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**Healthy is as healthy does.**

**Examining concepts of personal health and practice to inform  
interprofessional education at the foundational, tertiary level.**

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# Abstract

The purpose of this research is to analyse the conceptions of health and healthy living practice held by students in their first year of tertiary health education. This study brings to light students' currently held health conceptions and healthy living practices and discusses the findings in the context of informing relevant curriculum development within tertiary interprofessional health education. From a large (n=901) research cohort, a mixed methods approach involving an open and closed question survey and focus groups provided both quantitative and qualitative data. Analysis was provided through descriptive statistics, content analysis, and thematic analysis. The findings of this research indicate the complex methods used to define and shape how health is conceived. Corporeal underpinnings and healthism were identified as factors that contributed to one's health definition and healthy living practice. These concepts are juxtaposed with psychosocial priorities of health maintenance and development. The findings also indicated that health professionals should share a common understanding of health. Additionally, the identification of personal values and reflective practice around personal health definitions are integral to the development of interprofessional health education students. Creating a strong first year curriculum to assist identification of personal health values and their possible difference from those of others is a useful first step toward creating progressive, collaborative, healthcare professionals. This study concludes with some implications for interprofessional educational practice being identified, limitations of the study, and some closing remarks around health being the foundational component of all interprofessional boundary crossing.

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## List of Abbreviations

AUT – Auckland University of Technology
CAIPE – Centre for the Advancement of Interprofessional Education
GRR – General resistance resources
IPE – Interprofessional Education
IPL – Interprofessional learning
MoH – Ministry of Health
NCIPECP – National Centre for Interprofessional Education and Collaborative Practice
SIHS – School of Interprofessional Health Studies
SOC – Sense of coherence
TEPOU – Te Pou o te Whakaaro Nui
WHO – World Health Organisation

## **Attestation of Authorship**

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

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## **Ethics Approval**

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# Chapter 1 - Introduction

Health professional education primarily focuses on the development of an individual's skills in a particular health/clinical discipline. The intention is to use the disciplinary skills to monitor, maintain, and where possible, restore health in accordance to a prescribed health model. In this regard, many, if not all, health-related professions can be seen as having the same intention through a variance of practice and health model identification. Many health education programs and disciplines remain predominantly siloed within traditional curriculum that is primarily prescribed and developed by disciplinary experts (Jacob, 2015; Lawlis, Anson, and Greenfield, 2014). Although, tertiary health education programmes have undergone considerable specialisation development, there is a need to consider additional knowledge and skills our future health professionals require as part of their education (Frenk et al., 2010; Millar, 2016; World Health Organisation [WHO], 2009). It is critical for education to keep pace with the quickly changing face of health and maintain relevance in the workforce, with the ability to address current, large societal health problems (Frenk et al., 2010; WHO 2009; WHO 2010).

Factors such as an aging population, global obesity epidemics, general poor healthy living practices and an overall increase in the volume of health-worker related needs are creating strain on the current operation of our healthcare systems (WHO, 2009; Kadouh & Acosta, 2017). This includes the manner in which our healthcare and health professionals consider and interact with each other.

The global rise of aging populations, non-congenital chronic disease and the associated concomitant conditions has increased the need for a health delivery service with a more rounded knowledge base (Thistlethwaite, 2012). The complexity of the health environment has gone beyond what seems attainable through the actions, knowledge and skills of any single health profession (Bluteau & Jackson, 2009). Consequently, this has raised concerns that the current capacity of healthcare practitioners, particularly those new to the profession, may be lacking in the face of these challenges. The WHO has already made a call to healthcare educational institutions to reform their educational practices to better prepare graduates for this 'slow burning crisis' (WHO, 2010). The

reform is in the development of interprofessional education (IPE). IPE is defined as “occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services” (Centre for the Advancement of Interprofessional Education [CAIPE], 2018, para 1). IPE is a way of developing ‘communal’ thinking to look at larger, multi-subject or multi-disciplinary problems as opposed to discipline specific components of the larger problem.

In this movement away from traditional discipline-based structures, tertiary institutions are increasingly looking to create and develop curriculum in accordance with WHO recommendations. Discussions and attempts to address what modern, progressive curriculum should look like have positioned interprofessional learning (IPL) as a potential solution. Although there is increasing evidence of the benefits to collaboration of health professionals, and logic to collaborative practice frameworks helping to support health professionals in effective and efficient manners, there are still mixed responses and scepticism when it comes to incorporating the concept into an educational, curricular paradigm (Frenk et al., 2010; Millar, 2016). It is still not fully appreciated that the goal of interprofessionalism is not to dilute disciplinary of professions to a generic, all-purpose set of workers; it is to add an additional layer of professionalism to already existing professions. This creates overlapping boundaries of practice specialisation, providing opportunities to action more time-responsive solutions.

Many higher education programmes are attempting to integrate aspects of interprofessionalism into their programmes, previously bound by traditional disciplinary. A New Zealand-based example is within the Auckland University of Technology (AUT). AUT is currently the highest ranked university in New Zealand for clinical, pre-clinical, and health programmes by Times Higher Education world university rankings (2019). AUT formed an entire school for the foundational development of interprofessional healthcare graduates encompassing 14 health qualification majors and professional disciplines. Known as the School of Interprofessional Health Studies (SIHS), the school was created in 2009 along with the National Centre for Interprofessional Education and Collaborative Practice (NCIPECP). According to Reid (2012), a previous director of the NCIPECP, AUT also arguably trains the largest volume of allied health professionals in New Zealand. The SIHS aims to integrate the various disciplines and

approaches to health(care) to create faster solutions more effectively (Auckland University of Technology [AUT], n.d.). The SIHS is responsible for delivering a common core first semester to all students who are enrolled in a health-related discipline within AUT. Seven separate qualifications with more than thirty specialties or professional programmes include this common core semester. The semester one intake regularly reaches 800-1000 students annually.

Studies on the current approach to IPE report an instrumentalist orientation with a focus on the skills needed to practice professionally in a dynamic and changing workforce (Millar, 2016). While this can appropriately prepare the student for basic interactions and effective communication within healthcare practices and its associated constituents, this instrumentalist orientation also steers the student to a highly focused disciplinary background insufficiently integrating with the idea of professional boundary crossing. Further, there are currently no reported IPE pre-set curriculum standards for who takes part, what must be learned, or when it should take place (Millar, 2016). Inconsistencies remain for the reported interaction (amount and type) between people of different health disciplines, creating challenges in building common ground for IPE approaches (Thistlethwaite & Moran, 2010). Consequently, considerable autonomy is afforded to curriculum and programme developers with interpretation of IPE best practice. This non-prescriptive nature allows for variation in the specific content taught by each health education school. This includes the perceptions and practices embodied by the basic conceptions of health from an individual or professional perspective, at its very core. Conceptions of health are important to understand as they lead to personal identifications of healthy living practices, and hierarchical identification of health aspects.

Current Western, neoliberal political practices have created an ideology about positive health practice as a cultural and moral expectation of good citizenship (Ayo, 2012). This has led to the individualization of health responsibility, as well as a cultural phenomenon known as “healthism” that exemplifies this politically developed cultural characteristic. This context has shaped personal conceptions, and for student health professionals, can become translated into professional discipline identification, professional practice, and even imposed onto (future) patients. It has the potential to impact both the student’s education and their future interprofessional practice given

various conceptions can generate priority differences for both patient and (student) practitioner (Ballantine & Hammack, 2012). Therefore, health conceptions and the constituents of healthy living practice are critical, topical considerations for IPE.

In the foundational years of health professional study, it is important to create multiple opportunities for students to identify commonalities between the variant health professions they may encounter in their professional practice. These opportunities are the areas upon which professional and disciplinary boundaries are set. With health being the fundamental basis of each professional discipline in the health sector, the concept of health itself and its variant components factored into daily practice can be seen as one of the opportunistic common areas.

The present study addresses this fundamental aspect by investigating students' various health conceptualisations in their first year of AUT's interprofessional core curriculum. Specifically, the research focuses on how first year students engage with the concept of health, the shaping influences and associated practices. A mixed-methods approach combines large-scale quantitative survey data with in-depth qualitative insights from focus groups. The research population is a cohort of first year students enrolled in a core curriculum of study within the SIHS at AUT. The survey questions elicited participants' definitions and characterisations of their understanding of health as well as insights into the influence on the development of health concept and practice. The focus group questions probed for a more robust understanding of the common survey response data.

## **1.1 Thesis Structure**

This thesis is presented in seven chapters. Chapter one provides an introduction and an overview of the study. Chapters two and three explore the concepts and literature on the topic of health and interprofessionalism to scaffold the reader's understanding in the subsequent analysis. More precisely, chapter two reviews the use of common health models to conceptualise health. Further review establishes the enculturation of health into a neoliberal political culture. Chapter three broadens the context to literature on interprofessionalism in both educational and health educational contexts. In addition, the chapter establishes differences between types of mixed-discipline coursework and identifies the relationship between interprofessionalism and health education. Within this

relationship, relevant tenets of interprofessional health education curriculum are brought forward.

Chapter four presents the methodology and study design including the research question and the philosophical underpinning of the data. An explanation of data collection and analysis is outlined providing a discussion of the reliability, validity, reflexivity with ethical considerations. Chapter five delivers the findings of the study through both quantitative and qualitative methods; what Denzin and Lincoln (2011) describe as a *bricolage* of descriptive statistics, content analysis and thematic analysis. This ensemble of methods draw the various components of the research data together in a manner that, individually, each would be unable to accomplish. Chapter six is a detailed discussion of the identified key results. Aspects of the literature reviewed in chapters two and three are revisited in the discussion weaving through corporeal ideals and healthism, sociocultural demographics, the influences on health conception and decision-making. Additionally, a discussion pertaining to personal experience and learned health value is included. In the final chapter, conclusions are drawn and implications for interprofessional health education are presented.

# Chapter 2 - Literature Review – Health Models & Health Responsibility

## 2.1 Introduction

This chapter introduces the topic of health through several commonly accepted models. The models identified are: the medical model, social model, biopsychosocial model, Hauora - an indigenous New Zealand model of health, salutogenic model, and wellness model. While each of these models evaluate the concept of health, due to their paradigmatic differences they may not return the same summative assessment on the healthiness or unhealthiness of a person, and by extension, their living practice. The merits and fallacies are acknowledged for each model. This is followed by a discussion of literature on health responsibility in which the term healthism is introduced. Integration of health responsibility into health-education curriculum is reviewed. The issue of health responsibility then turns to matters of health-aspect priority. These concepts are related back to healthism and finally integrated with the topic of health evaluation.

Perception of health and research into the influences and constituents of health have created a multitude of health models. A health model is a conceptual framework for the way a persons' health is created, evaluated, or influenced. Depending on the model, a relevant scope of evaluation can be used to make conclusions on a person's overall health. These evaluation frameworks use different variables and components of a person's life. Components and expression of their personal maintenance form the basis of an evaluation for healthy living practice.

## 2.2 Health Models

### 2.2.1 Medical.

The medical model of health focuses on the physical nature of the body and is located in a scientific paradigm of understanding (Warwick-Booth, Cross, & Lowcock, 2012). This model holds that health can be measured, and health is located in the body. As health is located in the body, it can be taken that health maintenance is as simple as remaining free of disease or abnormality. This creates a strong association with a pathogenic perspective

(Quennerstedt & Öhman, 2014) in that health is the absence of disease or illness. If aspects of disease or abnormality are absent, the body is assumed to be healthy. The medical model of health formed much of the basis of healthcare provision in Western medicine (Warwick-Booth et al., 2012) bringing with it neoliberal views on health, i.e. maintenance by individual responsibility, rather than reliance on external regulators (Jackson, 2007). The model's dominance originates from its grounding as far back as the beginning of the Enlightenment (Ashcroft & Van Katwyk, 2016). However, it was in the 1800s when the scientific nature of this model was embraced over previous spiritually-dominated views of health (Ashcroft & Van Katwyk, 2016), when scientists began to isolate the organisms responsible for specific epidemics (Ashcroft & Van Katwyk, 2016). Towards the 20<sup>th</sup> century, medical breakthroughs continued under this objective, epistemological method of truth through replicability (Ashcroft & Van Katwyk, 2016). This has, in turn, created a diagnostic tool for many health professionals - still used today - to identify medical problems with the body. From a biological perspective, this model is a be-all and end-all solution. If something about a person has moved outside the realms of what is considered biologically 'normal', then the aspect in question should be remedied.

Larson (1999) suggests this scientific approach to health maintenance is reactionary. The models' success in combating disease has seen its widespread adoption in Western society, thus creating space for the development of legislature and financial reimbursement structures promoting its continued use (Ashcroft & Van Katwyk, 2016).

Heavy biological emphasis by this model discounts many social, environmental and psychological factors that can influence or determine a consequence on the physical body (Warwick-Booth et al., 2012). Not all symptoms necessarily indicate an illness or disease, or alternatively, not all disease is equally visually symptomatic. This model merely views the body's inability to contend with these influences as physiological weaknesses contributing to ill-health. Strong criticism of the model is often reported in the mental health field for both diagnostic practice and treatment. A prime example of this is the use of the medical model in psychotherapy. According to Deacon (2013), neuroscience has yet to identify a biological cause of any psychiatric abnormality diagnosis. This would indicate that biology alone may not be able to identify and remedy certain cases of disease or illness. This creates new windows of opportunity for other models of health to weigh-in on

the range of factors that can influence a persons' health and thus change the contributors to their healthy living practice.

### **2.2.2 Social.**

The social model of health stands in contrast to the medical model in that health is conceptualized through a large range of influences such as - but not limited to - politics, economics, health services, lifestyle choices, employment status, as well as social, psychological, cultural, environmental, and biological factors (Warwick-Booth et al., 2012). The social model of health focuses its determinants outside of the human body and identifies the causes of ill-health as being attributed to external factors. Health is seen as a social construct rather than physiologically constructed. Arah (2009) identifies the health relationship between a population and an individual as largely relative and dynamic throughout a person's full life course, with a person's continual adaptation to their changing environment and society. Arah (2009) continues to argue that neither a person's, nor a population's, health is identifiable or definable without contextualization within the other. He states,

...a person's health cannot be seen in isolation but must be placed in the rich contextual web such as the socioeconomic circumstances and other health determinants of where they were conceived, born, bred, and how they shaped and were shaped by their environment and communities, especially given the prevailing population health exposures over their lifetime. (p. 236)

This shifts the focus of health from the genetic ability of the body's cells to maintain 'normality' to social factors such as poverty, discrimination, housing and education in which the cells are forced to function. The WHO categorises the social determinants of health as either structural or intermediary determinants (Solar & Irwin, 2010). Structural determinants include aspects of an individual's life such as income, education, occupation, social class, gender, and ethnicity. These factors have a strong influence in shaping an individual's health outcome (Davis & Chapa, 2015). The intermediary determinants flow from the structural determinants presenting as: psychosocial factors such as stress, social isolation/cohesion; material factors such as housing or adequate clothing; and, behavioural factors such as smoking, dieting, and exercise. Indeed, the healthcare system itself also factors in its availability and ease of access. According to Davis and Chapa (2015) social determinants are completely entwined with the distribution of money, power, and resources within a society. Use of this model can help direct funding and resources to areas of greater

need in improving a population's health for a specific problem. Health promotion has a strong foundation in this social health model forming the framework for the creation of many programmes. Generally, when social health programmes are implemented at a community level, they focus on one or more intermediary determinants of health, with the aim to influence behaviour and factors affecting personal health outcomes (Davis & Chapa, 2015).

Counter to this, the social health models' vastly broad scope may be impractical to use (Warwick-Booth et al., 2012). Its enormous breadth means health promotion practices and public health development opinions need to be prioritized in their health focus. Specific problems within a specific population generally require a specific solution. Therefore, a 'one size fits all' solution to health and healthy living practices is insufficiently focused. This, in turn, can create political and financial differences as to the what, who and how of health promotion and care. As a result, many efforts to tackle these social and environmental causes of illness have been slow to gain traction (Davis & Chapa, 2015). Additionally, this model still relies on the medical model to understand the 'nature' of health (Warwick-Booth et al., 2012), as the external social model factors are influencers, rather than causes.

### **2.2.3 Biopsychosocial.**

The biopsychosocial model of health claims the basis for the WHO - International Classification of Functioning (2002) (Wade & Halligan, 2017). Critiquing the reductionist, mind-body dualism approach that characterizes the biomedical model of health, Engel (1977) presented the biopsychosocial model as a more complete account of how to view healthcare and illness behaviour. However, it was never intended as a replacement (Wade & Halligan, 2017). It was stipulated that in Western culture the attitudes and belief systems of physicians were moulded by the biomedical model long before they embarked on their professional education, thus becoming a self-perpetuating reinforcement of the belief system of health. He also argued the evolutionary shift of the biomedical model from one of positivistic scientific research to a cultural imperative of dogma which "requires that discrepant data be forced to fit the model or be excluded" (Engel, 1977, p. 196).

Engel articulated the physician's singular use of the biomedical model treated symptoms rather than patients, which did not necessarily cover the scope of an individuals' condition. In this model, health is more than simply the physiological ability of the body to remain problem free. It accepts the social and psychological factors of ones' life impact the ability to maintain a state of health, as in the social model. However, it also creates space for individual adaptation to their situation to overcome the physiological and sociological impediments in which they may be permanently or temporarily placed. His argument allows for a differentiation between patients, who as Engel (1977) described could identify as having "a problem with living", and those who (with the same condition) identified as being "sick" (p. 133). The biopsychosocial model's consideration of health as a construct gives healthcare professionals the ability to provide effective treatment in both patient identifications. Both the biology and *the sociology in which the biology lives* can be treated.

This differentiation has great implications within the fields of mental healthcare and rehabilitation where patients have shown quality of life improvement in the absence of tissue damage improvement (Wade & Halligan, 2017). An opportunity then arises for specific health disciplines focusing on different health aspects to establish common ground from which to start a patient-centred care plan. Allan, Campbell, Guptil, Stephenson, and Campbell (2006) add to this sentiment, identifying a multi-component model such as the biopsychosocial model as being a prime conceptual model for use in interprofessional health education. The only remaining factor to this is ensuring the patient and the health professional(s) share the same interest in goals. As Wade & Halligan (2017) identified, when differing models of understanding illness are used between healthcare teams and patients, collaborative practice is difficult to implement and illness management may fail.

The biopsychosocial model has much influence on the research, theory, and practice of various health professional practices such as psychology and, what are generally considered complementary, or, alternative methods of health practice (Warwick-Booth et al., 2012). The classification of this model and its functioning is often termed holistic. Allan et al. (2006) report the terms interchangeably in their review of the biopsychosocial model literature. The model is so ingrained in some health professional terminology, it is no longer referenced or explained (Allan et al., 2006). Despite its popularity in health sectors such as rehabilitation, chronic pain services, palliative care, learning disability services, and

psychiatry, it is yet to be ensconced in the acute medical and surgical community, or within the political or managerial arena (Wade & Halligan, 2017).

#### **2.2.4 Hauora.**

Culturally specific to Aotearoa, New Zealand, is the Māori<sup>1</sup> foundations of ora (health). The foundations have four key aspects: mauriora (cultural identity and access to the Māori world), waiora (environmental protection), taiora (wellbeing and healthy lifestyles), and whaiora (participation in wider society). With respect to healthy lifestyle, there are several models identified within the construct of Hauora. A commonly discussed model is Te Whare Tapa Whā (denoting the four corner stones of health) (Ministry of Health [MoH], New Zealand, 2017). This model's components identify as tinana (physical), wairua (spiritual), whānau (family), and hinengaro (mental health). A holistic view in this model is symbolically constructed as the four walls of a whare (house) (Durie, 2004). Should one of the walls of the whare become unbalanced the integrity of the entire structure is compromised as for a person's Hauora (health) (MoH, New Zealand, 2017). Additional to the Hauora model is the importance of wairoa (environmental protection). Wairoa includes a spiritual element linking human wellness with cosmic, terrestrial and water environments (Durie, 2004). This central element connects people with the natural environment including flora and fauna.

Indigenous communities have traditionally been underserved by Western civilization on a global scale (Durie, 2004). This parallels with many Westernized indigenous cultures experiencing sociological and physiological inconsistencies as well as an inability to adapt to Western societal norms and pathogen immunity (Durie, 2004). Singularly, each factor has put Māori culture at a physiological and socioeconomical disadvantage with an additional layer of reciprocal compounding (Durie, 2004). Health promotion initiatives have increased efficacy if they are based in the culture of the societal target (Durie, 2004). To improve Māori health a comprehensive primary care approach needs to incorporate indigenous health perspectives with a return to traditional healing methods (Durie, 2004).

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<sup>1</sup> Those indigenous to Aotearoa

### 2.2.5 Salutogenic.

The salutogenic model was initially proposed by Aron Antonovsky in 1979 (Antonovsky, 1979). However, its wellness promotion message is becoming more commonplace in the evolving medical model of the twenty-first century (Brown, 2014). This is, in part, due to its contrasting philosophical position on the currently dominant, pathogenic focus of health and its derivative view as health being the ‘normal’ human condition (Quennerstedt & Öhman, 2014). Quennerstedt and Öhman (2014) also identify that the concept of normal can be viewed both scientifically and morally, depending on the context from which it is viewed. Scientific and moral ontology leaves very little room for ambiguity in definition, thus anything outside of these is seen as disease/illness or immoral. This creates health perceptions as having a good versus bad overtone or standards on what should be ‘cured’ or not (Quennerstedt & Öhman, 2014). A flaw in this method of health evaluation, and its potential gravity can be seen in examples of societal standards of beauty or sexuality. Standards of beauty and acceptance of sexuality are culturally constructed, but it is difficult to argue their non-genetic determination. In this view, people falling outside the cultural expectation norms of these two exemplar factors, such as being gay, could be considered abnormal, immoral, and in need of being ‘cured’ (Quennerstedt & Öhman, 2014). There is still a biological underpinning as to why the person does not fit the standardised mould. Risk factors to be avoided then become the focus of health education.

As Antonovsky (1996) explains through his analogy of the current structure of health promotion, “the devotion of the disease care system [is] to saving swimmers from drowning downstream through heroic measures, rather than asking ‘Who or what is pushing them into the river in the first place?’” (p. 12). Antonovsky’s research supposes people can maintain good ‘health’ and a good life in spite of disease and stress occurring everywhere and constantly (Lindström & Eriksson, 2006). Chaos and stress are part of life and are natural conditions, he concluded (Lindström & Eriksson, 2006). This construct does not view health as a yes or no, health or ill-health distinction. In the salutogenic model, health is a continuum and is not focused on the identification of ill-health - as many of the other models do - nor is it about the absence of ill-health (Sturmberg, 2009). The focus of health in this model is on the ‘symptoms of wellness’, and the acceptance that we, as fluctuating and constantly changing organisms, will, at times, have something wrong with us (Warwick-Booth et al., 2012).

