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Article

Narratives from Malaysian Healthcare Workers: A Window into their Community of Practice

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Abstract: In Malaysia's complex healthcare environment, understanding the lived experiences of healthcare workers in a collective manner is vital to addressing challenges in service delivery. To this end, this study examines narratives from healthcare workers in a public hospital in Sabah as a way-in to explore the structure and functions of their Community of Practice (CoP). Narratives, collected through two online focus group discussions with eight participants, were transcribed verbatim and analysed thematically to identify recurring patterns and meanings. The research significance lies in demonstrating how storytelling functions as both a mirror and mechanism of a CoP. It makes visible norms and emotional dynamics that underpin collaborative practice. Findings reveal four thematic areas: hierarchical boundary negotiation, mentorship and cultural induction, emotional expression and coping, and identity formation with collective memory. These themes illuminated how members navigate professional hierarchies, introduce newcomers through culturally embedded advice, share emotionally charged experiences for mutual support, and preserve institutional memory through repeated stories. The results show that in a high-pressure, hierarchical healthcare setting, narratives provide crucial emotional and professional scaffolding, strengthening team cohesion and resilience while transmitting context-specific, practice-based knowledge. The study concludes that recognising and facilitating narrative exchange within healthcare CoPs can support workplace cohesion, mitigate burnout, and indirectly improve patient care quality. For the Malaysian context, this approach offers culturally attuned insights into sustaining professional communities amid structural and emotional challenges. Future research should extend narrative-based inquiry across diverse institutions and explore longitudinal changes in narrative repertoires.

Keywords: Narratives; community of practice; healthcare workers; professional identity; storytelling

Introduction

Communities of Practice (CoPs) have gained increasing prominence in healthcare as essential mechanisms for collaboration, knowledge sharing, and professional development (Noar et al., 2023). Introduced by Wenger (1998; 2009), CoPs may be defined by mutual engagement, shared repertoire, and joint enterprise that foster informal learning through situated practice and peer interaction. In such communities, knowledge is not merely transmitted but constructed, negotiated, and transformed through everyday work and dialogue (Jørgensen et al., 2021). As healthcare systems grow more complex, especially in contexts marked by professional hierarchies and shifting institutional priorities, CoPs offer a dynamic space where members can collectively adapt, innovate, and sustain clinical and organisational knowledge (Delgado et al., 2021). Yet,

understanding how these communities function requires more than observation; it calls for a closer inquiry into the lived experiences of their members.

Narratives serve as a valuable method to examine the inner workings of CoPs. Beyond describing tasks and routines, narratives bring to light the affective, ethical, and relational dimensions of professional life. They articulate not only what is done, but why and how it is done, capturing tensions between institutional demands and personal values, or between professional norms and individual learning paths (Ungar-Sargon, 2025). Narratives can also reveal how identities are shaped in response to disruptions or even interpersonal conflict. These insights are crucial in healthcare settings, where the ability to adapt to complex and unpredictable scenarios depends not only on clinical knowledge, but also on relational competence and emotional resilience (Delgado et al., 2021).

Despite the potential of narrative-based research, this research approach remains minimally used in the Malaysian healthcare context (Chong & Janan, 2025). Much of the existing literature continues to privilege quantitative indicators or formal outcome measures that overlook situated perspectives of those working on the ground. This creates a gap where sociocultural and tacit knowledge that includes how people negotiate and work together are not examined. Addressing this gap is important, as it would reflect how complex social interaction and decision-making processes unfold at the ground level. By foregrounding narratives shared within CoPs, this study illustrates the everyday realities of healthcare and medical professionals in Malaysia, drawing attention to the affective and social dimensions of their work.

