Quality Assessment and Improvement Report for IHHS 402

Prepared by Helen H. Kang

August 2012

LiVWELL Research Group

The LiVWELL Research Group is an interdisciplinary chronic disease research team bridging Simon Fraser University researchers with diverse backgrounds and disciplinary skill sets, ranging from Health Sciences, Kinesiology and Gerontology to Sociology, Anthropology and Geography. This team was initiated as a way to develop and further chronic disease research as SFU, through funding provided by SFU's Community Trust Endowment Fund.

The LiVWELL team members hold an integrated view of chronic disease and health research that emphasizes the interdependence of human beings, health and wellbeing, and the physical, political, and social environment in which humans live, work, and play. Recognizing the need for interdisciplinary research and collaboration on this wide-ranging area, the team's research program employs a number of different methodologies, ranging from ethnographic and qualitative interview to GIS, case control, and statistical analysis. To this extent, our research program is designed to cultivate a multi-level approach considering both the influences on and impacts of chronic disease at individual, environmental, and policy levels.

About the author:

Helen H. Kang received her PhD in Sociology at Simon Fraser University in the area of cultural studies, history of medicine and medical sociology.

This document is distributed for purposes of comment, discussion, and research only. It may not be reproduced without permission of the author.

Information reported in this publication was supported by the LiVWELL Research Group and funded through the Community Trust Endowment Fund at Simon Fraser University. The opinions expressed in this document are those of the authors and do not necessarily reflect those of the LiVWELL Research Group.

More information on LiVWELL Research Group can be found at: www.livwellresearch.ca. Contact us at: liv_well@sfu.ca.

Executive Summary

The main issues for consideration with regard to this report, regarding IHHS 402 HIV/AIDS Prevention and Care at the University of British Columbia College of Health Disciplines were the assessment and improvement in the quality of the course pedagogy in preparing students as members of an interprofessional team. A month-long ethnographic observation of the course has yielded the following observations and analyses of the quality of the course pedagogy:

1. Professional Identity: The PBL model allows students to shape their understanding of their professional roles in relation to other professionals during the formative years of their training. For some students, the emotional aspects of care were unexpected learning outcomes and for other students, taking a pause to reflect upon their professional practice was a valuable opportunity. Developing a sense of professional differences and boundaries in the context of a care team can also help to minimize or at least to help students to anticipate interprofessional conflict when they enter a health care workplace.

2. Interprofessional Collaboration: The clinical placements and the PBL groups help students to develop a perception of what characterizes a good collaborative team and a sense of the ethos of interprofessional collaboration, such as the importance of collegiality and of providing emotional support for the client as the task of all members of the team. They also come to articulate an understanding of "bad practice" and the potential impermeability of knowledge across professional boundaries, issues that could be further explored in the course.

3. Role of Patient-Client: The clinical placements and the presence of Positive Role Models and peer navigators in the course made a significant impression on the students with regard to the role of the HIV-positive person in the collaborative team—this person is not just a patient/client but an active professional member of the team with a distinctive set of knowledge and expertise. The interdisciplinary structure of the course allows an exchange of professional values across professional boundaries, such as an emphasis on social justice and patient advocacy.

The study yielded the following recommendations for the improvements in pedagogy:

1. PBL: a) for faculty and Positive Role Models to facilitate and guide rather than to teach/direct or to be too hands-off; b) to integrate more role-playing; c) to maintain the home-work structure; and d) to give more physical space between groups and to schedule PBL sessions closer to the beginning of the day.

2. Speakers and panel presentations: a) to emphasize more story-telling in presentations and lectures where possible with more examples of clients and cases; b) to distribute the syllabus to guest lecturers prior to the presentation; and c) to integrate more peer navigators into the course.

3. Student dynamics: a) to more explicitly explore working through interprofessional conflict through role-play; b) to maintain the diverse enrollment with respect to age, stage in training and exposure to issues in HIV/AIDS and social justice in order to facilitate peer learning; c) to have speakers and lecturers to more explicitly present on mediating interprofessional conflict in a clinical and/or community-based setting.