The salutogenic model sees health as a complex and dynamic state arising from within and its connection to a constantly changing environment (Sturmberg, 2009). The actual gauge of health is the individuals' ability to regulate themselves from a point of disturbance to a state of homeostasis. In this model, regulation is conceptually mediated by two concepts; general resistance resources (GRR) and a person's sense of coherence (SOC). The SOC is the ability to interpret, understand and effectively navigate one's way through both the ups and downs of health, and life in general. The GRRs are the biological, material, and psychosocial aspects of life with examples such as money, knowledge, (healthy) behaviour, social support, cultural capital, and view of life (Lindström & Eriksson, 2006). These GRR factors make it easier for people to perceive their lives as structured, consistent, and understandable (Lindström & Eriksson, 2006), helping a person to construct a SOC in their life experiences (Lindström & Eriksson, 2006). With strong GRRs, a person is more able to successfully navigate their way through constant disease and stress.

Salutogenesis is not simply the opposite of the pathogenic model approach; it offers an alternate starting point to health education than the maintenance of health as an absolute state. It is a redefinition of what is currently considered as health. Applied effectively, the framework can encourage GRR development, leading to insights about biological health (pathological or proactive) and assist in navigation through times of poorer health. Overall, it can shift people from their current state of health to a position toward the high level wellness end of the continuum (Quennerstedt & Öhman, 2014).

Quennerstedt and Öhman (2014) posit the salutogenic approach is in line with the WHO definitions of health and health promotion, as well as, health education curricula in countries like New Zealand, Australia, and Sweden. Lindström and Eriksson (2006) also argue the salutogenic framework is shared with interdisciplinarity (a topic discussed in the next chapter). Solving problems through broad means, addressing complex issues and achieving unity of knowledge on a limited or grand scale are all concepts shared between the two constructs (Lindström & Eriksson, 2006). Educational use of the salutogenic framework strengthens resources for all students, directs students towards active health development, and acknowledges health as a socio-cultural, not simply an individual, issue (Antonovsky, 1996; Quennerstedt & Öhman, 2014).

### 2.2.6 Wellness.

Wellness has become a trendy buzz-word in current Western cultures. Edlin and Golanty (2004) articulate the wellness model emphasising self-healing, health promotion, and the prevention of illness rather than solely the treatment of symptoms of disease. This appears encompassing of all the previously reviewed models. The model also boasts the WHO definition of health as a wellness definition (Edlin & Golanty, 2004). While wellness is considered a model of health, it is further considered to be a behavioural practice encouraging positive health or higher levels of health and wellness (Larson, 1999). The wellness model of health suggests the mind affects every physical process of the body; for example, digestion (Larson, 1999). The affect is less in regard to the ‘brain-nerves-effectors’ operation of the function, than the person’s mental state during the functional operation. Using the example of digestion, the wellness models suggests digestion during states of positive mood will have a different physiological impact on the body than digestion during a negative mood, the logic being that positive mood digestion is more beneficial to the body than the latter. Larson’s (1999) report implies wellness is behavioural and attitudinal in its nature. He identifies wellness and illness as being separate entities, rather than simply opposites.

Physiologically, the human body is capable of repairing damage to tissue and effectively resisting pathogens. The body has evolutionarily developed response mechanisms to physical stress that are effective to the point of survival as a species. However, modern societies along with modern stressors of mental and emotional origin have developed while human body evolution is unable to maintain the progressive pace. In response to mental and emotional stress, the body produces its only (generic) response, which is often counterproductive to solving or rectifying the initial catalyst. Thus, wellness as a practice within the model, focuses on factors to reduce mental, emotional, and potentially physiological stress on the body in order to minimise the body’s natural stress response.

The wellness model is not designed to evaluate a reduction in illness, it is designed to evaluate an improvement in health. Larson (1999) writes: “The wellness model forces medicine to focus not only on the whole person but also on promoting the positive aspects of health” (p. 131). The more engagement with wellness-promoting activities, the further

theoretical progression towards higher levels of positive health. This is somewhat salutogenic and biopsychosocial in nature as progress towards higher levels of wellness is to function as a more wholly integrated individual (Larson, 1999). Also, in agreement with the biopsychosocial model, the wellness model integrates a quality of life component into its evaluation with aspects such as energy, ability to work, efficiency, and happiness. The wellness model also identifies wellness as something perceived by the individual with variance according to age and cultural context (Larson, 1999). This indicates health consequences are greatly influenced by personal feelings and perceptions within particular situations (drawing similarities with salutogenics), calling to action practices such as meditation, mindfulness, and social network reliance. Difficulty is encountered, therefore, in monitoring and measuring outcomes of this model, given the extent of subjective perceptions obtained during evaluation studies (Larson, 1999).

### **2.3 Health Responsibility**

The variance in health's conceptual construction creates a variance in the necessary methods of health maintenance and restoration. It also highlights peoples' health practice attitudes are a reflection of the different meanings attached to the term. Regardless of the particular health model's view, they equate to a determination of health. A briefly identified aspect of this determination is that of responsibility for the maintenance of health. Initially popularised as a term in the 1980's by Robert Crawford (1980), healthism is a concept that has steadily drawn attention in relation to health education. More specifically, how health is viewed in society and educational paradigms. The healthism phenomenon resulted from the development of health knowledge through scientific discovery and popularisation of wellness therapies as practices for maintaining and restoring positive health in a holistic fashion (i.e. all aspects of ones' reality impacting upon the body) (Crawford, 1980). Its popularisation came about as a result of a 1970s movement of health-conscious behaviour. Along with the popularisation of health consciousness, so too came consumerist campaigns promoting countless ways of positively impacting the body, all in the name of health.

Healthism refers to health being very much influenced by the individual, therefore issuing individual responsibility to maintain and develop good health as an expectation of a social cultural norm (Crawford, 1980). This idea of self-care is described by Levin (1976) as "a process whereby a lay person can function effectively on his[sic] own behalf in health

promotion and prevention and in disease detection and treatment at the level of the primary health resource in the health care system” (p. 206).

Through health consumerist campaigns, healthism began to pervade primary and secondary physical and health education curricula, evolving from physical preparedness for military service to a focus on the individual and with it a morality component of ‘this is healthy for you, so this is good and doing the opposite is bad’ (Quennerstedt, Burrows, and Maivorsdotter, 2010). This similarity of delineation between health choice and morality has already been identified in the above depiction of the salutogenic health model. The healthism view, however, can be identified in any model that besets health as individualised and behaviourist in its manifestation.

Changing views of health and educational directions were tracked and described by a Quennerstedt et al. (2010) investigation of health education curricula documents from both Sweden and New Zealand. The shift in education directions from biomedical health education (military preparedness) to healthy lifestyles was thought to develop learners’ attitudes of information on healthy lifestyles which would, in turn, lead to behavioural changes in healthy living practice. Instead, healthism began to exude an ideal of moral high-ground as health education and learning curricula prompted messages of expectation for health: ‘These are the things I should do to be healthy’.

Our current tertiary health education students, however, were exposed to progressive attempts to adjust this healthist individualistic sense by developing a socio-cultural perspective. Although, as Quennerstedt et al. (2010) identify, the discourses of current global health problems, specifically fitness and obesity, are manifesting in schools, texts, and curricula. Their argument posits that as curricula development has allowed for the opportunistic advancement to alternatively consider and practice health, it has been hijacked by, and again directed towards, education on behaviour change and, by extension, moral imperative. Thus, the concept of health, its maintenance and therefore lifestyle practices, is still an expectation of the individual rather than the socio-cultural whole.

### **2.3.1 Health aspect priority.**

Current research indicates poor expression of healthy living practices are an international problem (WHO, 2009). Multiple studies have shown student health professionals are similarly afflicted (Klainin-Yobas, He, & Lau, 2015). Blake, Malik, Mo, and Pisano (2011) found health students presented as a higher risk to ill-health than the general public. Variant conceptions can generate priority differences for both patient and (student) practitioner. A person may fail to, respond to, or suggest measures designed to improve health because they misperceive the measures as related to their conception of health (Baumann, 1961). Healthy living practice can be understood as the collection of choices influencing a persons' overall health. This ideal has neoliberal undertones as it suggests individual responsibility for wellbeing through the practice of health-promoting lifestyle behaviours (Ayo, 2012). People with a narrow view of health, and therefore what constitutes healthy living practice, may have difficulties accepting or engaging with the variant ideas of health models and alternate healthy living practices. Conflicting perceptions of healthy living practice could lead to inconsistent therapeutic concept creation and engagement between professional health disciplines. Likewise, it can create inconsistencies with interpretation of health information between professionals, or between patient and professional (Bientzle, Cress, & Kimmerle, 2013).

A large amount of literature suggests health students are not meeting the health expectations of the world health community (Al-Kandari, Vidal, & Thomas, 2008; McSharry & Timmins, 2016). If health students are not meeting health expectations, it may be implied, they are not practicing healthy living. In their study, Blake et al. (2011) identified most participants had a high level of knowledge about the benefits of physical activity, as well as an awareness of their personal level of healthy living practice, however, their knowledge was misaligned with actual practices. Although student health professionals know the recommended daily physical activity level, they do not prioritise its importance and benefits for themselves. The context of these study evaluations infer a medico-health education imbued with the idea information dissemination generates attitude and behaviour change in those that imbibe it.

## **2.4 Summary**

Although knowledge of the above mentioned models may broaden an individual's perspective of health, individuals do not need to be specifically cognisant of the model constructs in order to subscribe to their framework of how health is created. An individual's actions, practices and beliefs will naturally lead them towards one of these models and can also influence one to make assumptions on others' health (Cohen, Manion, & Morrison, 2007; Creswell, 2003). Health is a personally constructed concept, and maintenance is generally viewed as the responsibility of the individual in traditional Western cultures. Although there are commonly used and referred to definitions, the explanation of its practice will vary from person to person. Health is a continuum of immediate and long-term outcomes based on the continued impact of daily choices (Warwick-Booth et al., 2012).

Healthy living knowledge and healthy living practice are not always a reflection of each other. Conceptions of health then, and the constitution of healthy living practice can be seen as topics that interprofessional study must consider, especially as it promotes health student's engagement with other health disciplines and their variant perspectives.

# Chapter 3 - Literature Review – Interprofessional Education

## 3.1 Introduction

This section introduces the concept of interprofessional education, with a particular focus on multiple health disciplines. Using relevant literature, a general background of the emergence of IPE in health is outlined and the differences between educational terms are discussed to provide a better understanding of the concept of IPE versus other teaching modalities. The relationship between interprofessionalism and its utility within health education is identified. Challenges to the development of IPE in health and commonly identified skills within IPE teaching are discussed. Finally, aspects of the relevant tenets of an IPE health curriculum are brought forward, identifying the challenges to the creation of stable curricula, including contestation of subject matter, goals of the curriculum, methods of learning and overall timing.

## 3.2 Interprofessional Education

### 3.2.1 Introduction.

An interprofessional practice and interprofessionalism is the goal of an educational programme promoting a focus on patient-centred, collaborative care. The Centre for the Advancement of Interprofessional Education (CAIPE) has defined IPE as: ‘occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services’ (Centre for the Advancement of Interprofessional Education [CAIPE], 2018, para 1). In essence, this collaborative practice mentality not only has the ability to test, diagnose, and treat patients but also the professional awareness to look beyond the limitations of ones’ own personal practice domain. It encourages a willingness to accept a single professional discipline and health view may not require prioritisation in a patients’ healthcare plan.

### 3.2.2 Interprofessionalism and interdisciplinarity.

In order to work effectively as an interprofessional, one must also be able to work collaboratively with alternate health disciplines to their own. The practice of

interdisciplinarity requires health students to learn both discipline-specific and generic health knowledge. Development of health knowledge in health education, regardless of the health-related discipline, is based upon fundamental understandings of both physical and sociological constructs of health being the cornerstones of any health-related profession. Likewise, disciplinarity and its focus on a concentrated component of health must originate from, at least, the smallest part of generality in order to identify distinctions from the common. These ‘common ground’ overlaps are what makes the opportunity for interprofessional collaboration possible. Disciplinarity is not the intention of IPE, rather, the purpose of IPE is to have students learn about health and health treatment from various discipline viewpoints. In order to accomplish this, a certain amount of learning needs to be accomplished through interdisciplinary and multidisciplinary lenses, where students from different disciplines will advance through curriculum together.<sup>2</sup>

### **3.2.3 Clarity of terminology.**

Traditionally, health professions have operated from well-defined boundaries between disciplinary fields (Buring et al., 2009). More recently, there has been advocacy for, and a movement towards the adoption of practices that are more patient-centred rather than discipline-focused. While this is a fairly recent occurrence in healthcare, the development and delivery of curriculum courses identifying with more than one discipline is not a new concept to education. The term interprofessional is occasionally overlapped with the term interdisciplinary depending on the aspect being discussed (Thistlethwaite, 2012). It is used to describe a style of educational practice that integrates curriculum content between/among different disciplines (Holley, 2017). It does this with an emphasis on how the content relates and interacts with all of the different disciplines represented within the course. The goal of the content, however, is not necessarily patient goal-focused. IPE can be seen as the process to produce competent graduate interprofessional health practitioners who utilise *interprofessionalism* in their respective practices. Interprofessionalism can be effectively conducted through the knowledge of *interdisciplinary and multidisciplinary*

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<sup>2</sup> For the purposes of this literature review, the CAIPE definition of Interprofessional will be used as the differentiator of what is, and is not classed interprofessional education. In this regard, the terms interdisciplinary and interprofessional are used interchangeably in the wider literature and will be used interchangeably in this literature review, reflecting the terminology used by the researchers and writers in the field with the provision of the CAIPE definition in mind, as the subjects involved in the research are enrolled within a school of interprofessional health education.

teaching and learning. To clarify these terms, an interprofessional has undertaken an educational programme incorporating disciplinary, interdisciplinary and multidisciplinary educational opportunities to produce a graduate able to work with other disciplines towards the benefit and/or goals of a specific client (or in the case of healthcare, patient). Further, during the course of health education study, students learn (about) various skills from within their own and other disciplines in order to graduate and practice (interprofessionally) as a designated health professional. They would practice in their profession with other, similarly educated individuals, potentially from different health-related professions. Ideally, for the betterment of patient care and positive outcomes, these graduated professionals would work collaboratively for their patients in an *interprofessional* manner.

As early as 1972 with the publication of a report by the Institute of Medicine titled “Educating for the Health Team”, the concept of interdisciplinary education has been associated with health professions (Brandt, 2018, p. 65). This is where two or more disciplines are combined under a common subject matter introducing a new level of integrative learning. The boundaries between subjects are broken down and the curriculum is not delivered as a simple addition of each subjects’ component parts. As this idea has gained traction, many variant terms have been used in the concept description, with subtle differences. Holley (2017) breaks down the most common of these variant terms succinctly as follows: (i) cross-disciplinary, where one subject borrows the tools, methods, concepts, or theories used in another subject to expand understanding in a given field; (ii) multi-disciplinary, where different disciplines learn a common topic but retain their individual identity and no effort is made to integrate them, and; (iii) trans-disciplinary, where two or more discipline perspectives intertwine, holistically, to create a subject matter, and curriculum content different to what one would expect from the sum of the disciplinary parts. These terms all relate to the discussion and study of topics intertwining various disciplines (Holley, 2017), the most regularly used being interdisciplinary and multidisciplinary education. These two terms are differentiated in their integration of knowledge for student cohorts of different disciplines. A multidisciplinary course is seen as one containing multiple disciplines, but its content, while relevant to all disciplines, is not interrelated to the individual discipline. Students integrate new knowledge only within the contextual understanding of their discipline (Holley, 2017).

For IPE, the purpose and product of collective-discipline content development is the same. As an example, Jacob (2015) states: “interdisciplinary practices in higher education refer to the integration of two or more disciplines or fields of study in relation to research; instruction; and programme, certification and/or degree offerings” (p. 2). In this definition, Jacob also refers to the idea of IPE as ‘two or more disciplines’ being integrated in relation to at least research and/or instruction. Provided these courses improve collaboration and quality of care and services, they can also be included in the classification of interprofessional. This correlation is important to make as the wider literature carries with it similar definitions of CAIPE’s IPE definition with variants of the subject term. Incorporating and including variant subject terms to the wider body of knowledge about IPE is relevant as the ideas discussed within them correspond to the CAIPE definition.

#### **3.2.4 Interprofessionalism and interdisciplinarity summary.**

Interprofessionalism and interdisciplinarity must share commonalities of goal, context, or subject matter in order for effective border crossing education to take place (Holley, 2017). A fundamental component of all health education programmes, deliberate or hidden within curriculum is a construct of health and its methods of practice, including cultural behaviour. Within health education, the different disciplines, although using different skill sets, have a somewhat similar disciplinary practice goal - to assist patients in the management of their health through knowledge development and/or intervention. Therefore, there is a requirement for each health profession to have a clear understanding of the goal they are working towards as they create a remedy for their patient. Since the methods they invoke to create change will impact a patients’ health, it is important for students to have clarity on which perspective they are viewing the solution. Are they working towards improving their patients’ health through methods within their own definition of healthy living practice, or the patients, or somewhere in between? This can challenge many health professionals and health education students when questioned about the definition of health, and their practices. To this point, Bientzle et al. (2013) found student health professionals would modify inconsistent therapeutic concepts towards their own personal therapeutic perspective, reporting not a single case where subjects deviated from perspectives in line with their own.

### **3.3 The Call for Change in Healthcare Education**

The main drive for IPE incorporation can be linked to the call from reports such as the Lancet Commission (Frenk et al., 2010) and the WHO - Framework for Action on Interprofessional Education and Collaborative Practice (2010). The premise of these reports are reform of healthcare education due to a ‘slow burning crisis’ of ill-equipped graduates unprepared for the shift from acute health service delivery to chronic care models. They identify interprofessional care and collaborative practice as having a positive effect on patient satisfaction and outcomes. To this end, increasingly, educational institutions have started to incorporate IPE into their curricula with the broad themes for learning outcomes being teamwork, roles and responsibilities, communication, learning/reflection, the patient, and ethics/attitudes (Thistlethwaite & Moran, 2010). This is a shift from the ‘hard’ technical skills of a health profession discipline to what could be considered a knowledge-based ‘soft’ skill of the trade - skills required by every discipline member of an interprofessional team. As a result, the intention is to produce health professional graduates who have been exposed to interprofessional collaboration, which, in turn, should improve their ability to function in a collaborative professional practice. This is said to benefit both the educational institutions, as they can boast ‘more effective’ graduates for the future, and the student, as they are trained into processes they are likely to encounter in a professional setting. Educational institutions are taking financial advantage of the opportunity to combine similar disciplinary programmes under the premise of IPE ideals. Along with advancements in specialist knowledge, higher education institutions offering more than one health discipline programme have seen a marked increase in the prevalence and marketability of interprofessional programmes in recent years (Millar, 2016).

IPE is still in its developmental stages, yet to be firmly established as the commonplace development process for students and professionals. In addition to WHO’s reports, studies in IPE have identified student and staff feedback pertaining to the benefits of interprofessional collaboration (Curran, Deacon, & Fleet, 2005; Tsang, Cheung, & Sakaibara, 2016). Despite gaining traction both academically and professionally, the development of programmes promoting IPE seem somewhat tidal in their inclusion and retraction from programmes of academic study (Holley, 2017). Impediments to incorporation and/or development can include basic logistical issues between the various professional schools forming interprofessional teams. Buring et al. (2009) and Curran et al.

(2005) suggest issues generalised as simply ‘scheduling’ can include aspects such as rigid curriculum within education programmes, to geographical problems where disciplines are not in a close enough proximity to create opportunities for IPL to occur. Also identified was the idea of ‘turf battles’ over specific content disciplines were unwilling to share. In addition, attitudinal differences amongst previous generation health professionals and faculty members can lead to a resistance to change due to a lack of perceived value (Buring et al., 2009). Holley (2017) notes many current curricula developments are quick add-ons to existing programme content. While there is no one specific reason identified for this, much health professional education curriculum is focused on the ‘hard’ skills of disciplinarity. Many health professional practice disciplines are governed by their own regulating bodies dictating the criteria needed for licencing in practice.

Educational institutions have a vested interest in not only producing effective graduates, but doing so in an efficient time frame. As a result, institutions can be hesitant to add more requirements, and therefore, time to their educational curricula fearing the deterrence of potential students eager to enter the workforce. In this state, educational institutions perceive less opportunity and latitude to alter already established curricular outcomes or practices. Consequently, IPE opportunities are rendered impractical to the purposes of specific discipline development (Buring et al., 2009; Holley, 2017).

Variance in available discipline selection for IPE within an institution creates clusters of knowledge of interprofessionalism often exposing epistemological gaps left unexplored (Holley, 2017). While Millar (2016) outlines many arguments posited for the inclusion of IPE, there is little discussion within government and institutional documents and wider literature investigating IPE content comparisons to discipline-based curricula.

Despite implementation issues, IPE is increasing its influence over the development of future health professionals. In parallel, the gaps and overlap in understanding various assumptions and inferences about health, and ones’ healthy living practice become more relevant. Allan et al. (2006) argue a fundamental step in the development of an IPE programme is the foundational use of a common model of health. Adding a common model to the current active use of the variety of health models, prompts a key question as to what model should be used and who should decide on which one? If we look to the definition of

interprofessionalism, the goal is patient-centred care, so perhaps this decision is best left to be discovered in discourse with the patient. In order for these discourses to be effective, it would, in turn, dictate that practitioners have a working understanding and appreciation of various types of health models as well as a reflective understanding of their own health perception and its creation and maintenance on a daily basis.

### **3.4 Changing the Curriculum**

In a health context, it seems apparent that the purpose of IPE is centred on patient health outcomes as a by-product of improving patient care through collaborative knowledge development and synthesis. This can only be accomplished through complex problem solving beyond the capacity of any single health profession. In order to have better patient outcomes, healthcare professionals facilitating these outcomes need to both collaborate and expand the diversification of their own knowledge base.

