also see comment on timing of interviews under "Methodology"). Conclusions The Conclusion section's last paragraph is more of a discussion and could be moved into that section. Instead, please add more on actual conclusions, and how you see that the can "help to better anayse(d) practical issues and resistances".

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Jess Drinkwater Drinkwater, University of Leeds
Comments to the Author:

This is an important and well-conceived addition to the literature on PPI in health service improvement and should be published. The study focuses on the identity of professional partners in patient-partnering work which is an overlooked topic. However, there is detail

missing in the methods, and the focus of the results and discussion slips toward patient partners' identities rather than professional partners' identities.

  - We revised the whole article to clarify the focus on professional's identity. (see below)
  - We added more information in the Methodology section as it was suggested in the next comments.

Methods

I would like more detail or a reference to explain what the authors mean by "Participatory ethnographic study". There is a wide literature on participant and non-participant observation in ethnography that could be used.

  - We had more references and developed the section about Data collection.

  The study followed a participatory ethnographic design (5-9). In this ethnographic approach, MPC (family medicine resident), PK (family physician) and GR (patient partner) were observers as participant (10, 11), both members of the committee and the research team.

I would like more detail on the study context. How many patients and staff does the family medicine clinic have? How often did the committee meet? How long were meetings? Were observations made opportunistically between meetings, or were observations limited to the meetings and time around the meetings?

- This information has been included in the methodology section:
  "The clinic was a large academic primary care group practice located in Montreal, caring for approximately 13,500 patients with the help of 80 health professionals. This clinic has a longstanding tradition of interprofessional care, but no previous experience with patient involvement in quality improvement. The quality improvement committee functioned from summer 2017 to summer 2019, meeting lasting two hours approximatively each two months.

  After each meeting, participants were met informally over the following days by one of the research team members to gather feedback on the committee. A summary of these informal "corridor discussions" was collated.

  Semi-structured interviews, lasting about two hours, were conducted with professionals and PP around the end of the committee's mandate.

How were the ethical issues of participant observation addressed?

- This project involved to related component
  - 1. A quality improvement component (the quality improvement committee on lab results), whose approval is under the authority of the health institution (detailed below)
  - 2. A research component (reported in this article, including participant observation and individual interviews), which was approved by the research ethics committee for research on addiction, social inequalities, and public health of the *CIUSSS Centre-Sud-de-l'Île-de-Montréal* (DIS-1718-38).
- An agreement was reached from the clinic's medical Chief to allow the research team to be integrated into the committee. All members of the committee agreed to have the research team join the committee as part of a participatory ethnographic approach. For the members of the committee, their participation in the Quality Improvement Committee was not conditional on their participation in the research project. They were free to withdraw, at any time, both from the

committee and from the research project. One of the patient partners was being followed medically at the clinic itself. However, members of this patient's health care team were not on the committee. Moreover, our interest in study was the experience of professionals and not that of the patient.

- Interview transcripts were anonymized before being analyzed. Only the principal investigator had access to the participants' names in the transcripts. Observations, as well as logbook data, were also anonymized. Because our group of participants was relatively small, we decided not to separate the different types of caregivers (pharmacist, nurse, doctor, etc.) and group them under the same label of "health professionals" in order to protect the confidentiality of participants. However, the risk of some members recognizing other participants in the excerpts cited remains possible. This was mentioned in the consent form.

There are 12 committee participants and only 9 interviews, but this is described as 100%. I'm assuming the participant observers weren't therefore interview, but this needs clarity as does the role of the participant observers.

- All members of the committee were invited to participate in the ethnographic process. Of these members, only health professionals and PPs were invited to participate in individual interviews, as our project focused on health professionals' identities.
  All participants (n=12) agreed to contribute to the participatory ethnographic process. Of these participants, all health professionals and PP (n=9) agreed to participate to individual interviews (RR=100%).

  This information has been included in the new version.

__Data collection:__ **Who conducted the interviews? Was each person interviewed once or more than once, and at what time points in the process were they interviewed? How many meetings, or hours of observation, were conducted?**

- Semi-structured interviews, lasting between 90 and 120 min, were conducted by MPC with professionals and PP around the end of the committee's mandate. The questions in the interview guide were developed on the basis of Ghadiri's identity markers (ex: - Did you feel any tensions or conflicts during the process? - What is an ideal PP? – What is the role of the PP? -What is your role in the committee? Etc.).
  Also, after each meeting, participants were met informally over the following days by one of the research team members to gather feedback on the committee. A summary of these informal "corridor discussions" was collated.

  This information has been included in the new version.

