Emergent interprofessionalism: An exploratory study of health graduates' transition into contemporary professional practice

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Abstract

The thesis examines graduates' experiences of practice roles in their respective field of health care and in collaboration with other professions. An interpretivist orientation underpins the research, using hermeneutic phenomenological methodology to study the temporal process of health science graduates' first year of professional practice in contemporary health care contexts. Specifically, it focuses on 18 graduates from six health professions, who develop their practice in working contexts that intersect professional boundaries.

In complex health environments, where health challenges go beyond the knowledge and skills of any single profession, there is growing concern that health care practitioners lack capability to collaborate with each other. Traditionally health professions maintain distinctive practices and members are expected to adhere to the norms and codes of conduct overseen by accreditation and regulatory authorities specific to the profession. In working contexts of uncertain and changing health complexities, health professionals are increasingly required to work collaboratively to provide effective, efficient health care delivery. Graduates now entering the health care workforce can expect to undertake professional and interprofessional practices, requiring them to intersect knowledge and practice boundaries that have been built over years of socialization in their respective professions.

Findings of this exploratory study provide unique insight into graduates' early professional practice at and beyond the interface of professional boundaries. Graduates' professional identity is strengthened through communicating a distinct professional perspective to other professions, while professional knowledge and practice boundaries become increasingly permeable through collaborative practice. Over time, graduates expand their professional perspectives and extend their practice roles when working collaboratively. Thus, graduates are shown to develop dual practices: at times working

in their respective professions, concurrent with establishing flexible working relationships with members of other professions.

These findings support continuing socialisation into distinct professions during initial professional education programmes, in order to develop graduate capability for becoming a functioning member of a profession. Concurrent with early socialisation into professions, there is an additional requirement for continuing development of interprofessional education that prepares graduate capability for working in dual practice. Specifically, the timing and placement of interprofessional education (IPE) initiatives should be considered, to ensure the relevance of IPE to the developmental stages of student learning. Equally, professional development during the graduate year should focus on graduates establishing dual practice capability, through ongoing opportunities to develop flexible working relationships among professions.

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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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Chapter One

Introduction

Graduates transitioning from health science education into work as health professionals may be ill-prepared for practice contexts that intersect professional boundaries (Frenk et al., 2010; Green, 2009; Lee & Dunston, 2011). Currently, undergraduate education is predominantly siloed in particular disciplines and the process of socialisation for professional practice is primarily in isolation from other professions (Adams, Hean, Sturgis, & Clark, 2006; Hall, 2005; Hammick, Freeth, Copperman, & Goodsman, 2009; Petrie, 1976; Zwarenstein & Reeves, 2006). This educational approach is uncertain in preparing graduates for the collaborative working environment that most will enter as professionals (Green, 2009; Kemmis, 2009; Lee & Dunston, 2011). These authors attest to the disparity between professional education programmes (in distinct knowledge fields, or disciplines) and practice contexts that require professions working together to construct knowledge and utilise new and innovative modes of communication and practice roles to address complex health concerns. If a new ideology of professional practice is gaining momentum, as suggested by these authors, it leads to questioning whether this equates to a philosophical shift regarding traditional notions of professionalism.

Professionalism, traditionally premised on qualities of expertise (specialist knowledge and skill), altruism (serving the public good), and autonomy (jurisdiction over discretionary judgment) may remain central to professional work (Crowley, 2014; Freidson, 2001). In changing healthcare contexts, however, with increasing need for professions to work interdependently, the historic boundaries delineating one profession from another are becoming tenuous (Bluteau & Jackson, 2009; Brown et al., 2011; Sargeant, Loney, & Murphy, 2008). Additionally, if professional identity in a particular field of health care practice is at risk of being subsumed into a generic interprofessional

identity, the implications for graduates currently entering the health care workforce are profound.

Research into the first year of professional practice reports that graduates focus is on establishing their identity in their chosen profession, so changes in practice contexts that impact on cementing practice roles in distinct professions may be problematic (Black et al., 2010; Camilleri, 2008; Cowan & Hengstherger-Sims, 2006; Toal-Sullivan, 2006). In this situation the implications for undergraduate curriculum and teaching-learning engagement are also brought into question, particularly given the current territoriality around professions, which remains evident in academic and practice contexts.

With an aim to develop new understanding of the relationship between areas of professionalism, identity and collaborative practice, this thesis examines professional practice in an evolving health workforce, through the experience of graduates in their early work as registered health-care practitioners. Graduates' experiences of concurrently developing their professional and collaborative health care practice—as a temporal process—has not been studied. The aim of this thesis is to explore how graduates' professional identity evolves, and in what ways, at the interface of professional and interprofessional practice. The thesis is located in the work practices of health science graduates who are navigating their first year as health care practitioners, after completion of predominately unidisciplinary education in particular health professions. The question that formed the basis of the research project was:

How do graduate health practitioners understand professional work in an interprofessional context?

This thesis centres on health science graduates' transitions from student to professional practitioner amid a socio-cultural tradition of professional protectionism and professionalism that is premised on specialist knowledge, skills and practices residing in

distinct professions (Frenk et al., 2010; Freidson, 2001). Specifically, the thesis focuses on graduates' understanding of professional roles in practice contexts that require interprofessional working relationships. Underpinning the thesis is an interpretive research approach that draws on the multiple perspectives of graduates experiencing their first year of practice as situated both in specific professions and in collaboration among health care professions.

Chapter One provides the background for viewing contemporary health care practices, as situated within shifting global demographic and epidemiological challenges in the provision of health care services. Practice and education implications for health professions are then discussed, in response to current and projected challenges confronting health care workforces worldwide. Specifically, an overview of the New Zealand health care system structure suggests changes in the way health professions engage with each other, in the provision of effective, efficient health care services. The current research, located in New Zealand, originated in response to the challenges of preparing students, through professional education programmes, for the work environments they enter as graduates.

Chapter Two presents a theoretical context for the research question, through synthesis of current literature and research in the key areas of professionalism, collaboration, and professional identity. To provide a social context in which professions are situated, an examination of two sociological perspectives that are associated with professions and professionalism are presented. In the context of this thesis, the focus of this literature review is on health-care professions; how professions in the field of health have maintained their structure over time and the influence of interprofessional collaboration on those who identify as health professionals. Specifically, the focus is on the intersection of professional identity and collaborative

practice among graduates in their first year of work, following extended education in a designated field of health care.

Chapter Three details the methodology that supports the research approach taken in this exploratory study. The philosophical and theoretical underpinnings are discussed, through which the hermeneutic phenomenological methodology and methods are developed. Included are the profiles of the 18 graduates who participated in the study, which was conducted over a year and focused on their experiences of intersecting professional work in their chosen field with collaboration among professions.

Chapter Four presents the findings of this study, through the interpretation of the participants' experiences and perspectives of their graduate year in professional practice. This chapter presents a conceptual model of the temporal process of graduates' understanding of professional work in an interprofessional context (Figure 1, p. 1266). The conceptual model is fully explained through rich descriptive prose, exemplified with graduates' "voices" to show the meaning they attributed to the phenomena of interest: graduates' professional work in interprofessional contexts.

Chapter Five discusses the study findings, in relation to previous research and literature in the key areas of interest: professional and collaborative practice, identity and notions of professionalism. In this chapter the conceptual model is again presented with three convergent themes inserted to depict the interlinking aspects of identity, collaboration and notions of professionalism in graduate practice (Figure 2, p. 168). This chapter draws together the thematic threads, with the findings from this explorative study providing a unique perspective on graduates' early professional practice intersecting the knowledge and practice boundaries of other professions.

Chapter Six commences with the presentation and outline of a concentric model that illustrates the interrelated features of graduates' professional dimensions and the temporal process of developing professional practice (Figure 3, p. 211). Educational and

practice implications related to graduates' preparation for collaborative practice and ongoing professional development are discussed in relation to the model. Specifically, the positioning and timing of interprofessional education initiatives into current professional education programmes are addressed, through proposal of experiential learning strategies and "real-time" collaborative engagement that positions learning activity in and through practice (Thistlethwaite et al., 2014). Suggestions for further research are presented, specifically related to findings from this study. This includes ongoing research into the evolving relationship between professional affiliation, identity and collaborative practice beyond the graduate year. Following on from the education and practice implications, possible study limitations are recorded. The chapter concludes with comments that draw the thesis to a close, through positioning the study findings into the social context of graduates' developing professional practice in contemporary health care contexts.

1.1   Background

Health science students engage in prolonged tertiary education, which includes academic and clinical application of disciplinary knowledge and skills commensurate with a health professional role in a specified field (Hall, 2005). Socialisation into a health profession is pervasive, ensuring graduates develop affiliation and identity in their respective professions (Camilleri, 2008; Shulman, 2005). Specifically, graduates from professional education programmes anticipate their future work as situated in a distinct profession (Hall, 2005). This thesis will argue that graduates face challenges in transitioning from their professional education programmes to professional practice, primarily because they may be ill prepared for working in collaborative practice among professions (Green, 2009; Lee & Dunston, 2011).

1.1.1 Contemporary health care contexts

Worldwide, current health practices are questioned in meeting challenges, complexities, inequities and costs of health systems (Frenk et al., 2010; World Health Organization [WHO], 2006). Inequities in health care provision are glaringly obvious in and between countries, with a significant imbalance in the health workforce composition between underdeveloped and developed countries (Frenk et al., 2010). Simultaneously, new and existing epidemiological risks threaten the health status of peoples across countries (Frenk et al., 2010). Climate change and escalating environmental disasters with subsequent human morbidity and human conflict—resulting in human suffering— further impact on the demands of already stretched health systems (Frenk et al., 2010; WHO, 2013). In response to both real and anticipated challenges facing health workforces worldwide, the World Health Organization (2009) advocated change to existing health care workforces. One of the changes advocated is an interdependent professional workforce, with health workers able to respond flexibly to both known and uncertain challenges.

In New Zealand, the public health system is confronted by increasing numbers of people with chronic diseases and lifestyle disorders who require on-going health-care service (Ministry of Health, 2013a). At the same time, demographic changes in New Zealand indicate population health challenges in the near future (Ministry of Health, 2013a). Low fertility and mortality rates among New Zealanders over the past decade have resulted in an increased median age of the population. Due to increased longevity, the number of New Zealanders over the age of sixty-five continues to grow. This demographic trend alone is expected to present health service challenges in the future, including support and management of physical and mental aging processes (Health Workforce New Zealand, 2013). Furthermore, the escalating cost associated with maintaining a publicly funded health care system in New Zealand, as it is currently

structured, appears unsustainable in light of current and future demographic trends (Ministry of Health, 2013b).

In New Zealand, as in other countries, epidemiological risks, environmental change and demographic trends challenge health systems and the provision of health care services. Integrating professional knowledge and practices amongst health practitioners is considered significant in the provision of health services and to better meet the needs of health care consumers (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; WHO, 2010). Given the urgency of worldwide health concerns, and the apparent inability of current health workforces to action effective responses, it appears change is necessary in the way health professions work (Frenk et al., 2010; WHO, 2009, 2013).

Collaborative practice is viewed positively as a means for encouraging professionals to think and work together (Frenk et al., 2010; McCallin, 2005). Frenk et al. argue that health professionals "in all countries should be educated to mobilise knowledge and engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams" (p. 1924). Furthermore, McCallin advocates the need for professions to share knowledge and responsibility for client care, which differs from traditional practices of working alongside each other with clearly defined scope of practice.

In New Zealand, scope of practice refers to health services that practitioners in a specified profession are permitted to provide (Health Practitioners Competence Assurance Act, 2003). Equally, scope of practice regulations limit the intended flexibility of an interdependent health workforce, as practitioners in New Zealand are currently certified to work within clearly defined practice boundaries commensurate with their field of knowledge and practice competencies. Consequentially, members of distinct professions are required to maintain practice boundaries to ensure they do not

practice outside their defined scope of practice. While the scope of practice regulations protect members of the public by ensuring health practitioners are competent to undertake their professions' prescribed health services, the regulated practice parameters have also ensured that the health professions work in relative independence of each other, with knowledge and practice boundaries claimed as specialisations (Eraut, 1994; Freidson, 2001). In contrast, collaborative practice in health care "occurs when multiple health workers from different professional backgrounds provide comprehensive services by working [together] with patients, their families, carers and communities to deliver the highest quality of care across settings (WHO, 2010, p. 13). Hence, this situation of health practitioners working within clearly defined scopes of practice creates challenges for developing collaborative practice among professions. Challenges include variable understanding among the professions of the distinct roles, and health service responsibilities of each other, which acts as a barrier to collaboration (Hall, 2005).

In order to develop collaborative practice there is therefore a need for health care practitioners to avail themselves of opportunities to learn from, and understand the professional roles and current responsibilities of others (Hammick et al., 2009). A lack of understanding among professional practitioners is evidenced through team conflict and the inability of team members to work effectively together (Brown et al., 2011; Hall, 2005; Suter et al., 2009). Reasons for lack of understanding of different professional roles and responsibilities, between professions, include a focus on health care practice from single health perspectives (Hall, 2005), maintaining strict adherence to scope of practice regulations (Brown et al., 2011) and tension regarding accountability for team actions (Suter et al, 2009).

1.1.2   Focus on practice

Collaboration has been broadly defined as "an active and ongoing partnership, often between people from diverse backgrounds, who work together to solve problems or provide services" (Barr et al., 2005, p. xxii), and is synonymous with teamwork (McCallin, 2001; Sargeant et al., 2008). These authors identify the interdependent nature of health-care teamwork where all members jointly share common goals, understand and respect the distinct roles of each other, communicate clearly and inclusively, resolve conflict effectively and demonstrate flexibility. Furthermore, effective interprofessional health-care teams are viewed as those who, "understand how to optimize the skills of their members, share case management and provide better health-services to patients and the community" (WHO, 2010, p .10). Thus, effective collaborative teams, comprised of members from a number of health-care professions, draw on the specialist knowledge and skills from all members to optimise effective health outcomes (Weller, Thwaites, Bhoopatker, & Hazell, 2010). Working in this way requires change in how professions work together, with a proposed shift in the orientation of professions towards each other. A new orientation shifts from a focus on professionalism being profession centred to linking in collaborative practice (Holtman, Frost, Hammer, McGuinn, & Nunez, 2011).

In complex health environments where health challenges go beyond the knowledge and skills of any single profession, there is growing concern that health care practitioners lack the capability to collaborate (Bluteau & Jackson, 2009). These authors join others in questioning the ability of professions to transcend carefully protected philosophical, knowledge and practice boundaries that delineate professions from each other (Brown et al., 2011; Sargeant et al., 2008). Countering this concern, WHO (2010) considers the urgency in addressing current and future health challenges, nationally and

globally. This requires a shift from professions working in isolation, or alongside each other, to active collaboration across profession boundaries.