#### **3.4.1 The curriculum is contested.**

Curriculum is generically identified as the subjects of learning within a specific programme of study. Inside the subjects of learning it is the task of educators to incorporate effective methods of learning and teaching to achieve a desired outcome skill or ability. The curriculum, regardless of the educational paradigm, does not come from a neutral position as the people creating curricula will have specific perspectives and ideals influencing the discussed topics and course design (Holley, 2017). Lawlis et al (2014) aggregated three main aspects (government and professional, institution, and individual) encompassing the majority of elements acting as barriers to the development of IPE curricula. Under these headings, the breadth of barriers is spread greatly, including factors such as biases and timing.

External stakeholder influence in directing curriculum is now unprecedented (Millar, 2016). Understandably, a professional body governing a specific health discipline determine the required demonstrated criteria before the incumbents are deemed worthy of the professional title. These same governing bodies have a set scope of health-related ideals hidden within the development of these skills and practices relevant to their discipline. Thus, in creating curriculum directives the bias of a discipline viewpoint will be evidenced.

The challenge of identifying bias can also be set back by timing. Lawlis et al. (2014) identified the compounding issue of organisational change at the government and professional level. Staffing and structural changes stymie momentum through losses in enthusiasm and communication between stakeholder groups. Thus, timing for student learning development within an IPE context requires alignment with external stakeholder values and interests as they shape and mediate the creation and conduct of the curricula.

In this reality, perhaps the best course of action is to create discipline-related curriculum content that is student-focused. This approach removes the need to prioritise any particular vision of health in the construction of curricular material, and can be delivered in a reflective manner as an effective construction of learning activity for the curricular outcomes to be accomplished.

Thistlethwaite (2012) aggregated six general learning outcome categories for IPE in a review of literature. Predictably, these outcomes were patient-centred, team-focused, and reflective in their expectation. Langlois (2016) mapped clinical topics able to be delivered in an IPE curriculum. From the 11 different programmes offered by the university, it was found there was almost no overlap between curriculum topics either in participation of topic, or topic depth. Identified topics were related to professional practice development rather than ideology development of the healthcare professional. If the development of health ideology is inherent in the development of a health discipline, and the healthy living practices undertaken by students mismatch with the ideals or expectations of the taught health ideology there is a shortfall to instil the values of that health model and its practices in health students. If poor healthy living practice is an international problem, an investigation into student perceptions of healthy living practice is warranted.

As Holley (2017) identified, there remains much that stems from a multidisciplinary curriculum perspective that does not give specific attention to issues of integration of knowledge or interdisciplinary methodology. There is also a research focus on the skills arising from IPE, rather than the content itself (Millar, 2016). While these skills need to be developed and cultivated, simply identifying they are needed does not determine content

matter that a curriculum should (or could) incorporate to develop these skills. It also does not define how knowledge development is legitimated.

### **3.4.2 Goals of the curriculum.**

The process of knowledge formation is central to the three types of learning; cognitive, skill-based, and dispositional (Wyse, 2013). For many, the period of beginning and progressing through higher education is one where students establish and solidify lifestyle habits including dietary practices, sleep habits, and physical activity practices (Fedewa, Das, Evans, & Dishman, 2014). Evoking dispositional learning in future healthcare workers, especially in their foundational years of tertiary study creates potential for greater dividends in their professional practice. Practitioners subscribing to a healthy lifestyle are more likely to discuss their practices with patients. Wills and Kelly (2016) identified health students who had a greater association with living a healthy lifestyle were also more likely to have discussions about healthy living practice with patients/clients showing higher confidence levels in the process. The ability to discuss a topic from a personal experience perspective allows for considerate advice for effectively assisting patients/clients in their own self-care (Stark, Hoekstra, Hazel, & Barton, 2012). While these research findings do not legitimate students' beliefs of healthy living practices as being appropriate for everyone, the indication for their inclination to discuss the concepts of healthy living practice is important. It shows an awareness of the idea that health and health practice are multifaceted and constantly influential, thus not necessarily tuned to their own health model or the health model of their professional discipline.

The overall goal of any educational programme regardless of level is to advance and integrate knowledge and understanding. Millar (2016) found academics teaching both discipline specific topics and interdisciplinary classes wanted students to form a broad understanding of different disciplines. The report expresses the increasingly specialised nature of disciplines and the complexity of knowledge now facing tertiary students, often requiring an interdisciplinary approach to ensure understanding. For students progressing into a multidisciplinary and interprofessional healthcare field, developing understandings of health from alternate contexts may help to broaden both their personal and professional horizons. More importantly, it may improve their perception of healthy living practice and, by extension, their own lived experience.

Practically, educational programmes must run to a schedule and thus curriculum content is constantly under time restraints and trade-offs must be conceded. For an increase in breadth of knowledge, one will lose depth of knowledge (Millar, 2016). In the same study, Millar (2016) found this ‘depth of knowledge’ issue was raised in the interviews conducted. Many interviewees believed “interdisciplinary subjects and degrees do not give the ‘problem portable’ foundations of a more traditional physics degree” (p. 477) regarding the discussion of interdisciplinary nanotechnology-related courses versus traditional ‘pure’ physics course work. As the concept of health and healthy living is increasingly argued as a subjective and contextual ideal, a breadth of topic development in the context of health would serve to produce a more ‘problem portable’ foundation when moving between interprofessional health teams.

### **3.4.3 Combining curriculum subjects and goals.**

So, while the skills of interprofessionalism are developed, the subject on which this is accomplished needs to be through a topic of interdisciplinary commonality. The overarching ideology being the framework and curriculum content of these courses will ideally increase the breadth and depth of knowledge for all learners. This content will form a common body of knowledge students will be able to absorb as fundamental components of a paradigm or concept relevant to all associated professions (Holley, 2017).

The learning experience of the students within these programmes will be guided by the curriculum. Curriculum is based on a philosophical construct of how knowledge is developed (Scott, 2014). As Scott (2014) argues, how knowledge is delivered in curriculum is a declaration on how knowledge is constructed in a legitimate and, by the same token, illegitimate manner. This also identifies, and to an extent dictates, how learning is, or will be, accomplished by the learner as curriculum is essentially the framework for learning. Most of the various healthcare-related disciplines (physiotherapy, nursing, etc.) are focused on practice skills. If students are to be fully rounded in their educational interdisciplinary paradigm, personal healthy living practice needs to be addressed as a competent skill rather than an assumed practice. It should not be automatically assumed as a by-product of knowledge delivery of compartmentalised health information from various instrumental courses. The importance of this can be emphasised by remembering that for many, the

period of starting and going through higher education is one where students establish and solidify lifestyle habits including dietary practices, sleep habits, and physical activity practices (Fedewa et al., 2014). Also, the enactment of health promotion through healthy living practice can be demonstrated and practiced by any level of health-related profession (Hivert, McNeil, Lavie, & Arena, 2017).

Keeling and Templeman (2013) provide an analysis of Bandura and McDonald's theories of value change to argue that the observation of influential role models, especially when they appear successful, is a powerful mechanism to facilitate the evolution of personal values. If role modelling can influence change in patients and our health professionals are all modelling healthy living practice, it would seem logical that this should be a given aspect to include in IPE curriculum in the interest of patient-centred care. Thistlethwaite (2012) identified a challenge to evaluating the efficacy of IPE was the diversity in the range of programmes, modules and learning opportunities delivered internationally. This is due to the fact that "decisions about what to offer, and when and how to do so, are often made on a pragmatic and logistical rather than pedagogical grounds" (Thistlethwaite, 2014, p. 64). Incorporating healthy living practices into IPE curriculum satisfies both pragmatic and logistical aspects as well as being supported by a sound pedagogical rationale.

Most health disciplines share a primary purpose to help individuals return back to, or surpass, a previous standard of health. However, one health discipline's view of what constitutes complete health may differ from that of another discipline or, potentially, a practitioner of the same discipline. Many solutions to healthcare problems presented by different health professionals will remedy parts of the problem, however, they may not necessarily be ideal. The core competencies of an individual discipline, while still valid and highly valuable, are no longer necessarily enough to comprehensively effect the complete health benefit of patients. In this way, employers and universities have recognised the need to have graduates and employees who are capable to 'round the edges' with the sufficient competencies, skills, and abilities to adapt to the changing and diverse needs of a modern population (Jacob, 2015).

Buring et al. (2009) views the key mechanisms for effective interprofessional education to include principles of adult learning and staff development to improve group facilitation.

Skills such as active listening, team work, and cooperation need to be developed in order to improve the result for the end benefactor, the patient. As these skills of interprofessionalism seem to align with all disciplines, they should be considered foundational principles and skills. Therefore, an effective place to begin the incorporation of these skills would be at the beginning of a health education programme in the basic, foundational courses (Barr & Ross, 2006).

#### **3.4.4 Methods of learning.**

A competent health student with the ability to interact and knowledgeably converse with other students, patients, or clinical supervisors, must first have a broad foundation from which to draw. Health, as a concept, has already been identified as being constructed in a personal, experiential and social manner. Reflective practices are needed to clarify an individual's own health construct and are frequently noted in general education literature as a more commonly accepted essential practice in the development and maintenance of competent health care professionals (Mann, Gordon, & MacLeod, 2007). The pedagogies of adult learning, including methods like experiential learning, inquiry-based learning, problem-based learning are often grounded in reflective learning practices (Hean, Craddock, & O'Halloran, 2009). If these future interprofessionals are to actively support care that is truly patient-centred, then it is important they not only know what health is in its variant constructs but also how it is constructed within themselves.

From an IPE standpoint using reflective practice, simply understanding one's own construct of healthy living practice is insufficient. It must be broadened and discussed with those of variant disciplines and with others of ones' own discipline to develop an awareness of the level of difference between their views and those of their future colleagues.

#### **3.4.5 Timing.**

Opinions on when IPE should be incorporated into curriculum are varied. Two projects investigated by Millar (2016), suggest interprofessionalism was either best done in the later years of undergraduate or at post-graduate and research levels, or a small amount of IPE coursework at the undergraduate level was reasonable, as long as it did not crowd out the ability to form a strong discipline knowledge base.

This is not to say IPE should only be introduced and included in one section of an educational curriculum and then forgotten about in lieu of discipline specific skills. Rather, IPE and interprofessional practice are not add-ons or after thoughts for a healthcare professional or practice experience, it is a keystone component in the delivery of patient-focused healthcare that supersedes the health bias of a single profession or practice.

Based on the results of Langlois (2016) indicating that ideology development is not a topic of importance to interprofessional development, students are being left to develop and maintain opinions of their own creation that may not be fully informed. These opinions are present at the onset of their tertiary education. Health perceptions can range in regard to self-expectation, future profession, expectation of others in health professions, and patients.

This would indicate, perhaps, the level of interprofessionalism of the curriculum is dependent on the paradigm, as well as the content, of interprofessional skill/knowledge that is being developed with both of these aspects not being mutually exclusive to each other. For example, when a topic like health is being studied as a concept rather than a goal construct for an individual, it would potentially be better served as an undergraduate course or topic that can effectively encompass all different health disciplines - all drawing from the same basic pool of knowledge. In contrast, where the focus of study is health being the goal construct for an individual rather than a generality, it is a topic better left to the end of an undergraduate programme or post-graduate students who have a more refined understanding of what their discipline can offer.

One of the discussion points in the research by Millar (2016) was whether it is possible to structure interdisciplinary curricula and teaching in a way that provides a stronger foundational knowledge and therefore reduce issues of a lack of depth. For an educational concept so broad as health, laying a foundational understanding of its component parts and how it is practiced (both ideologically and physically) could benefit all health disciplines towards the later years of undergraduate work where interdisciplinary/interprofessional practice begins to play a real-world role in the application of skill towards patient goals.

### **3.4.6 Curriculum summary.**

Interprofessionalism brings with it the specialised nature of professionalism; that is, discipline specific knowledge and ideas (Millar, 2016). This is a necessary component in IPE as it brings knowledge, thoughts and ideas together from different specialties. The wider literature suggests IPE is relevant to all health disciplines, and could provide topics that are suitable for foundational level curriculum (Buring et al., 2009). The initial knowledge, thoughts, and ideas brought to the classroom at this level of a health professional educational programme are already formed preconceptions. This adds weight to the importance of understanding the perceptions of health and healthy living that foundational interprofessional health students hold as they enter their programmes of study. However, early identification or discussion of the variety of perceptions and practices, about health and healthy living embodied within an interprofessional cohort of health students and professionals is not reported in the literature. This presents a challenge to those tasked with developing IPE curricula as the underlying tenant of health education in and of itself is the construct and perception of health practice to establish and/or maintain positive health. It is also recognised that as health is such a broadly understood and interpreted concept, such variance is influenced by a wide range of perspectives, subjectivities and experiences that are, in turn, socially, historically and culturally rooted. Thus, there is an excellent opportunity to discuss this foundational and fundamental aspect of the health professions that seems to be missing. How do these health students perceive health and healthy living practice?

## **Literature Review Summary**

Interprofessionalism is a practice broadly taught in its scope but narrowly researched in its product. IPE has been called on for greater development to improve the abilities of future healthcare professionals due to a changing healthcare workplace. In the development of curriculum, issues of inconsistency in topic matter have been identified as common.

Interprofessional learning can be incorporated into education curriculum at any point in a programme of study provided the content being studied scaffolds the learner to a greater understanding of core concepts and paradigm specific knowledge. Health, while argued to be constructed in a personal manner can influence external perceptions and actions towards the practices of healthy living. Student health professionals have been identified as not living up to societal expectations of healthy living practice. However, these expectations are created from an external manifestation. Understanding peoples' health conception is a useful resource to future education on adopting more effective healthy living practice. An examination to see if there are indeed differences in health conception and how healthy living is practiced would be useful to the development of effective IPE curriculum and its teaching practices. Performing this analysis with students of different disciplinary programmes, but who are engaged in a core, interprofessional, first semester will help to identify the commonalities and gaps of health perspectives within our future interprofessional health teams.

In the chapter that follows, the methodology of this project is identified. The research question is identified and theoretical framework is discussed. The research design and data collection methods are discussed along with the methods of data analysis. Reliability and validity of the project design are examined along with the reflexivity and ethical considerations that went into the study.

# Chapter 4 - Methodology

## 4.1 Introduction

Health, as a construct, has no set definition and will vary in its explanation from person to person as it is a continuum of immediate and long-term outcomes based on the continued impact of daily choices (Warwick-Booth et al., 2012). Much of the literature on student health focuses on health performance through quantitative studies. Yet such studies fail to encompass the complexity of the health paradigm in which students view themselves. This project intends to refocus the health education lens to examine health students' definition and perception of healthy living. Of particular interest are explanations of how these perceptions are characterised and influenced.

## 4.2 Research Questions

How do first year, interprofessional health students perceive health, and its living practice?  
How can this impact and improve foundational, interprofessional health education?

## 4.3 Research Methodology

### 4.3.1 Overview.

Interpretivist ontological relativism tells us reality is subjective and differs from person to person (Scotland, 2012). Thus, perception is subjective. Gaining knowledge about perceptions of healthy living practice, then, must be acquired through personal experience. While health can be defined from both positivist and social paradigms of epistemology, perceptions on healthy living practice, while externally influenced, are inherently constructed and solidified individually and subjectively (Mack, 2010). A mixed-methods approach was chosen for this research as the research question explores participants' perceptions of a concept that is social and biological in its construct. Such constructs have the potential to contradict each other and mixed methods are useful in understanding the contradictions between quantitative results and qualitative findings. Mixed methods also "give voice to study participants while ensuring that study findings are grounded in participants experiences" (Wisdom & Creswell, 2013, p.3). This research also sought to

identify common themes amongst a cohort of interprofessionals, which is a term shared by a variety of qualitative analyses (Braun & Clarke, 2006).

#### **4.4 Theoretical Framework**

The health construct can be evaluated from a variety of viewpoints, as illustrated in the literature review. The variance in ones' view of health, then, can be seen in the interpretation of what it means to be healthy. From a positivist perspective, identifying and evaluating health is reliant on comparison of data within a larger cohort. Interpretivism is an epistemology emphasising an individual ability to construct their own meaning of the world around them (Mack, 2010). From an interpretivist perspective, health is established through one's own understanding of how they 'feel' and the evaluation of the experiences underpinning this feeling and its continuance. In line with Newby (2014), this makes it difficult to claim a specific paradigm when both quantitative and qualitative approaches may be used. To describe the common themes of a large cohort relating to perception, embracing both quantitative and qualitative frameworks is advantageous. Combining seemingly contradictory viewpoints to establish an understanding of the perceptions of a cohort then requires a pragmatic approach (Newby, 2014). Using descriptive statistical analysis in combination with the detail of qualitative analysis provides a broader perspective as a result of the strengths of the two paradigms (Creswell, 2003). As the goal of this study was to "understand, explain and demystify social reality through the eyes of different participants" (Cohen et al., 2007, p. 19), the dominance of the qualitative interpretive paradigm was ideally suited to this study.

A persons' health is something they (un)knowingly and (in)actively engage with every day. As Inglis and Thorpe (2019) identify, phenomenology is concerned with the mundane, everyday contexts in which people live their lives. Health and healthy living practice can be identified as a phenomenon of an individuals' and collectives' experience. Phenomenology seeks to investigate how individuals and collectives experience what many refer to as 'lifeworld' (Newby, 2014). The concept of lifeworld, "... refers to the everyday experiences that we live and which we reflect upon" (Bloor & Wood, 2006, p. 129). More aptly, health can be seen as an individual phenomenon that has an inter-subjectivity within cultures and populations that generate a natural attitude and a typification that has led to the

various models of health being created (Inglis & Thorpe, 2019). This typification also creates the opportunity of identifying an endomethodology within the phenomenon of health. The endomethodology in this instance is both that of the practices themselves and their influences of healthy living.

As the researcher, I have experienced the phenomenon of health in my own way. As an instructor of human anatomy and physiology, I also teach about the human body scientifically. This creates a dualistic positivist and interpretivist understanding of the phenomenon. Additionally, I cannot detach myself from the phenomenon of health and healthy living practice. In an interpretive epistemological paradigm, the researcher does not stand above or disconnected from the research participants. Being aware of how I view health and healthy living is important to acknowledge and disclose. It is also important to bracket my own understandings and expectations of the phenomenon in order to create as little bias analysis and interpretation as possible (Creswell, 2007). Bracketing these ideas and thoughts is also useful “in order to take a fresh perspective toward the phenomenon under examination” (Creswell, 2007, p. 59-60). In this way, it was possible to dissect the descriptions from participants to discover the essential meanings and interrelationships of the phenomenon to the participants (Moustakas, 1994). My intention, as the researcher, was to discern and understand the meanings and actions of the participants as they were expressed within specific social contexts (Newby, 2014).

## **4.5 Research Design**

### **4.5.1 Mixed methods.**

In this mixed methods study, student survey data was used to identify general perceptions of healthy living practice. Concurrently, the development and origin of students' healthy living perceptions and practices were explored using small focus groups. The reason for combining both quantitative and qualitative data was to better understand how interprofessional health students see health and its effective practice by converging both descriptive statistical analysis and the detail of qualitative research. Through the analysis and identification of themes within participant feedback, perceptions of health and healthy living practice were explored using both inductive and deductive developments of general

beliefs through to some of the reasons and intensities for these convictions (Stewart & Shamdasani, 2015).

#### ***4.5.1.1 Survey.***

The large (n=901) research cohort prohibited the use of qualitative methods alone to sufficiently represent its collective voice. An interpretivist paradigmatic assumption also posits a single voice of a single incident or event does not create voice for a cohort (Creswell, 2007). Additionally, within this large population of students, sub-cohorts of specific disciplinary exist under the umbrella term of (interprofessional) health student. Although less frequently used, as described by Bloor and Wood (2006), depictions of ones' own reality may be gathered through alternate documentary methods to singular interviews and narratives. Braun and Clarke (2013) identify open-ended surveys as simply being a self-administered interview. In this regard, survey use fit the necessary ability to cast a wide net, all the while allowing participants to express their voice with minimal external influence.

#### ***4.5.1.2 Focus groups.***

While the administration of a survey can produce a large data set, it does not necessarily show a context of reasoning or background for responses. As Malina, Nørreklit, and Selto (2011) identify, “qualitative analysis includes context and adds understanding that numbers alone cannot.” (p. 64). The depth of this research required elucidation of the reasoning behind the formation of certain views and their origin. The topic of healthy living practice and the reasoning for ones' views, has the potential to be a sensitive topic. While perhaps seeming contradictory, such sensitive topics may not be suited to other personal data collection methods such as interviews. Sensitive topics can be uncomfortable to discuss; however, people can feel less uncomfortable discussing sensitive topics in a collective, rather than an individual, context (Braun & Clarke, 2013). The potential for sensitivity of health topics to be discussed resulted in incorporation of a focus group method, allowing stimulation of more detail and depth to the context of the research topic.

#### **4.5.2 Sampling.**

Upon ethics committee approval, permission to contact potential participants was obtained through the Head of School of the SIHS at AUT. This school was chosen for its dedication to the promotion of interprofessional health education. It delivers a common, core, first semester to seven different qualifications with more than thirty qualification majors or professional programmes (Table 1). It is also the school for which I teach interprofessional first year students. This created both convenience for this study, and distinct ethical considerations, addressed in a section 4.10.

A member of the SIHS administration office generated an email list of all students enrolled in all the core courses of first year, interprofessional health studies. Only students enrolled in Health programmes were listed. As the intention of the study was to identify the perceptions held by first year health students, it was important the students were not undertaking additional courses to their respective disciplines in addition to these four, core courses. The total student sample was 901.