4. Feedback structure: to repeat the dual structure of having one session without faculty present and the second session led by faculty at the very end of the course.

Contents

LiVWELL Research Group 1

Executive Summary 2

1.0 Study Frame 5

2.0 Observations and Analyses 7

2.1 Exploring and Forming Professional Identities 7

2.2 Interprofessional and Collaborative Team 10

2.3 The Patient-Client and the HIV-positive Person 14

3.0 Conclusions and Recommendations 17

3.1 PBL Groups 17

3.2 Speakers and Panels 18

3.3 Student Dynamics and Conflict 19

3.4 Feedback Structure 20

Appendix A 21

Appendix B 22

1.0 Study Frame

The main issues for consideration with regard to IHHS 402 HIV/AIDS Prevention and Care at the University of British Columbia College of Health Disciplines were the assessment and improvement in the quality of the course pedagogy in preparing students as members of an interprofessional team. In order to accomplish this overall goal, this Quality Assessment and Improvement Study was framed by the following questions:

1. How do students describe and approach interprofessional team work? How do students describe their own professional identities in relation to other professional identities, particularly in terms of practices and values? How do students respond to the collaborative process, including communicating with other professionals and negotiating conflicts?

2. Do these descriptions and approaches change over the course of the month? If so, how do these changes reflect the goals of the course to prepare students as members of an interprofessional team? Are there any gaps between the goals of the course and the students' descriptions and approaches to interprofessional team work?

3. Are there any areas of the course that can be improved to better foster collaboration among the students?

In order to address these questions, I conducted a rapid ethnography of the month-long course in summer 2012, which consisted of:

a. Attending and observing every class, which included listening to guest speakers, panel presentations and class discussions;

b. Sitting in and observing each PBL group for one scenario discussion (there were a total of six scenarios and six PBL groups);

c. Conducting two informal focus groups (during the lunch break on the second and third Monday), each with six randomly selected individuals from the class, for feedback on guest speakers and panel presentations;

d. Attending and observing final PBL group presentations on the last day of class;

e. Leading a feedback session with the entire class on the last day without faculty present (which took place just after lunch on the final day of class);

f. Observing a faculty-led feedback session with the entire class (which took place during the last hour on the final day of class).

These opportunities allowed me to become as deeply immersed as possible in the dynamics between students, students and faculty, and students and Positive Role Models in the short period of time of the course.[1]

This report is divided into two main sections: 1) Observations and Analyses and 2) Suggestions and Recommendations. The first section contains my observations and analyses of classroom discussions, PBL group sessions and break periods, with an attention to the ways in which the course structure facilitates the exploration of professional identity and an understanding of interdisciplinary/interprofessional collaboration. This section also examines the contributions of the course to the career of students as they enter into the health care workplace. The second section contains suggestions and recommendations based on my observations and on the feedback that I received from students throughout the course.

---

[1] I was introduced to the students as the teaching assistant ("the TA"). I assisted with the technical and logistical aspects of the course, which included note-taking, as I conducted the qualitative assessment and improvement study. My dual role allowed my presence to be readily accepted by the students but at times my role was confusing to students since I was not a typical TA. One student asked me near the end of the course, "What are you taking notes on?", which indicated that there was some mystery around my note-taking.

2.0 Observations and Analyses

My observations and analyses yielded the following thematics: 1) interprofessional collaboration; 2) professional identity; and 3) the patient-client and the HIV-positive person. The sections below more closely examine the ways in which the students in the course engaged with ideas under each thematic. The sections also indicate any shifts and changes that occurred among the students during the course.

2.1 Exploring and Forming Professional Identities

Students' understandings and approaches to professional identities—their own and those of their classmates—were most visible during in-class PBL group sessions and the final PBL presentation. These were the times when students practically enacted and explored their professional roles in relation to others in a collaborative setting.

On the first day of the course, the students were placed into their PBL groups and had their first team meeting along with their first PBL scenario. Each session ended by assigning the group to come up with a care plan for the client, during which the group discussed and negotiated the role of a particular profession. These roles were not always self-explanatory so that students may ask: "Is this what I would do as a pharmacist?" or "Should I take the person at this point to a nurse or a doctor?" Sometimes, older and more experienced student of a different discipline may teach another student in the group of his/her role on the care team: "This is what you would do as a nurse."