In a 2010 report titled *Framework for Action on Interprofessional Education and Collaborative Practice,* the WHO endorsed the importance of collaborative healthcare practices in the provision of health care services. Authors of the report noted that that "it is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional. By working collaboratively, health workers can positively address current health challenges, strengthening health systems and improving health outcomes." (pp. 36–37). The report recommends the development of interprofessional capability, through education and changes in professional practice towards a flexible, responsive and interdependent workforce.

Encouraging professionals to actively work together has been viewed with scepticism, even though there is increasing evidence of the benefits of collaboration between health professions and the logic in developing educational and practice frameworks to support health professionals working effectively and efficiently together (Frenk et al., 2010; Freeth et al., 2004; Suter et al., 2009). In a global independent commission on health professions in the twenty first century, Frenk et al. (2010) identified "the so-called tribalism of the professions—i.e., the tendency of the various professions to act in isolation from or even in competition with each other" (p. 1923) as a key concern hindering progress in establishing interdependence among health professions.

This is not surprising, considering the traditional structural knowledge and practice boundaries that distinguish one profession from another (Sargeant et al., 2008). Furthermore, professions are traditionally premised on specialised knowledge and related skills that are developed during formal education and enacted in work contexts

(Freidson, 2001). Key characteristics of professions and connected attributes of professionalism encompass specialist knowledge claims, formal education in a designated field or discipline, and a commitment to ethical conduct that is commensurate with the profession and enacted in the service of others (Beaton, 2010; Crowley, 2014). Importantly, members of professions have traditionally maintained autonomous practice, in the use of specialist knowledge, and have been answerable to their own professional bodies for their conduct (Professions Australia, 1997).

Professionalism entails the process of education and socialisation into a profession, which is further nourished through membership and practice in the profession (Freidson, 2001). Webster-Wright (2010) puts forward the view that professionalism focuses on "a way of thinking and being" (p. 25). From this perspective, professionalism is linked to ways of viewing the world (ontology) and associated understanding of the nature of knowledge (epistemology). As such, professionalism has a profound effect on how members of distinct professions view knowledge and furthermore and how they enact knowledge through their work (Eraut, 1994). Additionally, profession-centric knowledge claims are pivotal to the health-oriented perspectives that delineate practice realms of particular professions (Pecukonis, Doyle, & Bliss, 2008).

Another perspective on professions, when viewed sociologically as a typology of occupations, sees professions as collectively restricting access to rewards of social status and remuneration associated with the societal value placed on exclusivity of knowledge claims (Freidson, 2001; Larson, 1977; Macdonald, 1995). Furthermore, through scrutinising and limiting admittance to educational opportunities and through maintaining members' autonomy over the services they provide, professions establish exclusionary boundaries that set them apart from others. In doing so, professions maintain socially elite positions in society (Larson, 1977). Concurrent with this

sociological perspective is the view that while professions collectively maintain distance from other occupational groups, individual professions continually compete with each other to ensure their knowledge and practice boundaries are not breached (Abbott, 1988).

Despite the call for collaboration as a way forward in developing an interdependent health care workforce, consideration must be given to the pervasive nature of professionalism in health professions. Along with the expression of scepticism by some authors on the ability and willingness of professions to collaborate (Frenk et al., 2010; Freeth et al., 2004), there is also concern expressed by others who caution against professional vulnerability and potential rupturing of professional identity in collaborative work (Brooks & Thistlethwaite, 2012). The integration of knowledge and practices from various health professions—viewed as interprofessional collaboration—has potential to alter notions of professionalism, i.e., professions as distinctive occupations and related occupational identity in a profession.

Added to this concern is a more general risk of reducing professions to generic all-purpose workers, with expertise that is based on specialist knowledge replaced with functional practice (Freidson, 2001, Headrick, Wilcock, & Batalden, 1998). This is not, however, the intent of proponents of interprofessional collaboration, who suggest that interprofessionality is viewed as an additional layer to existing professionality (Edwards, Lunt, & Stamou, 2010; Holtman et al., 2011; Reeves, Lewin, Espin, & Zwarenstein, 2010). Viewed in this way, interprofessionality combines the use of traditional tenets of professional specialisation with overlapping practice boundaries to action more effective time-responsive health care. If this is the way forward in viewing interprofessionality, it is the work that is required at the boundaries, or borders of professions that will challenge how professions work together in the future (McCallin & McCallin, 2009; Wenger, 1998). Challenges include professions' ability to understand

different orientations to health and negotiate practice roles (McCallin & McCallin, 2009) additional to constructing mutual enterprise, or engagement among professions (Wenger, 1998). Working at the borders of professions may be problematic for graduates who have been socialised predominantly in profession-centric professional education, and have limited understanding of experience of working with other professions.

1.1.3 Focus on education

Interprofessional education has been advocated as a pedagogical approach to developing collaborative capability among professions (Arndt, King, Suter, Mazonde, Taylor, & Arthur, 2009; Bjorke & Haavie, 2006; Charles, Bainbridge & Gilbert, 2010; Cooke, Chew-Graham, Boggis, & Wakefield, 2003; Hind et al., 2003; Margalit et al., 2009; Miers, Rickaby, & Clarke, 2009; Wright & Lindqvist, 2008). Interprofessional education (IPE) is defined as intervention(s) "where members of more than one health or social care profession, or both, learn interactively together, for the explicit purpose of improving interprofessional collaboration or the health/well being of patients/clients, or both" (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013, p. 2). Proponents of interprofessional education advocate early student experiences to encourage collaboration and limit the negative impact of pre-existing stereotypes on health professions as distinctly different from each other (Bjorke & Haavie, 2007; Charles, Bainbridge, & Gilbert, 2010; Horsburgh, Perkins, Coyle, & Dajeling, 2006). Reasons for this include professional stereotypes that can become entrenched during undergraduate study and are then frequently perpetuated through on-going socialisation and clinical practice (Hean, Macleod-Clark, Adams, & Humphris, 2006; Hind et al., 2003; Perkins, Horsburgh, & Coyle, 2008).

Yet most undergraduate health science programmes currently have limited interaction among disciplines, and pedagogical approaches vary among programmes

(Hall, 2005; Hall, Weaver, & Grassau, 2013; Hammick et al., 2009; McKimm et al., 2010; Zwarenstein & Reeves, 2006). Additionally, the educational intention of members of different professions in learning and working together is problematic, given the knowledge and scope of practice boundaries that traditionally differentiate professional groups (Hall, 2005; Hammick et al., 2009; Pollard, Miers, Gilchrist, & Sayers, 2006). Freidson (2001) links the establishment of a professional identity to membership in an occupational community that cultivates certain characteristics. Individual characteristics include aspiring to become a participating member of a profession and subsequently a willingness to persevere through extensive education. Freidson further suggests identity is developed through sustained commitment to training in a specialised knowledge area, over a prolonged period of time, in a cohort of like-minded individuals who have similar career aspirations. In addition, Freidson notes a sense of "community, or solidarity" (p. 101) is fostered through keeping disciplines separate.

Traditionally, during undergraduate study in health sciences, students begin the process of developing an identity with a specified profession (Freidson, 2001). Education occurs primarily in student cohorts whereby individuals work jointly and severally to advance their knowledge and skills in the profession, in isolation from other professions (Hammick et al., 2009). In formal academic and clinical settings, knowledge and skill acquisition is closely monitored, to ensure adherence to the profession's governing principles, values and practices (Shulman, 2005). Learning in this manner, over time and through the monitoring of behaviour and mentoring roles by those experienced in the profession, students develop their professional identity (Adams et al., 2006).

Professional identity refers to "the conscious awareness of oneself as a [professional] worker" (Skorikov & Vondracek, 2011, p. 693), related to a developing sense of purpose and ability in a chosen field of practice. This suggests that professional

identity develops in and through practice; due to both the time and personal resources people invest in their work and the interpersonal relations with others in the same occupation (Wenger, 1998). Professions depend upon their members to develop an identity with the occupation. In doing so, members may then be relied on to act in accordance with professions' tenets of expertise, altruism and autonomy. Through working closely with more experienced members of a profession, over time, graduates establish their identity in a profession (Black et al., 2010; Camilleri, 2008; Cowan & Hengstherger-Sims, 2006; Toal-Sullivan, 2006). Furthermore the early years of professional practice are deemed most influential in developing proficiency in a professional role, through establishing what Eraut (1994) claims are "the personalized patterns of practice that every professional acquires" (p. 11).

Establishing patterns of practice is an ongoing process that spans initial education and graduate work. In work contexts that differ from those that graduates are prepared for, in terms of education and socialisation, the risk of practice discord is high (Brooks & Thistlethwaite, 2012). Practice discord and lack of job satisfaction are frequently cited as reasons why graduates become disillusioned about their choice of occupation, noted primarily in nursing graduates who comprise the largest group of health care professions (Duchscher, 2009). This has implications for the initial and ongoing education of professionals, and importantly in the mentoring of graduates. If the ability to collaborate effectively among professions is important, then graduates require early and ongoing support to incorporate interprofessional knowledge and skills into their practice, while concurrently developing their professional identity.

1.1.4 New Zealand health context

In New Zealand, the structure of the current health care system is predominantly publically funded with additional specialist services provided via a private self-funded sector (Ministry of Health, 2013b). Via the publically funded system, New Zealanders

have free access to public hospitals, which are increasingly used in the provision of acute and emergency care services. In addition, the Accident Compensation Commission (ACC) provides public funding, generated through levies on people's earnings, payrolls from businesses, fees related to vehicle licensing and petrol, and additional government funding, that subsidises the cost of treatment and rehabilitation following accidents. Lastly, public funding provides access to primary health care services, which are located in communities and provide necessary services outside hospitals. Primary health care initiatives aim to optimise the health status and support the health needs of people in their communities, while decreasing patient admissions and length of stay in hospitals (Ministry of Health, 2013b). The further aim is financially driven, with a goal to decrease the burgeoning cost of hospital admissions. Operating alongside the public health care system is a private health care sector that offers a range of specialist services. This sector supports the public system, through offering non-emergency services, but at a personal cost to the service user.

The New Zealand health care system, as in other countries, is challenged to meet current and future health concerns affecting its people. In 2009, the Ministry of Health established Health Workforce New Zealand (HWNZ). The role of HWNZ is to advise both the Ministry and the Director General of Health on trends in workforce planning, education and training to reflect changing health service priorities. In 2010, HWNZ identified key change indicators that will impact on current health care practices in New Zealand. The first of these indicators is the urgent need for a more flexible, responsive health care workforce, in addressing the challenges of workforce shortages and future health service demands. The second indicator refers to the education and training of health care workers, advocating the need for alignment between actual and forecast changes in New Zealand health demographics and a workforce able to provide health care services in ways that differ from current models of care. It is envisaged that this

will include the extension of current practitioner roles and development of new roles "to make best use of the skills of all members of the health care team" (Health Workforce New Zealand, 2013).

This is the current health care context that graduates enter upon completion of their initial education. Yet, in New Zealand the education for a range of health professions is still predominantly in isolation from each other, with inconsistency in the amount and type of interaction among students during their years of undergraduate study. There are inroads forged to incorporate interprofessional education initiatives into existing study programmes (McCallin & McCallin, 2009; McKimm et al., 2010) but there is no overall strategy in the New Zealand tertiary education sector to address the need for graduates' interprofessional capability. It is therefore questionable whether graduates in New Zealand are adequately prepared for entering work contexts that require collaborative working relationships among professions.

Future health care practice appears to be expanding knowledge and practice boundaries beyond the current profession specialities. In contrast, education of future practitioners seems out of step with changing work contexts that are ill defined and uncertain. What is known is the need for professions to develop new ways of working together. This will require professionals working at the borders of professions, which may alter traditionally held notions of professionalism and profession identity. If a new professionalism is envisaged—with a concurrent influence on professional identity—this will influence graduates' transition into professional practice.

1.2 Positioning the researcher

This doctoral thesis stems from personal disquiet over a shift in academic focus from educating undergraduate health science students for practice in professions to enabling interprofessional capability. In itself, adding interprofessional capability to existing competencies for professional practice may be viewed as a logical step in preparing

graduates for working interdependently among professions. Yet within the context of predominantly siloed education for professions, the idea is problematic. The aim in undertaking the research was to investigate the interface between notions of professionalism, professional identity development and interprofessional collaboration. This focus was sparked by the palpable tension between entrenched disciplinary isolationism in a university health faculty, and the intention to educate students for future employment as collaborators within diverse health care professions.

In relation to undergraduate education, the organisational structures of most tertiary institutions overtly perpetuate disciplinarity, veiled in the term 'specialisation' (Eraut, 1994). University faculties have been criticised for the narrowness of disciplinary curricula in preparing students for the reality of life beyond academia, "impeded by the fragmentation resulting from discipline–based approaches" (Ellis, 2009, p. 6), at the expense of a broader curricula that prepares students for employment and engagement in contemporary society (Freidson, 2001; Holley, 2009). Interdisciplinary education is viewed favourably as a means of merging disciplinary knowledge boundaries (Amey & Brown, 2004; Ellis, 2009; Holley, 2009). However, these views of pedagogy do not appear to have traction in the health disciplines (Lee & Dunston, 2011).

With increasing pressure on health professionals' employment requirements specifying the ability to think well and expansively, there is a need to question the effectiveness of perpetuating disciplinary knowledge and practice boundaries (Kreber, 2009). Disciplinary boundaries create challenges for professional practice in contemporary health contexts that favour collaboration between health workers. Traditionally, codified bodies of knowledge have remained within the boundaries of specified health professions. Further, professions have individually controlled access to

specialist knowledge and autonomy over regulation of work practices (Hammick et al., 2009).

Contemporary social and economic developments are, however, challenging the notions of professions as separate with exclusive rights to knowledge (Dall'Alba, 2009). Frenk et al. (2010) concur with Dall'Alba, advocating reform in the education of health professionals to develop collaborative capabilities, in part to reduce the risk of "miscommunication, misunderstanding and boundary disputes" (Barr et al., 2005, p. 3). Globally there is a perceived need for health practitioners who can think critically and are competent to practice in complex health situations (WHO, 2006).