Table 1. Qualifications, Majors and Professional Programmes Related to Health at AUT

Qualification	Major	Professional Programme
Bachelor of Health Science (BHSc)	<ul style="list-style-type: none"> <li>• Standard Pathway</li> <li>• Case management</li> <li>• Counselling</li> <li>• Health Administration</li> <li>• Health Promotion</li> <li>• Managing care of the older person</li> <li>• Paramedicine</li> <li>• Psychology</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Midwifery</b></li> <li>• <b>Nursing</b></li> <li>• <b>Occupational Therapy</b></li> <li>• <b>Oral Health</b></li> <li>• <b>Physiotherapy</b></li> <li>• <b>Podiatry</b></li> </ul>
Bachelor of Medical Laboratory Science (BMLS)		
Bachelor of Science (BSc)	<ul style="list-style-type: none"> <li>• Applied Conservation</li> <li>• Biomedical Science</li> <li>• Chemistry</li> <li>• Environmental Science</li> <li>• Food Safety</li> <li>• Food Science</li> <li>• Geospatial Science</li> <li>• Health Protection</li> <li>• Marine Biology</li> <li>• Microbiology</li> </ul>	
Bachelor of Sport and Recreation (BSR)	<ul style="list-style-type: none"> <li>• Standard Pathway</li> <li>• Coaching</li> <li>• Exercise Science and Nutrition</li> <li>• Health and Physical Education</li> <li>• Management</li> <li>• Outdoor Education</li> <li>• Sport and Exercise Science</li> </ul>	
Diploma in Applied Science (DipAppSc)	<ul style="list-style-type: none"> <li>• Pre-Chiropractic</li> <li>• Anaesthetic Technology</li> </ul>	
Diploma in Outdoor Recreation Leadership (DipORL)		
Diploma in Paramedic Medicine (DipPSc)		

## **4.6 Data Collection**

“Anonymity of the research site and the participants is absolutely necessary as you process the data” (O’Toole & Beckett, 2013, p. 104). The office administrator was provided with a generic recruitment invitation email, containing the link to the survey, to be sent to each potential participant (see Appendix B – Resources) via the SIHS administrative office. This step removed the opportunity for the email addresses to be known to the researcher, creating the first layer of anonymity to participants. Once the invitation email was sent, participants who accessed the survey had their responses collected and processed simultaneously through the digital survey program Qualtrics (Qualtrics software, 2018) saving anonymous responses to a secure account. The survey allowed for respondents to self-select for focus group participation.

Although the potential for 901 survey responses to indicate willingness to participate in a focus group, a large number of focus groups to add to the data pool was realistically unfeasible for the size and time frame of the project. A maximum of three focus groups would be created to sufficiently allow students the opportunity to share their experiences as well as provide time for processing data. Between four and six participants were allocated for each focus group. This size of group is closely consistent with the Braun and Clarke (2013) suggestion of smaller groups (three – to – eight) being most effective for generating rich discussion and ease of management. Contingency planning allowed for a high response rate where the opportunity to participate in the focus groups outweighed the availability or feasibility of groups, participants would be randomly selected and placed into a focus group based on heterogenic factors discussed below (4.6.2 Focus groups). Participants not selected would be notified by email and thanked for their time and interest.

### **4.6.1 Survey.**

#### ***4.6.1.1 Survey development.***

The purpose of the survey in this study was to canvass a large number of students in an efficient and timely manner. Many previously applied assessment instruments identified in literature searches either measured health promoting lifestyles (Walker, Sechrist, & Pender,

1995), or wellness wheel personal inventories. However, these instruments were measures of practice rather than perception. An individual's perception is a product of subjectivity, and subjectivity is qualitative in its ontology. Thus, the questions of the survey needed to prompt open-ended responses. Surveys containing qualitative questions align with principles underpinning more frequently used qualitative research methods (O'Toole & Beckett, 2013). Moustakas (1994) lists two essential questions when inquiring into phenomenological concepts; (i) what have you experienced in terms of the phenomenon, and, (ii) what context or situation has typically influenced or affected your experiences of the phenomenon? They focus attention on data collection for rich, description of experiences (Creswell, 2007). At the same time, they aim to develop an account of the personal reality experience from the subjects' point of view.

As health and health practice are multifaceted, Moustakas's two essential questions were simplified to components of the subject of health interpretation, perceptions of health and health-practice, influences on health, and health as it relates to professional and interprofessional health practice. According to Andres (2012) the first two guiding principles of creating survey questions is to ensure the questions are answerable by your participants and only a single thought or idea is represented in each question. Andres (2012) states "from a mixed method perspective, it is impossible to privilege one type of questionnaire format over the other or to separate them into two camps" (p. 9). The breakdown of these two essential questions from Moustakas yielded twelve questions of both open and closed variety (see Appendix B - Resources). This was accomplished through cyclical rounds of consultation with academic colleagues. The open-ended questions allowed respondents to answer questions in their own words without restriction. This can lead to the illustration of ideas that have not previously been considered (Andres, 2012). Closed question prompts allowed respondents to focus on specific contexts surrounding the development of perception of healthy living practice. Additionally, four demographic identification questions were included to assist in descriptive statistical analysis. The questions within the survey were formatted into a logical sequence of ideas for participants to expand on. Answering one question should naturally lead on to answering the next (O'toole & Beckett, 2013).

The finalised survey was digitally created using the program Qualtrics (Qualtrics software, 2018). Digital surveys reduce distribution and response times (Cohen, Manion, & Morrison, 2011). Respondents were able to complete the survey from a personally selected location at a personally selected time of convenience (Cohen et al., 2011). A digital survey also provided the benefit of minimising the time burden of the potential participants (Cohen et al., 2011). The completion of the survey digitally also reduces the coercion effect of a study representative waiting to collect finished surveys which can improve the authenticity of the responses (Cohen et al., 2011).

#### ***4.6.1.2 Survey administration.***

Data collection strategies, including time frames should be realistic in the circumstances of the study (Punch, 2003). “Greater effort in data collection means better quality data” (Punch, 2003. p. 41). An initial email invitation with the survey link was sent with a two-week period of availability. The response availability ended before students’ period of exam study so as not to overlap. A secondary reminder email invitation was sent one week after the initial invite.

#### **4.6.2 Focus groups.**

The response rate of interest in the focus groups was such that it would have not filled more than one full group of the original group-size plan, so the decision was made to reduce the group sizes and accommodate all of the respondents as best as possible. The main drawback of focus groups is logistical (Braun & Clarke, 2013). The organisation of two groups was devised through heterogenic factors to maximise interesting discussion (Braun & Clarke 2013). These students were all similar in that they were all collectively based within the research criteria, however, they were heterogenic in that they all study a different discipline within the AUT faculty of Health and Environmental Science. They were also mixed in terms of their age, gender, and culture. Due to scheduling difficulties it was necessary to facilitate the groups with a different number of participants: one group with four participants, and the second group with two participants. While this situation was not ideal, it should be noted that smaller group sizes can be better for more potentially sensitive topics such as health (Smith, 1995b; as cited in Braun & Clarke 2013, p. 116). Braun and Clarke (2013) suggest the similarities and differences of focus group participants not be

based from their 'person' per-se, but from the focus of the research topic. In this case, the perceptions of health from health students of different health disciplines is the focus. Both participants in focus group number two were contacted ahead of time and confirmed their comfort with a smaller group. While Braun and Clarke (2013) identify several factors that can be considered in the formation of focus group members, ultimately much of the decision making needs to be pragmatic. In this case, two of the focus group members wished to participate together, not due to the need for support for one another, but for logistical transport reasons. In order to produce a focus group promoting the best possible outcome for diverse discussion of health and healthy living practice, these two participants were included in the larger of the two focus groups.

The researcher facilitated the focus groups for the purpose of gaining experience in the research process. This also allowed for capturing the richness of discussion data rather than transcript interpretation alone. While the format of each session was semi-structured, as identified by Berg and Latin (2008), the focus group method required developing a detailed protocol. Discussion questions were developed from survey response data and revised through consultation with qualified academic colleagues and the project supervisor. Once a final draft of questions was produced, and an outline plan of the session was developed, they were piloted with colleagues for clarity and feedback. A funnelling approach (Stewart & Shamdasani, 2015) of questioning was utilised in each focus group session. This was to allow the participant group to explore the subject matter with some guidance to orient the discussion to the intended topic (Stewart & Shamdasani, 2015). The focus group sessions each ran for one hour and were recorded via two digital recorders for later transcription.

#### **4.7 Data Analysis**

The research data was examined through multiple levels (Creswell, 2009). The overall goal of the analysis was to thematise meaning of the qualitative data, which is a term common to qualitative analyses (Braun & Clarke, 2006). Conjoining the qualitative story with that of the quantitative results creates a richer, more meaningful understanding of the phenomenon (Creswell, 2009; Vaismoradi, Turunen, & Bondas, 2013).

#### **4.7.1 Survey data analysis.**

Initial content analysis of the survey data was conducted through the process described by Elo and Kyngäs (2008). Before any examination, the survey was closed and data were downloaded from Qualtrics (Qualtrics software, 2018) onto a secure computer. Survey responses were read through several times to gain familiarity of the data (Elo & Kyngäs, 2008; Vaismoradi et al., 2013). Open coding was completed during several further read-throughs of the survey data. The process of review and coding provided the opportunity to become more familiar with the data as presented by the research participants (Stoneman & Gilbert, 2016). These coded groups could then be organised under higher order headings creating a picture of general perceptions of health and healthy living practice (Vaismoradi et al., 2013). Alongside these general perceptions, the scores of the Likert scale, and ‘rank order’ questions further illuminated understanding of the participants’ perceptions on their prioritisation and importance of the components of health. Descriptive statistical analysis of the survey data set was conducted to identify prevalence of commonalities and differences of the coded groups, Likert scale, and ‘rank order’ questions.

#### **4.7.2 Focus group data analysis.**

Thematic analysis inquiry can be used in both a “data-driven ‘bottom-up’ way, on the basis of what is in the data; alternatively, [it] can be [used] in a more ‘top-down’ fashion, where the researcher uses the data to explore particular theoretical ideas...” (Braun & Clarke, 2013, p. 178). The focus group questions were bottom-up in that they were developed based on survey response data. Subsequently, analysis of the focus group data took a top-down approach. It provided a method to identify the concepts and ideas that underpin the “explicit data content, or the assumptions and meanings in the data” (Braun & Clarke, 2013, p. 178). As a result, this aspect of the data analysis process was a deductive process. This process was completed using the thematic analysis protocol proposed by Braun and Clarke (2013). Focus group recordings were transcribed verbatim. Initial codes were generated through several readings of the focus group transcripts. These codes were then reviewed and collated into initial themes gathering all of relevant data on a concept. The pattern frequency of the codes was not the only factor in generating the themes. As Braun and Clarke (2013) identify, more meaningful codes may be less frequent but more relevant to the research question. Through the revision process the various themes were refined and

named to generate an overall story. The data analysis process was recursive rather than linear with several revision cycles to establish final themes (Braun & Clarke, 2013; Vaismoradi et al., 2013).

#### **4.8 Reliability and Validity**

A challenge of mixed methods research is ensuring both quantitative and qualitative measures are held to as high a level of accountability as possible, while still allowing for the parameters of their counterpart (Cohen et al., 2011). Quantitative research is often focused on producing generalisable data and seeks to minimise the influence of the researcher (Braun & Clarke, 2013). Internal and external validity of the survey data was upheld by removing researcher participation from the data collection process - data collection was completed digitally, and all data was safe guarded for anonymity. The duration of survey data collection was held to strict time restraints and, as the survey was digitally completed, its presentation would have been identical to all participants (Creswell, 2009).

To ensure qualitative survey data validity, respondents were able to engage and respond to the survey themselves without pressure or input from the researcher. Multiple questions were posed about the concept of healthy living practice to triangulate and illustrate the perceptions that respondents have to healthy living practice (Creswell, 2009). Intercoder agreement was also used during the development of the results (Creswell, 2009).

Quantitative and qualitative reliability lies in the ability of research method to deliver consistent replication of similar results. To retain reliability in the qualitative process, a detailed documentation of the procedures and steps was taken in the data collection process (Creswell, 2009; Zohrabi, 2013). Ethical approval was sought and granted following the authorisation of the research proposal. Prior to any research participants being contacted permission was also sought from the Head of School for the SIHS. Transcripts from the focus groups were proof-read and compared to the recordings for accuracy.

The focus and breadth of this study is unique in its nature, thus lending it traits of an initial pilot study. To obtain a higher level of quantitative reliability as stability, the survey of the study would need to be re-administered to future cohorts of first year, interprofessional health students (Cohen et al., 2011). It should also be noted that the quantitative aspect of this study is purely descriptive in its nature. Neither the survey questions, nor the focus group questions were set up to compare two groups of students to ascertain reliabilities of equivalence or internal consistency.

#### **4.9 Reflexivity**

Acknowledging that I, as the researcher, have my own experiences of health and perceptions on healthy living practices is important to the research process. Personal interests motivated my desire to conduct this research. It is not possible to fully detach myself from the research or the interpretations of the results (Mack, 2010). Braun and Clarke (2013) identify that both functional and personal reflexivity must be undertaken as a part of producing good qualitative research. In attempts to prevent any unintentional development of bias in the research process and ensure a neutral position, survey and focus group questions were checked and revised by several academic colleagues. There is no possibility of ruling out researcher bias completely in the interpretivist paradigm (Mack, 2010). In this same vein, personal reflexivity can be shown through the predesign and the congruent method of delivery of every focus group. It is understood that conducting the focus groups myself was a weighed risk of loss of personal reflexivity as my embodiment could have influenced the production of data within the research (Braun & Clarke, 2013). However, this was seen as a worthwhile risk for the reward of experience and exposure to the research process, as well as, the first hand witnessing of focus group participant responses and interactions. Mitigation of this influence was completed through the development of the questions and protocols for the conduction of the focus groups. The questions for the focus groups were designed to be semi-structured. Initial conversation starter questions were predetermined and used in both focus group sessions. Questions were delivered by reading them from a printed sheet in order to maintain a common point of origin of the conversations. Other questions within the focus groups were intended to steer the conversation toward desired issue discussion (Braun & Clarke, 2013). The initial

questions of the focus groups were moderated over several versions with feedback from academics with appropriate experience.

#### **4.10 Ethical Considerations**

Ethics permission was sought through an application made to the Auckland University of Technology Ethics Committee. Permission was granted on the 23<sup>rd</sup> of May, 2018 for a period of three years, reference 18/183. Participant information forms were produced for both the survey and focus groups, and consent forms for the focus groups (see Appendix B – Resources). Implied consent was assumed for survey responses given.

Ethical consideration was given to required transparency of the potential for a perceived power differential between the researcher and the participants of the study. As a teacher on one of the core courses, respondents may be one of the researcher's own students for human anatomy and physiology. Therefore, as mentioned above, measures were taken to ensure the anonymity of any participant in the survey. These included having a member of SIHS administration team email the recruitment letter to all potential participants, conducting the survey digitally so that participants could not be identified through handwriting, providing the opportunity to complete the survey anywhere at any time, and disclosing to all potential participants that their involvement would neither advantage them or disadvantage them in their studies. Also, individuals interested in participating in focus groups were instructed to contact the researcher of their own volition. The researcher did not actively recruit focus group participants. In addition, focus groups were not held until all the students within the research study cohort had received their grades for the semester, rendering them no longer the researcher's potential student.

# Chapter 5 - Results

## 5.1 Introduction

This section presents the results from the research data collected. The order follows in a manner coinciding with the progression of the issued survey. As outlined briefly, in the methodology chapter, the data that were collected from the survey results influenced the development of the focus group questions and thus the resulting focus group discussions. Therefore, the findings of the two methods of data collection are presented concurrently. As the majority of the survey responses were concise and pointed, where needed, the focus group discussions add a level of contextual richness to the prominent points. Inclusion of relevant quotes from both data sets illustrate and exemplify identified themes. Results are presented in nine sections:

- Study cohort demographics
- Components of health
- Control
- Descriptions of health
- Health component priority
- Health influences
- Catalysts to change
- Compliance and conformity with 'healthy living' convictions
- Health professional health priority

These sections represent some of the contextual understanding and different angles from which the concept of health and healthy living practice can be viewed by this cohort of students. These themes are illustrated by several different - and sometimes opposing - views on the construct of health, its practice, and their influencers.

## **5.2 Study Cohort Demographics**

### **5.2.1 Survey data demographics.**

The survey was sent to 901 (N) students via email with 223 (25%) students accessing and beginning the survey. Of these, 154 (n, 17%) students completed the survey in its entirety.

The participant age demographic was heavily weighted towards the 16-20 age bracket providing 68% (n=104) of the completed surveys, followed by the 21-25 age bracket (16%, n=24). Twenty percent (n=31) of respondents identified as male, and 80% (n=123) of respondents identified as female. No participant that completed the survey identified that they would rather not disclose their gender.

Eight of the fourteen majors/programmes were represented within the response data. The highest proportional response was received from students undertaking the Bachelor of Health Science (Standard pathway, Case management, Counselling, Health administration, Health promotion, Managing care of the older person, Paramedicine, Psychology) with 29% (n=44) of completed responses (Table 2). This was followed by Bachelor of Health Science (Physiotherapy) with 25% (n=39). Some qualifications were not represented with student responses (see Table 2). It is possible no students under these disciplines were engaging with the core papers at the time of survey administration, however these data were not recorded for comparison. Alternatively, the students of these programmes and programme disciplines simply may not have chosen to participate. As this survey was only open to students enrolled in a health programme it is likely the 11 respondents (7%) selecting 'other', were responses from students yet to be enrolled into their specific programme/qualification of preference.

Although participants are enrolled in a study of Health Science, they were asked about previous health study, with the majority (n=94, 61%) indicating they had not previously conducted health-related study. Prior health study was contextually grouped into study of health as a physical science (e.g. biology, anatomy, human physiology, pathology) and study of health as a social science (e.g. psychology, public health, counselling). The 39% (n=60) of participants with prior health study experience, more commonly identified a combination of both social and physical aspects. When only one aspect of health was

identified, the study of health as a physical science was twice (n=23) as frequently referenced as compared to study of health as a social science (n=10).

Table 2. Survey Response by Programme Code

Qualification (major/programme)	Responses
BHSc (Standard pathway, Case management, Counselling, Health administration, Health promotion, Managing care of the older person, Paramedicine, Psychology)	44
BHSc (Physiotherapy)	39
BHSc (Occupational Therapy)	22
BHSc (Nursing)	16
BHSc (Midwifery)	13
Other	11
BHSc (Oral Health)	7
BHSc (Podiatry)	2
BSR (Standard Pathway, Coaching, Exercise Science and Nutrition, Health	0
DipAppSc (Pre-Chiropractic, Anaesthetic Technology)	0
DipORL	0
DipPSc	0
BMLS	0
BSc (Applied Conservation, Biomedical Science, Chemistry, Environmental Science, Food Safety, Food Science, Geospatial Science, Health Protection, Marine Biology, Microbiology)	0

The majority of respondents identified as New Zealand Europeans (n=91, 52%). This was followed by the selection of ‘other’ (n=40, 24%) which then prompted participants to state their ethnicity. Students who identified as Māori contributed to nine percent (n=17) response. Table 3 provides further details of the selected and manually entered responses through the selection of ‘other’. It should be noted that the totals do not add up to the number of completed surveys as some participants chose to select more than one ethnicity.

Table 2. Ethnicities Selected and Manually Entered into Survey by the Selection of 'other'

Ethnicity Identified	Number of times identified
New Zealand European	91
Māori	17
Samoan	4
Cook Island Māori	2
Tongan	5
Niuean	0
Chinese	6
Indian	9
Other	40
African	3
American	2
Arabian	1
Australian	1
Bangladeshi	1
British	2
Bulgarian	1
Canadian European	1
Chilean	1
Dutch	2
English	2
Fijian	2
Fijian Indian	2
Filipino	7
French	1
Iraqi	1
Israeli	1
Korean	1
Laotian	1
Malaysian	3
Middle Eastern	2
Pacific Island	1
Russian	2
Singaporean	2
South African	8
South East Asian	1
Swiss	1
Taiwanese	1
Welsh	1

Although unintended as the primary purpose of the study, survey data was compared both bi-culturally and multiculturally to investigate potential anomalies or data that may be culturally related. The frequency of codes used in the descriptions, priorities, characteristics, and influences of health, presented no major differences in the overall

message of health. Similar results were found for the cohorts' ideals and expectations for health professionals with respect to conceptions of health and its practice. This indicates that the end goal of health - culturally, bi-culturally, or multi-culturally - for this cohort is the same even despite differing explanations and descriptions.

A cultural difference, however, was identified in the survey section asking participants recommendations for a person they identified as less healthy than themselves<sup>3</sup>. The noted aspect was the order of suggested methods of accomplishing an improvement in health (discussed in greater detail later in the chapter). Students identifying as Māori, while suggesting changes similar in context to the rest of the cohort, would more frequently prioritise self-efficacy and social approaches before diet and exercise changes (12 of the 17 responses who identified as Māori). Similar ordering of responses were found for participants identifying as Pacific Islander (7 of 12). The reverse prioritisation was true for the rest of the cohort. The array of suggestions from the Māori and Pacific Islander demographics were also more diverse in their initial suggestion of health intervention.

### **5.2.2 Focus group demographics.**

Specific demographic data was not collected for the six focus group participants, however, during the discussions, some demographic data was revealed by the participants. In order to ensure anonymity, participant nationalities and programmes of study are not revealed here, however, it can be noted, they presented a similar diversification of cultural heritage, and stratification of programmes of study to mirror the survey participants. So too, was the equity of gender differential from the focus group to survey participants.

### **5.3 Components of Health concept**

Following demographic items, the question posed was: 'To you, what is health?', revealing unique and individual responses. No two responses contained the same description indicating the cohort's expansive variety of understanding and definitions of health. Participants' perception of the complexity of health ranged greatly. These were analysed by grouping the number of component factors used in their definition - as described here.

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<sup>3</sup> With the exception of this cultural anomaly, this section of the survey will be discussed in section 5.8.

### 5.3.1 Singular.

When a singular component was used in a health definition, it was unanimously that of the physical body. Some definitions identified health as solely a physical construct that was modelled in an ‘absence of disease’ medicalised fashion. These biomedical model style definitions made up 15% (n=23) of initial ‘To you, what is health?’ data. Some indicative responses are exemplified below.

*“Health is a good lifestyle and not being sick.”*

*“Not feeling sick. Overall, a physical wellness. [sic] Don't care about the mental wellbeing, since if you're a [sic] focused and know what you want mental sickness won't have a chance.”*

*“Health is anything that involves any part of your body, concerning your body.”*

*“Health is the main factor of a living organism's life. If not taken care of, this could kill you and if taken care of, it will be your best friend.”*

*“No allergy [sic] in winter. Not feeling tired every day. No period pain every month.”*

These definitions suggest health as something to be both lost and accomplished or possessed and must be maintained. Its evaluation seems to be retrospective in that a current ‘lack of health’ is due to previous ineffective measures of preservation. The resultant determination base for these definitions are portrayed as actions - or lack thereof - to protect and maintain the physical. As the extensive biomedical model of health literature suggests, the focus of health for these individuals rests in the absence of illness rather than the presence of health.

Continuing in the paradigm of physical health, participants also identified physical health in terms of a persons’ ability to do ‘things’ or surpass an unidentified level of fitness (or activity). References to these abilities incorporated both objective and subjective judgements of ability.