__Data analysis:__ **I am not sure what "analysis by conceptualising categories" means. The authors' state the coding was "entirely revised by ML" - was this a second analysis or a second coder? It would be nice to have more discussion of reflexivity in relation to the data collection and analysis. Particularly as observations were conducted by multiple observers, with different identities, of the same meeting – which is a strength.**

- You're right, this needed to be clarified. We added references to better explain the analysis by conceptualising categories. This method was well described by Pierre Paillé. We added reference to better explain the analysis by conceptualising categories. It consists of doing the coding analysis using concepts that emerged from analysis to express ideas and meanings rather than pre-established themes.

  The data was coded and grouped around major emerging categories by the principal investigator (MPC) and by ML as a second coder to enhance trustworthiness. All data collected from participatory observations, logbook notes, and semi-structured interviews was analyzed using Ghadiri's conceptual framework. The analysis was then entirely revised by AB and PK. The analysis was then finally revised again by all the research team (MPC, PK, GR, ML, AB). The socioprofessional background of every researcher was different (resident in family medicine, psychologist, physician, and patient). We therefore discussed and compared each other's ideas and interpretations until a consensus was obtained among all researchers, giving us the opportunity to enrich our analysis.

  Data consisted of participatory observations, logbook notes, and semi-structured interviews. Logbook notes testified to the principal investigator's impressions and feelings as a resident in family medicine throughout the process to enrich the participatory ethnography process and analysis.

- This information has been included in the new version.

<u>**Results**</u>

I would be interested to know whether there were differences in the different professionals' identities. Particularly if there were differences between the clinical professionals and the secretary, receptionist, and manager who I assume do not have a clinical professional-patient relationship/identity. This is important as much of the discussion is related to professionals' clinical identities.

- We didn't include in our analysis the secretary, receptionist and manager data, as we focused specifically on the health professionals' identity with a clinical care role. This has been specified in the methodology section. Receptionists and managers can be considered "professionals" but they don't provide clinical care, and we assumed that the underlying identity tensions would be different and chose to focus on the care-giver/colleague tension.
- Also, because our group of participants was relatively small, we decided not to separate the different types of caregivers (pharmacist, nurse, doctor, etc.) and group them under the same label of "health professionals" in order to protect the confidentiality of participants.

The first two sections of the results (stories and ideals), clearly focus on the findings related to the professionals' identity. The last three sections (balance, categorisation, and symbols) switch between professionals' identities and professionals' perceptions of patient partners' identities. I think the paper would have a greater impact if the focus remained on professionals' identities. I accept professionals' identities are influenced by patient identities, but this could be described more clearly.

- We modified the last three sections as suggested to really focus on professionals' identity.

For example:
P16 line 13-20 it could be argued professionals struggled to balance their identity of carer and partner, and as a result project vulnerability onto patients even when they are in a partner role.
P16 line 31-42 I know representation is a big issue, but I'm not sure it adds to this paper. Unless, the issue is professionals struggling to balance their own identities, because they are in flux with patients' identities. This is described in the next section (p16 line 45-55) – the

patient switching identities forces the professional to confront their identity. Rather than reflecting on their own identity, they reflect on the patient identity and project a lack of legitimacy onto the patient.

P16 line 26 – I think "morally reprehensible" is a bit strong. Professionals do confront patients on many issues (eg weight, drug use etc), therefore it's not "morally reprehensible", it's just uncomfortable and no one likes it.

- The new section:

  "Data suggests that, in the committee, professionals had two competing identities (colleague and caregiver), with which they had to deal with simultaneously. Even as the professionals aimed to consider PP as colleagues, interviews showed they also viewed them as innocent, vulnerable beings that they felt responsible for (cf Table 1.3.a). After all, professionals consider that the PP who joins the committee is still a patient of the clinic and, as such, a recipient of care. Consequently, professionals find confronting the PP very uncomfortable, at least openly (cf Table 1.3.b).

  If professionals see PP as full members of the team, they will distance them from the "ordinary" patient and consider that they are all part of the same "professional family". However, this was also seen as a negative element by the professionals, since the PP would no longer be able to adequately embody the identity of an ordinary patient and would be too far removed from the "real world" (cf Table 1.3.c). This issue was repeatedly expressed by professionals as a concern regarding the insufficient "representativeness" of the PP.

  Corridor conversations and direct observations also revealed another identity tension among professionals regarding the balance between their identity as colleague and as caregiver: if a PP asked for a medically-related personal service (e.g. help getting an appointment with a doctor, medical advice, or a referral), the professional felt uncomfortable and hesitated about the correct way to respond to this request (as a doctor? A colleague? A friend?)."