Literature Review

Communities of Practice (CoPs) are increasingly recognised as vital components of effective healthcare delivery, serving as platforms for identity formation and professional learning. In complex, multiprofessional healthcare settings, CoPs help to bridge interdisciplinary communities, though challenges remain when crossing epistemic, semantic, and pragmatic boundaries between professions and institutions (Kislov et al., 2011). Tools such as knowledge brokers, boundary objects, and digital platforms are essential in facilitating communication across these divides. Importantly, CoPs not only offer practical mechanisms for knowledge exchange but also serve as analytical frameworks for understanding how identities and roles are shaped through participation (Kislov et al., 2011; Ranmuthugala et al., 2011). Their structure and purpose may vary from improving clinical practice to enhancing communication. These structure of CoPs may become visible and be expressed through face-to-face interactions, virtual platforms, or hybrid modalities (Ranmuthugala et al., 2011; Jiménez-Zarco et al., 2015). Despite the variation, the common thread lies in the informal, peer-driven learning that allows for the transfer of both tacit and codified knowledge among members of a community (Noar et al., 2023). Even in digital spaces, CoPs have demonstrated an ability to mobilise large numbers of professionals around shared goals, disseminating evidence-based practices across geographical and institutional boundaries (Keir et al., 2021).

However, CoPs are not without limitations. Establishing a multiprofessional CoP remains a complex endeavor due to entrenched hierarchies and differing institutional agendas (Kislov et al., 2011). Even within existing CoPs, sustaining engagement is often threatened by time constraints, limited digital infrastructure, and a lack of organisational support (Noar et al., 2023). The fluidity of CoPs also complicates efforts to evaluate their impact using conventional methodologies (Ranmuthugala et al., 2011). Nevertheless, where CoPs thrive, they do more than improve clinical outcomes; they also foster a sense of belonging and mutual respect. Through shared experiences and collaborative problem-solving, healthcare workers negotiate their professional identities and build collective memory, which, over time, strengthens both team dynamics and institutional culture (Jiménez-Zarco et al., 2015). This resonates with the Malaysian healthcare contexts, where hierarchical cultures and institutional pressures are well-documented (Dousin et al., 2022). In light of this, CoPs may be a potentially useful counter mechanism to help healthcare providers create and maintain a sense of belonging with their feelow colleagues.

The formation and maintenance of CoP is also supported through the provision of constructive feedback and collaborative engagement, and not just the transmission of information (Portoghese et al., 2014). This renders a CoP as a space for meaning-making, for which narratives can act as a powerful medium. These

stories not only cultivate a sense of community and continuity but also serve as pedagogical tools that guide behaviour and sharpen professional identity. Through these processes, the CoP becomes not just a site of learning, but a space for becoming where shared narratives ground the culture of care and define what it means to belong in healthcare (Seibert, 2015).

The Malaysian healthcare system provides a vital lens through which we can examine the lived experiences of medical professionals and the broader institutional challenges they face. As frontline workers, healthcare providers in Malaysia have not only shouldered the physical burdens of patient care but also carried substantial emotional and psychological weight, particularly intensified during the COVID-19 pandemic (Che Yusof et al., 2022; Che Sat et al., 2025). Studies have shown that depression and suicidal ideation among healthcare professionals were significantly higher than national averages during this period, with depression emerging as the strongest predictor of suicidal ideation even among those with mild symptoms (Sahimi et al., 2021). Younger healthcare workers and those with fewer years of service were particularly vulnerable, pointing to the importance of institutional support and early intervention strategies. This reinforces the view that mental health challenges are not isolated individual issues but are symptomatic of larger systemic weaknesses. The need for timely, stigma-free access to mental health care has become an urgent call for action (Sahimi et al., 2021; Zakaria et al., 2022). From the perspective of a CoP, these highlight how peers can provide crucial and timely emotional support, and ultimately buffer against the isolating and debilitating effects of stress.

Beyond psychological strain, burnout remains a pervasive and multifaceted issue among Malaysian healthcare workers. Research from various public hospitals has demonstrated alarmingly high rates of work-related and patient-related burnout, particularly among nurses and pharmacists (Rezuan et al., 2025). These experiences are shaped by long working hours, poor leadership communication, inadequate support systems, and understaffing, all of which are compounded by hierarchical institutional cultures and bureaucratic practices (Soomro & Ramendran, 2024). While coping mechanisms such as religion and emotional reframing are common, their effectiveness remains questionable given the persistent levels of burnout (Rezuan et al., 2025). Notably, burnout not only undermines individual well-being but also impacts productivity, care quality, and institutional stability. For instance, studies in Kuala Lumpur hospitals have shown that nurses' subjective well-being mediates the relationship between job demands and work performance, suggesting that burnout cannot be understood without considering its material impact on the healthcare system (Bai & Mohammed, 2024). Furthermore, Malaysia's pandemic response disparities in resource distribution and infrastructure, particularly across states with differing population densities (Hamzah et al., 2021). These point towards the practical framework through which members of a community may voice concerns and develop coping strategies. This would bridge the gap between individual distress and institutional imbalances.