Yet, these explicit conversations regarding professional roles were fairly rare during PBL discussions. Most of the time, I was not sure who represented which profession in the PBL groups. The team members would discuss the client and the scenario of the day without much regard for professional roles; everyone would more or less equally raise questions and contribute to discussions regarding clinical issues (such as CD4 counts and viral loads) as well as relational aspects of care (such as finding out whether the person has disclosed his/her status to support networks or whether the person has a place to sleep). It was not until the students were at the point of devising a care plan that the individual roles became more apparent—particularly among the pharmacy students whose task involves dispensing medications—and even then, the roles were not always crystal clear for me as an observer.

An interesting feature of the class composition was that there was a disproportionately high number of social work students (about one third of the class). This meant that the power dynamics among students were not necessarily reflective of what would typically occur in a health care workplace where physicians or nurses

may have the higher degree of authority when it comes to directing care. This tension between an over-representation of social work students and a clinical dominance in health care in general played out in interesting ways, as exemplified by an episode in one PBL group session. The student in the role of a physician (pre-med student) proposed a way to inform a patient that he/she is HIV-positive, to which the two social work students on the team as well as the Positive Role Model quickly objected for artificializing a process that they thought should be organic. The pre-med student tried to explain the rationale of his method but faced gentle resistance from the social work students. What followed was a discussion about different standards of care across disciplines. The process of devising a care plan as a group involved unlearning and relearning for some (such as the pre-med student) and for others (such as the social work students) developing a communicative strategy in order to teach what is considered to be common sense in their own discipline to someone outside of their discipline.

The value of the course in fostering an interdisciplinary and collaborative team is in the PBL model and the timing of the course in students' careers. The students come to understand their professional roles in relation to other professionals during the formative years of their training. Instead of first being socialized into their professional role in the isolation of their particular disciplines and then being placed into collaborative teams—a sequence that may foster greater antagonisms between disciplines, difficulty in translating ideas across disciplines and obstacles to creating understanding across professional boundaries—the students develop a sense of what it means to be a professional of their discipline in terms of their role in a team. In other words, the students form their professional identity relationally in the practical context of a care team. The course is a forum for students of various disciplines to discuss and to debate professional roles/boundaries prior to entering into the health care workforce, which can help to minimize or at least to help students to anticipate interprofessional conflict.

Shifts and Changes

Some students had to fill the role of another profession in their PBL group where there were no students from that discipline present in the group. There were a very few dietetics students in the class and so several students—many interdisciplinary students—filled the role of a dietician in their groups. One such student mentioned during the final day feedback discussion that she was on rotation with a dietician on IDC whose breadth of knowledge impressed her so much that she decided to take on the role of a dietician in her PBL group. One student described another member of his PBL group thusly: "I'm not convinced that she's not a dietician!" These instances demonstrate the potential fluidity in professional identities, particularly during the stage of training. The interprofessional context of the course allowed these students

to explore other professional identities that they may not have considered in a context in which they were supported by experts in the area as well as by their student peers.

During the final day feedback session with the faculty present, there were two types of perceptions among students with regard to their journey through the class:

A. Unexpected: The pharmacy and pre-pharmacy/pre-med students indicated that their expectations of what their training would be prior to starting the course and what they realized during the course were significantly different: "When I signed up for the course, I wasn't expecting this. I thought I'd learn some things about prevention and medications but what I got was something totally different." One student, who had been quiet for most of the course (including during her PBL group session that I observed), was overwhelmed with emotion when talking about her first clinical placement. Another student stopped a faculty member and myself in the hallway after the end of the last class and repeated, "I learned so much," with much emotional emphasis. Many among this group of students[2] appeared to be younger and to have fewer experiences in the field, be it in a community-setting or in a clinical context, than the social work, nursing and medical students in the course. Hence, what they appear to develop during the course is a practical and emotional sense of what it means to be a practicing professional of their discipline.