Over the past 30 years I have been a health educator, for many years in schools of nursing and more recently in interprofessional education. Having worked as a nurse and as a clinical educator, I was conversant with the challenges that confront health care practitioners as they negotiate and enact their professional roles. As an academic I am cognisant of the challenges that face students and educators when balancing theoretical, practical and social components towards graduate capability for work in a specified health profession. Currently I teach in a School of Interprofessional Health Studies (SIHS), situated in a New Zealand university health faculty. The school was established in 2009 to develop and teach interdisciplinary papers in the Faculty, including all papers offered in the first semester of Bachelor of Health Sciences (BHSc).

During 2009–2010, while teaching undergraduate students in their first semester of tertiary study, I became perplexed by the notion of introducing interprofessional education (IPE) in undergraduate study programmes. I questioned the intent of IPE initiatives in undergraduate education where students had enrolled into a specific health discipline with the goal of graduating as a practitioner in a specified field. Further, the specific professional education programmes, into which students moved once they had completed a compulsory common first semester of shared papers across all health and

allied health disciplines, were resistant to shared learning experiences among professions, claiming "shared" learning took students away from being socialised into, and learning their distinct professions. I understood the reasoning behind a proposed move towards IPE interspersed in existing discipline specific programmes, but could not reconcile the current siloed territoriality among disciplines with a proposed shift towards introducing interprofessional education.

Interprofessional education is broadly defined as occasions when "two or more professions learn with, from and about each other to improve collaboration and the quality of care" (Centre for the Advancement of Interprofessional Education [CAIPE], 2002). This definition of professions learning with, from and about each other remains the overarching tenet for IPE initiatives worldwide, attesting to the interrelated nature of interprofessional learning (Colyer, Helme, & Jones, 2005; D'Amour & Oandasan, 2005; Reeves et al, 2013). A collaborative approach to patient care service between professions does, by its integrative nature, necessitate an amalgamation of knowledge and practice to effectively and efficiently provide patient care. Hence, D'Amour and Oandasan (2005) have defined interprofessionality as a "process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population" (p. 9). In defining a new terminology, D'Amour and Oandasan proposed a fundamental shift in thinking about professional practice, both in education and in practice. This is an important conceptual move in the often-convoluted use of language and meaning related to collaborative practice between health care practitioners (Thistlethwaite, 2014; Reeves et al., 2013).

With this in mind, and in response to my concern in 2009–2010 regarding exposure of students to IPE in a situational context that perpetuated disciplinarity following an initial common semester at university, I reflected on the notion of professionalism, professional identity, and how professional identity interfaced with

collaborative practice expectations among health care practitioners in the workplace. If a new ideology of professional practice was gaining momentum, did this equate to a fundamental shift in thinking about professional practice regarding notions of professionalism? Additionally, was the notion of professional identity in a specific field of health care practice likely to be subsumed within a generic interprofessional persona? If this were the case, the implications for undergraduate curriculum and teaching-learning engagement were profound, particularly given the current professional territoriality that remains evident in academic and practice contexts.

In an attempt to explore these compelling questions, I was conscious of a possible "conflict of interest" in my undertaking research that involved participants in undergraduate professional education programmes. I currently hold an academic role in this sector but this does not include teaching students in the final year of undergraduate professional programmes. Hence there was separation between my role as an academic and as a researcher. In addition, this thesis has focused on the transitional phase from students in undergraduate health science education to practitioner roles in professional practice. I therefore chose to position the research in the work practices of health science graduates who were navigating their first year as health care practitioners, after completion of predominately unidisciplinary education in specified health professions. I aimed to examine current notions of professionalism and developing professional identity in an evolving health workforce, through the experience of graduates in their early work as registered health-care practitioners. More specifically, I focused on how professional identity evolved, and in what ways, at the interface of professional and interprofessional practice.

1.3   Positioning the research

The purpose of this thesis is to consider how graduates currently understand their work as professionals, as they navigate and negotiate an interface between specific profession

identity and interprofessional collaboration. Research findings indicate this group of novice practitioners enter work contexts anticipating they will establish their professional practice as situated in a particular profession and conforming to scope of practice boundaries commensurate with their profession (Black et al., 2010; Cowan & Hengstberger-Sims, 2006; Evans, 2001; Fenwick et al., 2012; Toal-Sullivan, 2006). This thesis argues that the way graduates are expected to work pushes them, by default, into an interprofessional way of thinking and practice. Thus, they enter the workforce with specific knowledge, skills, values and approaches but these are actually tempered by practice and they become broader in their thinking.

Exploring the meaning graduates attribute to their early professional practice will provide a valuable contribution to a substantial body of knowledge of professionalism, particularly as related to the intersection of knowledge and practice boundaries in health. Specifically, knowledge of how professionalism and professional identity are understood in a collaborative context, by those in their first year of graduate practice, will provide a unique contribution to pedagogy on developing graduates capabilities to practice effectively and efficiently as health practitioners in the future.

How graduates develop an identity in the first year of practice has been explored (Black et al., 2010; Cowan & Hengstberger-Sims, 2006; Evans, 2001; Fenwick et al., 2012; Toal-Sullivan, 2006) but not in relation to intersecting professional boundaries for collaborative practice. Lee and Dunston (2011) support the need for research in this area, in order to make visible "the ways in which new practice challenges require new and different kinds of practices" (p. 487). Further, they reinforce the changing notions of professional practice whereby "professional knowledge and expertise remain important but consistently become coalesced into interdisciplinary or interprofessional forms of practice, requiring new and different kinds of knowledge and expertise" (p. 487). Edwards (2010) concurs, suggesting work at the boundaries of professional

knowledge and practice relies on a relational turn in the structuring of health care practice so practitioners "know how to engage in fluid working relations" (p. 41) and are able to attend to "the spaces at the boundaries where the intersection of practices actually occurs" (p. 41).

The overarching enquiry through this thesis is to examine how graduates construct meaning to new or changing ways of working in health care contexts. An extension to this enquiry is an argument that if graduates engage in interprofessional collaboration as regular work activity, this will necessitate them changing their conceptions of traditionally held notions of professionalism; including the rupture of autonomous practice, claims to specialised knowledge and techniques, and hierarchical work relations. Therefore, the questions addressed in this thesis are:

- How does the concept of professionalism relate to contemporary health care occupations?
- How do health professionals work collaboratively with other occupations?
- How do graduates understand professional practise in collaborative health-care work contexts?

If graduates, as suggested earlier, are entering work contexts where they are expected to work collaboratively, it is important to understand their practice trajectory towards becoming professionals in contemporary health care contexts that extend beyond traditional professional boundaries. The aim in gaining insight into graduates' practice trajectory is to inform pedagogy on preparing graduates for practice roles in and beyond their respective professions. Equally, exploring the perceptions of graduates related to professionalism will provide insight into notions of what it means to work professionally, in a specified field and collaboratively with other health and allied health disciplines. Gathering graduates' perceptions of professional work adds to the substantial knowledge of professionalism, in relation to contemporary health care

practices. Furthermore, gaining an understanding of graduates' evolving identity as health practitioners in specified fields and collaboratively with other professions will add a unique perspective to existing knowledge on collaborative practice among professions. In doing so, the aim is to add to the existing knowledge and research bases of both collaborative practice and interprofessional education, in order to support change in health care practices.

Research exploring graduates' understanding of the relationship between identity, professionalism and collaborative practice in their first year of professional work has not been conducted. Findings from research into this relationship will contribute to educators' understanding of the challenges facing graduates as they embark on professional practice in working contexts that may differ from what they have been educated for. It is envisaged that research findings will assist educators in the ongoing development of teaching and learning strategies that support graduates' transition into work contexts. Equally, from a practice orientation, insight into the graduates' transition from graduate to a functioning member of professional practice— across a number of professions—will assist in ongoing clinical education and support for graduates as they navigate their first year of working in health care practice.

Chapter Two

Literature Review

2.1 Introduction

The purpose of this thesis is to examine how recent graduates, in their first year of clinical work, make sense of their professional practice in contemporary health-care occupations. Specifically, the thesis is focused on graduates' perceptions of establishing a practice role in collaborative work contexts where they intersect knowledge and practice boundaries among health professions. Collaboration among health professions has been viewed favourably in providing effective health-care service (McCallin, 2005). In support of professional boundaries intersecting, WHO (2010) has described collaboration amongst health practitioners as occurring when "two or more individuals from different backgrounds with complementary skills interact to create a shared understanding that none had previously possessed or could have come to on their own" (p. 36). It further advocates the need for effective teamwork, particularly in primary health contexts where an adaptable workforce with flexible knowledge and skills is required to address the scale and complexity of human health issues (WHO, 2006; 2010).

Collaboration, viewed by McCallin (2005) as synonomous with teamwork, is questioned by Reeves et al. (2010) in regards to professional practice and related interprofessional activity. Reeves et al. (2010) provide a typology of interprofessional work that differentiates professional practice spanning limited networking and referrals between professions through coordinated parallel working, to collaborative interactive activity among professions. Further, Reeves et al. (2010) differentiate teamwork from collaborative activity, with teamwork encompassing a "shared team identity" (p. 254) while collaboration is a "looser form of interprofessional work, as shared identity and

integration of individuals was less important, but there were some shared accountability and interdependence between professions" (p. 254). Thus, these authors draw attention to the various forms of interprofessional work enacted across health care settings, which are dependent on the complexity of health issues or concerns.

Graduates currently transitioning into the health-care workforce are therefore entering work environments for which they may be ill prepared (De Vries, 2012). A lack of graduates' preparation for collaborative practice is attributed to the predominantly siloed education into respective health-care professions (Adams et al., 2006; Hall, 2005; Hammick et al., 2009; Petrie, 1976; Zwarenstein & Reeves, 2006). Establishing a professional identity is part of this integration process, fostered through a sense of being recognised and valued by members of one's chosen profession (Camilleri, 2008).

Additionally, the first 12 to 24 months of graduate practice are challenging as novice practitioners navigate their roles in complex health contexts, leading to either job satisfaction, or conversely dissatisfaction and disillusionment (Clark & Springer, 2011; Duchscher, 2009). Job satisfaction is a key contributor to organisations retaining qualified workers in the health-care workforce. It is a concern if, during the transition from new practitioner to integration as a member of a profession, graduates experience misalignment between their perception of establishing their practice in a specific occupation and the reality of working interdependently across professions (De Vries, 2012).

Chapter One detailed the health care context that graduates currently enter as qualified health professionals. It positioned the proposed study into a challenging climate of complex health concerns, globally and in New Zealand. Chapter Two initially locates the study within a theoretical context, drawing on literature that provides a broad sociological perspective on professions and professionalism. The

thesis draws on the sociological perspectives of Freidson (2001) related to professionalism and from Macdonald (1995) in regards to professions as occupations. Additionally, Eraut's (1994) analysis of professional knowledge acquisition and application elaborates on the relationship between specialist knowledge and the pursuit of professionalism. In so doing, professionalism is positioned in a broader context of work and workers in order to foreground professionalism as a sociological concept embedded and mediated in the culture of employment.

Following a review of the broader sociological perspectives connected to both professions and professionalism will be an examination of professional practice and collaboration in relation to health-care occupations. Within health-care, there are a diverse number of professions laying claim to their own specialised knowledge and practices (Hall, 2005; Shulman, 2005). Knowledge specialisation has influenced how professions worked in the past and has implications for how they may work in the future (Eraut, 1994; Styhre, 2011). Linked to professional practice, collaboration refers to teamwork among professions (McCallin, 2005). A key element to successful collaboration in health care practice is the interdependent manner in which professions work together to achieve mutually decided goals (D'Amour & Oandasan, 2005; McCallin, & McCallin, 2009).

Finally, the enquiry will draw on identity theory and research, in regards to developing a professional identity in health-care occupations. Identity refers to aspects of self–definition, including personal understanding of self in relation to others (Burke & Stets, 2009; Camilleri, 2008; Tajfel & Turner, 1986; Wenger, 1998). In professions, identity is viewed as integral to membership in a profession and subsequent adherence to the standards of professional conduct, or professionalism.

The review examines literature in the areas of professionalism, professions and practitioners, with the aim of drawing together threads of professional practice towards

an integrated understanding of the complexity that exists in the area of interprofessional practice in contemporary health-care occupations. The intersection of knowledge and practices among professions is of particular interest. How graduates establish a professional identity when engaged in collaborative work is the specific focus as this appears contrary to customary western world notions of professional practice, identity and professionalism as centred and enacted in distinct professions (Abbott, 1998; Freidson, 2001; Larson, 1977). Thus, developing an argument for examining the intersection of developing professional identity and interprofessional collaboration in contemporary health care occupations is focused on the first year of graduate practice, as this is when novice practitioners transition into a professional role and establish their identity in a chosen occupation.

From a sociological perspective, a profession may be viewed as an occupational group of people who possess specialist knowledge and skills obtained through formal and ongoing education (Freidson, 2001). They apply this knowledge and use the skills in the work they do in the service of others. A profession is bound by a code of ethics that underpins the activities of its members and is also governed by a regulatory body to ensure members adhere to high standards of conduct in respect to their work with colleagues and to the services they provide (Professions Australia, 1997).

Professionalism relates to the standards of conduct expected of a profession and that governs the members' activities. Specifically, professionalism defines the values and beliefs embedded in a profession, and identifies expected behaviours and relationships that are concurrent with these attributes (Hilton & Southgate, 2007). Health science graduates transition into professional practice after years of academic and clinical preparation; during this time they develop and adopt notions of professionalism and expectations of professional conduct specific to their chosen profession (Hammick et al., 2009). The review begins by examining the concept of

professionalism in a general sense and then specific to health professions. Underpinning this section is the question of how professionalism relates to health-care occupations.

2.2 Sociological perspectives

Two contrasting sociological approaches that will be considered in relation to professionalism are functionalist and structuralist approaches. A functionalist sociological orientation focuses on the importance of professions in general—and their ethical practice specifically—in ensuring stability of moral authority in society (Macdonald, 1995). From this perspective, professions function as stabilising elements in society, of benefit to society through preserving and advancing knowledge in specific fields. Equally, professions are viewed as upholding altruistic service values, observed in behaviours that may be trusted by members in society. Altruism may be broadly defined as consciously prioritising the needs and interests of others over the perceived needs of one-self, and is associated with "concepts of responsibility, service, de-prioritization of material rewards, and a commitment to making a difference" (Benade, 2012, p. 63). In health professions, altruism traditionally has been described as selfless regard for the welfare of others, whereby practitioners provide services and duty of care underpinned by "moral and ethical practice that puts the interests of their clients above their own" (Hilton & Southgate, 2007, p. 267).