All these reflect the critical view that personal experiences and narratives of healthcare providers are not ancillary but central to understanding the functioning and sustainability of healthcare provision in Malaysia. By situating these experiences within the framework of CoPs, this study demonstrates how professional identity and institutional realities are continuously shaped through storytelling and collective meaning-making. Their voices are essential for informing reforms, guiding policy, and designing responsive interventions tailored to the realities on the ground.

Methodology

This study involved eight healthcare workers employed in a public hospital in Sabah, Malaysia (Table 1). All participants were practicing at the same hospital, which allowed for shared experiences and overlapping spheres of interaction within their CoP. Participation was voluntary, and all individuals were assured anonymity to encourage candid sharing of experiences. Both researchers were involved in conducting the sessions, adopting a facilitative rather than interrogative stance to foster openness and rapport (Geampana & Perrotta, 2025).

The sample size of eight participants was purposively selected to capture a range of professional roles while allowing for depth of narrative engagement. In narrative inquiry, smaller samples are often appropriate because the goal is not statistical generalisation but the elicitation of rich, detailed stories (Gordon et al., 2015).

Data collection and analysis proceeded until no substantially new insights were emerging, suggesting a degree of thematic sufficiency had been reached.

Since the primary aim was to explore naturally occurring narratives relating to the CoP, no predetermined interview questions were used. Instead, participants were invited to recount any workplace stories, reflections, or incidents they considered significant to their professional experience (Kennie-Kaulbach et al., 2024). This open approach aligns with narrative inquiry traditions, where the use of prompts rather than structured questions encourages participants to shape the direction of their stories, thereby preserving authenticity and context (Gordon et al., 2015; Riessman, 2015). They were free to narrate in the language(s) they felt most comfortable using, including English and Malay to preserve authenticity of expression and cultural distinctions.

Table 1. Participants (pseudonyms) and their occupation

Participant (Pseudonym)	Occupation
1. Participant 1	Medical laboratory technologist
2. Participant 2	Medical laboratory technologist
3. Participant 3	Obstetrician–gynecologists
4. Participant 4	Ophthalmologist
5. Participant 5	Obstetrician–gynecologists
6. Participant 6	Medical laboratory technologist
7. Participant 7	Ophthalmologist
8. Participant 8	Ophthalmologist

A qualitative, narrative-oriented approach was adopted to collect and interpret the data. Before data collection, the research plan including the data collection protocol was scrutinised by a research and ethics committee. The research work started only after permission was granted (GSM2417). The data for this study comprised two focus group discussions (FGDs), each lasting approximately one hour. Both FGDs were conducted online to ensure accessibility and minimise scheduling constraints for the healthcare professionals. The virtual format also provided a more relaxed setting in which participants could share experiences without the logistical pressures of face-to-face sessions (Janjang et al., 2023). The discussions were audio-recorded in full with the participants' consent. Recordings were subsequently transcribed verbatim, retaining not only the content of speech but also linguistic markers such as code-switching, discourse particles, and colloquialisms. This approach aligned with Henderson's (2017) emphasis on capturing "actual meaning" by preserving the pragmatic and interactional features of spoken language. The final corpus of transcripts amounted to approximately 9,300 words.