[2] These students were quite vocal and were some of the first to speak voluntarily during the feedback session but many of them also had difficulty staying awake during class and were often on their electronic devices during lectures. While this apparent discrepancy may be part of the performative aspect of education (i.e. playing the part of an appreciative student during feedback), I am more inclined to see this as a clash of disciplinary norms and styles of learning between the primarily lecture-based style of their own disciplines versus an emphasis on hands-on learning of this course. There was also the issue that these students were generally younger and were either in undergraduate programs or recent graduates. Hence, it is not that these students were not interested in the materials (as indicated by their contributions in their PBL groups) but that they were not accustomed to the style of learning and the etiquette that is expected of students in a PBL-based professional course. This may be something that the faculty will see more often as they increase the enrollment of students from these disciplines.

B. A pause for reflection: The social work students, who tended to be older and more experienced in community and clinical settings, seemed to have already been aware of what the course was about prior to enrollment. There appears to be a high degree of communication across cohorts in the social work department so that senior students who had taken the course before would pass on their experiences in the course to the subsequent cohorts. Indeed, several social work students remarked that they registered for the course at the recommendation of senior students. Thus, these students indicated a slightly different type of shift in their sense of professional identity. One student remarked that she was glad to understand the theory behind what she does automatically as an embodied practice. Hence, the value of the course for these students is in the opportunity to take pause and to critically reflect on the connection between theory and practice in the context of clinic-based training.

2.2 Interprofessional and Collaborative Team

Students' perceptions and approaches to interprofessional collaboration were most evident during PBL group sessions and class discussions, particularly during early morning discussions on the day after clinical placements.

During the first week of the course, students came up with a team name for their PBL group and visually represented the goals and ethos of their team (see Appendix A), which they presented to the class. These images and the verbal presentations that accompanied them drew upon a fairly established discourse around collaboration and interdisciplinarity. The images often included stick figures, representing the students in the group, holding hands in a line or in a circle, which is in sync with the students' emphasis on communication and rapport among team members. The figures are more or less identical, indicating an attention to a sense of equality, and their linear or circular configuration also gestures toward notions of non-hierarchical relations. The images also contained words that indicate values of collaboration and interdisciplinarity, such as "equal voice", "listening", "trust" and "being non-judgmental." However, these articulations should not be taken at face-value as students' embodied knowledge of interprofessional collaboration but more as their familiarity with this discourse, that they have at least some exposure to the ideas of collaboration without necessarily a familiarity with a team-based work environment.

What the students developed during the course with respect to interprofessional collaboration were the following:

A. Team structure: Early in the course, the students identified one of the clinical placements, the Immunodeficiency Clinic (IDC) at St. Paul's Hospital, as a model of how a collaborative team may ideally function. When reporting back to the class about what they observed and felt during their placements, many students recognized the attributes of the IDC team, particularly the efforts among team members to communicate, both through face-to-face conversations and detailed notes. The students identified this communication strategy as an example of good practice. As an accompaniment to this discussion, role-playing during PBL groups were great practical ways by which students explored the communicative structure of the team. For instance, in one group, a student role-played with another student (playing the role of the client) and asked questions (to the group and to faculty and Positive Role Model) regarding what to do, e.g. who to ask for blood work, etc. The theoretical discussion about what constitutes good practice and playing it out in the PBL group facilitate learning about how and when to integrate the team while in the moment with a client.

B. Ethos of team collaboration: During PBL group discussions, students from the diverse disciplinary backgrounds explored and negotiated professional roles and boundaries in the context of interdisciplinary collaboration, particularly around what is acceptable and what is not. In the group in which the pre-med student suggested a model for telling the client that he/she is HIV positive, one of the two social work students actively validated the pre-med student's efforts. In other words, this student drew on his disciplinary values and strategies in order to provide emotional support for his team member whose ideas were being rejected by the group. This was a passing moment in the group discussion, which was not pointed out by anyone on the team, but a very important one for setting the tone for what it means to provide a space in which to learn and to make mistakes.