P17 line 8-21 focuses on the definition of the patient partners' role. I am more interested in the discussion of the professionals' patient identity. I would focus this section on the professionals struggling with their multiple identities, including as patient. Therefore they project their identity issues onto patient partners which is my understanding of quote 1.4.b.

- We modified the last three sections as suggested to really focus on professionals' identity.

  The new section:

  The data shows that the boundaries between PP and professional identity are sometimes blurred and that, for professionals, the definition of the PP's role remains ambiguous. This complicated the way professionals viewed the PP's category (cf Table 1.4.a) and, as such, the proper way to work with them. Some professionals noted that if the discussion touched them personally, they tended to recall their own experiences as a patient. Thus, they considered that the "patient" label could be applied to them as well. Professionals therefore expected PP to bring to the table knowledge that was different from that of other team members (cf Table 1.4.b).

Moreover, we observed that certain situations helped increase the PP's legitimacy and clarify the boundaries between PP's and professional's identity (cf Table 1.4.c). Such cases help the professional establish an identity boundary that categorizes the PP as "colleagues with a different expertise".

Section five needs to be clearer how remuneration effects professionals' identity (for the record I agree it does). Do professionals' question why they are being paid for improvement work and what I assume is a differential pay structure amongst different members of staff?

- Several identity symbols were challenged by PP involvement in the committee. Notably, PP's remuneration raised not only financial questions, but also questions around roles and status. Beyond its practical implications (Should they be paid? How much? Who should pay?), remuneration debates crystalized identity questions (eg. Did a salary imply employee status? How does it distinguish patient partners with professionals' roles?). Most of the professionals concluded that, as they all shared the same identity within the committee, they should all be paid. However, when questioned on the salary PPs should obtain, professionals showed discomfort. Their opinions were divided because different professions were paid a different hourly rate for their participation. Some of them expressed their beliefs that PPs should not be paid more than the lowest paid participant around the table. At the same time, they expressed concern about the fact that PPs should not be the lowest paid participant since they felt someone's value was somewhat reflected in their salary (cf Table 1.5.a.).

Discussion

As with the results the discussion slips into discussing professionals perceptions' of patient partners' identity rather than focusing on professionals' identity and the implications for partnership work. For me the message in the data is that professionals struggle trying to be both carer and colleague. They then impose this confusion on patients, and blame them, rather than acknowledging that they need to do the work to become comfortable with both identities. For example p19 lines 10-14 are currently written as the patient needs to do the identity work, but actually it might be the professional being unable to shed their carer identity and projecting a patient role onto the patient.

- As suggested, the discussion is now more focused on the professional's identity:

  This study reports and interprets how working with patients is a new way of entering into relationships and how this transforms the identity of professionals. Even if, in this study, all participants agreed that the experience was a success in terms of partnership with patients, transforming the "caregiver–patient" relationship into a "colleague-colleague" relationship generated identity upheavals among the professionals, relating to the "good professional" ideal, the impermeability of the patient and professional categories, the interweaving of the symbols associated with these identities, and the inner balance between the roles of carer and colleague. Professionals struggle with this dual identity and transfer this ambiguity on the patient's identity. This could explain some professionals' perception of PP identity mentioned in the literature as ambiguous and poorly defined (23, 40).

  Given the coexistence of multiple identities, striking a balance between them brings many challenges for the professional. While balancing identities is complex, the professional cannot relinquish either of his identity ideals without consequence. On one hand, if the professional perceives the patient as sufficiently distanced from this image of care receiver, he will feel comfortable to work in a colleague-colleague relationship. The energy will be focused more on productivity than on creating a positive relational experience. On the other hand, if the professional sees the PP as too far removed from what is considered an "ordinary patient" identity, the professional will consider the person's presence to be less legitimate, even irrelevant. This is mainly because the professional grants the person legitimacy on the basis of a patient identity, while giving the person access to real relational reciprocity on the basis of a co-worker identity. Partnership with patients imply the construction of a new relational framework, flexible and dynamic, that takes into account this co-existence of identities.

I think the final paragraph of the conclusion could be clearer.

- We clarified and moved the last paragraph in the Discussion section:

  Finally, some might conclude that this research calls for ways to help professionals minimize these identity tensions. However, it is important to consider whether, in essence, creating identity tensions is not the very strength of working in partnership with patients. This would perhaps need to be questioned yet again if ambiguity and relational discomfort were to disappear and be replaced by a relationship that is too "complacent".

Language and references

The manuscript needs proof reading as there are a few small typos regarding tenses and multiples - especially the summary box, abstract, and article summary.

- We corrected the typos errors.

The PP acronym is not explained.

- Done.