Data analysis proceeded in several iterative stages, guided by thematic analysis (Roberts et al., 2021). First, the transcripts were read multiple times to achieve immersion and familiarity with the content. The analysis was primarily content-driven, with a focus on identifying themes and patterns in the narratives that reflected the social dynamics, interpersonal relationships, and shared practices within the CoP. Narrative excerpts were examined in relation to their context of telling, with particular attention to how they constructed, reinforced, or challenged shared understandings within the professional group. Emergent categories were grouped under broader thematic headings, enabling the researchers to interpret not only what was being narrated but also the functions these narratives served within the CoP. The thematic mapping allowed for a contextualised understanding of the perspectives and practices common to the hospital-based healthcare community, and highlighted the ways in which storytelling contributed to identity formation, coping strategies, and collective knowledge within the group. Furthermore, throughout this analytical process, researcher reflexivity was maintained: both researchers are seasoned social science researchers and they acknowledge how their professional backgrounds and interpretive lenses may shape the reading of participants' narratives. Regular memo-writing and peer debriefing were employed to critically reflect on positionality and minimise undue bias (McGrath, 2021).

The Findings

In this section, the themes from the analysis, along with excerpts from the participants' narratives are provided. Excerpts are provided verbatim, with Malay responses being translated into English [in brackets]. The themes and brief explanation are presented in Table 2.

Table 2. Themes and their explanation

Theme	Short Explanation
Hierarchical Boundary Negotiation	Narratives show how healthcare workers perceive and navigate professional hierarchies. This reflects both conflict and solidarity as members make sense of authority and power dynamics in daily interactions.
Mentorship and Cultural Induction	Storytelling acts as informal mentorship where unwritten rules or workplace norms are shared. This practice helps familiarise new members into the CoP.
Emotional Expression and Coping	Sharing emotionally charged stories provides a space for collective coping and reinforces values such as empathy and resilience.
Identity Formation, Reflexivity, and Collective Memory	Stories contribute to professional identity formation by reflecting on growth and lessons learned. They also serve as collective memory, advocating for patients, and reinforcing shared cultural and professional values within the CoP.

1. Hierarchical Boundary Negotiation

In a healthcare CoP, power relations are often embedded in the day-to-day interactions between different professional roles. Narratives that surface in these contexts not only recount specific incidents but also reveal how members perceive, navigate, and sometimes contest professional hierarchies (Gonçalves et al., 2022). The telling of such stories within the CoP serves to articulate shared understandings of status and boundaries that shape workplace dynamics. These narratives allow members to reaffirm collective experiences of tension or conflict, and to make sense of the rules, both formal and informal, that govern their professional interactions.

> "*HO atau MO yg tidak puas hati dengan kami yang tidak layan urgent test... Dia tidak puas hati dengan jawapan saya tu, pukul 3 pagi pun mau bawa gaduh*." (Participant 1)
> [HO or MO who was not satisfied with us for not entertaining the urgent test... He wasn't happy with my answer, and even at 3 a.m. he still wanted to start an argument.]

This account highlights a clash between the clinical urgency perceived by doctors (House Officers and Medical Officers) and the procedural adherence required of medical laboratory technicians (MLTs). In CoP terms, this is an example of boundary negotiation where professional identities and responsibilities intersect, sometimes contentiously. The narrative frames the medical officer's persistence even at 3 a.m. as a display of authority and entitlement, which disrupts the cooperation needed for effective collaboration. In retelling this story to peers, the speaker not only shares a personal frustration but also reinforces a shared recognition among MLTs about the challenges of working within a hierarchy where medical dominance can override procedural norms.

> "*Kami teda sempadan antara Dr dan MLT. Kalau dia datang, boleh masuk ja gi lab, dia mau serang kau pun bole*." (Participant 2)
> [We don't have boundaries between doctors and MLTs. If they come, they can just go into the lab, and if they want to confront you, they can.]

This narrative moves beyond a single conflict and reflects a systemic absence of clear professional boundaries. In the CoP framework, such a lack of demarcation can blur role distinctions, creating situations where one group (doctors) can unilaterally intrude into the working space of another (MLTs). The imagery of "just walking into the lab" and the possibility of confrontation paints a picture of unregulated access that instigates professional dominance. By sharing this account, the narrator signals the emotional impact of these encounters and implicitly calls for solidarity among peers who have had similar experiences. In doing so, the story becomes a communal reference point within the CoP, reinforcing the collective awareness of power imbalances and the need for mutual respect across professional roles.