In another PBL group, one pre-med/pre-dentistry student (who may have been the youngest member in the group) twice raised the issue of boundaries of what one is supposed to do in one's professional role: the first instance was around counseling ("Doctors shouldn't counsel because they're not trained to do it") and the second instance was around how much a social worker should ask about the financial matters of a client. Other (primarily social work and nursing) students in the PBL group, the faculty tutor and the Positive Role Model responded that empathy is the work of all members of the team and that doctors should not try to pawn off the emotional work to peer navigators. Another student (in medical school and so older and more socialized in a professional context) in the group mentioned that she feels relief that

she can rely on the team to share in the work of empathy. In some ways, the comments by the pre-med/pre-dentistry student and the medical student were not so different: both sought to explore the boundaries of what is expected of a physician on a collaborative team. However, the younger student was clumsier in his articulation, while the older student was more polished in her delivery. What the younger student was exposed to, via the team discourse, was know-how in terms of how to talk about such matters in a way that fits with the ethos of interprofessional collaboration.

While the PBL group sessions were important structured moments in which students developed an ethos of interprofessional collaboration, the students also actively engaged in team-building during breaks. They discussed their observations during placements informally with other students, often with those from other disciplines. They also socialized across disciplinary lines, a practice that resonates with the course content that trust and rapport must be built in the team. During these unstructured and informal moments, students taught one another, not only content (such as drug information or service resources) but also a particular ethos of working in an interdisciplinary team and in a community-based model of care.[3]

While the students are generally already familiar with the discourse of interdisciplinary collaboration, the value of the course is in allowing them to develop a practical and embodied sense of what is good practice and what are the acceptable (and unacceptable) practices in a team context. This development includes knowing that that they can and should ask for help from their colleagues and knowing what kinds of things their colleagues would be experts on, a disposition that requires both an understanding of the communicative structures of a team as well as some awareness of the values and techniques of other disciplines. The fact that the students are interprofessionally trained prior to graduation allows them to develop a sensibility that team work is important and valuable and a practical sense of how it may be actualized in real life. The strategies of working collaboratively across

---

[3] For example, during a lunch break I was walking in the West End with a group of students of diverse disciplines and came across a person who appeared to be greatly agitated by a passing and completely respectable remark by one of the students. One student remarked that the person must have been having a bad spell of mental health issues, which is an observation that is in-keeping with the values of the course but still somewhat dismissive and stereotypical. Another student responded that the person probably has post-traumatic stress disorder (the student's analysis of the person's comment about having been in the military) and explained that she learned on her clinical placement that such individuals are often hypersensitive to being ridiculed due to having been neglected after returning from military service.

disciplines were never explicitly articulated by the students but were enacted through the ways in which they related to one another. This suggests that the sensibilities and know-how of interprofessional collaboration cannot be taught explicitly but must be allowed to develop and to become embodied in students via an immersion in a team, i.e. a PBL group.

Shifts and Changes

Given the initial high degree of fluency among students with regard to the discourse of collaboration and interdisciplinarity, change was most observable in the ways in which the students described and expressed conflicts and tensions between the professions:

A. Bad practice: In conjunction with identifying and describing examples of good practices in collaborative team care, the students also articulated notions of "bad practice," which emerged quite strongly in the final presentations by the PBL groups. At least two presentations dramatized a physician with bad bedside manners: not empathetic, not listening, speaking too quickly, etc. In many ways, these characters were caricatures of "bad doctors." Indeed, one such character was performed by a medical school student, who stated during the question and answer period that doctors, in fact, get trained to properly break a bad news to a patient and so this caricature of a doctor probably would not have been able to pass medical school in the first place. These performances drew much laughter from the class. What is interesting about these caricatures is that they were primarily cast as physicians, whereas such "bad practices" could be found among other professions, such as nurses and social workers, a fact that would have been familiar to the students in these disciplines. This gap suggests that casting the physician in the role of the bad practitioner was safer for the students in order to maintain camaraderie within their interprofessional group. The cold and uncaring doctor, who can still practice because medicine has a high degree of dominance as an expertise, is a familiar stereotype that may have been more comfortable to refer to in order to articulate examples of bad practice, even for a physician-to-be.

