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In my work as a researcher of regional collaborative patient care across organisational boundaries, or primary and secondary care, the Cultural Historical Activity Theory (CHAT) is a helpful theory because of the common object in such care trajectories between these organisations. These organisations are still separate activity systems with their own rules, division of labour and community, using all kinds of tools to communicate about their common (chronic) patients. Apart from CHAT, we used the Change Laboratory and the Expansive Learning Theory as a theoretical background. Even though, in our research there was no researcher interventionist. We analysed interviews and an existing collaborative process of a group of health professionals negotiating existing and changing responsibilities in their collaborative patient care. At the congress of the International Association for Health Professionals Education, AMEE 2019, where the main topic was activity theory and the facilitation of learning, with Professor Yrjö Engeström as plenary speaker, I was honoured to be asked to be one of the symposium speakers.

The first use of CHAT was in research where general practitioners and medical specialists were interviewed, some of whom created a collaborative patient care agreement (CPCA) and others who worked in their daily work with CPCAs created by other professionals. We analysed their ability to identify contradictions and to learn in an expansive way when they were co-creating CPCAs. For the interviewees who were not part of the CPCA group, it was more complex to deal with contradictions (1).

In the second study, a case study of a CPCA process about a chronic disease, health professionals created a new CPCA in four meetings. We studied the collected discourse data and the concept and final CPCA documents with a coding framework for manifestations of contradictions and the steps of the expansive learning cycle. This discourse analysis showed that expansive learning took place, shared knowledge and the creation of new ways of working together and responsibility

agreements. However, not all the contradictions could be resolved due to the lack of perspectives, for example those of the trainees who had an important role in the clinical work, as well as the patients' perspective (2).

In the discourse of the CPCA process, all professionals working with patients have been able to identify and analyse contradictions and they all have facilitator roles. However, as researchers we identified many more contradictions than the health professionals identified and explained. And they did not identify the contradiction 'conflict'.
One possibility is that a researcher interventionist can help to make the contradictions explicit, but on the other hand there may be opportunities to teach professionals to identify and make explicit their contradictions (2).

We have also written a reflective article about using CHAT to facilitate collaborative continuous and expansive learning. We have experienced using CHAT in our research even when not all parts of the change laboratory were there (3).

The third way I find the CHAT useful is as a teacher and an educational developer, where part of my teaching is to embrace your contradictions and explore them. Contradictions are the start of changing collaborative care. In this way, as a start for transformative agency, I am looking for ways in which trainees and their trainers can learn to feel and analyse their contradictions. Because in today's healthcare, with patient care across organisational boundaries and networks, these skills are needed.

References

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