The text could be de-gendered by using their/they rather than he/him (see p16 line 33 'himself' and 'him', p19 line 10 for example – but other examples too).

- Done.

P9 line 54-56 – I think this sentence needs rephrasing particularly ending on 'the traditional way of doing'

- Done.

P10 line 5 – I think it should be 'business literature' rather than 'business sector

- We changed it.

P12 line 35 should be "at the same level of the other co-researchers"
The references need checking – references 17-19 don't appear to be used and P20 line 9 references 33-36 don't appear to be the right ones.

Reviewer:2
Prof. Ida Gremyr, Chalmers tekniska hogskola
Comments to the Author:

Dear authors,

Thank you for the opportunity to read your manuscript. The topic is interesting, and it is in my view important to touch upon topics that address some of the challenges with patient involvement as a means to support further implementations of such initiatives. In the following I have chosen to organize my comments per section of the manuscript.

- Thank you.

Introduction

In following a common introduction model, the research area that will be contributed to is expected to be established in the introduction. As your introduction reads now there is a lack of mentioning of models/theories about identity. This is very central in your work, at least the Ghadiri model, so it should be mentioned already in the introduction. I would also expect some problematizing on the choice of model for the reader to understand why this model is the best choice for your study.
There are some sentences about studies on identity tensions in the business sector that are mentioned in the last paragraph of the introduction. These needs more elaborations so that the reader can see what you bring from these studies into your own study.

Later in the manuscript, see e.g. comment on methodology, it is clear that you in this study focus identity of the professionals. This choice of perspective should be made even clearer in the introduction, alongside a motivation of this choice of perspective.

> To better explain our choice of identity model, we modified the introduction and added multiple references as follows:
>
> Over the past decades there have been growing calls for greater patient and public involvement (PPI) in health care systems around the world (2-5). The PPI movement is today one of the main vectors for creating different initiatives and new models of care (6-11). Despite the problematic context of the COVID 19 pandemic, many new initiatives are now recruiting patients to help rethink policies (12, 13) and medical education (14).
>
> Studies conducted in the wake of PPI initiatives have identified the emergence of several barriers and resistances. Questions have arisen about patients’ status within teams (15, 16), the legitimacy of their knowledge and contribution (16-18), the impacts on care quality (3, 19), and the new power relationships being formed within healthcare teams and the health system (20, 21). While some have attempted to understand the issues raised by such experiences (17, 21-23), no study, to our knowledge, has focused on understanding the potential identity tensions between patients and professionals when they are called to interact outside of a simple therapeutic relationship. This is important as many new care models posit that patients should be integrated as partners to contribute to quality improvement, medical research, teaching programs, and health institution governance (8, 19, 22, 24, 25). These initiatives seek to involve them in all stages of decision-making (26). However, professionals and

patients' identities are fundamentally based on a caregiving relationship in which professionals are responsible for caring for the patient (27). Therefore, for health professionals, working with patients not as caregiver, but as partner, directly affects the traditional way of doing and viewing oneself, as health professional (28). This could explain some barriers and resistances experienced on the field.

The present study thus examined identity changes that can arise when patients and health professionals begin working together as partners. Understanding success or failure of organizational change from an identity perspective was mainly used in the business literature (29-33). Uncovering these tensions and how these tensions are experienced on the ground by health professionals could bring a deeper understanding of professional barriers and resistance to PPI (17), and potentially reorient implementation strategies.

Methodology

The format of the Methodology section is similar to a structured abstract and is a bit hard to read, I'd prefer regular paragraphs.

- Done.

In the section about the chosen conceptual model there is a lack of motivation of the choice of model, as well as a lack of use of complementary references, which leaves a core concept – the identity model – relying only on one reference and not properly anchored/motivated with a basis in your specific purpose.

We changed the introduction and the methodology to show more strongly why we chose this model and what it is about:

This study was based on the conceptual model of identity threats developed by Ghadiri (2014). Sacha Ghadiri's work was particularly interesting for our research question as it proposed a model to understand resistance to change resulting specifically from identity tensions.

Identity answers the fundamental question, "who am I?"(12). Identity changes and is transformed in response to several factors: personal characteristics, context, sense of belonging, relationships with others, and how others view us (12). Individuals or social groups are strongly attached to their identity. Change, however small it may seem, may threaten the identity of an individual or group (2, 4). If that identity is threatened, individuals and groups will defend it strongly, whether consciously or not.

To facilitate the implementation of change, Ghadiri proposes to undertake an identity analysis of the issues involved. To do so, he suggests focusing particularly on certain manifestations of identity that he calls "identity markers": stories, ideals, balances, categorizations, and symbols. These markers are manifestations of identity that are more susceptible to tension when change occurs and can generate resistance when they are shaken up.