A structuralist approach to professionalism takes a different sociological orientation in viewing professions as an element of socio-economic stratification. Stratification is based on the value and control of work (Macdonald, 1995). Viewed from a structuralist orientation, professions act to safeguard their knowledge claims and control over the work they engage in to preserve their self-interests and standing in society. Self-interest may be broadly defined as prioritising one's own interests before those of others. In relation to professions, Macdonald (1995) likens the notion of professional self-interest to that of social closure, whereby "groups engage in social

closure in the course of furthering their interests and they attempt to exclude others from their group" (p. 27). Macdonald further explains that through close monitoring of membership, professions limit access to the profession, primarily based on academic and social suitability. This equates to social determination of eligibility to join a profession, or elitism. Furthermore, Larson (1977) views professions as professional projects that develop and sustain privileged positions in society through actively pursuing monopoly of knowledge, and of knowledge-based services.

Viewed from either sociological approach, professionalism encompasses both elements of self-interest in the protection of knowledge and practice claims and altruism in the duty of care towards members of society. Larson (1977) proposes occupations that are mandated by society as professions are generally held above societal scrutiny and reproach. Hilton and Southgate (2007) describe this relationship between members of society and professions as an "implicit 'social contract' between professions and the societies they serve" (p. 267), based on trust. Professionals are trusted in the work they do and professions are expected to regulate their members to behave responsibly and ethically in the services they provide.

Professions are also known to protect knowledge and practice domains competitively and to ensure exclusivity to the work they do, both in relation to other professions and other occupational groups (Freidson, 2001). This could be construed as self-serving from a structuralist sociological perspective. Alternatively, from a functionalist sociological perspective, a hallmark of professions includes upholding tenets of knowledge and practice that underpin the use of discretionary judgment in the service of others. Drawing on sociological foundations of professionalism, Freidson (2001) depicts professions within a typology of ideal-type occupations, referring to those occupations in the workforce whose members have autonomous control over the type of work that is carried out, and by whom.

2.2.1 Ideal-type occupations

Medicine, law and theology are viewed as ideal-type occupations (Freidson, 2001). As many occupations fit this ideal-type, Freidson further differentiates professions from other types of work by the forms of knowledge and skills upheld by a group of workers and how they obtain and retain control over specific knowledge claims. To show this, Freidson proposes a typology of work differentiation that includes work that is predominantly manual, requiring high manual dexterity in actioning reliable work segments towards a unified task. In contrast are professions, which differ from other occupational groups in their ability to conceptualise a task in its entirety; tasks that require primarily codified knowledge (intellectual knowledge) to underpin the use of abstract concepts, judgements, and decision-making. Professionals have ownership over their work in ways that other workers do not, including the ability and knowledge to cope with unexpected changes that require their use of discretionary knowledge, judgement and reflection.

Additionally, occupations that are invested with professional status depend on specific codified knowledge, originating and maintained through sustained formal education over time (Eraut, 1994) and actioned through use of abstract concepts, discretionary judgements and decision-making, and occupational autonomy (Freidson, 2001, Macdonald, 1995). For Freidson, "the ideal-typical position of professionalism is founded on the official belief that the knowledge and skill of a particular specialization requires a foundation of abstract concepts and formal learning and necessitates the exercise of discretion" (p. 35). Discretion—the freedom to make decisions—is a key attribute of professionalism. The ability to make discretionary judgements about human problems, utilising codified knowledge and skills that are essentially unquestioned but taken on trust by the public, is traditionally a hallmark of a profession.

2.2.2   Jurisdiction over work practices

Divisions of labour in a workforce can be viewed from distinctly different orientations, related to the people in a work organisation who have legitimate power over the tasks to be performed and the people who will undertake to perform the tasks (Freidson, 2001). Professions are positioned by Freidson as one of three primary divisions of labour in a workforce. As an occupational group, professions differ from a bureaucratically controlled labour force that relies on managerial organisation of tasks and those who will provide labour. Equally professions differ from a consumer driven labour force, which relies on consumers having ultimate control over production of goods and those employed to produce commodities. In contrast to consumer and bureaucracy driven market forces, professions directly control their work activity, including the use of discretionary knowledge by members, narrow occupational flexibility, and jurisdiction over membership and organisation of specialised work.

Macdonald (1995) agrees, but views discretionary knowledge—carefully attained, monitored and protected by professions—as a bargaining tool in negotiating and maintaining social position in society. Thus, Macdonald advocates self-interest as a key characteristic of professionalism. Other authors have taken a structuralist perspective to view professionalism as a product of social stratification (Larson, 1977). Taken from this perspective, Larson considers professions engage in continual effort to defend, uphold and improve their social status. This is achieved through professions maintaining exclusive rights to certain types of knowledge (Eraut, 1994), monopolising knowledge-based services (Larson, 1977) and developing a culture of trust and respectability between society and the profession. Professional groups compete for authority over knowledge that is mainly abstract (Macdonald, 1995).

It is not surprising that abstraction, viewed as discretionary knowledge (Freidson, 2001), is not only a defining characteristic of professionalism, but can also be

viewed as a source of competition among occupations vying for societal trust and respectability (Abbott, 1988). Collectively, members of professions demonstrate observable uses of knowledge abstraction in their work. Yet among professions, members closely guard knowledge and practice domains: out of self-interest in maintaining a professions social status, but also in preservation of knowledge claims and discretionary judgment in the services provided. Preservation and advancing knowledge to benefit human lives and conditions are seen as a key attribution in favour of societal support of professions (Freidson, 2001).

2.2.3 Specialist knowledge claims

Professionals, as members of a profession, engage both with, and in knowledge during their work. Freidson (2001) proposes the following traits of an ideal-type professional worker: Someone with specialised knowledge and related skills, and who controls the nature of work that demonstrates discretionary judgement in diagnosing, inferring and treating human problems. Professional practice may be viewed as the enactment and advancement of specialist knowledge (Styhre, 2012). Thus, members of a profession lay claim to specialised knowledge, and monopoly over work that advances that knowledge in a public arena (Eraut, 1994). This latter aspect of advancing knowledge, and professions being seen to advance knowledge, is important in maintaining the trust invested in professions to act in the interests and to the benefit of others (Hilton & Southgate, 2007). Freidson (2001) refers to advancing specialist knowledge as a "complex craft that has value to others" (p. 10). The value placed on certain types of knowledge by people who only have limited access determines the degree of trust placed in professions to uphold and use the knowledge wisely.

From a sociological functionalist perspective, knowledge is protected by professional groups, advanced, and utilised in an ethical manner to benefit society. Equally, society grants professions the legislative authority to guard and advance their

knowledge claims. So while professions enact specialist knowledge through their practice, they also ensure limited access to specialist knowledge beyond those who are qualified and certified into the profession.

In contrast, from a structuralist sociological perspective, knowledge enables certain occupational groups to maintain power over others in society. This is achieved through offering expert knowledge and specialist skills at the discretion of the occupation. The use of discretionary judgment is a distinguishing characteristic of professions, founded on distinct bodies of knowledge that are engaged through the professions' work (Eraut, 1994; Styhre, 2010).

2.2.4 Professional practice

Through legitimising their claims to expert knowledge in distinct fields and displays of specialist skills in the services they provide, members of professions have ensured their ability to work autonomously (Freidson, 2001). Thus, professions can negotiate distinct practice domains, utilising discretionary knowledge to determine which tasks are required and how these will be undertaken. Importantly, specialised knowledge and associated skills become stabilised as members of distinct occupations "have the exclusive right to perform the tasks connected to them" (Freidson, 2001, p. 56). Hence professions maintain control over their work context and exert exclusive authority over who is eligible to work in the occupation. Further, professions determine the qualifications required by members to undertake practice and control the licensing procedures that are required by law. Through these processes, professions maintain jurisdiction over the nature of tasks performed and who is able to perform them. Thus professions maintain control over their practice boundaries, what will be produced, and the conduct of members in the work that is produced (Freidson, 2001).

So, while professions have established niche occupations that appear above societal reproach, professionals—as members of a profession—are trusted by society to

uphold codes of ethical conduct and high standards of behaviour in their practice (Hilton & Southgate, 2007). In effect, this amounts to societal expectations of altruism, whereby professionals prioritise the needs and interests of those they serve ahead of their own. Professional regulatory bodies, which serve to uphold both the moral and ethical standing of respective professions and the trust of the public in the services provided, monitor adherence of members to specified codes of ethical conduct. Practitioners' adherence to ethical conduct in distinct health professions is achieved through defined scopes of practice, to ensure the health and safety of members of the public is upheld (Health Practitioners Competence Assurance Act, 2003). Departure from the professions' defined practice scope is grounds for disciplinary action by the relevant regulatory body and censure of the transgressing practitioner.

2.2.5   Ethical conduct

Altruism is a further traditional cornerstone of professionalism and enacted through the ethical conduct of professions, in the provision of distinct services and further through actioning duties of care. Specifically, altruism counters the claims of professions as acting primarily out of self-interest (Macdonald, 1995). Responsibility and accountability are conceived within the notion of altruistic behaviour (Benade, 2012). Benade links key values and beliefs associated with ethical conduct and professional self-interest with those of provision of service and sense of duty.

Contrary to the expectation of professions acting in selfless ways, Bishop and Rees (2012) forward the view that balancing self-care with that of others is a healthier perspective than altruistic endeavour. These authors, working in the fields of medicine and health education, question the value in putting the needs of others before one-self. Rather, they advocate a repositioning of altruism with pro-social behaviour, which retains an ethic value of service to others while espousing a responsibility for taking care of oneself. This view, however, runs counter to the ideology of professions

working in the service of others (Hilton & Southgate, 2007). Society invests professions with practice autonomy based on trust that they will act selflessly to benefit those they serve. In doing so, professions are expected to uphold the ethical values of accepting responsibility to benefit others through the work they do and being accountable to their professions for their actions.

There is merit in considering pro-social behaviour as a premise for ethical conduct (Bishop & Rees, 2012) in preference to altruism being viewed as a unidirectional provision of selfless service by professions (Hilton & Southgate, 2007). Rather, Bishop and Rees (2012) argue, "that in learning to care for the other, one is shaping oneself and in learning to be for the other, one must take care of oneself" (p. 397). Repositioning the ethic of altruism as professional responsibility to self and others suggests a shift towards a more equitable relationship between those involved in the provision and use of health care services. Furthermore, viewing professional accountability from a pro-social position opens possibilities for practitioner's personal values, beliefs and empathy to be infused into the work they conduct on behalf of their profession (Bishop & Rees, 2012). Taken from this orientation, professionalism is seen to shift from traditional notions of professions, wherein members must think, value and behave in accordance with the professions tenets of ethical behaviour towards others. Rather, pro-social behaviour acknowledges the self as separate to, rather than embodied in the profession.

Within the context of workforce capability, professions are being positioned as occupations that have established clear demarcation boundaries from other divisions of labour (Freidson, 2001). Furthermore, this thesis considers professions to hold and advance specialised knowledge claims and skills that set them apart from other occupational groups. Concurrent with the claims to specialist knowledge are the professional values and beliefs of ethical conduct in provision of services that benefit

others. Included is a pro-social orientation to ethical conduct that proposes a shift from professions' selfless service to balancing the inclusion of self-care when acting for the benefit of others. The review will now centre on health professions within this context, focusing on tensions that challenge the boundaries of discretionary knowledge and scope of practices that currently differentiate occupational groups in health care professions.

2.3   Health professions

Health professions have developed a seldom-questioned position in society (Freidson, 2001). Medicine—as a profession—can be traced back to the earliest days of civilisation, where the public held those with a special gift for healing in high regard. Indeed Hippocrates (460–377 BCE) is purportedly the originator of early western medicine, breaking away from viewing medicine as having supernatural powers, to grounding medicine in natural philosophy. Through the ages, there has been a shift in medical professions' knowledge from supernatural healing to rational scientific discoveries (Hilton & Southgate, 2007). Prior to the late nineteenth century, women were unlikely to attend university and thus the professions of medicine, law and theology were predominately male (Hall, 2005). In the medical field, women who were interested in studying medicine were encouraged to enter nursing as a vocation better suited to assist doctors in their provision of care.

Over time, nursing has evolved as a profession with its own jurisdictional claims and regulatory body (Hall, 2005). This has not occurred without openly challenging the authority vested in medicine as a profession, nor the boundaries of medical knowledge and practice claims (McCallin, 2001). Other neo-professions have also proliferated in the health domain, creating knowledge and skill boundaries to secure their inclusion as health professions, alongside medicine and nursing. Gieryn (1983) describes this

process as boundary-work, used to promote a profession's ideology and further, to cement a distinctive health perspective, or worldview.

Additionally, boundary-work heightens differences between professions and has fostered rivalry and territoriality between health professions (Frenk et al., 2010). Recent research into primary health care teams of professions working together identifies the influence of boundary-work in creating barriers to effective teamwork (Brown et al., 2011). This phenomenological study included a large number (N=121) of participants from a range of health and allied health professions, working in primary health care teams in Canada. Findings from participant interviews relating to conflict within teams identified that role boundaries prevented members of interprofessional teams from understanding either the health care perspectives of others, or their professional roles. Specific role boundaries included lack of understanding among the team members both on the different roles within the team, and the importance of drawing on select skills from team members. In addition to the lack of awareness, there was scepticism expressed on sharing practices when professional boundaries were threatened, due to scope of practice breaches.

Similarly, Suter et al. (2009) undertook research into the views of health practitioners on relevant competencies for effective collaborative practice. Interviews with a total of 60 members from nursing, medicine, allied health providers and administrative staff working in a variety of health care sites, identified a commonly held perception of professions talking and working past each other. Although practitioners acknowledged the effectiveness of working interprofessionally, Suter et al. (2009) identified the difficulty expressed by participants—from across the professional spectrum—in understanding the roles and health perspectives of others in a team. Furthermore, participants in the study acknowledged they did not avail themselves of

opportunities to learn the roles and responsibilities of others and therefore, remained

working autonomously within their own professions' scope of practice.

A lack of understanding of the roles and health care perspectives of other

professions has led to health care professionals working in isolation of each other to

ensure members of distinct professions "have common experiences, values, approaches

to problem-solving and language for professional tools" (Hall, 2005, p. 190). Despite

health practitioners sharing common knowledge, distinctive health professions construct

specialist knowledge and practices from different perspectives (Eraut, 1994), resulting

in members from each profession following differing philosophical orientations to

knowledge and practice (Shulman, 2005).

Shulman suggested that this process of enculturation commences in formal

education, stating, "if you wish to understand why professions develop as they do, study

their nurseries…their forms of professional preparation" (2005, p. 52). Through years of

formal education, a hallmark of professions, including those in health, students learn the

knowledge and practice skills commensurate with their chosen field along with the

values that underpin the profession. Simultaneously they are socialised into distinct

ways of viewing health care and this forms their professional worldview or distinct

health perspective.