B. Accessibility and familiarity across disciplines: During the feedback session with the class regarding the speakers for the course, one social work student referred to a speaker presentation that she personally found to be too medical and not very accessible to "non-medical people" in the class. In response, two medical school students and other students from more technical disciplines (pharmacy

and pre-med) stated that this lecture was great for them. What followed was a back-and-forth discussion between these groups about what feels familiar and accessible to different disciplines: the care disciplines found the technical presentations difficult to follow while the clinical disciplines found the social determinants material more difficult. The feedback session provided a forum for students of different disciplines to voice their affinity or discomfort with respect to course materials and then to discuss the ways in which the class content must reflect the differences among the students in the course. Hence, this discussion delved into questions of what are the more salient aspects of care in HIV/AIDS that involved different professional values as they come into conflict with one another.

2.3 The Patient-Client and the HIV-positive Person

While I expected the first two thematics to emerge during the course, the third thematic was rather unexpected. The perception of the patient-client and the role of the HIV-positive person in care increasingly played a crucial place in the students' understanding of their own professional identity as well as of interprofessional collaboration. Many of the visual representations of the PBL groups (*see* Appendix A) included a figure representing the patient-client, usually at the centre of the image, which indicates that students were familiar with the idea of a patient-centered model of care. However, students were able to draw on the discourse of patient-centered care without necessarily the practical sense of what this really means. For about one-third of the class, the course was their first exposure to anything related to HIV/AIDS.[4] Hence, HIV/AIDS was not in the realm of their lived reality prior to taking the class. On the flip side, there were about half-a-dozen students who were already

[4] During the first day of class, the faculty conducted an informal survey of the students, which included questions such as "When did you first hear about HIV or AIDS?" and "When did you first have your HIV anti-body test?", in order to get a sense of their baseline knowledge and experience. This survey was administered visually: the students placed a colour sticker on a timeline (by years starting in 1980) for the corresponding year for each question (*see* Appendix B). This survey indicated that for 11 out of 35 students in the class, 2012 marked the first time that they met anyone living with. It is my estimation that at least a portion (if not all) of the 11 students had first met a person living with HIV on the first day of this class.

working in community-based settings in which they came across HIV/AIDS on a regular basis (e.g. InSite, 10C ward of St. Paul's and Vancouver Native Health).

Given these diverse backgrounds, there were two major changes in the students' descriptions of the patient-client and the HIV-positive person:

A. Social justice and patient advocacy: The notion that health care professionals can and should be attuned to patients-clients' social, economic and political well-being as part of their care practice was new to some students. Students from disciplines that are more known to integrate social justice and client advocacy as part of professional practice, such as social work, were familiar with and open to this idea but students from disciplines that do not necessarily emphasize such issues, such as pharmacy and science undergraduate programs, had to learn to connect clinical practice with social justice. An example of such incident was in a PBL group in which a pharmacy student was advised by the faculty to learn the appropriate language with which to describe peoples living with and affected by HIV/AIDS, such as LBGT, as part of appropriate care practice. At least one student (pre-med/pre-dentistry) in the class was visibly resistant to the idea of social justice and patient advocacy and it was not clear whether the student had altered this initial perception by the end of the course. In many ways, this student's attitudes are in keeping with the dominant culture within health care, which tends to prioritize clinical aspects of a patient-client's health over the socio-economic. The interprofessional context of the course allowed students to be exposed to the values of all disciplines, via the course materials and interactions between students. This is particularly transformative for students in traditionally more clinical disciplines. In addition, all members of the faculty, including those from more clinical professions, demonstrate a commitment to social justice and client advocacy in the context of interprofessional collaboration. Their care philosophies serve as important model for students, particularly for those in traditionally more clinical disciplines.