When discussing the study context there is no mentioning of the content of the work that the improvement committee carried out, some details are needed for a reader to eb able to judge e.g. transferability to other settings.

- Its mandate was to optimize the management of laboratory results at the clinic.

In Data collection there are no examples of exact interview questions, please add. As this manuscript focus identity tensions arising in new ways of interacting with patients it is beneficial to add information on when the interviews were carried out – at the start of the new way of working? Only at the end? Both? Etc. further the number and length of interviews should be stated.

- We modified the Data collection section as suggested:

  Data collection began in 2017, when the committee was officially created, and ended in winter 2019. It consisted of participatory observations, logbook notes, and semi-structured interviews. Participatory observations included involvement in the recruitment of PP and attendance of all committee meetings by MPC, PK and GR. Participatory observations captured summaries of participants' interventions during the meetings and the decisions taken by the committee. The participatory observations also included a summary of all informal discussions among participants and the research team concerning the implication of a PP in the committee. After each meeting, participants were met informally over the following days by one of the research team members to gather feedback on the committee. A summary of these informal "corridor discussions" was collated.

  Logbook notes testified to the principal investigator's impressions and feelings as a family physician throughout the process to enrich the participatory ethnography process and analysis.

  Semi-structured interviews, lasting about two hours, were conducted by MPC with professionals and PP around the end of the committee's mandate. The questions in the interview guide were developed on the basis of Ghadiri's identity markers (ex: - Did you feel any tensions or conflicts during the process? - What is an ideal PP? – What is the role of the PP? -What is your role in the committee? Etc.).

Further, for the findings section to be easier to access identifiers of interview persons would be beneficial, as it stands now a reader cannot know if all quotes just reflect one interviewee or if you have a balanced use of your data.

- Done.

When you discuss data analysis, please clarify what data you worked with – only interview data analyzed in this way, or also data from the observations?

- All data collected from participatory observations, logbook notes, and semi-structured interviews was analyzed using Ghadiri's conceptual framework.

  This information has been included in the new version.

<u>Results</u>

As above, the style is similar to a structured abstract and is a bit hard to read, I'd prefer headings and paragraphs.

- Done.

Regarding Table 1, the comment above on adding identifiers to interviewees (e.g. I1, I2 etc) is related to this table and the trustworthiness in showing that the empirical examples used are emanating from various “data sources”.

We added identifiers as suggested.

Discussion

Table 2 could be enhanced and clarified by adding a column to the right of the characteristic labels (e.g. Identity of physician) with a concise description of what you mean by the labels. As it stands now, especially the last one “Responsibility” is unclear as it has not been clarified what type of responsibility this concerns. Overall, could the contributions to theory bee more explicitly stated in the discussion?

- We added more descriptions and clarified the meanings of Table 2. We also moved Table 2 to the Results section.

  Our results, summarized in table 2, showed that these two relational models are based on identity ideals with potentially conflicting requirements. Even as professionals strive to attain the ideal of partnership, they also hold another pre-existing, strong, and deeply entrenched relational ideal: that of the "good caregiver" looking after patients. Particularly present among the physicians in the committee, this ideal is embodied in the image of the caring doctor responsible for his or her patients’ well-being.

One of the most important objective for caregivers is to protect the patients’ trust in their professionals. Professionals will oppose anything that could jeopardize the trust needed for the care relationship. They are afraid to become too familiar or to reveal flaws or imperfection and believe that, in order to prevent this, they must maintain a professional “healthy distance”. This identity ideal is also reinforced by the code of ethics to which professionals adhere (14).

Strengths, limitations, and future research
Also, in the last paragraph of the discussion you mention “initial interviewees” and this time aspect could be interesting to exploit further in the discussion (also see comment on timing of interviews under “Methodology”).

- We clarified that in the methodology section.

  We also changed the paragraph as follows:

  The methodology used (participatory ethnographic approach) carried out over a period of more than two years, greatly enriched the understanding of the phenomenon under study, allowing researchers to have access to ~~formal and~~ informal corridor discussions that helped uncover identity tensions that were not obvious **in individual interviews.**

Conclusions

The Conclusion section's last paragraph is more of a discussion and could be moved into that section. Instead, please add more on actual conclusions, and how you see that the can "help to better anayse(d) practical issues and resistances".