Distinctive perspectives that arise from novices learning specific knowledge and

associated skills for practice in a chosen field of health care, combined with

socialisation into the respective value and belief system are seldom challenged by those

in the profession (Dombeck, 1997; Hall, 2005). In fact, the duration and nature of

professional education programmes, noted in western countries and spanning years of

university study, is critical to shaping the "character of future practice and in

symbolizing the values and hopes of the professions" (Shulman, 2005, p. 53). Shulman

joins other authors (Dombeck, 1997; Hall, 2005) in drawing attention to the

pervasiveness of professional education programmes in perpetuating distinctive patterns of thought, action and values for practice.

2.3.1   Socialisation in health professions

Traditionally, professional education has developed graduate capability to practise in a manner acceptable to the profession (Freidson, 2001). This involves more than acquiring specialist knowledge. It also includes socialisation for practice, so distinct practices are overt and relied on by others in the profession (Dombeck, 1997; Shulman, 2005). Shulman observed that professions contain signature pedagogies that are restricted to a profession and thus distinguish it from others. Signature pedagogies refer to "the cultures of professional work and provide the early socialization into the practices and values of a field" (p. 59). Specifically, signature pedagogies are aimed at education for thinking, performance and integrity in a professional field, initially in academic settings and progressively through integration into practice contexts. Signature pedagogies are often subtle, but pervasive in shaping distinct orientations to health and health care practices.

Hammick et al. (2009) reinforce the notion of signature pedagogies as being instrumental in the development of distinct practices; influenced by the culture, values and beliefs that underpin each of the health professions. These authors advocate that through the initial education and ongoing learning in professional practice, "practitioners from a particular profession adopt certain attitudes and conduct their practice in certain ways" (p. 19). Furthermore Hall and Weaver (2001) suggest that professional education promotes a specific health perspective, or orientation, from which members adopt "similar approaches to problem solving, common interests and understanding of issues" (p. 867) in support of Shulman's (2005) notion of signature pedagogies. Socialisation is achieved through routinising and shaping the cognition,

emotions and behaviours commensurate with a specified professional occupation, described by Petrie (1976) as cognitive mapping.

Cognitive maps provide a cultural lens for professions, through which their members view their practice. Importantly, differences in cognitive maps influence "categories of observation, [whereby] quite literally, two opposing disciplinarians can look at the same thing and not see the same thing" (p. 11). While the need to prepare graduates for distinct roles and responsibilities in the provision of health care is acknowledged (Hall & Weaver, 2001; Hammick et al., 2009; Petrie, 1976; Shulman, 2005), there is concern regarding the isolationist nature of traditional education for distinct professions, in relation to shifting health service priorities that favour greater interdependency among professions (Hall, 2005; Hall & Weaver, 2001; McCallin, 2001).

2.3.2   Professional education programmes

Students enrolled in professional education programmes are currently socialised into specific ways of thinking and practice that exemplify the culture of particular professions. Arndt et al. (2009) describe the socialisation process as moulding students into becoming professional beings who are capable of functioning autonomously, while sustaining occupational solidarity with those others who have equivalent qualifications to practise (Freidson, 2001). Through prolonged immersion in formal uniprofessional education and continual interaction with influential role models from the profession, individuals acquire a professional identity (e.g., nurse, doctor, physiotherapist) that underpins the professional group solidarity (Arndt et al., 2009; Bluteau & Jackson, 2009; Pollard et al., 2006). A qualitative study undertaken by Arndt et al. (2009) on socialisation processes in health education confirmed the fundamental role of programmes in developing professional identities. Participants from different professions and stages in their career advocated socialisation into a profession occurred

through academic and clinical experiences that developed "students' professional identity and ability to take on a role through acquisition of discipline-specific knowledge, values, and skills" (p. 20).

However, Coster et al. (2008) revealed contrary findings from a longitudinal study of students' perceptions of professional identity formation and changes over the duration of their undergraduate study. Students, drawn from one of eight health or allied health professions in their final year of undergraduate study, indicated a diminished sense of professional identity as they approached qualification. Coster et al. (2008) suggested this change might have resulted from students experiencing the reality of clinical practice and possible disillusionment as compared to their first year counterparts. In a similar study on perceptions of health science students on professional practice, Pollard et al. (2006) found that students in their final undergraduate year, from diverse health professions, had a strong sense of professional affiliation as they moved towards graduation. These students had encountered interprofessional learning opportunities through their undergraduate study and it was anticipated that interaction would positively influence attitudes towards working with others.

Conversely, there was diminished interest in working with other professions, which led Pollard et al. (2006) to conclude that interprofessional experiences had little bearing on changing attitudes towards collaborative working. If anything, professional solidarity had strengthened as a result of interprofessional learning opportunities, which led Pollard et al. to compare the survey findings with those from a group of students who experienced only uniprofessional education. Students in the latter group revealed less interest in professional affiliation, aligning with the findings of Coster et al. (2008). This suggests that students perceive interaction with other professions during undergraduate programmes as promoting "a marked level of awareness about the need to establish working relationships with their [own] professional colleagues" (Pollard et

al., 2006, p. 549) as opposed to other professional groups. The strengthening of solidarity within a profession as a result of interaction with other professions appears to dispel the concern of those who caution against interaction between professions, particularly during undergraduate education, until a professional identity is firmly developed (Carlisle, Donavan, & Mercer, 2005; Charles, Bainbridge, & Gilbert, 2010).

2.3.3   Influence of professional stereotypes and attitudes

It is suggested that professional stereotypes and associated attitudes towards specific health professions influence students' willingness to interact with others. Specifically, students entering undergraduate study with existing stereotypes appear resistant to altering their perspectives (Hean et al., 2006; Hind et al., 2003; Horsburgh et al., 2006). Hean et al. (2006) surveyed a large student cohort, focusing on the link between first year undergraduate student perceptions of professional stereotypes and interactivity with other professions. Results revealed consistent perceptions of professional hierarchies. Hierarchies were primarily based on perceived academic ability, which was aligned with professional competence and leadership potential. In particular, doctors were viewed as possessing greater decision-making ability than other groups and therefore natural leaders. On the other hand, doctors and pharmacists were rated lower than other groups on interpersonal skills and working in a team. The implications of these perceived conflicting attributes, an ability to make decisions and lead others while lacking in interpersonal skills and teamwork approach, are concerning if collaboration between health professions is expected. In particular, the importance of teamwork has been identified as integral to collaborative practice (McCallin, 2001), although this is questioned by Reeves et al. (2010) in favour of pratitioner competencies that reflect wider forms of interprofessional work.

Stereotypes regarding doctors' unwillingness to work collaboratively with other professions may be justified. A New Zealand study on the views of medical, pharmacy

and nursing students towards professional work found distinct differences between nursing and medical students understanding of professions working together. Medical students favoured an individualist in contrast to nursing students' collectivist approach to clinical work (Horsburgh, et al., 2006). Horsburgh et al. highlighted the challenges in fostering interaction between professions when students enter programmes with well-formed attitudes that conflict. A later survey (Perkins et al., 2008) of students in their final year of study, that also included practitioners in the three professions, found a strong correlation between practicing professionals' attitudes, values and beliefs and those of emerging professionals. In particular, medical students' continued positivity towards the individualistic nature of medical work appeared to be influenced by established medical practitioners.

2.3.4 Impact on working relationships among professions

In the provision of health care, the inability to view health issues from the perspective of other professions has resulted in poor communication and substandard working relations between professional groups, often resulting in poor patient outcomes (Weller, et al., 2010). Weller et al. (2010) support the need for more effective clinical teams, working interdependently to limit health service errors. Equally, more open effective communication between clinical teams, closer working relationships and collaborative practices among health professions are viewed favourably in optimising patient care (Hall & Weaver, 2001; McCallin, 2001). Despite the efficacy in promoting effective clinical teamwork, implementation is problematic when professions continue to perpetuate boundary-work to promote distinct ideology, specific health perspectives and related autonomous practice (Hall, 2005).

Inability to view the perspectives of other professions is evident in the findings from a recent New Zealand study that explored graduate nurses' and doctors' experiences of working interprofessionally in the provision of health care (Barrow,

McKimm, & Gasquoine, 2011; Weller, Barrow, & Gasquoine, 2011). The study, consisting of semi-structured interviews with 12 nurses and 13 doctors in the second year of graduate practice, identified markedly different views between the two groups on how the two professions interact in healthcare contexts. Generally the junior doctors in this study upheld a traditional notion of doctors maintaining overall authority for making decisions, suggesting that doctors were the leaders of health care teams. In contrast, although nurses were equally adamant that doctors assumed a leadership role, they were not consensual on a number of decisions made in team meetings and frequently actioned alternative decisions via management structures (i.e., protocols and guiding principles).

Although Weller et al. (2011) reveal positive aspects of collaboration, including mutual respect among professions and sharing of information, they acknowledge the barriers that exist in achieving interprofessional collaboration. Barrow et al. (2011) suggest, "different groups of new graduates have qualitatively different conceptions of how to work together, particularly around notions of leading, following and managing" (p. 27). Despite the small number of people involved in this study, its findings do signal marked differences in the perspectives of two primary health professions. Of concern in the findings from Barrow et al. is the lack of overt consensual decision-making between the two professions, particularly when considering the practitioners who are relatively new in their professions. Eraut (1994) adds to this concern by pointing out that the first few years of graduate practice are most influential in "developing personalised patterns of practice that every professional acquires" (p. 11).

On one hand this aligns with a notion of social closure (Macdonald, 1995), whereby members of a group further their own interests through closing access to the occupation. On the other hand, esoteric communities could be viewed as altruistically upholding the moral and ethical stability of societies, through use of discretionary

judgement, wisdom and expertise (Hilton & Southgate, 2007). As with other aspects of professionalism, socialisation in health professions has traditionally involved members adopting elements of both social closure—or perpetuating notions of self-interest—and of ethical conduct underpinned by altruistic values.

2.3.5   Calls for change to professional socialisation

Current siloed education and socialisation into specific ways of perceiving health and health care, with associated specialised knowledge and practices, fosters the development of professional identity in isolation of other professions (Dombeck, 1997; Hammick et al., 2009; Shulman, 2005). Equally, the adoption of specific health perspectives during socialisation into particular professions favours certain ways of viewing and understanding health issues (Barrow et al., 2011; Hall & Weaver, 2001). Furthermore, professional practice that occurs predominantly in isolation of other professions, as has been evidenced in the past, has led to miscommunication among health professions, with the risk for mismanagement of patients' health outcomes (Weller, 2012). So, while development of professional perspective is fundamental to maintaining the ideology and functionality of a profession, it appears the provision of effective health services requires new ways in which professions work together; specifically related to enhancing communication and loosening the distinct perspectives that currently orientate professions to approaching health care provision through a myopic or narrow lens.

In relation to changing health care practice contexts—with increasing demand for a flexible workforce who are able to work collaboratively—there is an increasing number of writers questioning the logic of maintaining the prevalence of professional socialisation into esoteric occupations with protected boundaries (Dall'Alba, 2009; King, Shaw, Orchard, & Miller, 2010; McCallin, 2005; Weller et al., 2010). Dall'Alba (2009) argues that the ways in which professionals are currently prepared for practice

"are generally limited in scope and inadequate for dealing with the change and uncertainty they encounter in contemporary professional practice" (p. 4). In addressing this concern, there is suggestion that professional socialisation needs to support the development of both professional and interprofessional identities (King et al., 2010). These authors propose a shift in attitudes, beliefs and behaviours of professions towards collaborative practice can only occur if there is noticeable change to traditional notions of health professions as distinct from each other.

In order to bring attention to areas for change, King et al. (2010) developed self-evaluative tools for determining the effectiveness of interprofessional education (IPE) in shifting away from professional stereotyping and exclusivity. Specifically they propose that over time and with refinement, these tools may assist in targeting where education and support—both in academic and in practice contexts—are required to facilitate change in preparing students and existing practitioners for enacting and shaping collaborative care. In support of using self-evaluative tools to determine the effectiveness of IPE initiatives, O'Brien, McCallin and Bassett (2013) used the Interprofessional Socialization and Valuing Scale (ISVS) questionnaire in a NZ study of students at the conclusion of clinical placement in an integrated health care clinic. Results from questionnaires completed by students (N=37) across three identified professional groups indicated students' perceived benefit in working with other professions, primarily in developing their understanding of the roles of others.

The authors (O'Brien et al., 2013) reported, however, that only 27% of the students thought they would seek to work in interprofessional work contexts following graduation. O'Brien et al. (2013) speculated that this result, regarding future expectations of working contexts, led students to experience uncertainty and possible false reporting (Hoerger, Quirk, Lucas, & Carr, 2012). O'Brien et al. (2013) concluded that positive attitudes towards interprofessional collaboration could be fostered through

ongoing interprofessional clinical exposure during professional education programmes. In addition they support Pollard et al. (2012) and Hoerger et al. (2012) in concluding the value of IPE may not be realised by students until they have graduated, "and are working collaboratively to achieve optimal patient treatment outcomes" (O'Brien et al., 2013, p. 85).

Other authors have supported moves towards narrowing the divide between specialist knowledge acquisition in formal education—away from the workplace—and the realities of practice (Argyris & Schön, 1974; Green, 2009). Green draws attention to the importance of experiential learning in practice, in the real-time experience of grappling with knowledge and skills embedded in practice. Green proposes that learning in practice contexts should be viewed as developing practice knowledge, which aligns with Argyris and Schön's (1974) concept of theories–in-use. These authors emphasised the divide existing between formal theories espoused in formal education and the real time experience of developing theories of action in and through practice. From this perspective, espoused theories may be viewed as conceptualising technical knowledge of the expected consequence of acting in a prescribed manner in specific situations. Furthermore, development of espoused theories for the appropriate actions to be taken in specified situations is synonymous with learning for practice, away from the workplace. For example, students in professional education programmes are taught appropriate actions to be taken in assessment, diagnosis and interventions of specific health conditions. Espoused theories are easily communicated to others, as these theories are articulations of how a person anticipates acting in certain specified situations.

By contrast, theories-in-use are the observable actions in practice, which may only partially represent espoused theories. Theories-in-use encompasses espoused theory, interconnected with "assumptions about self, others, the situation and the

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connections among action, consequence and situation" (Argyris & Schön, 1974, p. 7).
The complexity of theories-in-use, connecting practitioners' assumptions of certain
actions leading to specific consequences—an espoused theory—with a matrix of
variable situations, responsive action and uncertain consequence often detours from
desired outcomes. Thus, in contrast to espoused theories, learnt away from the
workplace, theories-in-use are multiple, responsive to situations in practice, and
increasingly difficult to communicate to others. Argyris and Schön (1974) suggested
theories-in-use in practice contexts are frequently at odds with espoused theories learnt
in academic contexts.