B. Patient-client as a health professional: The course in 2012 took place after the Seek and Treat for Optimal Prevention of HIV/AIDS project was implemented through the BC Centre for Excellence in HIV/AIDS, in which peer navigators[5]

[5] The peer navigators are people living with HIV who have developed a wealth of lived knowledge about how to navigate "the system" (i.e. health care, social benefits, housing, social support, etc.) in ways that fill the gap in care services provided through the health authorities.

have been employed for the study. Several of these individuals participated in the course as Positive Role Models and as panelists during class lectures. For students in social work and those already working in HIV/AIDS-related community-based organizations, the peer navigators pushed the limit of their understanding of HIV-positive persons: they are not only clients who are on the receiving end of professional care can also be (paid) professionals in their own right as people living with HIV/AIDS. This notion goes beyond the idea of patient-centered care, in which patient is still the object of professional practice and knowledge. This is an important perception to acquire given the history of collaboration between patient-clients and care providers as well as patient activism in the history of HIV/AIDS.

3.0 Conclusions and Recommendations

Given the observations and analyses during the course, I have come up with the following conclusions regarding the contributions of the different aspects of the course to the development of interprofessional collaboration among students, as well as related recommendations for future offerings of the course.

3.1 PBL Groups

The PBL group format is highly effective in providing a structure in which students may explore and "try out" different aspects of their professional identity and become familiar with issues related to interprofessional collaboration. The format facilitates peer teaching and learning across disciplines, which not only allows the transference of knowledge but also of values and ethos related to professional identity, collaboration and social justice.

Recommendations: Among the PBL group sessions that I observed, the groups that more successfully accomplished the above goals had the following characteristics:

A. Facilitation rather than directing: Faculty and Positive Role Model act as resource (i.e. students ask them questions) and only intervene when necessary (i.e. when students get off track from the PBL scenario, where there is a lull in the discussion, when students "get it wrong" and when students' lack of knowledge and experience in the field has them going in circles). The interventions may consist of asking open-ended guiding questions that redirect or jump-start the discussion or of mediating conflict. Student-led discussions tend to foster more dynamism and exploration but some students/groups may require more intervention by faculty or Positive Role Model.

B. Role-playing: I did not always observe role-playing in PBL groups since not all scenario instructions asked students to engage in role-play. The one role-play that I observed was extremely helpful for students to "play out" the exact conversation that takes place during care provision. It also allowed students to ask very specific questions regarding communication chains within a care team as well as the ethics of care, i.e. what to say, how to say it and what not to say. I strongly recommend that role-play be integrated into more PBL scenarios, either explicitly in the instructions or by faculty initiation.

C. Homework: In most groups the faculty and the Positive Role Models assigned homework tasks, such as searching for treatments available for Hepatitis C and for language-specific resources in certain geographic areas. This is a great practice that allows a greater continuity between the PBL group sessions and teaches how roles may be allocated in a collaborative team.

D. Space and timing: Finding a quiet area to work in a PBL group seems to be important. When the entire class is in one room, the more soft-spoken students/groups tend to get drowned out. I recommend spacing out the groups during the PBL group sessions. Also, PBL group sessions scheduled at the end of the classroom day, particularly near the end of the course, seem lead to fatigue and a decreased level of participation. Since the PBL groups constitute an important pedagogical tool in the course, I recommend that the group sessions be scheduled either earlier in the day or in the middle of the day (the second option can also help to break up the series of lectures).

3.2 Speakers and Panels

The month-long intensive course with alternating days of in-class lectures and clinical placements is ideal for students to engage with a large amount of material in a short period of time. The structure also helps to join together theoretical training (lectures), participation and observation in the field (clinical placements) and fictionalized practical explorations (PBL group).

Recommendations:

A. Repetition and overlap: During my Monday focus group sessions, several students mentioned that there is a considerable overlap between the lectures, particularly in content that deals with discrimination faced by different groups affected by HIV/AIDS. One student said that she liked the overlap because "you can always hear it again." Interestingly, the students who asked for less overlap were those who were less versed in anti-discrimination discourse while the student who liked the overlap was more familiar with the discourse. I recommend that the repeated focus on anti-discrimination be maintained in the lectures and panel presentations. However, all students asked for more real-life examples and cases because these narratives are much more engaging than abstract concepts. The students seem to be more receptive to the story-telling format when it comes to course content that is more socially and politically oriented. The students also suggested that the guest speakers be provided with the syllabus so that they know what material have been covered.