2. Mentorship and Cultural Induction

Within a CoP, socialisation into the group is not always conducted through formal orientation or procedural manuals. Instead, it often happens through storytelling, where experienced members share narratives that communicate the unwritten rules, cultural norms, and personalities that shape everyday work life (Delgado et al., 2021). These stories serve both as practical guidance and as a means of embedding new members into the social fabric of the workplace. In healthcare contexts, where high-stakes interactions and strong personalities are common, such narratives act as a form of mentorship where local knowledge is passed on to help newcomers navigate challenges effectively.

> "*Benda first orang bagitau sy, bukan pasal ward. Satu saja kau kena tahan, pakar kita sangat strict*." (Participant 3)
> [The first thing people told me wasn't about the ward. There's only one thing you need to endure, our specialist is very strict.]

This excerpt functions as an informal initiation message for new staff. Instead of focusing on the practicalities of the ward or job scope, the very first piece of advice centres on interpersonal dynamics, which was especially visible through the strictness of a key figure in the workplace. In CoP terms, this is the transmission of situated knowledge essential for group integration (Weinberg et al., 2021). It highlights how personality can shape the working environment as much as organisational structure does. By sharing this early in a newcomer's journey, experienced members prepare them psychologically for what lies ahead, signalling both the expectations and the emotional tone of the workplace culture.

> "*First orang kasitau saya, satu saja ko kena tahan, pakar kita sangat strict...Newcomers tu jarang sudah kami kasitau awal sebab nanti dorang lari*." (Participant 3)
> [The first thing people told me was, there's only one thing you need to endure—our specialist is very strict... As for newcomers, we rarely tell them in advance anymore because they might run away.]

This follow-up narrative illustrates a shift from open disclosure to strategic omission. While the earlier approach involved forewarning newcomers, over time the group learned to withhold certain information to prevent discouragement or attrition. In CoP theory, this represents a form of protective storytelling, where members manage the pace and nature of cultural induction to maintain the stability of the community. It reflects a balance between honesty and care: the recognition that some realities of the workplace are best learned gradually. At the same time, it normalises challenging conditions as part of the shared professional experience, reinforcing resilience as a valued trait in the community. These narratives reveal how mentorship in this healthcare CoP operates less through formal training and more through culturally embedded communication. Stories about key figures, told in informal settings, act as social tools for preparing newcomers, managing expectations, and strengthening group cohesion. By passing down these narratives, experienced members help preserve the shared identity of the community while also adapting their induction strategies to retain new talent.

3. Emotional Expression and Coping

In a healthcare CoP, the sharing of emotionally charged experiences is an important mechanism for mutual support and identity reinforcement (Findyartini et al., 2022). These narratives allow members to process the emotional labour inherent in their work while also affirming shared values such as empathy, resilience, and solidarity. In this context, emotional expression is not merely personal as it functions as a form of collective coping, where stories serve as both emotional release and a bonding practice that strengthens the group's cohesion.

> "*Saya beli dia helium balloon, spend birthday at the hospital, sadly she passed away*." (Participant 3)
> [I bought her a helium balloon, spent her birthday at the hospital, and sadly, she passed away]

The narrative by Participant 3 above captures the emotional labour involved in caring for terminal patients. By recalling the personal gesture of buying a helium balloon for a patient's birthday, Participant 3 demonstrates how care in this CoP often extends beyond clinical duties to acts of compassion that recognise the patient's humanity. Such gestures are part of the tacit knowledge shared within the community where emotional connection can be as critical as medical intervention in end-of-life care. The sharing of this story reinforces a collective understanding that compassionate acts are integral to professional identity.

> "*Anak dia yang 9 tahun tu was crying and hugging me. Doctor ko tidak dapat selamatkan mamak saya*." (Participant 3)
> [Their 9-year-old child was crying and hugging me. Doctor, you couldn't save my mother.]

Here, the narrative conveys both the grief of a bereaved family and the sense of helplessness felt by the healthcare provider. In the CoP, recounting such moments helps to normalise the emotional impact of patient loss, allowing peers to empathise and validate each other's experiences. The direct quotation from the child retains the emotional rawness of the encounter, making the story a powerful tool for fostering empathy and resilience within the group. These shared reflections help members recognise that feelings of inadequacy and sorrow are common and collectively navigated.