Hall and Weaver (2001) partly support this view. On the one hand they suggest
the complexity of health care issues is aligned with the need for increased specialist
knowledge and skills of health professions in order to provide comprehensive health
services. On the other hand, while the need for increased knowledge and skill
specialisation is necessary to advance understanding of current and future health service
requirements, Hall and Weaver (2001) suggest that the complexity and multiplicity of
health issues cannot be addressed by single professions, learning and working in
isolation of others. In addition, espoused theories of practice, developed in distinct
professional education programmes, may be at odds with the reality of professional
work in complex, multifaceted health care contexts, whereas theories-in-use reflect the
dynamic nature of collaborative practices among professions. So, while changes to
professional socialisation are advocated to better reflect the nature of professional
practice (Dall'Alba, 2009), it is important to consider the impact of possible change on
existing professions and professional practice.

2.3.6   Possible impact on existing professions

In contemporary health care—where interprofessional collaboration is promoted—there
is general understanding that change is needed in the way professions work (Brooks &

Thistlethwaite, 2012; Edwards, 2010). Although Edwards questions whether professional strongholds are out-dated and in need of restructuring, she argues that professional practices oriented towards a distinct health perspective cement working relationships among members of a profession, in the collective work of the profession. What a person cares about is often what leads an individual to embark on professional education in a specific field of health care practice and later to practice in that field. From Edward's perspective, "identity is what connects practitioners to what they care about" (p. 11), evidenced by the way practitioners navigate and negotiate their professional work. Brooks and Thistlethwaite (2012) agree, bringing attention to the underlying tensions between traditional notions of autonomous practice by professions and possible restructuring of work contexts. Their view is that "although 'collaborative practice' is a term with currency in both education and healthcare, the underpinning concepts remain tricky and contested" (p. 409). Furthermore, they propose consideration of changes in the ways professions work together may create conflict with the established values, perspectives and practice protocols of distinct professions.

In case study research that in part explored health practitioners' perceptions of roles, identity and status among professions working in teams, Baxter and Brumfitt (2008) reported on findings that uphold the views expressed by Brooks and Thistlethwaite. Thirty-seven practitioners from a range of professions were quite definite in describing their distinct roles in the care of patients, based primarily on their distinctive health perspectives underpinning their practice. Specifically, this was noted in relation to power and status differentials where nurses viewed doctors as ultimately responsible for decision-making regarding patients, but other professions were less inclined towards a hierarchical approach. For example, occupational, speech and physical therapists suggested doctors possessed limited ability to make in-depth decisions on specific therapies related to their professions and further differentiated

between medical and rehabilitative models of care in operation. Baxter and Brumfitt's later finding supported the strength of socialisation into different professions, resulting in members of professions adopting distinct perspectives on their health care practice.

The adoption of a distinct health perspective is linked to identity with a profession. Social Identity Theory (Tajfel & Turner, 1986) proposes individuals develop social identities through their membership to groups. Having a particular social identity means being similar to others in the group and adopting ways of thinking and acting that conform to normative behaviours in the group. In addition, having a particular social identity means seeing things from the group's perspective. Equally, comparisons and distinctions are made between those who are part of a social group, and those who are not. This creates perceived psychological boundaries so group members view themselves as a social unit.

Health professions consist of occupations conforming to the prototypical, or ideal social unit. This is evidenced by the socialisation process into particular professions, which is pervasive and encourages both adoption of distinct health perspectives and development of identity with the group (Shulman, 2005). Returning to Edwards' (2010) contention that identity connects people to what they care about—which in relation to health professions is frequently cited as a reason for choosing to study in one profession over another—it is necessary to be mindful of the potential disruption to professional identity in changing work contexts (McNeil, Mitchell, & Parker, 2013). This leads to the next enquiry into how health professionals work collaboratively with each other and the challenges facing an interdependent health care workforce.

2.4 Interprofessional collaboration

This section begins by bringing attention to the challenges that confront health systems. These challenges are two-fold. On one hand, health systems recognise the need for, and

actively seek, professional specialisation in the service of health care provision. On the other hand, these systems are confronted by escalating costs of financing health services. Added to escalating costs of health care services worldwide are inequities of health care delivery, leaving populations in underdeveloped countries in desperate need of health assistance and without the means or personnel to cope (WHO, 2010). In response, world health authorities have advocated the creation of interdependent health care teams, comprised of health professionals and health-care assistants, "as an innovative strategy that will play an important role in mitigating the global health workforce crisis" (WHO, 2010, p. 7).

In developed countries, there is also a need for a more flexible integrated health care workforce able to respond effectively in providing services across primary, secondary and tertiary health sectors. In New Zealand, for example, the Health Workforce Advisory Committee (HWAC) (2003) considers "hierarchical ways of working will need to change in favour of working in networks and effective teams to optimise co-ordination of care of individuals and their families" (p. 8). Furthermore, HWAC recommends "[t] he precise mix of disciplines is not as important as the combined knowledge, skills and attitudes of the group and the willingness and ability of members to work together as a team to achieve shared objectives and desired health outcomes" (p. 8).

Collaboration among health professionals has been promoted as a way forward in managing the complex challenges facing health professionals (WHO, 2006, 2010). Interprofessional collaboration requires consistent on-going partnerships among health professions in actioning clearly defined goals (Barr et al., 2005). Effective interprofessional collaboration does not, however, occur easily or spontaneously, as the construction of professional knowledge and practice boundaries create barriers that are

difficult to negotiate (Bluteau & Jackson, 2009; Freidson, 2001; McCallin, 2001; Nancarrow & Borthwick, 2005).

Taken from a functionalist sociological perspective, professionalism has been premised on the ability of occupations to retain jurisdiction over their discretionary knowledge and work activity (Freidson, 2001; Macdonald, 1995) and therefore the view of an interdependent workforce with intersecting professional boundaries is problematic.

There are a number of reasons why intersecting professional boundaries are viewed as problematic. First, professions are traditionally considered to be strongholds of specialist knowledge and have established privileged occupational positions through controlling the social and economic boundaries within which they operate (Larson, 1977). Additionally, professions have protected their knowledge and practice domains through establishing professional organisations (Freidson, 2001). These act to monitor and regulate the activity of members of a profession to ensure they maintain currency in their practice and adhere to ethical conduct in their service to the public. Further, education—generally separate from other professions—both educates and socialises nascent professionals into respective health professions (Shulman, 2005).

2.4.1   Existing challenges to an interdependent health workforce

Current professional boundaries that support and sustain health professions have a profound effect on how professionals practise and with whom. This is evident in health care practices, where a hierarchical professional approach to health care delivery has hindered collaborative relationships (Hammick et al., 2009; Nancarrow & Borthwick, 2005). Furthermore, the processes of socialising into health professions during extensive formal education and of establishing an identity with a chosen profession cement the centrality of the professional self (Freidson, 2001).

In addition, professional stereotypes and attitudes among health professionals influence the willingness—or otherwise—of practitioners to interact with other professions (Adams et al., 2006; Horsburgh et al., 2006). Adams et al. (2006) conducted research in 2003 that, in part, investigated aspects of professional identity development in first year students across ten health care professions. Findings from questionnaires to a large cohort of students (N=1254) indicated students enrolled into health care programmes with a strong pre-existing sense of identity towards a particular profession. This finding was attributed to students' prior knowledge, exposure to role models or working experience of a profession before their selection into an undergraduate programme.

Furthermore, Horsburgh et al. (2006) suggest students enter health care programmes with stereotypical attitudes towards other professions. Their research, conducted in New Zealand, sought to examine the views of medical, pharmacy and nursing students towards professional work. Survey results showed distinct differences between nursing and medical students understanding of professions working together, with medical students shown to favour an individualist in contrast to nursing students' collectivist approach to clinical work. In contrast to these polarised attitudes, pharmacy students reported less definite views on professional work (Horsburgh, et al., 2006).

In contrast to these findings, Hind et al. (2003) reported a more positive response from their research into students' perceptions of their chosen versus other health professions. Questionnaires distributed to students (N=517) in the early weeks of enrolment in one of a number of health professional programmes (dietetics, nursing, pharmacy, physiotherapy and medicine) sought their views on both their chosen profession and other professions. The results identified variable rates of positive correlation between identity with a professional group and positivity towards other groups. In particular, physiotherapy students were shown to have high regard for their

own profession as well as positive regard for those in other professions. Conversely, nursing students viewed their own and other professions less favourably. These authors had not expected these results and questioned whether lack of early contact between the various groups may have resulted in a buoyancy effect of students feeling well disposed towards others. Their results however do indicate that those who expressed a strong identity with their chosen profession upon entry into their programme also expressed positive regard for other professions, with converse responses from those who expressed a weaker sense of identity with their respective professions.

This led Hind et al. to conclude that interprofessional learning, commenced early in professional education programmes, may increase the likelihood of students' willingness to work among the professional groups, and reduce pre-existing stereotypes. Although the authors did not focus their research on students' views on stereotypes, but rather on identity, they did hypothesise that developing professional identity was linked to viewing other professions less favourably. Though their results did not support this hypothesis, a survey (Perkins et al., 2008) of students in their final year of study, that also included practitioners in the three professions, found a link between the attitudes, values and beliefs espoused by practicing professionals and those expressed by emerging professionals in a specific health care field. In particular, medical students' continued adherence to the individualistic nature of medical work appeared to be influenced by established medical practitioners.

Perkins et al. concluded that the perceptions some people have of other professions—although often incorrect—are resistant to change, particularly when these are reinforced in clinical practice. Thus, the combination of students assuming an identity in a chosen field prior to commencing their professional education, along with holding stereotypes of other professions, are attributes that foster professional selectivity. Furthermore, a practitioner's evolving identity in a profession, which begins

during undergraduate education and is nurtured and consolidated through comparison with those from other professions, generally favours one's chosen field in relation to others.

According to McCallin (2001; 2005), tensions between health professions limit the scope for developing a culture of collaborative practice, including adherence to professional boundaries and stereotypes. Further tension arises between the development of professional knowledge and related competencies to practise as a professional, and the reality of working in an increasingly interprofessional context where collaborative teamwork is expected (WHO, 2006; 2010). Frenk et al. (2010) suggested that continued professional "tribalism" by health professions has produced an isolationist rather than an interdependent workforce capable of collaborative practice. These authors advocated the need to intersect current professional boundaries, so a responsive professional workforce could address health challenges. Encouraging an interprofessional workforce is viewed as challenging when those entering the two largest health care professions—nursing and medicine—appear to possess conflicting views on how their professions practice (Horsburgh et al., 2006). Equally challenging is the reinforcement of these differences by experienced clinical staff in practice (Perkins et al., 2008).

2.4.2   Interprofessional practice

Interprofessionality, a term most often associated with collaborative practices, is used to describe health practitioners from any number of specified professions, working together in an integrated, interdependent manner, to provide effective and efficient health care services (D'Amour & Oandasan, 2005). Although interprofessionality is advocated as the way forward in meeting challenging health agendas (Frenk et al., 2010; WHO, 2010), the process of collaboration necessitates blurring the knowledge and practice boundaries built and sustained by the professions (Engel & Prentice, 2013).

This is problematic, given the jurisdiction of knowledge claims and practices underpinning professions as distinctive occupations (Fournier, 2000).

Consequently, members of professions—in responding to potential breaches in established professional boundaries—may choose to retreat into their strongholds (Mitchell, Parker, & Giles, 2011). In particular, these authors argue that threats to professional identity limit willingness to work interprofessionally. In a study undertaken to examine links between professional identity and interprofessional teamwork, Mitchell et al. distributed surveys to members (N=218) of a number of established interprofessional teams (N=47) working in the Australian healthcare system. Although the makeup of professions that comprised the survey sample was not supplied, nor their stages of clinical experience, results indicated that developing teams with distinct identities should not be at the expense of individual members' professional identities.

In teams where distinct professional identities were acknowledged and furthermore diverse perspectives were valued, team identities flourished. Conversely, threats to professional identity resulted in low motivation to contribute to teams, leading to limited team effectiveness. Mitchell et al. concluded the effectiveness of interprofessional teams is dependent on members forming a team identity, but not at the risk of undermining or limiting their professional identity. Brooks and Thistlethwaite (2012) agree, suggesting a change in the way members of respective professions think about and act towards each other requires a shift from maintaining professional autonomy towards interprofessional collaboration. These authors do, however, draw attention to the fact that working among professions with different orientations to healthcare practice may be disconcerting and cause disruption to notions of professionalism that have formed the structure of particular professions. Another option, they suggest, is towards changing the way members of respective professions think

about and act towards each other, requiring a shift from maintaining professional

autonomy towards interprofessional collaboration

2.4.3 Weakening of professional practice strongholds

From the evidence reviewed so far, it appears that in occupations such as health where

there are a number of specialist professions within a larger meta-professional basis of

work activity, the feasibility of maintaining professional strongholds is questionable.

Frenk et al. (2010) highlight the challenges facing professions as they confront complex

health issues on a number of fronts; including global inequities in health, changing

epidemiological trends of communicable and non-communicable diseases, and

escalating costs associated with health care provision. Furthermore, advances in

information technology and the ease of access to information from multiple sources, has

enabled public access into knowledge domains previously under the auspices of

professions (Fournier, 2000).

Paralleling service users' increasing access to health related knowledge is an

interest in participatory health care, whereby members of the public may wish to take an

active role in planning and implementing their health care (Hammick et al., 2009). This

has led to a shifting focus in health care from professionals being the sole providers of

health care to instead working with patients, families and communities "as needs are

assessed and delivery of services are planned" (Hammick et al., 2009, p. 104). In

addition, the ability of health professions to maintain jurisdiction over knowledge

claims is coming under increasing scrutiny, with notions of subjectivity (Camilleri,

2008), relational agency (Edwards, 2010), and intuition intersecting with scientific

reasoning and evidence-based practice. This suggests a shift in thinking on the ways

professions view knowledge as rational, underpinned by scientific explanation and

lodged in disciplines. In relation to professions maintaining jurisdiction over knowledge

claims, sociologists such as Freidson (2001) and Larson (1977) focused on realist objective knowledge in differentiating professions into distinctive occupations.