*“Fitness, absence of illness and quality of life.”*

*“Good health is people that do not have any illnesses, can do everyday things without struggling and don't face any struggles. For example, someone might be overweight but they go to the gym and can run for the same period of time as someone who isn't overweight (they are still fit despite their weight).”*

While these examples are pointed, indicating the participants recognise a disease/illness factor, in regard to the concept of ability, the disease/illness component no longer seems to

be the focus of the concept. It alludes to the ideal of health being internally generated by the individual. The statements of fitness relate to the body's ability to do work indicating a physically focused paradigm. Quality of life would suggest the persons' ability to accomplish tasks in a problem-free manner is a definitive of what makes a person healthy. This suggests a closer affiliation with a biopsychosocial model which moulds health to the perception of the individual and whether or not they believe they have a problem. It also allows for the ability to improve health without restoring the full physical ability of the individual. This concept was reinforced through several questionnaire submissions advocating a persons' health being their ability to accomplish tasks and enjoy a perceived problem-free lifestyle.

### 5.3.2 Bifactorial.

Amongst the response data, participants frequently identified health as being comprised of two main parts thus creating a non-singular locus of origin for health as a concept. Word counts identified the most common terms being 'physical' (n=80) and 'mental' (n=75). A list of the most common terms used in the definition of health can be found in Table 4. Associated terms and concepts with these two health components (e.g. physically, physique, mentally, mentality) were coded and recounted for frequency. This revealed the root conceptions of 'physical' and 'mental' occurring together in 85 of the 154 (55%) responses.

*"Health is being physically fit, avoiding sickness and being mentally happy"*

Table 3. Word Frequency Count Within Responses to Question 'To you, what is health?'

Word used	Frequency count
Physical	80
Mental	75
Wellbeing	37
State	34
Spiritual	29
Emotional	28
Social	24
Overall	22
Physically	22
Mentally	18
Disease	16
Illness	14
Balance	12

### 5.3.3 Multifactorial.

Other responses would advance the segregation of components to multiple factors such as emotional, spiritual, social, intellectual and, less commonly, environmental. The Hauora model was specifically identified several times, with other definitions identifying an ‘overall’ evaluation.

*“I like to view health in a holistic way. Much like the Hauora model of health does. I feel that all aspects of health rely on one another and without one you won't feel "healthy". You need to be physically, emotionally, spiritually and socially healthy to attain overall health.”*

*“Heath to me is the overall well-being of a person that includes physical, emotional, spiritual and mental health.”*

*“Health to me is being physically healthy, emotionally healthy, and socially healthy. Pretty much the same as the Maori health model of Hauora but without the spiritual health as I don't believe in that.”*

Although the te whare tapa wha model of Hauora focuses on four major components, the actual component number is less relevant than the resultant ideal of holistic consideration and evaluation to a level of personal satisfaction in order to be established as healthy.

## 5.4 Control

With an increased complexity of categorisation of health, was the perception as something to be influenced. As such, these explanations of ‘what is health’ expanded into views on health influences, as illustrated below. Influences identified in the definitions had a propensity to indicate personal responsibility in health maintenance. References to one’s choices and actions were frequent, albeit each expressing unique phrasing.

*“Health is a person’s mental and physical state of wellness, that can be maintained on a day to day basis through correct eating and exercise”*

*“The way you take care of yourself and your body.”*

*“Health is a person’s mental and physical state of wellness, that can be maintained on a day to day basis through correct eating and exercise.”*

During the focus group sessions, one participant voiced their view that they measured health insofar as the barriers they were able to overcome, creating a contextual illustration of Antonovsky’s salutogenic model at work.

Participant 2: *“I think [sic] sort of see health more in the form of like barriers. So like a sickness against your health and like bad habits that sort of thing. ... That’s sort of how I measure my health anyway.”*

Facilitator: *“So are you measuring your health more in terms of the battles that you’re winning?”*

Participant 2: *“Yeah, and the battles that I have to fight.”*

Facilitator: *“Ok, so it’s overcoming adversity.”*

Participant 2: *“Yeah, in all the mental, physical...”*

Personal control of health did not revolve solely around the maintenance of the physical body. Many individuals alluded to the maintenance of both physical and mental factors that created their health concept. One individual went as far as to acknowledge that physical injury was an accepted aspect of their life and was best treated, or worked through, by non-physiological prescriptions.

*“A well rounded, all-encompassing idea of looking at health not just from a perspective of treatment. Rather than waiting for problems to arise, health should be seen as the way one maintains their good health both physically and mentally and the way we aim to prevent further problems rather than waiting to treat them.”*

*“Health is feeling the best that you possibly can in that given moment. It is about maintaining a balance between healthy eating, exercise, study, sleep, family commitments, work and social life. Health is recognising when something is out of balance and taking a step back to realign yourself.”*

*“Health is the culmination of a number of factors. For me, those factors include my physical, mental, emotional and social wellbeing. Being an athlete, I am often nursing injuries and therefore might not be considered healthy from a medical perspective, but as I’m aware they’re a natural part of sport, I am able to maintain a positive mindset - and don’t see myself as unhealthy. However, variations in my mental and emotional wellbeing affect my overall feeling of being healthy more significantly. If I’m feeling down or am unable to shake away negative thoughts, I notice the impacts a lot more compared to a physical injury. Also, as a social person I gain a lot of my energy from interactions with others. So, if I don’t engage in interactions regularly it starts to affect my wellbeing. On the other hand though, I often need time to myself, and with my close family and friends, to reset.”*

As with several of the quotes already identified, the model of wellness and the term ‘wellbeing’ was also commonly found through these multifactorial explanations of health. The terms wellness and wellbeing in these descriptions provide little further insight into the cohort’s voice other than to add an extra synonym to the description of what health is.

*“To me health is wellbeing. It determines things you are able to do or not do depending on how you are feeling.”*

*“All aspects of wellbeing being free from illness.”*

### 5.4.1 External control.

Rarely was it identified that health was externally influenced without control of the individual. Comments identifying health as being under external control referenced community as the core of health creation and maintenance.

*“Health is the population's health, keeping mind, body, spiritual and emotional health well individually and as a cohort population. Looking out for each other and ensuring we are all performing to the best of our ability with optimal health.”*  
*“Your wellbeing, health status, living conditions and environment etc, all working together to support our health from the way we live.”*

### 5.4.2 Feeling health.

None of the participants identified health as being specifically created, but many stated health was evaluated through feelings or personal feedback. The ‘feeling’ of health or ‘feeling’ comfortable about the different aspects included in the concept of health shows health as a construct of the mind. The reported methods of evaluation varied between setting health on a continuum, to being the ‘sum of parts’, to each part being subject to individual evaluation. These evaluations resulted in a health ‘feeling’ rather than a tangible result of health. The following examples exemplify the diversity of health ‘feeling’.

*“Health is when your all-round being feels good and at balance.”*  
*“Mental wellbeing and feeling physically fit as well.”*  
*“Health is feeling the best that you possibly can in that given moment. It is about maintaining a balance between healthy eating, exercise, study, sleep, family commitments, work and social life. Health is recognising when something is out of balance and taking a step back to realign yourself.”*

Along with presence in survey data, focus group data indicated health classification as a state of being or as a construct of the mind.

Participant 4: *“Yeah, I feel like, as humans we are constantly evolving so I think health will forever progress but mainly just because of our perception or understanding of it. Ummm, yeah.”*

Facilitator: *“From you [Participant], I hear, in sort of the undertones, that health is a very mental, uh state, rather than a physical one. Choices and mindset is [sic] very important to what health is. Does that seem...”*

Participant 4: *“Yeah I feel like that’s fair, because I feel like our vessel is just a reflection of what we see from our mind right, what we can create umm, due to that particular drive. Yeah.”*

The main emerging theme elucidated from ‘To you, what is health?’, is one of health being personally intrinsic regardless of how it is defined. It seems to be regarded as something mystically ‘yours’ with the factors that define it are also factors that can influence it as well.

## **5.5 Descriptors of Health**

To the survey question: ‘What words would you commonly use to describe a healthy person?’, more than 50 descriptive words were reported multiple times.

### **5.5.1 Be fit, be happy, be healthy.**

The physical characterisation of health was emphasised with frequent use of the term ‘fit’. Mentioned a total of 91 times, ‘fit’ was the most frequently used descriptive characteristic of a healthy person. Next, ‘happy’ was the second most frequently used term (83). The next most popular term, ‘active’, was reported 35 times (less than 22%). The popularity of the terms ‘happy’ and ‘fit’ is consistent across the study disciplines indicating different programmes share similar sentiments of these two characteristics being representative of a healthy person. These terms were evidently favoured in the survey data, warranting a deeper exploration within focus group discussions.

When these two terms (fit, happy) were posed to the focus groups their responses for describing them or defining them were self-evaluative and modular in regard to frame of reference.

*‘fit’ discussion –*

Participant A: *“I always think fit’s very physical and it probably shouldn’t be but that’s how I always see it. It’s being physically strong, I don’t know able or run a while, so I would say I’m not fit, is what I’m saying.”*

Participant B: *“Fit I feel like personally I think being fit, like, I still think physical activity is important in terms of being healthy and fit, but you don’t have to run for five or six km or (overlap, Participant A laughing) whatever you’re running in thirty minutes but umm, like, like just being able to go for a walk every day like things like that. Like I think if your body is able to do things like that then you’re fit. You know you’re healthy. Obviously, when you talked about the obesity and the like, umm, anorexia like, they’re probably not able to walk around the block or something like, umm, so I’d probably define that as unfit. But umm, but then I also think that it changes person to person, like I might not run for two weeks and I’ll feel unfit, whereas somebody might not run for two months and feel fine, you*

*know, kind of thing. So it does change from person to person, as long as you're able to do things that you want to physically, then I feel that you're fit."*

...

Participant A: *"I do like the idea that being fit is different to different people. I never really thought about that, because I walk a lot. So I do tramps, umm, I walk to school every morning and I've always considered, that's why I consider myself healthy. Because I do 'do' physical activity, it's just a lot slower than most people. But I still, yeah, so I like the idea."*

'happy' discussion –

Participant B: *"...umm, being comfortable in the skin you're in and who's around you. Like just as long as you've got people around you that make you happy and you're happy in yourself, then."*

Participant 3: *"To be content with your life with what you have with the life you lead, I think it is [sic] happiness."*

Participant 1: *"...It's hard to describe what happy is but if everyone's happy it's hard to not be happy you know?"*

...

Participant 4: *"Your vibe attracts your tribe."*

...

Participant 2: *"I think happiness for me, isn't so much, or not enough to be content but you have to be proud of yourself more."*

### **5.5.2 Ability over aesthetics and personality.**

Returning to the survey data, references to physical qualities describing a healthy person were expressed in a number of ways from, stating a person is:

*"physically capable of activities of daily living",*

to that of resilience, to more subjective qualities exemplified by comments such as:

*"glowing".*

However, the physical qualifier generally had little to do with being attractive and more to do with physical capability. Terms and/or phrases associated with a physical nature (e.g. fit, strong, able) were recorded in 138 responses (90%), while terms and/or phrases associated with a dispositional nature (e.g. happy, positive attitude, compassionate) were recorded in 118 responses (77%). Physicality and dispositionality were found together in 70% of the 'descriptors of health' responses. The remaining terms (e.g. 'balanced', 'well', 'energetic', 'good', 'stable', 'mentally', 'aware', 'free') were ambiguous to not allow confident categorisation here. Rather, these terms were classified among the descriptive phrases -

rather than single word adjectives - to identify their health component description. Noteworthy characteristic groupings or concepts used to classify responses included self-satisfaction, balance (not to be inferred as equilibrium), diet/nutrition, and of social nature. The ordinal frequency of these groups can be found in Table 5. Of special noteworthiness, due more to omission rather than inclusion, is spirituality. Not one individual who completed the survey specifically identified anything relating to spirituality as being a characteristic of a healthy person.

Table 4. Health Characteristic Coding Frequency

Characteristic Grouping	Frequency of mention within survey responses
Physical nature	138
Dispositional nature	118
Balance	20
Nutrition/Diet	16
Self-satisfaction	10
Social nature	9

Alongside these descriptive terms, participants included actions and characteristic practices associated with their consideration of healthy. Examples included statements like:

*“drinks plenty of water every day.”*

*“A healthy person is someone that takes care of their body as they know their body is their temple.”*

Participants also drew on negative directives in relation to these characteristic practices such as:

*“Doesn’t use drugs.”*

*“Doesn’t get sick often.”*

*“Not overweight.”*

Consistently, when characteristic practice statements were made of a healthy person, they related to things directly impacting the physical nature of the person. This reinforces the dominance of physicality over the depiction of health.

## 5.6 Health Component Priority

Similar to the large response variance described above, were the responses to the question of prioritisation of five different health-related components (physical, emotional/mental, social, intellectual, and spiritual). Participants shared a relatively common view on the

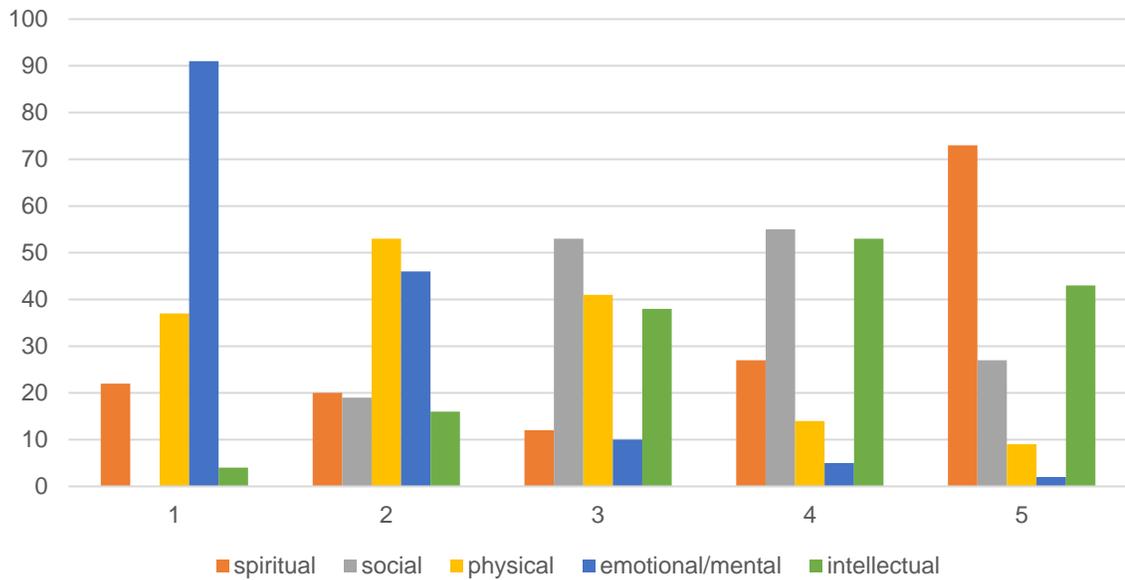
importance of two components; spiritual, and emotional/mental. Emotional/mental health dominated the primary position of importance with spiritual health being consistently lowest rated (see Figure 1).

Using these rankings as a basis of comparison against questions about participation in previous health study, recall that it was more prominent that the physical (or, biomedical) aspects of health received greater academic attention. With this in mind, it is interesting to note the respondents' high ranking of emotional/mental health with respect to personal health priority. However, the majority of students reported undertaking no previous health study. Perhaps a more appropriate comparison may be seen in the words used to describe a healthy person. Comparatively, this survey question had a more fruitful response when compared with previous health study. Describing a healthy person was again biased towards descriptions of physicality. Compared to the indication, by this same cohort, that emotional/mental health is of primary importance a juxtapositional delineation between what they prioritise and what they describe as characteristics of a healthy person is apparent.

Despite being a cohort engaged in education - specifically health education - intellectual health was not of great priority to this group. It ranked third (n=38), fourth (n=53), or fifth (n=43) among responses (Figure 1). Further to this, ideas and descriptors about an intellectual paradigm of health were sparse throughout the personal definitions and descriptors of a healthy person.

Not a single respondent identified social health as the most important aspect to their own healthy lifestyle. Social health was ranked towards the middle-lower end of the five suggested components with most responses classifying it as third (n=53) or fourth (n=55) (Figure 1). While not highly prioritised of these five components, social health is valued by this cohort given their use of descriptors of a healthy person being one with whom it is easy to socialise (e.g. happy, confident, motivated, social). Indeed, social health is a fundamental catalyst required for the development of their, other more highly prioritised, domains of health.

Figure 1. Responses to prompt ‘Please order the following health domains for importance to your OWN lifestyle, where 1 is most important, and 5 is least important.



## 5.7 Health Influences

Survey participants were asked an open-ended question regarding who and/or what influences their healthy lifestyle. Frequently participants indicated they felt they, themselves, were responsible for the influences on their own healthy living practices. The individual ‘self’ was identified in 22% (n=34) of responses. Statements such as:

*“I believe I influence my own health as I have no caregiver or role model”,*  
 or single word answers of *“myself”*, were common. Other than ‘self’, the most commonly cited influencer terms were:

*“family”, “friends”, “university”, “parents”, “time”, “finances”, and “partners”.*

To illustrate these common responses in context, two examples are shown here:

*“Availability of food sources and how much energy I have to make food. Definitely having all fast food around the campus does not help with my personal health levels because of the temptation. What my parents make for dinner, [sic] cannot be too picky, just eat whatever is made. Lack of money as a healthy lifestyle (involving gyms, healthy food and vitamins) can become expensive.”*

*“My family and the fact that I live with them influence my lifestyle a lot. As well as my university. If I did not live with my family I believe I would eat healthier as I could make my own food choices. My busy uni schedule sometimes influences my mental health.”*

Participant responses were coded into three higher order groups to encompass the diversity of responses: ‘close relationships’, ‘objects of interaction’, and ‘personal experiences/drivers’.

### **5.7.1 Close relationships.**

Of the most frequent response terms, the category of close relationships dominated.

*“Probably my dad. He is a good example of maintaining balance. He works hard but also takes time to have a social life and can recognise when he needs a mental health day to go surfing or hiking if he's particularly stressed.”*

*“My children influence my lifestyle. Being very young I have little time to take care of myself. I influence my current lifestyle by wanting to better myself every day.”*

*“My friends, my family, my partner, my studies.”*

This category carried with it the fewest codes of the three groups but the highest frequency of occurrences (160) within the 154 completed surveys. Interestingly, although close relationships were the reported dominating influence to health, social health was less prioritised as to its importance to maintaining health as described above.

### **5.7.2 Personal experiences/drivers.**

Personal experiences/drivers were so stratified, no apparent delineation was able to be made from the responses. The Personal experiences/drivers grouping had the largest number of variant codes. The main codes of frequency in this group were ‘desire’ (n=7, 12%), ‘motivation’ (n=5, 8%) and ‘health professionals’ (n=5, 8%).

*“The ability of bearing children in the future and my vulnerability to developing breast cancer (strong family history and the only daughter) is what influences me to adopt a healthy lifestyle now!!!!”*

The vast majority of the responses included in this grouping were unique enough to warrant their own code, thus many of the codes were singular in their use. This would indicate personal experience to be important, however, remains a subjective aspect in terms of its specific influence.

### 5.7.3 Objects of interaction

Objects of interaction codes describe places and things participants encounter in their current lifestyle. Frequently, responses included codes such as ‘university’ (n=19, 16%), ‘time’ (n=15, 13%), and ‘finances’(n=13, 11%). These places and things account for the physical and psychological environment in which an individual experiences health. They are also key components to this cohorts’ development and continuity of their academic progression as they are in first year university.

*“The time I have (or lack of) to organise healthy food for myself consistently influences my lifestyle.”*

*“financial strain, parenting alone and lack of support/time”*

*“AUT - Stress*

*Parents -Stress*

*Church -Stress*

*Overall – Depression”*

Unfortunately, many of the responses received were quite pointed and did not elaborate on the context of their answers. Of those providing some context for their answer, both positive and negative health as well as healthy living consequences were identified within the three representations of influences.

*“The gym influences how physically fit I am able stay. The frequent spare time I have due to the University structure, influences how I am able to stay social and pursue current hobbies. The support from my parents allow me to have a less stressful lifestyle compared to those who are studying and working at the same time.”*

University study was frequently identified as an influence on students’ healthy living practice with references to the creation of stress from either time or financial restrictions.

*“Studying at university has both positively and negatively affected my health. Because of close access to the gym and regular group classes being optional it is more motivating. Physical exercise in turn helps my mental health. However, when I have many assignments due in a short space of time my health suffers as I have little time to exercise and become stressed which affects my mental health.”*

When university study was mentioned, the context of the answer was detached from that of their specific discipline, except for one entry referencing their programme of study.

When health professionals (both allied and front-line) were mentioned, they were never mentioned with a negative connotation.

*“Naturopath, Chiropractor, Yoga. My current lifestyle is influenced by myself and my attempts for good health and wellbeing.”*

Further in-depth discussion within the focus groups proved difficult to separate these groupings. The focus groups consistently identified meaningful experiences and the influence of close/primary social circles as the reasons for their health values and convictions. These experiences did not necessarily need to be positive in nature, rather, simply meaningful.

*“Umm, I guess, since I had money to spend on junk food, I’ve eaten much. SO my Mom doesn’t really eat junk food so I mean I wouldn’t say it’s the healthiest, it’s not, but it’s you know not fizzy drink, not chips, those kinds of things, and once I had money to spend that’s where I spent my money, and that’s where I still spend my money. ... I guess when I went [sic] round to other peoples’ places they would have so like or maybe birthday parties like, I don’t know, you kind of know, you go shopping with your mom, you see them [‘junk food’] at the supermarket, but you know if you ask your Mom’s [sic]gonna say ‘no’.”*

#### **5.7.4 Influences on values.**

Respondents were also asked to identify who/what the influences were on their healthy living *values*. The responses to this question took a similar form to the ‘influences of lifestyle’ question above. The commonality of the response of ‘self’, however, was much less frequent - ‘(my)Self’ was again mentioned, as the fourth highest (n=16, 10%) influence of healthy living practice values. ‘Close relationships’ were again the most frequent identification of value influence on healthy living practice with almost one code per response that would tie to this category (n=147, 95%). The word ‘family’ was mentioned 54 times (37%) and ‘friends’ reported 30 times (20%).

Media and social media were also recognised as an influence on personal values. The influential stance (positive vs. negative) of these references was mixed in regard to if and how they prompted action in the individual.

*“I believe social media has influenced my choices as I think seeing others live a healthy lifestyle makes me want to as well.”*

*“ [sic] Society around me, especially social media influences when they eat healthy food, they can either motivate you or make you feel self-conscious.”*

*“Have mainly been influenced by social media, and what others perceive as healthy.”*

The focus groups also identified values being changeable given the contextual situation even if they are not for the better of your health.