- We moved the last paragraph as suggested and modified the conclusion as follows:

  This research provides a new perspective on understanding how working in partnership with patients transform health professionals' identity. When they are called to work with patient outside of a simple therapeutic relationship, health professionals may feel tensions between their identity as caregivers and their identity as colleague. This allows us to better understand and address practical issues and resistances elicited by the arrival of different patient engagement initiatives. Partnership with patients imply the construction of a new relational framework, flexible and dynamic, that takes into account this co-existence of identities.

VERSION 2 – REVIEW

REVIEWER	Dr Jess Drinkwater Leeds Institute of Health Sciences, University of Leeds UK
REVIEW RETURNED	24-Mar-2021

GENERAL COMMENTS	Thanks for asking me to review these revisions. I really enjoyed this article and think it is a really important contribution. The amendments are a big improvement in terms of clarity. Thanks! There are a couple of places where I think it could be clearer still. Introduction There are a couple of lines which need to be strengthened to reflect the emphasis of the paper on identity tensions for professionals not patients: P6 line 21 – as I understand it the tension is not between the patient and professional, but within the professional identity. Therefore this could read: "the potential identity tensions for professionals when they are called…" P6 line 26 – This could be more sensitive about patients identities as some patients reject the 'patient' label. Eg "However, to professionals, professional and patients identities are…" Methods I am still unclear about four things which are now slightly inconsistent in the manuscript (P7 line 17-20, P9 line 9-11, P9 line 19-21, P10 line 1-3, P10 line 16, P11 line 2-8, P11 line 12-14, P17 line 12-13)): • Who exactly were the participant observers (descriptions change between the above lines) and how did they record data – did they make felid notes? Record conversations? • What is the difference between participatory observations/field notes and logbook notes? • It appears the observers are included in the n=9 participants. This is fine, but were the observers also interviewed and if so who interviewed them? It's a small sample so this needs to be clarified. • I think GR was a participant observer and involved in collecting

	data – but this is not clear. This is a strength and should be highlighted. In the data analysis section is still a little unclear. Was Ghadiri's conceptual framework used to develop the original coding or was it applied as a result of emerging categories? P10 line 17-19 – you mention the analysis was entirely revised – this does not make sense. Do you mean refined? Results The revised results are great. However, I would add an example to explain "certain situations" on P16 line 7 Discussion The discussion is great. I especially like the revision on P19 line 1-5. I think this is really important and strong. Maybe it is time to revisit professionals' codes of ethics for relationships with patients! Language There are still considerable grammatical issues with tenses throughout the manuscript, and gendered references on P17 line 15 and 17. Correcting these would make the paper easier to read, but they are not now affecting the message.

REVIEWER	Prof. Ida Gremyr Chalmers University of Technology Sweden
REVIEW RETURNED	12-Mar-2021

GENERAL COMMENTS	Dear authors, Thank you for all work put into revising your manuscript. I am pleased with the updates and improvements but have some minor comments more related to format and structure that I think would improve the manuscript even further. A very minor aspect on formatting, should the heading numbers be at second level already for e.g. Introduction? Abstract Towards the end of the abstract you state that "This allows us to better understand and address practical issues and resistances elicited by the implementation of patient engagement initiative." Having double-checked in the Conclusion section, the exact same sentence is found there. In both places (or at least in the Conclusion section) I would like to see exemplifications of what these "practical issues" could be. Article Summary Under the first bullet point, starting "The methodology used…" I'd like the word "greatly" to be deleted to avoid self judgement. Under the second bullet point, please exemplify the issued refereed to in "Shedding light on issues…". Introduction In the end of the introduction, the (second last sentence could perhaps be improved by changing "was" so that it reads "perspective has so far mainly been used…". The very last sentence in Introduction, what does "on the ground" refer to (I get it in everyday language, but it stands out a bit in this academic text)? Take out? Methodology Under Methodology/Conceptual model it says "To facilitate the

	implementation of change, Ghadiri…” Does it refer to change in general or specific as to changes influencing identity? Under Methodology/Study context a very minor addition would enhance readability “summer 2017 to summer 2019, with a meeting…” (“with a” added). Under Methodology/Patient and public involvement: the she in “project. She was involved” –reference her is a bit unclear, please change to GR. Results I am confused as to why the info on participants is the start of the Result, I would like this information to be moved to Method/Data collection. As it reads now it is a bot hard when you read the Table to understand what the citations under “c” refers to, this could easily be improved by moving the paragraph after the table so that it comes before, i.e. the paragraph starting “During the field observations…” Discussion I really like the added last paragraph in Discussion, opening for tensions as perhaps being something positive. Conclusions See comment under Abstract regarding exemplification of “practical issues.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2
Prof. Ida Gremyr, Chalmers tekniska hogskola

Comments to the Author:
Dear authors,

Thank you for all work put into revising your manuscript. I am pleased with the updates and improvements but have some minor comments more related to format and structure that I think would improve the manuscript even further.