In contrast to this definitive conception of knowledge is a view of knowledge as tentative and unsettled, with a shift towards greater interaction and integration both of objectivity and of subjectivity in knowledge claims (Crowley, 2014). Crowley uses the term "asymmetry of knowledge" in reference to possible changes in the way knowledge is considered and used in an altered relationship between professions and those they serve. Within an altered relationship, professions retain both their in-depth and current understanding in specified fields of knowledge, and their ability to offer wider terms of reference to presenting concerns. Concurrently, in an altered relationship Crowley (2014) suggests a shift in how professions interact with the public, aiming towards a more inclusive relationship of joint decision-making with professionals guiding, rather than dictating this process.

Shifts in thinking about professions in relation to those they serve, attempt to cross existing knowledge boundaries towards relative ways of knowing. For example, Nancarrow and Borthwick (2005) position the growth of person-centred care in a model of health care practice that alters the focus of professional practice. Person-centred care emphasises the centrality of the patient to his or her care, of shared decision-making between a patient and health care professionals and implementation of treatment or assistance based on informed choices about available options for and with a patient (Hammick et al., 2009). Furthermore, a patient's autonomy and independence is valued in this model of care, where health professionals work with individual patients, rather than making decisions on their behalf (Manley, Hills, & Marriot, 2011). Cameron (2011) suggests this is a move away from "traditional patterns of services designed around professional interests" (p. 54). With this in mind, Cameron questions the ability, or indeed willingness of professions to adapt to a shifting focus from autonomous

practices based on specialist knowledge and discretionary judgement to less certain health care structures. Crowley (2014) argues to the contrary, emphasising that in the twenty first century, professions—as distinct groups and collectively— need to expand their perspectives on what constitutes knowledge so they are better able to engage and explore with others "from very different backgrounds, issues of significance to [their] professional practices" (p. 50).

Masterton (2002) has posed the challenge for health professions, questioning their "willingness to share and indeed to give up exclusive claims to specialized knowledge and authority if other professional groups can meet patient/client needs more efficiently and appropriately" (p. 333). An example of unwillingness to cross boundaries was evident in Timmons and Tanner's (2004) ethnographic study of operating theatre staff, which focused on how established nursing practices intersected with a "new" profession of operating department practitioners. Participants described practice disputes, alluding to blurred boundaries and role uncertainties. In particular, nurses were unsure of who the new practitioners were assisting and considered them as inferior, lacking in accountability and caring; claims that were disputed by members of the "new" profession (Timmons & Tanner, 2004).

2.4.4   Intersecting professional boundaries

Jones (2007) suggests that professional boundaries may be viewed as "interfaces, clear dividing lines between areas of different ownership or shared areas of contact" (p. 356). However, Cameron (2011) questions the permeability of professional boundaries, instead proposing the need "to understand how individual professionals perceive and experience the boundaries between professional groups" (p. 53). This is in response to tension between professionals' relationships with each other and the reality of a healthcare workforce that may not be equipped to meet the challenges of contemporary and future health needs. Cameron suggests, in relation to knowledge and practice

claims, "exploring how professionals themselves understand the concept of boundaries" (p. 58) is an important aspect in consideration of professional-interprofessional relationships and collaborative practice.

In this regard, Cameron advocates the need for professions collectively to question their processes of maintaining professional independence and territoriality; viewed as "isolation and boundary construction" by Fournier (2000, p. 73) and based primarily on assertions to expert knowledge claims being bound in respective professions. Edwards (2010) agrees with Cameron (2011), by contending "the learning that occurs in these boundary sites is not a matter of learning how to do the work of others. Rather it involves gaining insight into purposes and practices of others to enable collaboration; and it will make demands on the practices that are brought together" (p. 41). Preservation of professional boundaries is shown in findings from an ethnographic study undertaken by Reeves et al. (2009) with a range of health care professions. These authors examined the interactions between professions during formal and informal practice contexts, and found communication between doctors and other health professions was terse, with doctors communicating formally and in a unidirectional manner with those from other professions.

In contrast, members from other professions maintained collegial communicative channels, often informally in the course of their respective work (Reeves et al., 2009). Importantly, findings identified the mutual exchange of information between nursing and other health care professions was largely absent when any of these professions communicated with doctors. Of equal importance was the view held by a number of the allied health professions that team ward rounds were a low priority as they were seldom able to negotiate their perspectives within the largely dominated medical priorities.

Doctors were shown to have limited interest in working collaboratively. In contrast, the level of negotiation and discussion among the other professions was spontaneous, often unscheduled and viewed positively by those involved. Nurses and other professions interacted collaboratively in both formal and informal contexts, involving exchanges that were "richer and lengthier in nature and consisted of negotiations which related to both clinical as well as social content" (Reeves et al., 2009, p. 643). A possible reason forwarded by Reeves et al. (2009) for doctors' reluctance to interact was due to the maintenance of traditional social closure by medicine as a founder of health care professions (Freidson, 2001).

Edwards (2010) suggests practitioner intentionality and relational agency are crucial capabilities required when working at boundary 'sites'. Here, relational agency refers to "a capacity that arises when professionals bring their specialist expertise to bear in their joint action" (p. v). Both Cameron (2011) and Edwards (2010) advocate the importance of expanding knowledge boundaries with Edwards suggesting knowledge is a contestable construct and therefore open to deconstruction and analysis. This suggests a move away from considering knowledge as factual and absolute (Crowley, 2014), and paves a way towards negotiating and expanding knowledge boundaries towards more dynamic practice (Wenger, 1998).

The notion of relational agency is promising in promoting collaboration among health professions, but will require change in the way professional groups view themselves in relation to each other. As an example, Akkerman and Bakker (2011) suggest professional identities tend to be validated among members when a profession is threatened in their knowledge and practice claims. This was demonstrated in a study of health care professionals, whose employing organisation altered the clinical uniforms worn by practitioners (Timmons & East, 2011). Changing from clearly identifiable clinical outfits to a generic dress code left physiotherapists and occupational therapists

"reinforcing their occupational boundaries" (p. 1043) so they were not perceived as nurses, particularly by medical staff. Meanwhile, nurses were concerned the hierarchical status within the nursing profession was being eroded. Timmons and East (2011) concluded "the changes to uniforms…were interpreted as an assault on professional boundaries, and thus on the status and jurisdiction of the professions themselves" (p. 1045).

Wenger (1998) has argued that intersecting boundaries and indeed learning opportunities at the borders of practice communities fosters dynamic practice, or connectivity "between people from a number of practices in addressing conflicts, reconciling perspectives, and finding solutions" (p. 114). Dynamic practice occurs through members of different professions engaging in joint activity towards achieving goals that are unlikely to be achieved by a single profession. In support of Wenger's proposal, Styhre (2011) reinforces this notion of dynamism by stating professions cannot work in isolation of each other and therefore professional practice is inherently social, with professions sharing knowledge. As professions work with complex problems, it seems logical they must cross knowledge boundaries in order to assist in reasoned decision-making.

Hall and Weaver (2001) add further support for Wenger's notion of dynamic practise and Styhre's logic of professions working together through sharing knowledge. They point to the original premise for interprofessional collaboration occurring in professional practice and not in academic settings, stating collaboration between professions "did not originate in the university health science programmes, but was formulated by front-line practitioners facing complexities of patient care" (p. 873). Professional education programmes are designed primarily to prepare students with the requisite knowledge and skills to practice in distinct professions. Although there is inevitable overlapping of knowledge, values and perspectives between professional sub-

specialities there are also distinctive approaches taken in the use of knowledge. Hence, students graduate from professional education with well-formed notions of practice expectations that may be only partially met during their transition into the work environment (Argyris & Schön, 1974). This leads to the final question of enquiry, asking how graduates understand professional practice in collaborative health-care work contexts.

2.5 Transition into professional practice

The graduate year—when newly qualified health care practitioners first begin working in their chosen field of health care—is a time of transition into a credible functioning role within a professional occupation after years of formal education. Transition from student to participating member of a profession is complex. Graduates frequently experience a sense of being overwhelmed as they negotiate their first year of responsibility, decision-making, and accountability in a professional role (Black et al., 2010; Clarke & Springer, 2011; Kelly & Courts, 2007; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001). Tryssenaar and Perkins (2001) conducted a small study of occupational therapists' (N=3) and physical therapists' (N=3) transitional experiences from student into practitioner roles in their chosen field. Use of reflective journaling during the transition identified a collective sense of expectancy of becoming professionals, tempered with uncertainty as to their initial ability to function in their practice roles. The reality of early work was perceived as a shock as many graduates had thought working would be less stressful than being a student. Additionally, they grappled with the various workload demands in their professional practice, which decreased as graduates became familiar with their work contexts. As they adapted to their specific work contexts, they developed confidence to practise in their respective professions.

In another study of graduates' transition into practice, Clarke and Springer (2011) conducted focus group interviews with 37 new graduate nurses with lengths of practice experience varying from between 1–19 weeks. Findings from the total of nine group interviews, attended at least once by each participant, were similar to those of Tryssenaar and Perkins (2001). Nurses experienced a sense of being overwhelmed by the reality of workload demands, including the pace at which they were expected to work. In contrast however to the findings from Tryssenaar and Perkins that occupational and physical therapists' early graduate focus was on familiarity with specific work contexts, Clarke and Springer (2011) reported nurses' attention was on feeling valued for their contribution to patient care.

In a similar study of occupational therapy graduates' experiences of professional practice, centred specifically on the learning environment in their workplace, Toal-Sullivan (2006) identified the impact work contexts have on the development of practice in professions. Of the six participants in this study, those who worked in a public hospital context felt better supported in their learning than those in private practices. Interestingly, those who worked in private practices had learning support from a number of health professions, but this compared unfavourably with those in the hospital context who had support from designated occupational therapists. Furthermore, those working in private practice expressed more difficulties in adapting to practice role demands in their first year, citing conflicting values among the various professions and lack of learning support for them as graduates. Although this study did not seek to explore the impact of interprofessional work contexts on graduates' early work experience, findings do suggest graduates experienced tension in the interprofessional work context they were not expecting. Furthermore, they did not think the learning support offered from professions other than their own helped them develop their practice.

For many graduates, the ideal professional role does not match the reality of their work environment and this can lead to occupation dissonance, frustration and ultimately the choice to change career options (Johnson, Cowin, Wilson, & Young, 2012). Conversely, those who are supported in their early practice, appear better able to develop their sense of self-worth and self-esteem in their chosen profession. Each of these self-constructs has bearing on establishing a professional identity towards becoming a professional (Camilleri, 2008).

2.5.1 Establishing a professional identity

Identity is a psychological construct that is mediated through social interaction (Tajfel & Turner, 1986; Wenger, 1998). In a broader sense, identity refers to the response offered by individuals when asked who they are (Vignoles, Schwartz, & Luyckx, 2013). At a personal level, identity refers to aspects of self-definition, including an individual's personal understanding of their perceived attributes or qualities (Vignoles et al., 2013). Occupational identity extends individual self-definition into a working context, incorporating "an understanding of who one has been, a sense of desired and possible directions for one's future, and it serves as a self-definition and a blueprint for future action" (Skorikov & Vondracek, 2011, p. 698). As such, occupational identity "represents not only how we see ourselves, but also how we want to see ourselves and represent ourselves to others" (Douglas, 2010, p. 30). Douglas brings attention to the importance of using titles in support of developing professional identities, as titles reinforce the performative aspects of practices that differentiate one profession from another. Equally, professional identity is validated through dress code, as evidenced by the outrage expressed from members of a number of health professions when confronted with standardisation of uniforms (Timmons & East, 2011).

A further refinement of this definition—related to professional identity—is offered by Camilleri (2008), who refers to professional identity "as a person's concept

of what it means to be (beliefs and values) and act (thinking, actions and interaction) as a professional" (p. 37). This later definition presupposes a personal and social understanding of the attributes ascribed to professionalism, and is viewed as integral to an individual working in an occupation that has professional status. It is understandable that the development of a professional identity is pervasive, given the intensity of formal education and length of socialisation into health professions (Freidson, 2001, Shulman, 2005). Professional identity strengthens over time as fledgling practitioners interact with the practice community to which they are admitted. However, more recently, Johnson et al. (2012) have questioned the concept of self as inextricably interwoven with conceptions of professional identity, preferring to differentiate self and professional identity as different psychological constructs.

2.5.2 Professional self-concept

Following an extensive literature search of published research between 2001–2011 on professional self-concept and professional identity in nursing specifically and health care practice in general, Johnson et al. (2012) concluded a lack of cohesive understanding on what professional identity entails. Whereas self-concept defines "personal understanding of our perceived attributes (as a social, physical and cognitive person)… how we think and feel about ourselves thereby including the multiple selves of awareness, esteem and confidence" (p. 563), a professional identity "is a sense of self that is derived and perceived from the role we take on in the work we do" (p. 563). As such, professional identity aids in constructing the meaning people attribute to their work, including the categorisation and differentiation of members of one's group compared to others (McNeil et al., 2013). Education and socialisation into professions further cements the perception of distinct differences between professions, and therefore strengthens social identity of belonging to and favouring one group over another.

Furthermore, Johnson et al. (2012) suggest "professional identities are not always the most prominent aspect of our identity (who we think and feel we are) as a variety of socio-economic factors and opportunities can contribute to occupational appeal" (p. 564).

Similarly, Beddoe (2011) argues some health professionals have difficulty in developing professional identity in work contexts where they lack independence from dominant professions of medicine and nursing. For example, social workers practise in "contestable territory…[as] guests under the benign control" (p. 26) of these dominant professions. Social Identity Theory (Tajfel & Turner, 1986) describes identity in terms of how people perceive themselves in relation to others. Taken from this perspective, identity is socially mediated and dependent on interaction with others who are viewed as similar to one's perceived self. Equally, social identity is influenced through social comparisons made between groups, generally in favour of one's own group over others (Tajfel, 1981). Professional stereotypes are formed in this manner and are shown to have a marked influence on professions' views of each other during ongoing socialisation in professions (Bjorke & Haavie, 2007; Charles et al., 2010; Hean et al., 2006; Hind et al., 2003; Horsburgh et al., 2006; Perkins et al., 2008).

Understanding how professional self-concept and professional identity differ has implications for education, and practice in health care professions. In a doctoral thesis investigating the process of developing professional identity by graduate nurses, Camilleri (2008) conducted interviews with 11 registered nurses at regular intervals over 18 months following their graduation. She identified interesting findings related to the process of establishing a professional identity as a nurse. Participants had difficulty articulating when they acquired their nursing identity, with most stating it was an on-going process of becoming a nurse (Dall'Alba, 2009).