*“...but when I went [away] and danced over there I guess it was the first years away from home so I didn't have that support network and umm, I don't know, I've always been quite positive but when I was there it was very, it was quite cliquey and I definitely got into more of an addictive personality tendency so I wel.. [sic] yeah a lot of that year, I think I kind of lost more of my character while I was determined to be best at something and I ended up being very like strict with what I was putting into my body and umm, if I succumbed to eating like a chocolate biscuit I'd go for like 5k run or like it was terrible it was, it's shocking to think about how you treat yourself sometimes. Umm and so I definitely struggled with that umm and obviously like lost a few friends because I didn't want to socialise I wanted to you know, go for my workout and practice my dancing and umm not drink and not eat with my friends. And I think when my parents came over at one stage it was umm a certain performance and they I guess just realised how like a lot smaller I'd gotten or how different I was in my personality and they, umm, my Mum was like, I think it's time you needed to come home. So umm, yeah, so I kind of spent a lot of time recovering from that and the yoga definitely help me in that because I was still using my body so it's putting my energy somewhere but in a healthier, less competitive way.”*

## **5.8 Catalysts to Change**

What constituted health improvement was regularly identified as suggestions towards the improvement of physical health. Survey participants indicated a person that is in poor health equates to a person with a poor diet. Overwhelmingly, a recommendation of nutritional change or improvement was the most common suggestion for improving health. Improvement of nutritional intake was identified by 44% (n=68) of respondents. Suggestions for nutritional improvement were simple directives such as what to do and also, but less frequently, what not to do;

*“...eat healthy”*  
*“...quit sugar, drop alcohol intake...”*  
*“...eat less junk food”*  
*“...don't drink fizzy drink”*

Secondary to nutrition, changes to the physical nature of the body were recommended (n=39, 25%) before changes to the emotional/mental domain.

*“Exercise regularly”*  
*“Be more active”*  
*“Do not smoke”*

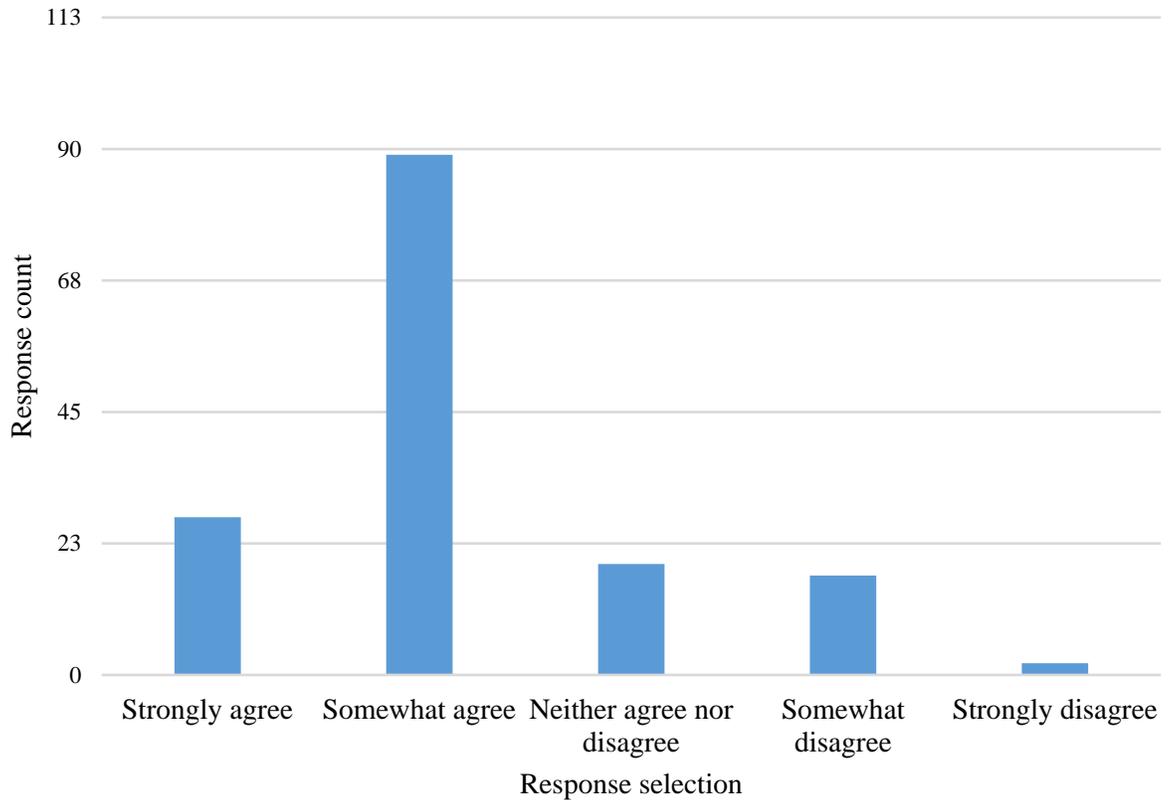
Both the aesthetic and physiological health of the body were identified when these individuals made suggestions to those less healthy than themselves.

In general, participants emphasised a small change as a good step toward improving health. Suggestions incorporating mental/emotional development included themes of personal love and kindness. Other than nutritional and physical engagement, suggestions on how to accomplish change, identified finding something one enjoys to make change more palatable, as well as, practicing reflection while identifying and ‘chasing’ happiness. Recommendations for social interaction were common, however, increasing the frequency of social interaction seemed to have less to do with public socialising and more to do with finding a support person or network to help maintain health improvement.

### **5.9 Compliance and Conformity with ‘Heathy Living’ Convictions**

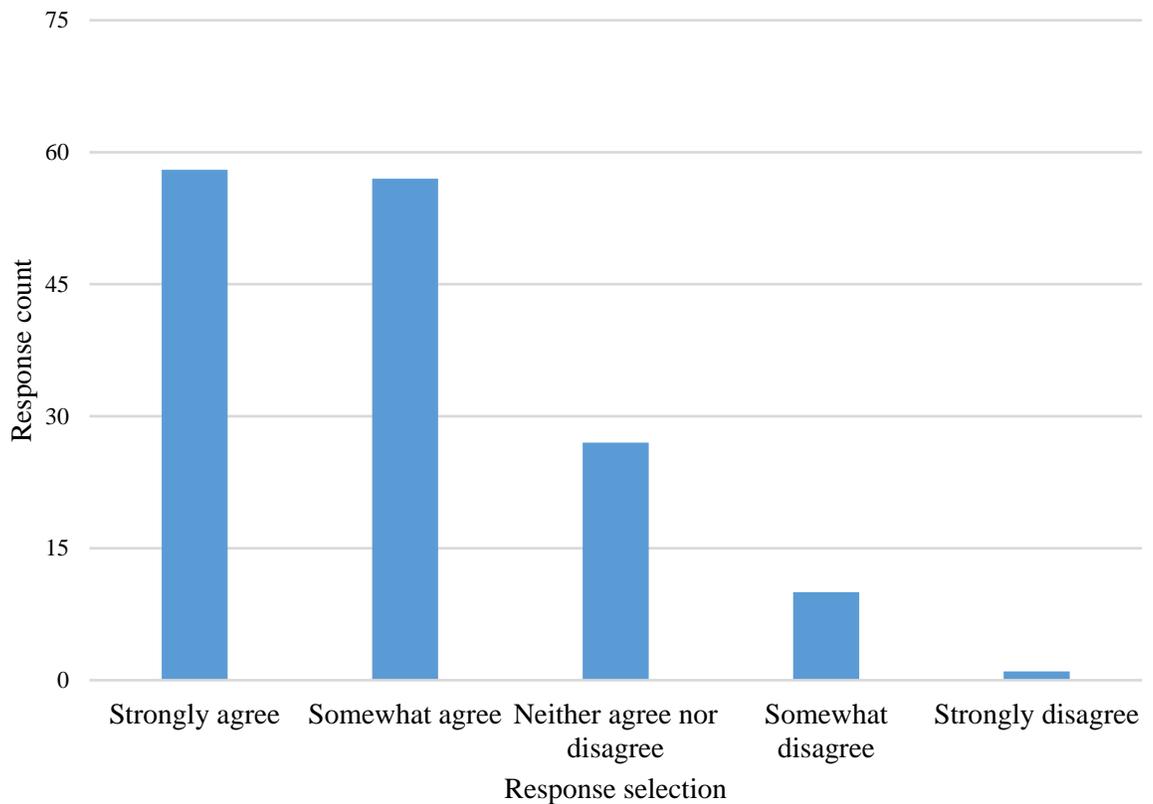
There were three Likert scale questions within the survey - relating to compliance and conformity with aspects relating to healthy living both as an individual and as a future health professional. Regardless of how the concept of health was evaluated, respondents mostly felt their own practices constituted living a healthy lifestyle (see Figure 2). Eighty-nine of the 154 respondents (58%) selected ‘mostly agree’ in response to the statement ‘I live a healthy lifestyle’ with another 28 (18%) selecting ‘strongly agree’. Visual analysis between responses of the different programme groups did not expose any noteworthy differential between the disciplines. There were similar response rates with regard to the statement; ‘My health and lifestyle practice reflect my values on what ideal health and healthy living looks like’. This would suggest the majority of this cohort believe they are living in accordance with their values.

Figure 2. Responses to the Survey Prompt ‘I live a healthy lifestyle.’



Lastly, the vast majority of respondents (n=115, 75%) agreed health professionals should share a common view of what it means to be healthy (Figure 3). Ten participants (6%) responded with ‘somewhat disagree’ and only one individual (0.006%) strongly disagreed with the statement: ‘I think it is important that all health professionals should share a common view of what it means to be healthy’. Participants of the survey would not have been able to see the other submitted responses, thus they were not agreeing as to which views of health should be shared as common, rather, that a common one should be employed.

Figure 3. Responses to the Survey Prompt ‘I think it is important that all health professionals should share a common view of what it means to be healthy.’

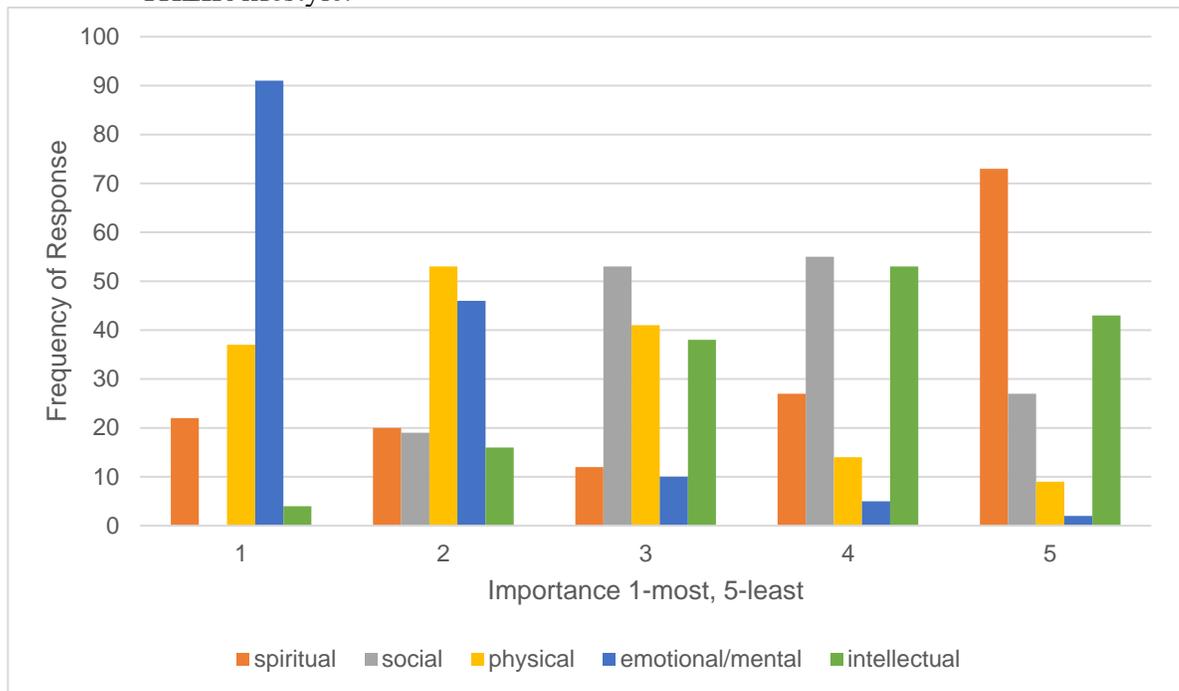


### 5.10 Health Professional Health Priority

The final survey question asked the respondents to use the same five components of health used in a previous question (physical, emotional/mental, social, intellectual, and spiritual) to rank what they deemed the health priority of a health professional should be. Once again, the highest priority (n=82, 53%) was emotional/mental health, and the least important was spiritual health (n=80, 52%).

Emotional/mental health occupied positions one and two for priority (Figure 4). Physical outranked other options in both positions two and three. Likewise, social health was ranked fourth (or third in importance when eliminating choices already identified). Intellectual health is steadily consistent throughout the ranking choices with the exception of ‘most important’.

Figure 4. Responses to Survey Prompt ‘For someone currently studying health at university, such as yourself, please order the following in order of importance to THEIR lifestyle.’



When the focus group participants were asked about what sort of role their own health played in their future profession, physical health again took a back seat to the importance of strong mental health and the importance of a strong social/support network. Setting a good example and role modelling were identified, but were conditioned with the importance of authenticity.

*“I think, surrounding yourself in a good social environment is very good [sic] cause I think it’s alright to say that if you’re going into the medical field you will be under stress. Just the patients you see and other personal circumstances that may arise. Umm, it will get very stressful and it’s good to have peers to talk to release and to just unwind and I think that a good social circle to be in is very important. They will support you, and at the same time you will support them, because you shouldn’t be taking everything and not giving anything back. Yeah.”*

*“I think that being a medical professional you should be in good health yourself because it is [sic] demanding job. So just keeping yourself healthy physically healthy, mentally healthy, is what determines will [sic] you be able to perform in your career. And about social or interactions, it’s also very important because from my own experience, burnout is a real thing when, like working for several years, you understand that it’s all pointless and you’re tired of that and you put in a lot of effort and you’re not getting back as much as you expected. I mean like satisfaction/dissatisfaction from your work.”*

## **5.11 Summary**

The key findings identified in this chapter indicate the complex diversity of methods used to define and shape how health is conceived, but there is a cohesive agreement on the fact that health professionals should share a common understanding of health itself. This clearly reflects the need for an interprofessional curriculum that engages student learning about health models and discussion about where health can/should be positioned in relation to the body. A strong psychological framing of health understanding cannot be discounted from this group, as well as holistic notions of health that move away from orthodox bio-medical perspectives. Of particular interest is that health as a concept is firmly integrated with physicality but, at the same time as having this corporeal undertone, there were also other resources that informed understanding of health and its practice. These other resources influenced health through close relationships, role models, and objects of interaction. In terms of how this may influence incorporation of health as a concept in IPE into a curriculum, the findings suggest the identification of personal values and reflective practice would be integral to the development of knowledge of health and healthy living practices. The following chapter will discuss and analyse these findings, with reference to critical literature covered in chapters two and three.

# Chapter 6 - Analysis and Discussion

## 6.1 Introduction

This chapter provides an analysis and discussion of the key findings. It explores the diverse use of health models by this cohort, describes the centrality of the physical body found in the definitions of health and healthy living practice, and identifies the issue of healthism. The intersection of corporeal ideals with psychosocial priorities is discussed. At this intersection, there lies a re-emergence of body-centred behaviours for health improvement. Development of the formation of health concepts are discussed. Ties to reflective practice, the importance of influences and, the impact they have on value creation and modification in the establishment of health and healthy living practice are also made. The results are discussed in the context of the key purposes and practices of IPE. The impact of health conceptions students bring into IPE is explored.

## 6.2 Corporeal Ideals and Healthism

### 6.2.1 Health models.

The findings of this research identified uniquely individual definitions of health, and the resulting health models into which these definitions could be placed, varied greatly between students regardless of their programme of study.

While not the dominant feature of participant response, descriptions of health aligning with the biomedical model were present and continuous. This ‘lack of illness’ model indicates the perception, within this cohort, of health remaining a medicalised ideal of the physical in that as long as all aspects of physical health fall within a range of ‘normality’ then there is no need for health intervention. These definitions also introduced the centrality of the body for health as a common perception, however, it was not just in the explanations students used to describe health. The importance of the physical body is prioritised – if not the singular aspect of importance – for many traditional health models (Warwick-Booth et al., 2012). Body-centric definitions do not solely reside in biomedical definitions. While different theoretical models of health aggregate different influences of existence into a formula for determining health, many of them still use the physical body to interpret the nature of health (Warwick-Booth et al., 2012). As mentioned in the results chapter,

participants view health as more than singular in its facets. In the majority of multi-faceted responses, a mental component was also present in their definition. Although this creates a divergence away from a purist biomedical model of health, it can still be seen that the body is very central to this style of health description.

In terms of alignment with described health models, the reported definitions and explanations move towards the biopsychosocial, often commonly associated with the holistic model (Allan et al., 2006), as well as the Hauora, and wellness models of health due to their multidimensional nature. This is a strong step in the direction of multidimensional health which is touted by world health bodies (WHO, 2005).

Many of the descriptions allude to concepts of functioning, ability and responsibility. These definitions carried with them an onus of responsibility squarely shouldered by the individual. This individual responsibility was dominant for definitions across the board ranging from singular to multidimensional.

Indications of personal responsibility and personal feelings within these statements are very telling. They identify there is a common, individualistic creation of health as a concept. These definitions demonstrate an undertone of healthism for the maintenance of their body-centric health ideals (Crawford, 1980). As Quennerstedt et al. (2010) identified, healthism rests the onus of responsibility for health on the individual. It also implicates a level of morality and societal expectation on the individual to develop and/or maintain their health as a societal expectation. Those that are not able to meet that expectation or do not have the ability to achieve that expectation are then seen as immoral, and less contributive to socio-cultural expectations.

Some descriptions diverged from this body-centric view. One selected response identified physical injury as an expected part of their life. In their own health description, this individual held great value in the physical capability of their body in terms of fitness but accepted temporary physical setback as not defining of overall health. In a more holistic reflection, they identified a choice not to engage in social interaction led to less resilience in health. This changes the focus of control from the physiological, to a responsibility matter of choice. As physical injury is a part of (their) life, health, then resides in their subsequent

management choices. While the physical body has now been removed from this responsibility explanation, we are still left with the identification of healthist views that they are responsible for their health maintenance and the engagement of their social influences. Even without the body being involved, this person has the expectation that it is up to them to search out social interaction and fulfilment. Hypothetically, if this individual was treating a patient who was socially reclusive, as a health professional, this perspective may shape the judgements and care plan for the patient.

These healthist views and their inclusion in health models can continue to be seen with frequent reference to wellbeing. The interpretation of wellbeing as a concept of health has seen a separation from the other multicomponent health descriptions, although it doesn't greatly differ in its formulation. Warwick-Booth et al. (2012) identify wellbeing as a 'slippery' word with little consensus as to its actual representation. The responses from this study's survey would indicate wellbeing relates to quality of life as described elsewhere (Warwick-Booth et al., 2012). Wellbeing is a component of wellness, which is generally identified as the practice of habits to improve personal health in both body and mind (Larson, 1999). This would then carry forward the non-singular locus of creation of the concept of health already mentioned, and would add weight to the participant subjective views of health, through the evaluation of ones' feelings of stress and how they can be eliminated or reduced in the body. There is a second possibility in that there is less faith in the participants' ability to define health. Wellbeing can also be a health synonym. The interchanging use of these terms may infer respondents do not fully understand the concept of health. However, this is, perhaps, unfair as experts in philosophy and science throughout history have been unable to unanimously define health. It does show a position, however, that health, as a concept, is poorly understood, or perhaps poorly appreciated.

Based on Crawford's (1980) creation and tracking of the concept and term healthism, these definitions would appear to be where one would find references and ideals to self-maintenance. Within the participant definitions of health, though, references to self-maintenance were minimally identified. Perhaps these expectations for quality of life were buried within the term itself. This does not rule out either of the possibilities for how participants viewed the term wellbeing, but it does add weight to the need for health

professionals to understand the concepts and terminology fundamental to the paradigm of their respective professions.

Even responses identifying with Antonovsky's salutogenic model were implicated with healthism. During the focus group sessions, one participant voiced their measurement of health only so far as the barriers they were able to overcome. This individuals' health will only be able to take them as far as their strength of coherence (SOC) has developed. When faced with an obstacle they cannot overcome, the limit is reached for their current positive health spectrum and new skill acquisition is required. These new skills are the General Resistance Resources (GRRs). As Antonovsky (1996) identified, in a divergent movement away from traditional health promotion, salutogenics accepts the human body as flawed and we will all, at some point, have our health challenged. Of importance is our ability to understand the challenge danger(s) and our ability to engage it (them). From this stand point, collectives' strategies for GRRs can be formulated and implemented for *all*, rather than for specific demographics, or at-risk communities. Developing and implementing GRRs does not require the individual to identify they have a problem in the first place. Although possible, these resources do not necessarily lead to intervention. Rather, the development goal of these resources is that of *pro*-activity rather than *re*-activity, it is just from a different starting point. This is likened to the idea that learning how to swim is a good idea, even if you do not own a pool. Learning to swim is not best learnt from the realisation you are drowning, rather, learning to swim is learnt with the idea in mind that there are bodies of water in the world that are too deep to touch the bottom. Proactive salutogenic health promotion is a change from the reactionary, Western, clinical bio-medical model. It also carries with it, however, moral and scientific faces in its conception. In treating patients with chronic illness, it is important the provider or provider-team does not forget they are treating the person, not just the condition. Salutogenic approaches must ensure they are instilling GRRs individuals can assimilate and make their own, while at the same time, moving them towards greater health in their own context (Antonovsky, 1996).

Results show the students' collective view of health as individualistic and will, therefore, most likely project responsibility onto the patient for their own actions and health situation. In this case, it is important first year health students are educated to broaden their understanding of health application to different people. Interprofessional education is

designed to tackle problems that are larger than one discipline alone can handle (Millar, 2016). As such, it is the ideal platform for providing educational scaffolding around patient expectation and a recalibration of engagement with health in professional practice. From an interprofessional, patient-centred, healthcare model, emphasis on foundational knowledge about health expectation is critical for interprofessional health team members. This presents a golden opportunity for interprofessional curriculum developers, of any institution, to ensconce a non-soft-skilled component into their curriculum design that is both theoretical and practical in its learning method and application, personally and professionally.