A very minor aspect on formatting, should the heading numbers be at second level already for e.g. Introduction?

We changed it.

Abstract
Towards the end of the abstract you state that “This allows us to better understand and address practical issues and resistances elicited by the implementation of patient engagement initiative.” Having double-checked in the Conclusion section, the exact same sentence is found there. In both places (or at least in the Conclusion section) I would like to see exemplifications of what these “practical issues” could be.

We modified this section as suggested:

This allows us to better understand some underlying tensions elicited by the arrival of different patient engagement initiatives (e.g professionals' resistances to working with patients, patients' status and remuneration, professionals' concerns toward patient "representativeness"). Partnership with patients imply the construction of a new relational framework, flexible and dynamic, that takes into account this co-existence of identities.

Article Summary

Under the first bullet point, starting "The methodology used…" I'd like the word "greatly" to be deleted to avoid self judgement.

Done.

Under the second bullet point, please exemplify the issued refereed to in "Shedding light on issues…".

Done.

Introduction

In the end of the introduction, the (second last sentence could perhaps be improved by changing "was" so that it reads "perspective has so far mainly been used…".

Thank you. We changed it as suggested.

The very last sentence in Introduction, what does "on the ground" refer to (I get it in everyday language, but it stands out a bit in this academic text)? Take out?

"On the ground" was removed.

Methodology

Under Methodology/Conceptual model it says "To facilitate the implementation of change, Ghadiri…" Does it refer to change in general or specific as to changes influencing identity?

It refers to change in general. We made the precision in the text.

Under Methodology/Study context a very minor addition would enhance readability "summer 2017 to summer 2019, with a meeting…" ("with a" added).

Thank you. We changed it.

Under Methodology/Patient and public involvement: the she in "project. She was involved" – reference her is a bit unclear, please change to GR.

We changed it as suggested.

Results

I am confused as to why the info on participants is the start of the Result, I would like this information to be moved to Method/Data collection.

The description of participants who were invited to participate is in the Data collection (this relates to the setting of the study). We considered that the number of participants who finally accepted to participate (n=9) had to be considered as a result.

As it reads now it is a bot hard when you read the Table to understand what the citations under “c” refers to, this could easily be improved by moving the paragraph after the table so that it comes before, i.e. the paragraph starting “During the field observations…”

Thank you, we changed it as suggested.

Discussion

I really like the added last paragraph in Discussion, opening for tensions as perhaps being something positive.

Thank you for this comment.

Conclusions

See comment under Abstract regarding exemplification of “practical issues.

We changed it.

Reviewer: 1
Jess Drinkwater Drinkwater, University of Leeds
Comments to the Author:
Thanks for asking me to review these revisions. I really enjoyed this article and think it is a really important contribution. The amendments are a big improvement in terms of clarity. Thanks! There are a couple of places where I think it could be clearer still.

Thank you.

Introduction

There are a couple of lines which need to be strengthened to reflect the emphasis of the paper on identity tensions for professionals not patients: P6 line 21 – as I understand it the tension is not between the patient and professional, but within the professional identity. Therefore this could read: “the potential identity tensions for professionals when they are called…”

You’re right. We changed it.

P6 line 26 – This could be more sensitive about patients identities as some patients reject the ‘patient’ label. Eg “However, to professionals, professional and patients identities are…”

We changed it by replacing « fundamentally” by “historically”.

Methods

I am still unclear about four things which are now slightly inconsistent in the manuscript (P7 line 17-20, P9 line 9-11, P9 line 19-21, P10 line 1-3, P10 line 16, P11 line 2-8, P11 line 12-14, P17 line 12-13)):

- **Who exactly were the participant observers (descriptions change between the above lines) and how did they record data – did they make felid notes? Record conversations?**

We clarified that:

“Three members of the committee were also members of the research team (MPC as a resident in family medicine, PK as a family physician, and GR as a PP).

…

Also, MPC, PK and GR met one or two times a month to debrief between meetings and to collect their different observations from their different perspectives. MPC took notes of all these different debriefs in the logbook."

- **What is the difference between participatory observations/field notes and logbook notes?**

The logbook is a personal journal where MPC wrote down her thoughts, feelings, questions (like a personal diary). You’re right, there might be some confusion. We clarified this and replace it with the term “personal diary”. The logbook is now the term used exclusively for the observations/field notes.

- **It appears the observers are included in the n=9 participants. This is fine, but were the observers also interviewed and if so who interviewed them? It’s a small sample so this needs to be clarified.**

The participant observers were indeed included in the n=9 participants. Two of the participant observers (GR and PK) were also interviewed by MPC (who was the principal investigator). Two additional investigators (AB and ML) were non-participants.