> "*Selalunya cerita-cerita hantu gini dicerita di meja makan. Pernah Dr X, dia pernah panggil satu Father untuk tengok, mau tanya mana yang ada vibe-vibe begitu, paling banyak di bilik store. Ada patient kami kerasukan gara-gara tu benda suka dia. Dia punya cerita tu dia dulu di hospital, bila bilik xray kena renovate, si Ros ni kira lemah semangat jadi si Ling-ling ni suka berkawan dengan dia. Dioarang pigi bawa berubat la dengan ustaz. Ada patient kami juga pigi teman dia*." (Participant 6)
> [Usually, ghost stories like this are told at the dining table. Once, Dr X called a Father to check and ask which place had those kinds of vibes—the store room had the most. One of our patients became possessed because that 'thing' liked her. The story goes back to when she was at the hospital; when the X-ray room was being renovated, Ros was rather faint-hearted, so this Ling-ling liked to befriend her. They went to get treatment from an ustaz. One of our patients even went along to accompany her....]

This ghost story, while humorous and eerie, reflects a cultural dimension of emotional coping in the CoP. By sharing such supernatural tales during informal settings like mealtimes, members collectively release tension from the high-stress environment of healthcare work. These narratives create moments of levity, offering psychological relief and reinforcing camaraderie. They also reflect the blending of medical culture with local belief systems, demonstrating how the CoP accommodates both professional knowledge and cultural traditions in sustaining workplace morale.

> "*Mula-mula dia datang tu dia agak denial la...Patient sangat motivated...kalau takde support dari family tak kan membantu juga*." (Participant 7)
> [At first when she came, she was rather in denial... The patient was very motivated... but without support from the family, it also wouldn't help.]

Participant 7's account draws attention to the role of relational support in patient recovery, connecting emotional resilience to the broader social network. Within the CoP, sharing such stories conveys the belief that patient outcomes are not determined solely by medical treatment, but by the combined support of healthcare professionals, family, and community. The narrative acts as a reminder to peers of the importance of engaging with patients' social circumstances, thereby embedding holistic care as a shared value in the group's practice. The emotional narratives in this section demonstrate how the CoP serves as both a repository and a processing space for the affective aspects of healthcare work. Through storytelling, members make sense of emotionally taxing experiences, affirm cultural and professional values, and maintain the psychological well-being of the group.

4. Identity Formation, Reflexivity, and Collective Memory

Within a healthcare CoP, identity formation is an ongoing process shaped by exposure to clinical realities, interactions with colleagues, and the accumulation of shared experiences over time. Reflexivity is a key mechanism through which members negotiate their place in the community. Alongside this, collective memory, expressed through the telling of workplace stories, plays a crucial role in transmitting shared values, lessons, and critiques of the system. Together, these elements form a cohesive framework for understanding how healthcare workers develop both professional competence and a sense of belonging.

> "*Dulu saya tengok orang sakit pun saya tidak rasa sedih. Saya masih kuat*." (Participant 3)
> [In the past, even when I saw people who were sick, I didn't feel sad. I was still strong.]

Participant 3's reflection marks a transition in emotional resilience, which might be described as the "hardening" that comes with repeated exposure to suffering. Within the CoP, such narratives are often shared to illustrate personal growth, signalling the evolution from a newcomer's initial emotional detachment to a seasoned practitioner's understanding of patient care. The story also normalises the emotional transformations that occur in the profession, helping peers make sense of their own changes over time.

> "*When we knew nothing, all we could do is to save whatever that we could*." (Participant 5)

Participant 5's statement reflects improvisation under pressure and the uncertainty faced during unfamiliar or high-stakes scenarios. In the CoP, stories like this function as collective learning moments, reinforcing humility and adaptability as core professional values. By sharing such experiences, members acknowledge their limitations, while also affirming the resourcefulness that emerges in challenging conditions.

> "*Lebih banyak workforce, lebih banyak problem pula*." (Participant 5)
> [The more workforce there is, the more problems there are.]