### **6.2.2 External judgement.**

An inadvertent finding of this study was a contradiction with an individualistic and healthist conception, in that socio-cultural parameters or compliance with expectations are generic and external to the self in their validation. Body-centric, or, corporeal ideals with regard to health definition were frequent, coming across both as subjective and objective in their explanations. One selected response identified body-centric parameters for defining health through biomedical lack of illness, as well as physical capability. As part of the explanation, they rooted their validation of health in parameters that are outside of themselves; “...and can run for the same period of time as someone who isn’t overweight (they are still fit despite their weight)”. This suggests a health justification in comparison to someone or something else, perpetuating cultural ideals that individuals may or may not feel able to achieve. To suggest a modification of this definition of health, perhaps a more productive completion of their example could be; ...someone might be overweight but they choose to go to the gym and can run for as long as they choose. If this subjective identification of health is left unchallenged, there is a hidden expectation projected, that ability level for adequate health is self-identified but culturally regulated. This proposition dictates the individual must be responsible for maintaining the cultural morals of their society. Morally, this creates expectations for the health professional to transfer to the patient. Within an interprofessional health team, this would similarly espouse expectation upon the patient, but could also imbue feelings of prejudice and judgement on behalf of a health community and self-efficacy degradation on the patient’s behalf.

### **6.2.3 Health priority.**

In addition to corporeal and healthist definitions, study participants indicated a juxtapositional view in their prioritisation of various components of health. Emotional/mental health priority dominated both personal and professional priority for health professionals. This component of health has strong ties to biopsychosocial models, and shows a strong socio-ecological, or holistic framing. The findings suggest this research cohort is creating a holistic health framework in its nature, while also being corporeal and healthist in its actioning and responsibility of maintenance. In simplistic terms, the group indicated the most important part of health is mental and people are expected to know how to, or be able to, establish and maintain health through physical actions. These two topics (holistic style frameworks and healthism), while seeming harmless in their integration with each other, are actually quite oppositional in nature (Crawford, 1980). In Crawford's original description of healthism, he describes almost exactly what is being found in this study's research data; "For the healthist, solution rests within the individual's determination to resist culture, advertising, institutional and environmental constraints, disease agents, or simply lazy or poor personal habits" (1980, p. 368). Another explanation may be the development of alternatives to an orthodox biomedical model perspective is pervading this cohorts' socio-cultural reality to create change, but at the same time, the infiltration of healthism is so rampant in Western cultural norms of New Zealand society that it forces these individuals to re-orient how they understand the alternatives. This holistic framing for health is seen as important, but it is obtained through self-mediated actions of corporeal ideal, i.e. going to the gym to exercise in order to look better and feel better.

### **6.2.4 Health characteristics.**

Here we draw on other aspects of the student cohorts' identification of health. The descriptive characteristics of health should provide a base as a reflection of the general priority of the cohort. However, they only loosely align. Physical and dispositional descriptions were most commonly recorded - again, illustrating the duality of concepts. The terms 'fit' and 'happy' were frequent amongst responses. The regular use of these terms indicate the need to display these traits in order to be externally labelled as healthy - lending support to the idea that healthism reorients the lens of non-biomedical health definitions. Although the survey results were unclear as to the required amount of fitness or happiness to be healthy, when raised for further clarification, only one of the focus groups

was able to engage in a discourse about how fitness could be evaluated. The significance of this discussion was realised in a new level of reflection from one participant (Participant 'A') who self-identified as someone who is not fit because they were not '*physically strong*' or '*able to run a while*'. When pressed as to what 'a while' was classified as, Participant A was unable to determine an amount as they hadn't had the experience. A second participant (Participant 'B') who self-identified as a very active and athletic person challenged Participant A's explanation of fitness with the idea that fitness is less about the capacity of the individual to exert high levels of effort but more relative to the parameters around their functioning in day-to-day life. Being provided with a different perspective on a descriptor of health seemed to give Participant A an opportunity to reflect on their own actions and choices and the intrinsic value that goes along with them. Participant A did feel as though they were a healthy person but not fit, as their assessment of fitness was a measure outside of their own perceived ability range. This exchange highlights societal expectation of others needing to fit to culturally pre-determined criteria. Returning to the idea of culture defining health parameters mentioned earlier, it is interesting to note that Participant A was easily able to identify their own efforts towards health as soon as the ideal of truly self-defined health was offered; 'I am fit for my purposes'. This interaction also highlights the effect that students engaging in discourse about health and healthy living practice gives them the opportunity to lean with, from, and about each other. The very bedrock ideals of IPE.

Both focus groups emphasised the importance of the past, present, and future, to identify 'happiness' - being at ease with the defining choices of the past, and to thoughts on (figuratively) future directions. Commonly discussed was the direct link between social relationships and generating happiness, inferring the need to be a participant of social culture. However, a caveat identified the need to live in a manner authentically, reflecting their inner truths. Lyubomirsky (2019) identifies that there are three major components to the source of happiness and the one that has the highest variance of impact is behaviour; the actions that one carries out on a daily basis.

If we integrate some previous aspects here, inner truth is made up of respecting or acknowledging corporeal ideas about biomedical health and actioning those ideas to a comfortable individual level. In order to accomplish these tasks, the individual will need to

interact with members of the greater society and culture holding common ideology, to create situations of inclusion and fulfilment. Thus, the emotion of happiness can be obtained through the self-evaluative and modular process of ones' past, present, and future.

Despite the emphasis on social inclusion, health behaviour was seen as being focused on the 'self'. From an IPE perspective, our health students need to understand this reality of 'healthy self' to ensure they can effectively help patients with self-care. This path would, however, perpetuate the healthist ideal of current dominant culture. Alternatively, there is the opportunity for curriculum designers to address and educate students about neo-liberal health culture. This does not necessarily need to be through a theoretical development model. Curriculum could include practical application where students learn how to practice 'healthy' in their own way. "Health education is then conceived as a practice – 'healthy-ing' – and not a fixed, static outcome set up by research and public health policies as something to achieve in education." (Quennerstedt, et al., 2010, p. 107).

### **6.3 Socio-cultural Demographics and Health Influence**

When it comes to physiology fundamentals, all human beings function the same way - hearts beat to shunt blood around the body; nervous systems transmit action potentials; cells replicate and divide. The introduction of variables in societies such as food, financial resources, time constraints, living conditions, psychological stressors, all impact physiological and psychological adaptation. These collective variables can be called culture and cultural influences (Macionis & Gerber, 2002), and have the ability to influence a person physiologically, psychologically, or both. Thus, it can be argued that culture influences health. This is a strong argument point for many of the multidimensional models of health described in Chapter 2. Although culture does not directly create health, it does foster values of specific health ideals. Culture is the expression of a set of practices, learned behaviour and moral values passed on from one generation to another (Macionis & Gerber, 2002). The majority of the cohort for this research identified as New Zealand European, and as such, there is a certain framework of socio-cultural values, practices and expectations to be achieved in order to be a contributive member of that socio-culture. As identified by Durie (2004), it can often be very difficult for the health values of minority groups within a larger society to amalgamate with those of Western cultural ideals. When alignment with healthist tones of neoliberal Western culture are not met by minority

groups, it may be due to inability, non-compliance or a rejection of the dominant cultural value, and hence a rejection of the inherent moral value (Quennerstedt & Öhman, 2014). Without awareness of the existence of these expectations, those within the dominant culture may simply see immoral, culturally resistant minority groups as a burden to what they see as a simple solution. This is not to say prejudices are actively engaged in this cohort, rather that along with cultural majority comes cultural health value expectation and the defining practices (personal or social).

Cultural consideration is critical in a society where minority groups, such as lower socio-economic, are most frequently in need of utilising the health services. These are also not typically the demographic engaging in tertiary healthcare education. An IPE approach to healthcare education, can therefore, expose students to and promote engagement with alternate cultures. Learning appropriate interaction with individuals of various social class, economics, gender, race, and geographic location are all important aspects when developing patient-centred practices for health teams (Macionis & Gerber, 2002).

Understanding someone else's values requires, to an extent, an understanding of their culture as well. Understanding cultural practices is important in the establishment of effective and respectful protocols needed within patient-centred practice (Durie, 2004; Shim, 2010). This study showed an overall similarity of content between the reported different cultural heritages representing health similarly across cultures. Durie (2004) identified that Māori require a broad approach covering a wide spectrum of interventions for health management. With this in mind, the *order* in which suggestions were listed for improving health was a noted difference in responses from those who identified as Māori or Pacific Islander from the rest of the cohort. Health intervention priorities are, therefore, different within Māori, and Pacific Islander cultures. Practices lead to values and the expression of health. This difference in presentation emphasises the importance of understanding and incorporating cultural capital into healthcare practice models (Shim, 2010). Learning about health not as an end product but as a way of becoming is a method of engaging with both health knowledge development as well as societal/cultural practice integration. This will allow our future health professionals to expand their understanding of health beyond the boundaries of their own conceptions as well as the paradigm boundaries within their respective health disciplines (Quennerstedt et al., 2010).

### **6.3.1 Health influence.**

A majority of participants felt they had not studied health before, however, all participants could provide definitions, characteristics, priorities, and suggestions to improving health. They were also able to identify the major influences to their current healthy living practices and values. Thus, the importance of non-prescribed educational influence on health practice and value cannot be overlooked (Spector, 2002). Aligning with Bandura (1998), the research data suggest close connections are an integral part to this cohorts' healthy living practice determination as interaction with these people allows for fulfilment and development of various subscribed paradigms of health. This also aligns with the argument for the social model of health from Arah (2009) in that the creation and practice of health ideals is reciprocal between the individual and the society around them.

### **6.3.2 Representatives for influence.**

While results show 'self' as influential to ones' healthy living practice, it is unclear as to the reasoning. The responses indicate strongly to the concept of individualism in health responsibility (Crawford, 1980). These individuals are, again, suggesting a subjectivist reality development (Scotland, 2012). But this reality cannot exist without interactions with external factors (Mack, 2010). An influence is not considered an independent choice, rather it is a situation or occurrence in your life causing sway in thinking about, or behaving in response to something. External factors, or influences, were identified in the results as close relationships, personal experiences/drivers, and objects of interaction. It was common for participants to hold their influence(s) as either role models/learning observers, and/or gate keepers. Role models: learning a practice from a person or thing or learning observer of proper health value was similarly being a role model themselves for those they are trying to be help become healthier e.g. children or close relations. Gate keepers indicated that respondents did not always feel there was a lot of choice in their health decisions as a result of external influences. Respondents identified close relationships as not only role models, but gate keepers in that they can control things like the food menu. The university campus itself, is identified as a gate keeper with ready availability of fast food and few alternative options. There was a belief living independently of family would improve health with freedom to make their own food choices. In this regard the close relationships of their

living situation can be seen as both a role model and a gate keeper in that the respondent feels as though their family is making poor nutritional decisions.

Also, gate keepers, time and finances require proper planning and preparation. Although health can be individually controlled, control can be difficult in the presence of role models and gate keepers and expectations on making the 'correct' choice. Quennerstedt et al. (2010) describe this mentality as the individual feeling responsible for the morally normative ideals of societal expectation. These morally suggestive expectations frequently came across in a negative light as a precipice for not being able to comply. University, for example, was rarely mentioned as being a positive influence. It was either singularly mentioned as part of a list or of a larger negative health influence, generally 'stress'. In the same, figurative breath, however, health professionals were unanimously identified as positive health influences as role models or objects of interaction. This is interesting as the cohort of this study is seemingly undergoing a perceived negative health influence in order to become a positive health influence and role model or object of interaction for others.

One influence surprisingly scarcely reported in the results, was media and social media. Social media is almost completely unavoidable for this cohort. It has entrenched itself as a virtual necessity for normative social integration and interaction - a reported health priority in this study. The limited inclusion of media in the survey responses could indicate the importance of what is specifically not said or potentially realised when it comes to health/health practice expectation and health culture. This platform contains an underpinning ideology strongly reinforcing a healthist culture providing an opportunity for its members to demonstrate their moral conformity to healthist culture in a way that is akin to the idea of hidden educational curriculum.

In Crawford's (1980) original work on healthism he identifies that "health has become not only a preoccupation; it has also become a pan-value or standard by which an expanding number of behaviours and social phenomena are judged" (pp. 380-381). This idea of social phenomena can be seen ever present today in the guise of social media platforms like Facebook and Instagram. In the unknowing name of healthism, participants of these types of platforms are constantly posting and being exposed to selected aspects of lives that demonstrate conformity with the expectations of healthist culture. Demonstrations and

evidence of things like happiness, fitness, beauty, and social engagement all seem to be highlighted, creating illusions of day-to-day reality of average lives. When mentioned, however, social media represented what they see in terms of an aspiration and motivation for their own lifestyle. It is interesting then that the aspects of our lives we post as social media members, are the same as the most commonly identified aspects of health as identified by this cohort.

## **6.4 Learned Health Value**

### **6.4.1 Experiences shape health values.**

Collectively, the different aspects of how health was defined, prioritised and evaluated can be triangulated to the common denominator of ‘value(s)’. Consciously or unconsciously held, the aspects of self in which a person holds value are likely to be associated with how their concept of health is created. These, along with beliefs and attitudes will influence daily choices (Kline, 2002). The finding of value was clarified within the focus groups as being created through meaningful life experiences. Each focus group member described experiences defining health and healthy living practice. One such experience was a focus group member moving away from home to pursue a career in dance - a time during which they underwent value change. This person was willing to sacrifice aspects of their life like social connections, mental equanimity, and personal forgiveness in the pursuit of something that was, at the time, more highly prioritised in their life - their physical body. This person acted according to their values at the time and was willing to make concessions about their lifestyle for the sake of maintaining a certain physical state. Reflectively evaluating their experience, and parental involvement (close relationship) at the time, comparing to their current values created meaning and value shift for the participant. This participant felt their current state of health was better in contrast to an entirely physical focus. This story highlights ideals of value change and the evolving nature of health as a concept not being created in a void. Our meaningful experiences and reflective practice must be acknowledged, but, so too must they be integrated as influencing factors in our own lifeworld experiences.

### **6.4.2 Social support is a part of experience.**

Within the experiences, themselves, of critical importance was the involvement of some sort of support that presented during the experience as an influence to change personal

value. This support was consistently present in the aspects of the focus groups' stories that contained the resolution or engagement of the health issue or critical situation. These moments and experiences were significant enough to stay in the individuals' memory to influence their choices about how they live (and also in most cases the career pathway in which they finally chose to take). This raises two key points in relation to the research question: personal values (in an action or a way of thinking) are created through meaningful experiences and the influence of close/primary social circles. These personal values seem to underpin descriptions of healthy and quality of life. Social support then, can be seen as an educational development area for primary values. If, as these students have suggested, we wish to enact a uniform health understanding that all health professionals ascribe to, we must engage in educational practices that include the entire populous of the health professional society in order to create cultural development in IPE.

Fedewa et al. (2014) identified that the dominant age demographic of this study cohort (16-20) was also the significant time in solidification of habits and practices that will be taken forward into adulthood. Developing programmes that work towards reforming health culture could also have the impact of improving the future personal lives of these students, outside an interprofessional or clinical setting.

### **6.4.3 Tying it back to value.**

Te Pou o te Whakaaro Nui (TEPOU) (2017) identifies that working in ways that acknowledge values helps to create strong relationships, and healthcare is based on relationships between people and groups. Working backwards then, understanding ones' own or anothers' view of health requires consideration of where value is held.

Understanding where value is held requires a certain amount of reflective practice on behalf of the individual. Within the study data, responses identifying health through synonyms rather than components, illustrated a poor understanding or practice in the reflection of personal values and influences. Creating a strong first year curriculum to assist identification of personal health values and their possible difference from those of other cultures is a useful first step toward creating progressive healthcare professionals. Combining these individuals into interdisciplinary teams to identify where their values converge and separate using constructs of health as a framework for discussion, will enhance the learning experience.

Finding methods of bridging the gap between the non-academically developed views on health and creating a multicultural professional disposition of health would help students to understand how health as a concept is initially created. A practice-based manner, rather than solely theoretically identified or conceptualized in a textbook or lecture - seems accomplishable through creating appropriate social and educational situations. These bring students closer together to discuss health topics and participate in learning that will generate interaction and the development of close social networks. Reflective practices are highly regarded in IPE (Millar, 2016), and are where educators and peers can sow the seeds of self-efficacy around 'healthy-ing' rather than prescribed (expected) healthy behaviour. For example, the argument preaching physical activity for both its physiological and psychological benefits that have been repeatedly clinically proven provides an expectation of practice for good health (and thus a moral imperative of good citizenship). However, it does not simply motivate active engagement and can create thinking of: 'I should because I'm told to and I'm not a good person if I don't'. On the other side, practicing, role modelling, and inviting patients to join practitioners in the participation of physical activity (of various types) leads to discovery and could help patients get in touch with their bodies on their own terms. This change is subtle but important. The difference in this second aspect is not telling the patient what they should do, rather it is inviting them to be a part of a community. Community breeds feelings of acceptance, and that acceptance is a strong motivator to compliance of activities that are once again clinically proven to benefit people both physiologically and psychologically. This transition to 'healthy-ing' helps people build socio-cultural value for physical activity. This is in opposition to building expectation of physical activity as an identifier of not letting down social culture. In this way, patients begin exercise because they enjoy the exercise itself and, more importantly they enjoy the community built around the exercise. To extend upon the analogy about learning to swim even if you do not own a swimming pool used earlier; there are many different ways to accomplish swimming, just as there are many different ways to accomplish 'healthy-ing'. Swimming also does not have to be rigidly prescriptive in order to be successful. It can be added that the act of swimming once learned can be quite enjoyable. Value is inherently intertwined with the concept of health. The key is finding a method that provides you with success and enjoyment.

## **6.5 Summary**

The results of this research have identified juxtapositions in the ways first year health students conceive, describe, prioritize, are influenced by, and suggest changes to health. What does this mean to education within an interprofessional setting? It tells us that all of our students, whether they have a background in health or not, are starting from different perspectives, each with their own unique take on health. As these individuals will be expected to practice together in the interest of someone else's health, it is important they understand the subjectivity of the concept of health and realise theirs is not the only perspective.

# Chapter 7 - Conclusion

## 7.1 Introduction

By identifying the perceptions of health and healthy living practice held by first year, interprofessional health students, this thesis shows a strong identification with corporeal ideals while simultaneously holding holistic mentalities for health priority and actualisation. These findings explored personal definitions of health, health characterisation and prioritisation, and external influences on health values and practices. This chapter discusses the implications of the key findings that emerged from this research project.

Firstly, the nature of health definition was uniquely tied to the individual but also intertwines with commonalities of health priority and influence for this cohort. Secondly, the body-centric focus of health is referenced by psychosocial priorities of maintenance and development. These priorities are influenced through personal experiences relating to the components of health. Experiential reflection creates values carried with the individual into current and future decision-making. Thirdly, the healthist tone in which students relate to the concept of health can influence wider values than their own if left unexplored and unchecked. Following this, an argument is made for the development of IPE curriculum content specifically relating to the identification of personal-health concept. Subsequently, limitations of the project are identified and suggestions for further research are proposed. The chapter concludes with a collective summary of the research project.

## 7.2 Implications for Educational Practice

Identifying the perceptions of health and healthy living practices adds an opportunity for interprofessional health educators to identify new methods of engaging with students of multiple discipline pathways in a manner fundamentally common to each health profession. This study has shown definitions of health held by first year interprofessional students are varied, but the influences and values that underpin these definitions are largely similar. There is also a belief for all health professionals to share common health values. Although participants express similar ideals towards the development of health, the manner in which they arrive at those ideals is unique to the individual. Specifically, this study identified close relationships, personal experiences/drivers, and the common objects of interaction relevant to their lives all combine to influence the perceived amount of value in the varying

components of health. This value development can then be used as a guide-to-practice in daily living contributing to a socio-cultural context of health identification and expectation. Thus creating a framework for a contextual discussion of health including interprofessionalism.

The adopted healthist view revealed in this research suggests a possible challenge to students/health professionals when addressing components of health in a patient-centred manner, as demonstrated with the examples of health aspects that cannot be tangibly accessed or one's inability to engage in self-reflection (Antonovsky, 1996; Crawford, 1981; Lindström & Eriksson, 2006; Quennerstedt et al., 2010). As a result of unknowingly thinking and acting in a healthist manner, these participants may be unaware of their impact on their learning and practice within their professional disciplines. Unchallenged this could lead to expectations on the patient/client and unjust judgements towards others who hold different lifeworld views on the concept of health.

As educators, if we are going to support a change in the development of our future healthcare practitioners to become more collaborative and patient-focused, it is important all students be provided with the opportunity to establish reflective knowledge about their own health ideals and practice. They also need to create a broad understanding of personal health and its maintenance as being personal. Left unchecked, healthist views carry an inconspicuous social and personal morality (Quennerstedt & Öhman, 2014), possibly leading the bearer to project expectation onto others in judgements on how they live their lives. These judgements will not just be projected onto patients, but also onto other health professionals. It also impacts self-judgement influencing self-efficacy and self-esteem during comparisons of dominant socio-cultural expectation.

Identifying the base perception of health and healthy living practices held by students, has educational and (future) practice implications in better preparing students to engage with the quickly changing face of healthcare and the need for new and better solutions (Bluteau & Jackson, 2009; Thistlethwaite, 2012). There is, therefore, a need for curriculum designers to address this concept; a timely opportunity to benefit professional disciplines and also IPE. Within the foundational years of tertiary health education, educators and curriculum designers have the obligation and directive to influence and establish wider consideration of

health views most appropriately from an interprofessional perspective. Additionally, as indicated by the study demographics, the dominant age range of this cohort is that of those at the point of cementing long term habits and practices (Fedewa et al., 2014), presenting a double phase of critical educational timing.

Currently, IPE focuses primarily on ‘soft-skill’ aspects of professionalism (Thistlethwaite, 2012). Scope then lies in exploring health as a concept through IPE initiatives that are not only foundational to interprofessionalism, but also to personal practice. Herein lies the potential for refining and emphasising an active learning IPE culture, even in a non-clinical setting. Engagement with - and reflective practices of - the active pursuit of personal health identification supports the notion of creating authentic opportunities for students to develop close educational relationships, have meaningful learning experiences, and create values of effective personal health practices. For example, experiential learning opportunities challenging students’ traditional practices in regard to a certain health aspect, or, experiences in favour of a specific health discipline concept.