In addition to the diary, the principal investigator was herself interviewed by ML (who was not present during meetings) using clarifying interview techniques. This data was used in the analysis to ensure the plausibility of the process and of the data collection, as described in authoethnography and participatory ethnography methodologies (34, 43-45).

Because MPC was interviewed in an ethnographic methodology, after discussions with the research team, it was decided that she would be counted also as a participant (n=9). If you prefer that we change this, we can make the modification.

The section is now:

Data collection began in 2017, when the committee was officially created, and ended in winter 2019. It consisted of participatory observations in a logbook, semi-structured interviews and the personal investigator diary. Participatory observations included involvement in the recruitment of PP and attendance of all committee meetings by MPC, PK and GR. Participatory observations captured summaries of participants’ interventions during the meetings and the decisions taken by the committee. The participatory observations also included a summary of all informal discussions among participants and the research team concerning the implication of a PP in the committee. First, after each meeting, participants were met informally over the following days by one of the research team members to gather feedback on the committee. A summary of these informal "corridor discussions” was collated by MPC in the logbook. Also, MPC, PK and GR met one or two times a month to debrief between meetings and to collect their different observations from their different perspectives. MPC took notes of all these different debriefs in the logbook.

Semi-structured interviews, lasting between 90 and 120 min, were conducted by MPC with professionals and PP around the end of the committee's mandate. PK and GR were also officially interviewed by MPC as participant in the committee. The questions in the interview guide were developed on the basis of Ghadiri's identity markers (ex: - Did you feel any tensions or conflicts during the process? - What is an ideal PP? – What is the role of the PP? -What is your role in the committee? Etc.). Ghadiri's conceptual framework was used during all the data collection process to built our interview guide and to help us guide our field observations.

The principal investigator MPC was herself interviewed by ML (who was not present during meetings) using clarifying interview techniques. A personal diary also testified to the principal investigator's impressions and feelings as a family medicine resident throughout the process. This data was analysed to ensure the plausibility of the process and of the data collection, as described in participatory ethnography methodologies ((34, 43-46).

- **I think GR was a participant observer and involved in collecting data – but this is not clear. This is a strength and should be highlighted.**

We agree. We clarified this point.

In the data analysis section is still a little unclear. Was Ghadiri's conceptual framework used to develop the original coding or was it applied as a result of emerging categories?

We apologized if this was not clear enough. Ghadiri's conceptual framework was used during all the data collection process (to built our interview guide and to help us guide our field observations). The data was coded and grouped around major emerging categories (without using the Ghadiri's framework). Finally, we used again the framework to help us organise and present our emerging categories in the Results section.

We modified the article to clarify this.

P10 line 17-19 – you mention the analysis was entirely revised – this does not make sense. Do you mean refined?

Yes, "refined" is the right word. We changed it. Thank you.

Results

The revised results are great. However, I would add an example to explain "certain situations" on P16 line 7

Examples are described in the table 1:

I. when PP surprised the team with information or suggestions based on their own care experience that none of the professionals had previously experienced or considered

II. when PP contradicted a preconceived notion held by professionals regarding patients' experience

III. when PP were able to touch team members emotionally with their personal experience of care.

Discussion
The discussion is great. I especially like the revision on P19 line 1-5. I think this is really important and strong. Maybe it is time to revisit professionals' codes of ethics for relationships with patients!

> Thank you very much for this comment, we're questioning ourselves about that in our practice!...

Language
There are still considerable grammatical issues with tenses throughout the manuscript, and gendered references on P17 line 15 and 17. Correcting these would make the paper easier to read, but they are not now affecting the message.

We corrected the gendered references. We also tried our best to correct all identified tenses errors.

VERSION 3 – REVIEW

REVIEWER	Dr Jess Drinkwater Leeds Institute of Health Sciences, University of Leeds UK
REVIEW RETURNED	06-May-2021

GENERAL COMMENTS	Thanks for asking me to review the revisions for this interesting and important paper. Thanks for making the corrections – I now think the methods are really clear and I think the paper should be published. There are a few typo's: P5 line 3 – I think it should be resistance not resistances. The same correction is needed on P6 line 18 and P21 line 18. P9 line 54 – it should say '…an interdisciplinary…' P11 line 17 – it should say '…interviewed by MPC as participants in the committee…' P11 line – it should be '…process to build our interview…' P19 line 14/15 – it should say '…transfer this ambiguity to their perception…' P19 line 44 – it should say 'This provides…'