Here, Participant 5 moves from personal reflection to cultural commentary, critiquing systemic inefficiencies. Within the CoP, such candid observations form part of the group's collective memory, capturing the everyday realities of organisational life. These stories also serve as subtle critiques of management decisions, enabling members to voice concerns indirectly while reinforcing shared perspectives on workplace challenges.

> "*The mother went to work, leave the kid with the grandmother... the mother say I also don't know the grandmother take care*." (Participant 4)

Participant 4's account shifts attention to child welfare and caregiver accountability. In the CoP, narratives like this broaden the scope of professional identity to include advocacy for vulnerable populations. They highlight the social dimensions of healthcare work, underscoring that medical care is embedded within wider family and community contexts.

> "*Kid come to the clinic very shy... only he realised that the child couldn't see, that it's affecting the social life, personality*." (Participant 8)

Participant 8's story illustrates how an initial misreading of behaviour can lead to an important medical discovery, in this case a visual impairment. The narrative highlights the importance of attentive, holistic assessment which may be reinforced within the CoP through repeated storytelling. By sharing such examples, members preserve practical lessons and reinforce advocacy as a critical aspect of their role. These narratives demonstrate how identity formation in the healthcare CoP is intertwined with reflexive practice and the preservation of collective memory. Stories serve not only as personal reflections but as shared resources for making sense of professional life. They allow members to process change, critique systemic issues, advocate for patients, and retain important lessons for future practice. Through this ongoing exchange, the CoP strengthens its shared identity while equipping its members to navigate both the emotional and systemic dimensions of their work.

Discussion

This study sets out to explore how narratives illuminate the CoP of healthcare providers at a hospital in Sabah, Malaysia. Drawing on the principles of CoP, which include mutual engagement, joint enterprise, and shared repertoire, the findings show that the narratives of the participants offer a diverse account of the community's inner workings. Narratives not only reflect the culture of the CoP but also actively shape and sustain it. One of the clearest contributions of this study is the demonstration that narratives provide an avenue through which to identify a CoP. Unlike formal organisational charts or procedural manuals, stories reveal the lived reality of work, exposing the norms, values, and interpersonal dynamics that underpin community membership. The accounts of hierarchical negotiations, mentorship encounters, and emotionally charged experiences show that the bond between members is not simply a shared workplace but their mutual engagement with its social and professional challenges (Kislov et al., 2011; Ranmuthugala et al., 2011). Furthermore, through these narratives, the CoP becomes visible as a network of relationships structured around both collaboration and tension. For example, accounts of boundary crossing between doctors and MLTs depict recurring interactions that both define and test the group's shared norms. These narratives highlight not only what members do but also what they collectively notice, remember, and choose to retell. In this way, the CoP is defined not just by its practices but by its discourse, which comprises stories that encode community knowledge (Jiménez-Zarco et al., 2015). Narratives also allow researchers to distinguish between a mere work group and a CoP. While any group may share a workspace, only a CoP develops a shared repertoire of narratives that members draw upon to interpret new situations. The recurrence of certain themes such as managing the personalities of key senior staff, or coping with emotionally intense patient encounters indicates the presence of established communal concerns and interpretive frameworks, all of which are indicative of an active CoP (Noar et al., 2023).

In the Malaysian healthcare setting, where formal hierarchical structures are embedded and where workloads can be overwhelming, the sustaining role of narratives within CoPs becomes especially important. The findings align with previous research showing that healthcare workers face high levels of burnout and emotional strain (Sahimi et al., 2021; Rezuan et al., 2025). In this context, the CoP's storytelling practices are more than social niceties. By providing a space where members can articulate frustrations, celebrate small victories, and reframe challenges, narratives help maintain morale and prevent professional isolation (Soomro & Ramendran, 2024). The communal sharing of stories reinforces the idea that no one is facing these challenges alone; instead, they are part of a collective with shared experiences, knowledge, and coping mechanisms (Bai & Mohammed, 2024). This study reaffirms the idea that narratives are not peripheral to the functioning of a CoP but central to its identity, regulation, and sustainability. They offer a means of identifying the community, transmitting its values, and regulating its norms. In doing so, they maintain the CoP's coherence and relevance in a demanding healthcare environment (Kislov et al., 2011; Ranmuthugala et al., 2011). For members, especially those who are new, these narratives are an indispensable resource, providing

insider knowledge that smooths the transition into professional life and fosters early integration into the community (Portoghese et al., 2014). For the community as a whole, storytelling strengthens bonds, preserves institutional memory, and supports collective resilience. In the Malaysian healthcare context, where the stakes of effective teamwork and mutual support are particularly high, recognising and nurturing these narrative practices can enhance both staff well-being and the quality of patient care (Sahimi et al., 2021; Rezuan et al., 2025).