Hivert et al. (2017) asserted positive health practice can be demonstrated by any health-related profession - primary or otherwise. The same can be argued for health education students. This study’s findings support the need for students undergoing health professional education to understand the foundational principles of health and its sources of development. Concurrently creating understanding of the cultivation of health as a concept and practice on behalf of both influencer and the influenced can support the development of students moving into disciplinary education with a common foundation from which to build further interdisciplinary practices and skills.

Within the literature, development and consistent inclusion of interprofessional curriculum into health programmes was identified as a challenge to IPE (Holley, 2017). Resistance to its inclusion remains, as well as debate on what constitutes relevant interprofessional content. Further compounding the discussion is appropriate timing of its incorporation and the goals of the curriculum (Buring et al., 2009; Curran et al., 2005). As IPE aims to improve collaboration with intention to maximise patient-centred outcomes, the idea of incorporating interprofessionalism at the start of a tertiary health education programme seems to lose some of its merit. At the beginning of a tertiary health professional education

programme, students do not yet have enough skill and disciplinary (or interdisciplinary) knowledge to warrant interactions with patients/clients. This does not, however, preclude these students from being able to develop fundamental habits of practice that can be incorporated by all health professionals.

In IPE, creators and facilitators of curriculum come from a mixture of professional backgrounds which can create contestation of content and inclusion/exclusion of topics. Additionally, external stakeholders keen to ensure their criteria are met can further bias content (Millar, 2016). So too, can the concept of health be enculturated into disciplinary as specific disciplines focus on specific aspects to a persons' health. These aspects are not argued, in fact, they are accepted. However, if these factors are considered against the idea of having students learn about the concepts of health in an interprofessional way—with, from, and about each other—the generation of a health concept-based curriculum has already espoused a solution for two fundamentally challenged aspects toward interprofessional programming.

One solution is that health, as a concept, has been identified as being described and understood in multiple models. The participants of this cohort have shown they identify health using varying aspects of these models more commonly than one specific model when it comes to creating, explaining, and exemplifying health and health practice in their own way. It could be argued, then, that all reported health models contain validity in their theory. However, simply learning specific model theory, or discipline-centred health model theory detracts from the goal of creating diverse health professionals with an ability to adapt to the changing and diverse needs of a population. Creating curriculum content centred around actively engaging with health concepts can be done in a way that is discipline related and *student* focused. This adds a fundamental component to both disciplinary and interdisciplinary development.

Another solution a health-concept based curriculum provides is learning, understanding and practicing health in a manner relating to a personal and physiological level of satisfaction, which can have positive influences on future interactions with patients/clients and greater confidence in discussing health strategy (Wills & Kelly, 2016). This, however, requires a change to the current method in which health education is practiced (Quennerstedt et al.,

2010). If curriculum continues to enforce the current dominant culture of healthism, then educators will continue to facilitate the production of health morality and expectation to societal standards. Opposed to focusing on telling students what they should do and just expect them to conform, it is suggested, alternatively, we have students participate in learning through experience and reflective practice. This is not to say certain activities should not be presented to students as models of positive health, rather, the focus of evaluation should be on the reflection of the experience rather than their ability to meet prescribed expectations. This considers knowledge construction in a different manner (Scott, 2014) and has the potential to establish genuine educational culture to foster the promotion of positive health practice.

These solutions do not need to remove the expectations of disciplinarity, but rather establishes the concept of health and healthy living practice is not something that is learned, it is something that is practiced and experienced. Creating opportunities for students to experience health in its various facets could be instrumental to the development of a healthcare workforce with a firm grasp on the importance of patient and community in the development of protocols and programmes to tackle our current and emerging healthcare problems.

### **7.3 Study Limitations**

The demographic results of the survey identify a skewed number of participants from each of the various qualification majors/professional programmes. There were a higher number of students within the professional disciplines as compared to other qualifications and majors and in some cases, no responses. This could be seen as a biased contribution of data from the various disciplines. The survey was open to all students who were, at the time, enrolled in the core curriculum courses of the SIHS. As identified in the introduction, AUT arguably trains the highest number of health professionals in the country. As such, higher numbers of students within these programmes increased the likelihood of engaging with the survey of the study, and further the focus groups. This consideration increases the representative capacity of the overall sample of the study. Additionally, the recruitment letters were sent to students enrolled in the core curriculum of study providing the possibility of some students being yet to declare or be accepted into their preferred programme/discipline of study. This does account for the selection of 'other' when

choosing program with these students still to identify with their chosen pathway. Thirdly, it was the very best opportunity of engaging with interprofessional opinions before the influence of disciplinarity took place. The identification of program pathway was included as a safeguard in the event of minimal survey interaction or if there was an identification of specific themes coming from students of one specific educational stream. Neither such situations presented themselves.

It is possible participants of the focus groups may have been swayed due to the semi-structured nature of the sessions to attest their experiences and opinions less candidly than an unstructured technique. Still, the use of semi-structured questions did not seem to limit the context or development of conversation pathways. The use of semi-structured questions brought about responses related to the context of the study topic but it did not influence the thoughtful and descriptive experience recounts provided by the participants.

The focus groups were small in their comparison size to the survey population. Participant recruitment for the focus groups was challenging. Adjustments were made to the original intended size in order to both increase the opportunity for diverse discussion and to accommodate and retain the individuals that expressed interest in participation. It was fortuitous that the individuals who participated in the focus group aligned so well to the demographic make-up of the survey participants. As such, while not speaking for the cohort, discussion around the concepts and ideas that the cohort raised was held to be acceptably managed.

#### **7.4 Future considerations**

Future research considerations related to this topic could investigate the longitudinal development of health perception and its daily practice once students have had time to engage with their specific discipline. This would build on, and develop the knowledge from this study which has shown that this cohort holds a mixed but strong holistic conception of health fundamentally underpinned by corporeal reasoning.

#### **7.5 Conclusion**

Exploration into the perceptions of health and healthy living practice held by first year, tertiary health education students has provided a unique insight into the variety and

individuality of the developed identification and lived experience of health. This has revealed a juxtapositional intersection of corporeal ideals with psychosocial priorities of maintenance and development. The formation of this intersection reveals ties to the practice of reflection and the importance of the factors that influence and impact value creation and modification. As a result, personal views of health and healthy living practice are established.

These corporeal underpinnings lead to the notion of healthism which has the ability to influence socio-cultural morality expectation as well as health management expectation. While healthism is not in itself a ‘bad thing’ it is important students should be aware of the ways in which they develop and express their views on health. These have the potential to impact not just themselves but also their future patients/clients and other interprofessionals.

The diversity of health models is robust and thus provides copious opportunity for differences in opinion and subscription. Understanding health and what it means requires reflection and experience. What happiness looks like will be different for different people, as will personal health. However, the greatest impact on happiness is behaviour; the actions one carries out on a daily basis forming a long-term effect on lives. With the correct framing and background, health choices will directly relate to happiness. Reciprocally, the choices made leading to happiness can influence our identification of health. The concept of the term ‘fit’ relates closely to this as ‘fit’ concerns the capacity of the physical body to do work.

In order to engage our future health professionals in a manner that can transcend practice disciplines there is an opportunity within their first year of study to engage these students in learning experiences that are both active and enjoyable. This can be done through developing curriculum practices that create a common foundation for all health disciplines to take up a common mantle in order to customise it appropriately in the future.

Health is the foundational component of all health-related disciplinary education. Its understanding is the ground work that all health knowledge is built from. It is put forth that, if this is the case, health can be metaphorically seen as the ground itself. The practice of interprofessionalism is the idea of crossing over a professional or ideological demarcation

line, a fence/boundary. If, as a part of an effort to develop interprofessional health-professionals, reflective practice and knowledge development of health concepts and personal practices was used as a foundational education component, we would be generating health professionals with a better understanding of their own profession and their place in wider healthcare. We would also be generating health professionals with an appreciation for what the 'landscape' both underneath, and on the other side of the disciplinary boundary, looks like. Thus, the foundational work for the further development of boundary crossing is already set in place.

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# Appendices

## Appendix A – Ethical Approval Confirmation

23 May 2018

Stuart Deerness  
Faculty of Culture and Society

Dear Stuart

Re Ethics Application: **18/183 Neophyte health student's perceptions of healthy living and its application within tertiary health education**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Subcommittee (AUTEC).

Your ethics application has been approved for three years until 23 May 2021.

### Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: <http://www.aut.ac.nz/researchethics>.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)

Yours sincerely,



Kate O'Connor  
Executive Manager  
**Auckland University of Technology Ethics Committee**

Cc: Geoffrey Passfield

## Appendix B – Resources

### Participant recruitment email letter.



## You are invited to be a research participant

**Date Information Sheet Produced:** 18 April, 2018

**Project Title:** Neophyte health students' perceptions of healthy living and its application within tertiary interdisciplinary health education.

### Invitation

My name is Geoff Passfield, and I am interested in finding out about your conceptions of health and what you feel are healthy living practices. You are invited to participate in this research. Participation is voluntary and you may withdraw at any time prior to the completion of data collection.

Some of you may know me from the tutorials that I teach in HAP1. If you choose to participate (or not), at all, it will neither advantage nor disadvantage you. I do not mark the exams in HAP1 as they are all multiple choice. I do not enter the grades that you achieve in your courses. This letter was sent to you from the administrative team in the school of Interprofessional Health Studies. I (Geoff) do not know who this email has been sent to and there is no way of me identifying your answers in this survey. It is completely anonymous.

This research is in contribution to a Masters of Education I am currently undertaking at AUT. I am using an online questionnaire to gather conceptions with regard to importance around the different aspects of health, as well as, healthy living practices (things that you do to contribute to your positive health). I will also be using focus groups to explore and understand some of the reasons for your thoughts and practices.

Choosing to participate in the survey is completely voluntary and anonymous. All of the survey data is collected digitally and I will not be able to know who is participating. I will not see the data collected until after the semester is completed. Your survey responses will not be identifiable even if you register interest in a focus group.

Choosing to participate in the focus groups is also voluntary.

If you choose to participate (or not), at all, it will neither advantage nor disadvantage you.

If you consent to participate in the survey, please click on the blue link below. This will take you to the online survey.

Participation in the survey will take no more than 5-10 minutes of your time.

A separate consent form will be issued to participants of the focus groups at a later date.

You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

[Click here to participate in the survey](#)

If you would like the opportunity to participate in a future focus group, please contact Geoff Passfield ( [geoff.passfield@aut.ac.nz](mailto:geoff.passfield@aut.ac.nz) ) to register your interest

## **Online survey – information sheet and questions.**

Note: This is an exported version of the survey document from Qualtrics. There are slight differences in the layout formatting to the actual online survey.

# **Interprofessional health student's perceptions of health and healthy living practice survey**

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## **Start of Block: Survey information**

### **What is the purpose of this research?**

I am interested in identifying the common conceptions about what health is and what healthy living practices look like from students that are starting health related tertiary education. It will potentially help to improve how educators support your conceptual development of health and how it relates to interprofessional study in your continued education. To the community, with improved learning opportunities for you, it will lead you towards being better prepared for entering into the health workforce. I also hope that this research will create new data to inform my own practices in Interprofessional Health education of students like you, as well as, help me towards completing my Master of Education study.

### **How was I identified and why am I being invited to participate in this research?**

You are invited to participate in this research as you currently enrolled in the core curriculum of Interprofessional Health Studies courses. This email has been sent to you through the administration office of the School of Interprofessional Health Studies with the permission of the Head of School. You are invited to complete the online survey. At the end of the survey you may register your interest in participating in a focus group, if you wish. Your survey responses will not be identifiable even if you register interest in a focus group.

### **How do I agree to participate in this research?**

To begin the survey just click the 'continue' button.  
Participation in the survey will take no more than 5-10 minutes of your time.

You are able to withdraw from the study at any time. If you choose to withdraw from the

study, simply do not complete the form, and your data will not be saved. Once the findings have been produced, removal of your data may not be possible.

**What are the discomforts and risks?**

There are no discomforts or risks involved.

**How will my privacy be protected?**

The survey is completely anonymous.

**What are the costs of participating in this research?**

Participation in the survey will take no more than 5-10 minutes of your time.

**What opportunity do I have to consider this invitation?**

The survey link will be available for 2 weeks from (to be input based on AUTEK approval)

**Will I receive feedback on the results of this research?**

If you would like to review the results of this project, you may email the researcher, Geoff Passfield [geoff.passfield@aut.ac.nz](mailto:geoff.passfield@aut.ac.nz).

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Stuart Deerness, [stuart.deerness@aut.ac.nz](mailto:stuart.deerness@aut.ac.nz) , 09-921-9999 ext. 7316. Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) , 921 9999 ext. 6038.

**Whom do I contact for further information about this research?** Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Geoff Passfield, [geoff.passfield@aut.ac.nz](mailto:geoff.passfield@aut.ac.nz), 09-921-9999 ext. 7113  
Project Supervisor Contact Details: Stuart Deerness, [stuart.deerness@aut.ac.nz](mailto:stuart.deerness@aut.ac.nz) , 09-921-9999 ext. 7316.

**Approved by the Auckland University of Technology Ethics Committee on 23 May 2018, AUTEK Reference number 18/183.**

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Please identify your programme of study

- Bachelor of Health Science
- Bachelor of Health Science (Midwifery)
- Bachelor of Health Science (Nursing)
- Bachelor of Health Science (Occupational Therapy)
- Bachelor of Health Science in Oral Health
- Bachelor of Health Science (Physiotherapy)
- Bachelor of Medical Laboratory Science
- Bachelor of Science
- Bachelor of Sport and Recreation
- Diploma in Applied Science
- 
- Other, please specify \_\_\_\_\_

---

Please identify your ethnicity (select all that apply)

- New Zealand European (1)
- Māori (2)
- Samoan (3)
- Cook Island Māori (4)
- Tongan (5)
- Niuean (6)
- Chinese (7)
- Indian (8)
- Other, please state (9) \_\_\_\_\_

---

Please select your gender

- Male (1)
  - Female (2)
  - I'd prefer not to say (3)
-

Please identify your current age bracket

- 16-20 (1)
  - 21-25 (2)
  - 36-30 (3)
  - 31-35 (4)
  - 36-40 (5)
  - 41-45 (6)
  - 46-50 (7)
  - 50+ (8)
- 

To you, what is health?

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What words would you commonly use to describe a healthy person?

---

---

Have you studied health previously to enrolling in your current course?

- Yes (1)
  - No (2)
- 

*Display This Question:*

*If Have you studied health previously to enrolling in your current course? = Yes*

On which aspects do you remember being the focus?

---

---

Please order the following health domains for importance to your OWN lifestyle, where 1 is most important, and 5 is least important.

- \_\_\_\_\_ spiritual (1)
- \_\_\_\_\_ social (2)
- \_\_\_\_\_ physical (3)
- \_\_\_\_\_ emotional/mental (4)
- \_\_\_\_\_ intellectual (5)

---

Please indicate how strongly you agree/disagree with the following statement:  
"I live a healthy lifestyle."

- Strongly agree (1)
  - Somewhat agree (2)
  - Neither agree nor disagree (3)
  - Somewhat disagree (4)
  - Strongly disagree (5)
- 

What and/or who mostly influences your current lifestyle?

---

---

---

What lifestyle tips would you give someone who you consider less healthy?

---

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---

Please indicate how strongly you agree/disagree with the following statement:

"My health and lifestyle practices reflect my values on what ideal health and healthy living looks like."

- Strongly agree (1)
  - Somewhat agree (2)
  - Neither agree nor disagree (3)
  - Somewhat disagree (4)
  - Strongly disagree (5)
- 

What and/or who has most influenced your healthy lifestyle values?

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Please indicate how strongly you agree/disagree with the following statement:

"I think it is important that all health disciplines share a common view of what it means to be healthy."

- Strongly agree (1)
  - Somewhat agree (2)
  - Neither agree nor disagree (3)
  - Somewhat disagree (4)
  - Strongly disagree (5)
- 

For someone currently studying health at university, such as yourself, please order the following health domains in order of importance to THEIR lifestyle, where 1 is most important and 5 is least important.

- \_\_\_\_\_ spiritual (1)
- \_\_\_\_\_ social (2)
- \_\_\_\_\_ physical (3)
- \_\_\_\_\_ emotional/mental (4)
- \_\_\_\_\_ intellectual (5)

**End of Block: Survey information**

## Participant information sheet (focus group).



### What is the purpose of this research?

I am interested in identifying the common conceptions about what health is and what healthy living practices look like from students that are starting health related tertiary education. It will potentially help to improve how educators support your conceptual development of health and how it relates to interprofessional study in your continued education. To the community, with improved learning opportunities for you, it will lead you towards being better prepared for entering into the health workforce. I also hope that this research will create new data to inform my own practices in Interprofessional Health education of students like you, as well as, help me towards completing my Master of Education study.

### Who is the researcher?

My name is Geoff Passfield and I am currently a teacher on HEAL505 (HAP1) and HEAL609 (HAP2). Some of you may know who I am from the tutorials that I teach. It is important that you understand that your participation in this research will neither advantage you or disadvantage you. I do not mark your HAP1 exams as they are all multiple choice and I have no role in entering the grades that you achieve.

### How was I identified and why am I being invited to participate in this research?

You are invited to participate in this research as you currently enrolled in the core curriculum of Interprofessional Health Studies courses. This email has been sent to you through the administration office of the School of Interprofessional Health Studies with the permission of the Head of School.

### How do I agree to participate in this research?

Please view the times below and respond to this email with any times that you are available. Once I have received times from the other candidates I will contact you directly with the location and time of the focus group.

You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

A consent form will be issued to focus group participants at the focus group.

### What are the discomforts and risks?

There are no discomforts or risks involved.

### **How will my privacy be protected?**

Focus group transcripts will be kept in a secure location to ensure confidentiality. Any specific quotes from participants that are used in the final report from the focus groups will be identified as 'participant'.

### **What are the costs of participating in this research?**

If you wish to participate in a focus group, it will require no more than an hour of your time.

### **What opportunity do I have to consider this invitation?**

Once I have offered you a focus group date, you will have 7 days to confirm your attendance.

### **Will I receive feedback on the results of this research?**

If you would like to review the results of this project, you may email the researcher, Geoff Passfield [geoff.passfield@aut.ac.nz](mailto:geoff.passfield@aut.ac.nz)

### **What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Stuart Deerness, [stuart.deerness@aut.ac.nz](mailto:stuart.deerness@aut.ac.nz) , 09-921-9999 ext. 7316. Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) , 921 9999 ext. 6038.

### **Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Geoff Passfield, [geoff.passfield@aut.ac.nz](mailto:geoff.passfield@aut.ac.nz) , 09-921-9999 ext. 7113

Project Supervisor Contact Details:

Stuart Deerness, [stuart.deerness@aut.ac.nz](mailto:stuart.deerness@aut.ac.nz) , 09-921-9999 ext. 7316.

Approved by the Auckland University of Technology Ethics Committee on 23 May 2018, AUTEK Reference number 18/183.

**Focus group participant consent form.**



*Project title:* Neophyte health students’ perceptions of healthy living and its application within tertiary interdisciplinary health education.

*Project Supervisor:* **Stuart Deerness**

*Researcher:* **Geoff Passfield**

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- I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- I have had an opportunity to ask questions and to have them answered.
- I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes   
No

Participant’s  
signature:.....  
.....

Participant’s  
name:.....  
...

Participant’s Contact Details (if appropriate):  
.....  
.....  
.....  
.....

Date:

***Approved by the Auckland University of Technology Ethics Committee on May 23, 2018  
AUTEC Reference number 18/183***

*Note: The Participant should retain a copy of this form.*

## **Focus group – guidelines and conversation prompts.**

Format: Semi-Structured

- Welcome
- Ensure understanding of session process by all members.
- Consent form completion
- Introduce the session, explain how things will run:
  - o Identify two active audio recorders on the table
  - o If there is something that they would like me to turn the recorder off for, please let me know
  - o Please try to keep conversations to one person at a time
  - o Remind participants that I will ensure their anonymity during the data presentation of the study
  - o Participants are encouraged to converse, enquire, and discuss with each other
  - o This is NOT a test, there are no correct/wrong answers, just experiences and opinions
- Present first discussion prompt and allow the conversation to progress.
- Redirect conversation or introduce a new conversation prompt when discussion has diverted or stopped.

Discussion prompts

Please tell the group about your movements in the journey to the decision of entering your health program.

What has your health journey been like from childhood until now? Have there been any times that your health has been different than it is now?

What is it about your desired discipline that has more appeal to it than others? What is it about the discipline you picked that had more appeal than other health disciplines?

What is being healthy? How do you get it? How do you do it?

Have your perceptions of healthy living changed at all since you started your study within the School of Interprofessional Health Studies?

What aspects of your healthy living practice are the most relevant or important to you and your future as a health professional? Why?

What does happiness mean? What does fitness mean?

## Appendix C – Thematic Analysis Coding Samples

### Survey

Initial codes	Organising themes	Global Themes
family, parents, mother, father, children, siblings	immediate family	Close relationships
family medical history	genetic linkage factors	
extended family	extended family	
daily social peers, friends, peers, social peers	friends	
time, day-to-day life, travel time, time management	time	Objects of social interaction
pets, social commitments, work commitments, university, work, being a role model	obligations	
finances, lack of nutrition control, lack of support, money, nutrition availability, nutrition, nutrition supply (supplier inclusive), convenience, food availability	resources	
living environment, work environment, physical environment, physical location, social environment, living arrangements, gym, environment	location	
student, education, social pressures, society, societal expectation, transport, community, religion	interactions with societal constructs	
celebrities, social media, media, online media	media	

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current understanding of health	knowledge	
love of yoga	pass times/hobbies	
desire (inclusive of all), motivation, personal interests, future family planning, goals	goals	
mental health, mood, experience, experience of ill- health, pain, personal struggles, personality, physical illness, previous experience, reflection, self, physical injury	personal	personal experiences/drives
upbringing, diet, routine, routine change, poor decision-making	practices/past experience	
observations of others, flatmates, culture	secondary social circles	
health professionals, coaches	mentor experience	

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## Focus groups – Conversation regarding happiness

Initial codes	Organising themes	Global Themes
satisfied		
pride is reflecting positively on past action - done by accomplishing and extending	self-evaluation	
accomplishments influence mental outlook		
reflecting on experiences and actions	reflection	past, present, future
reflection		
opportunity		
choice	perception	
change influences progression		
mindset influences ability		
mindset is important		
mental flexibility to alter your reality	mindset	
develop a reality you want to interact with		
being present		
community can maintain happiness		
connectedness		
people are drawn to like-mindedness	human interaction	relationships
socialisation is good for mental health		