B. Peer navigators: All students (very enthusiastically) asked to hear more from peer navigators. Several students wanted an entire panel of just peer navigators. One student stated that she would like to be challenged by peer navigators to face her own misconceptions and assumptions about persons living with HIV/AIDS. The students greatly enjoyed and appreciated having a Positive Role Model teaching them in PBL groups.

3.3 Student Dynamics and Conflict

I did not observe as much conflict of values during the course as I had expected. In many ways, such moments of conflict would not likely emerge in the context of a course, which is a relatively controlled environment. In addition, the culture of the course (anti-hierarchy among professions and collaborative) stands in contrast to many other contexts in the health care workplace. The students who enroll in the course must pass an interview process, which suggests that many students who take the course already embody the values of the course. In some ways, the course serves as an alternative space to help transform the culture of health care workplace more broadly; in other ways, students may face a very different workplace culture after they graduate without the skills with which to deal with the conflicts and tensions.

Recommendations:

A. Role-playing: Within PBL groups, it may be useful to explore examples of "bad practice" by having students play the role of a bad practitioner (of different disciplines) and then discuss the ways in which the conflict may be addressed. This could be a very delicate process and would require a significant amount of mediation by the faculty and Positive Role Models.

B. Diverse enrollment: The diversity among students with respect to their exposure to issues in HIV/AIDS and social justice can allow students to work through conflicts in values and to learn from one another. Hence, what may appear to be apathy or ignorance among some students could be seen as an opportunity for transformation.

C. Speakers: It may be beneficial to have more invited speakers to address historical and contemporary obstacles (institutional and cultural) to interprofessional collaboration and/or social justice. Their experiences and strategies in their own workplaces could also serve as useful examples of good practice.

3.4 Feedback Structure

The comments that I received regarding the course during the feedback session without faculty present and the comments that emerged during the feedback session with faculty present were markedly different. There were many more criticisms and suggestions on how things may be changed—namely the choice, content and organization of speakers—in the first session than in the second. In fact, there were virtually no negative comments during the feedback session with the faculty present. The possible reasons may be that: a) there were no faculty present in the first session that made it more comfortable for the students to voice criticisms and suggestions; b) students had already voiced their criticisms and suggestions so that by the final feedback session with the faculty, they felt that they did not need to repeat what was said; c) the feel of the two sessions were quite different—during the first session without the faculty, I was in the front of the room with a flip chart and the students were sitting in a lecture formation that felt more distant, while during the second session with the faculty, everyone was in a circle that felt much more intimate.

In addition, the feedback session without faculty present allowed students to engage with one another in a discussion about the course structure and materials. Hence, the overall feedback not only reflected thoughts by students from distinct disciplines but also by the students as an interdisciplinary group and they negotiated what constitutes the positive and negative aspects of the course for a group with at times conflicting learning requirements.

Recommendation: In the future, it would be beneficial to repeat this dual feedback structure so as to acquire a more rounded picture of the students' perceptions of the course. I think that both styles of feedback are important for different reasons. The more intimate feedback sessions at the very end of the course serves as an important ceremonial conclusion to the course.

Appendix A

Appendix B

1. When did you first hear of a disease affecting gay men, GRID, AIDS or HIV?
2. When did you first meet a person living with AIDS or HIV?
3. When did you first have your "AIDS/HIV 101"?
4. When did you have your first HIV test?
5. When did you first know someone who died from HIV/AIDS?

	Question 1	Question 2	Question 3	Question 4	Question 5
1980					
1981		3			
1982	1			1	
		1	1		
1983	2	2	1		2
1984	1	1			1
1985	2	1	1		
1986	3		1		
1987		1	1	1	
1988				1	1
1989	1	2	2		1
1990	2			1	
1991					
1992	1	1	1	1	2
1993	1				
1994		1	2	2	
1995				3	1
1996			2	1	1
1997	2	1			
1998	2				1
1999	2	1			
2000	3	1	2	3	
2001		4	1		
2002	1		3		
2003	2	2	2		

2004				2	
2005	2		2		2
2006	4	2	4	1	2
2007		2		2	4
2008	3		1	3	
2009		3	3		2
2010		1		2	2
2011		3	3	3	
2012		11			