When compared against other related international studies, there are several similarities and differences worth noting. For instance, in the Ugandan context, community health workers engaged with their peers through CoPs via structured feedback reports and constant communication through online platforms, which led to improvement meetings. These practices sought to emphasise accountability and problem-solving (Hennein et al., 2022). In Australia, on the other hand, special groups such as the ICUConnect VCoP were formed to connect critical care nurses to engage in benchmarking practices and to promote an open dialogue space that supported communication across hierarchies (Rolls et al., 2020). When considered against these international cases, the Malaysian socio-cultural context reveals unique features. Hierarchy is particularly pronounced in Malaysian healthcare, where seniority and rank strongly influence communication. Unlike the ICUConnect VCoP, where cordial disagreement was welcomed as part of professional discourse (Rolls et al., 2020), Malaysian narratives often reveal deference to authority and cautious negotiation of boundaries. Similarly, collectivism plays a dual role: it strengthens solidarity and shared coping mechanisms, much like the community health workers' meetings in Uganda that built trust and collective responsibility (Hennein et al., 2022), but it may also limit open critique when group harmony is prioritised over dissent. These dynamics suggest that while Malaysian CoPs share global features of mutual engagement and shared repertoire, their formation and sustainability are uniquely conditioned by cultural norms of hierarchy and collectivism.

Conclusion

This study aimed to examine how narratives shared by healthcare workers in a public hospital in Sabah, Malaysia, illuminate the structure, functioning, and significance of their CoP. Through the analysis of focus group discussions, narratives were found to serve multiple purposes: identifying and reinforcing professional boundaries, inducting newcomers into workplace culture, fostering emotional resilience, and preserving collective memory. These functions highlight the role of narrative as a vital tool for making sense of complex social and professional realities within the healthcare setting. From the findings, there are at least two implications worth considering. First, recognising narrative exchange as an integral part of professional life can enhance workplace cohesion, especially in multidisciplinary teams where differing roles and hierarchies may otherwise impede collaboration. Second, encouraging spaces where narratives can be shared may strengthen mutual understanding, emotional support, and organisational culture. Third, for newcomers, exposure to the community's repertoire of stories provides invaluable tacit knowledge that accelerates adaptation and fosters early inclusion in the team. This study also demonstrates the importance for healthcare institutions to acknowledge and facilitate the narrative practices embedded within their CoPs. Such practices not only support the well-being of staff but can indirectly improve patient care by promoting teamwork and ensuring the transmission of context-specific knowledge. In a sector where burnout and attrition are persistent challenges, nurturing the social and affective dimensions of professional practice is not optional.

Several limitations should be noted. The study focused on a small group of eight healthcare workers from a single public hospital in Sabah, which limits the generalisability of the findings. The reliance on voluntary participation may also have resulted in the underrepresentation of certain perspectives, particularly from individuals less inclined to share personal experiences. Additionally, the focus group format, while conducive to rich narrative exchange, may have influenced the types of stories shared, with some participants possibly self-censoring in a group setting. Future research could address these limitations by incorporating larger and more diverse participant samples across multiple institutions and regions. This is to enable comparative analysis between different healthcare contexts in Malaysia as well as abroad. Longitudinal studies could explore how narrative repertoires within CoPs evolve over time, particularly in response to organisational changes or crises such as pandemics. Furthermore, multimodal approaches could offer distinct

insights into how storytelling interacts with other forms of professional learning and knowledge transfer. These would provide alternative perspectives and a deepened understanding of how CoPs change and affect socioalisation within an organisation.

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