Hence, Camilleri (2008) concluded identity acquisition progresses from being primarily externally influenced through socialisation into a profession, with a concomitant sense from individuals of play-acting a role. During this phase, those involved were able to specify the knowledge and skills they were utilising in their role as a registered nurse. Additionally they were acutely aware of their developing competence and confidence in practice. However, by engaging an emotional dimension to their practice—often articulated as becoming integrated into a team and being valued by others—Camilleri noted, "descriptions of what they [participants] were doing and learning in practice became shorter and more vague" (p. 222). Thus Camilleri identified a shift from externalising the role of nurse, in which the graduate was an actor, to an internalising of identity as "being" a professional nurse.

Argyris and Schön (1974) referred to increasing familiarity, leading to habitual use of complex cognitive and related practical skills, as theory-in-use. This theory-in-use, or tacit knowledge, is procedural and requires little reflective thought. These authors argued a large amount of professional decision-making and judgements utilise theory-in-use and only when a practitioner is confronted with something out of the ordinary do they consciously engage in reflective practice. This is the situation graduates confront in their early practice, which they express as a sense of being overwhelmed by the enormity of their work expectations (Black et al., 2010; Clarke & Springer, 2011; Kelly & Courts, 2007; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001).

Graduates early focus on learning to function in the social context of work supports Camilleri's argument that forming a social identity precedes professional identity, inferring the malleable nature of identity acquisition in education and practice contexts. Importantly, the process of professional identity formation progressing from an external social to an internal subjective dimension does not appear explicitly in the

health professions research, where a focus on observable competency to practice takes precedence. Hence, Camilleri (2008) suggested the need for further research into the process of evolving identity acquisition, indicated by her finding that, "in being a nurse, one is always necessarily in a state of becoming, therefore the role of the nurse for individuals is continually evolving and changing" (p. 264).

2.5.3 Evolving professional identity

Of particular interest is how identity as a health professional in a chosen field is influenced, moulded or changed by engaging in collaborative practices in the graduate year. D'Amour and Oandasan (2005) have cautioned that interprofessionality, with related interdependence of health care practices, may alter professionals' scope of practices as practitioners work together. In addition, Edwards (2010) questions the influence of working interprofessionally in relation to establishing and maintaining professional identity, while Brooks and Thistlethwaite (2012) regard the values, goals and protocols of one's own profession may conflict with those of other health care occupations.

Given Camilleri's (2008) research findings of graduates' early practice of "playing" a professional role evolving into 'being' a professional as a gradual process, it seems logical that any number of interprofessional collaborative factors could influence a graduate's acquisition of professional identity. Miller (2004) had a different perspective to Camilleri (2008), in examining whether an established professional identity as a registered nurse influenced willingness or ability to work collaboratively with other health care professions. Four hundred nurses were surveyed, via a self-administered inventory on a number of professional attributes related to collaboration and professional identity. Of interest to this review was the finding that postgraduate educational attainment—at Masters and Doctoral level in the nursing discipline—strengthened professional identity but showed a weak relationship between identity and

collaboration. Miller (2004) proposed strengthening professional identity could negatively impact on willingness to collaborate. Miller also concluded there was need for further studies into the complexity of collaboration, specifically in relation to professional identity and from the perspectives of other health disciplines.

Camilleri's (2008) insight into graduate nurses' experiential process of developing professional identity into a chosen field is important to understanding the complexity of identity formation in social groups. Similarly, given Miller's (2004) finding of an uncertain relationship between professional identity and collaboration, it is worth reviewing the social contexts in which professional identity and collaboration are developed. Adams et al. (2006) suggest that professional socialisation "triggers the construction of professional identity" (p. 57) and cognitive flexibility (the ability to structure knowledge) may be influential in the constructive process. In this regard, flexibility in thinking may be advantageous in dispelling stereotypes and misconceptions by neophytes as they progress through professional education programmes.

2.5.4   Towards an interprofessional perspective

Learning to work collaboratively requires understanding the perspectives of other professions, awareness of what other professions care about, value (Edwards, 2010), and associated relational agency, "entailing working with others to strengthen purposeful responses to complex problems" (p. 31). This process may be obstructed by maintaining professional strongholds (Adams et al., 2006), and the influence of stereotypes and misconceptions aimed at different professions (D'Amour & Oandasan, 2005), including public perception of what a health profession encompasses (Camilleri, 2008).

To date, there is limited research on the influence of interprofessional collaboration on establishment of professional identity in the graduate year. Most

studies focus on the graduate year as a time for transition into a chosen field of practice only, although research into graduates' experience from allied health professions does broach collaborative interaction (Robertson & Griffith, 2009; Toal-Sullivan, 2006). Toal-Sullivan's research on the experiences of graduate occupational therapists showed a perceived lack of learning support when initiated by professions other than occupational therapy. Robertson and Griffiths' findings (2009) identified the impact of collaborative practices on graduates' preparedness for practice from an existing occupational therapy programme. While neither of the studies focused on collaborative practice as such, Robertson and Griffiths' findings identified graduates' difficulty in communicating their specific role and explaining their professions' contribution in team meetings due to incongruent language use and terminology among team members. In response to this finding, the authors advocated the need for graduates to develop their confidence and ability to articulate a distinct occupational therapy perspective in varied contexts and among a range of people. Furthermore these authors cited graduates' lack of clear understanding of their role during their initial education led to the difficulties they experienced in practice, when working in teams.

More recently Schwartz, Wright and Levoie-Tremblay (2011) conducted research focusing on the experiences of ten newly qualified nurses in collaborative practice contexts. Participants' graduate work experience ranged between 3 to 18 months, and all were involved in interprofessional mental health care, with a team-based approach to patient care that involved all members of designated health teams working collaboratively and interdependently in the best interests of individual patients. Similar to Camilleri's (2008) findings of graduates "role-playing" their early practice, Schwartz et al. (2011) found novice practitioners initially distanced themselves from actively participating in collaborative practice, favouring a passive role in observing others. They lacked confidence and did not feel competent to contribute information

from their nursing perspective. Willingness to participate as a contributing member of a collaborative team was determined by first establishing professional credibility and building trust with team members. It is worth noting the study was conducted in a specific work context — psychiatric nursing— and focused only on the nursing profession. In addition, graduates were entering a work environment where interprofessional teamwork was an established practice. Initially, novice practitioners remained peripheral observers, listening and watching rather than participating in collaborative work.

2.6   Conclusion

Although there is research into the experiences of new graduates navigating their occupation roles and establishing their identity in a chosen field, there is lack of research related to graduate practitioners' understanding of intersecting profession boundaries and what this will mean for their practice as health practitioners (Mitchell et al., 2011). As development of identity in a chosen occupational group is important to becoming a professional practitioner—one who can be relied upon to carry out a role in a manner that is ethically bound to the profession—it is important to understand how professional identity evolves in work contexts where interprofessional collaboration occurs from the time graduates commence practice in their respective occupation. I return to my original enquiry of asking how graduates construct meaning to new or changing ways of working in health care contexts.

It may be that graduates view professions and professionalism in new ways. Research indicates that traditional notions of professions as distinctive occupations remain strong. This is evidenced at entry into professional education (Adams et al., 2006; Horsburgh et al., 2006) and at completion (Perkins et al., 2008). Furthermore, graduates' primary focus on entry into the workforce is on developing competent practice in their particular profession (Black et al., 2010; Camilleri, 2008; Cowan &

Hengstberger-Sims, 2006; Toal-Sullivan, 2006). From a range of professions, the perceived threat to professional identity, when associated with collaborative work, impacts on the willingness of practitioners to work collaboratively (Barrow et al., 2011; Baxter & Brumfitt, 2008).

Despite evidence that professions protect knowledge and practice boundaries, there are advocates for change in the ways professions work together (Crowley, 2014; McCallin, 2001; 2005). The move towards patient or client-centred care has potential for shifting professional practices that are based on traditional notions of professionalism into new ways of working; primarily at the knowledge and practice boundaries of existing professions (Brooks & Thistlethwaite, 2012; Edwards, 2010, Hall, 2005). When graduates are engaged in interprofessional collaboration as part of their normal work activity, it is important to understand how they develop their identity and practice over time, in working contexts that intersect professional and interprofessional roles. Furthermore, viewed from graduates' perspectives, it is important to be cognisant of their understanding of working interprofessionally and the influence of collaborative practice on both their developing professional identity, and professionalism in the first year of registered practice.

Chapter Three

Research Methodology

3.1 Introduction

A graduate's first year of practice is a time of transition into the healthcare workforce and establishing a role in a specific health profession. As professional identity refers to the "sense of self that is derived and perceived from the role we take on, in the work we do" (Johnson et al., 2012, p. 563), identity is imbued with the meaning people attribute to their work (Burke & Stets, 2009). Professional identity is developed through socialisation into distinct professions during initial professional education programmes (Hall, 2005; Petrie, 1976; Shulman, 2005) and graduates then enter a health-care workforce with a primary focus on establishing a professional identity in their chosen field (Black et al., 2010; Clark & Springer, 2011; Kelly & Courts, 2007; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001). Yet, there is a progressive move in health-care practice towards collaboration among professions, and graduates entering the workforce are confronted with social working contexts that extend beyond their respective professions.

The social context of interest is the professional work environment where graduates participate in practices with others (Wenger, 1998). This research was therefore positioned in a context where people construct meaning to their everyday experiences (Van Manen, 1997). Wenger forwarded a Social Learning Theory that views participation as "shaping not only what we do, but also who we are and how we interpret what we do" (p. 4). From this perspective, graduates' active participation in practice shapes the development of their professional identity. In addition, Identity Theory (Burke & Stets, 2009) indicates that through participation in social contexts, persons observe, model and construct meanings to make sense of normative ways of

behaving, which reinforces a sense of identity. This research was therefore focused on graduates' experiences of participating in professional practices, and how they constructed meaning to those experiences in relation to their developing professional identity.

This chapter outlines the methodology of the thesis, as it sought to explore the phenomenon of graduates' evolving professional identity in both their chosen field and in collaboration among other professions in contemporary health care contexts. First, the philosophical orientation is discussed, related to the ontological, epistemological and axiological basis on which the research was premised. This is followed by discussion of hermeneutic phenomenology as a theoretical framework for considering the nature of multiple acts of interpretation and understanding that arise in and from experience. The research strategy, utilising case study as an appropriate research approach for exploration into evolving professional identity, collaboration and notions of professionalism in health professions is then detailed. This includes research methods of recruitment and selection of participants, data collection and analysis, and ethical considerations. Finally, the measures taken to authenticate the research will be explained.

3.2   Philosophical orientation

Underpinning any research activity is the basis of what denotes reality (ontology), including values and beliefs (axiology) on the relationship between enquirer and what can be known (epistemology). Although each of these philosophical perspectives may be described separately, they combine to form the basis from which humans interact both with the natural, biological world and with their social world (Lincoln & Guba, 2013). Furthermore, the ontological and epistemological views that researchers possess influences the type of research approaches they take to fields of enquiry (Crotty, 1998).

3.2.1   Ontological perspective

Different ontological perspectives have a bearing on how people approach the nature of existence, determined primarily by their views on whether reality exists separate to, or integral to humans' conscious awareness of that reality (Creswell, 2013). Crotty (1998) rationalised this notion by stating "the world is there regardless of whether human beings are conscious of it" (p. 10). He qualified this statement by questioning the type of world that exists for humans if there is no conscious engagement with it. Taken from this perspective, although a world and its component parts exists independently of human consciousness, the nature of human existence, of "being" in the world is determined by the meaning humans attribute to their existence (Crotty, 1998; Denzin & Lincoln, 2011).

There are a number of ontological orientations that fall within the continuum of reality existing outside of the human mind (Realism) and reality being dependent on human consciousness of their existence in the world (Relativism). Maxwell (2012) argues that realism combines the ontological view that there is a real world that exists independently of our human beliefs and constructions with an epistemological stance that our knowledge of this world is our own construction, created from a specific vantage point. Though acknowledging Maxwell's argument I have, however, distinguished between realism and relativism in order to contrast the essential nature of social research designs with scientific approaches to research methodology. In doing so, I acknowledge that this provides a stark contrast rather than recognition of the range of perspectives that form a continuum between distinctive ontological views of realism and relativism (Lincoln, Lynham, & Guba, 2013).

From a strictly realist ontology, reality or existence resides outside the human mind (Denzin & Lincoln, 2011). This view on the nature of reality is aligned with traditional notions of scientific research, specifically focused on researchers objectively

studying the natural or biological world and in the study of humans (Creswell, 2009).

Here the researcher aims to maintain a detached objective focus on discovering truth

elements of existence untainted by human subjectivity. In contrast to a realist ontology

of what constitutes reality, is the notion of relativism. Relativism refers to an

ontological view that reality resides in the consciousness of humans as they interact in

their world (Denzin & Lincoln, 2011). From this position, humans experience their

world and construct meaning to their experiences, individually and in groups (Fosnot,

2005). Taken from a relativist perspective Crotty (1998) proposes, "the existence of a

world without a mind is conceivable. Meaning without a mind is not" (pp. 10–11). Here

Crotty is referring to the interactive nature of humans with their world, in their

construction of meaning.

Much social research seeks to understand how humans experience and construct

meaning to their world, from the people themselves (Lincoln & Guba, 2013). This

forms the basis of an interpretivist view of what constitutes knowledge that is socially

oriented. While not denying the value of scientific enquiry that furthers natural and

biological sciences, I approached the current research from an interpretive perspective,

underpinned by a relativist view on social reality residing in the consciousness of

humans. In approaching the current research from this perspective, I aimed to embrace

the multiple perspectives from study participants, with the intent of "reporting these

multiple realities" (Creswell, 2013, p. 20).

3.2.2   Epistemological stance

Stake (2010) defined interpretive research as "investigation that relies heavily on

observers defining and redefining the meaning of what they see and hear" (p. 36).

Hence, from an interpretivist orientation, people seek to understand the world in which

they live (Creswell, 2013). Creswell stated that people develop particular subjective

meanings of their experiences, which are varied and multiple. Research undertaken

from this perspective therefore aims to explore the complexity of views from and with others, referred to by Lincoln and Guba (2013) as highly person-context specific.

I favoured an interpretive approach as appropriate to explore graduates' experiences and their perceptions of professional practice with the intent of making sense of, or interpreting, how others construct meaning to their experiences in the area of interest. I was not able to achieve this through research approaches that favour detached scientific rationality, when the underlying knowledge tenet is one of seeking truth that is objective, valid and may be generalised and where people are viewed objectively. This is not the intention of interpretive research approaches, which view people as subjective constructors of meaning through interpersonal communication between self and others (Fosnot, 2005).

In contrast to a realist ontology, whereby research approaches aim towards objectivity and researcher detachment in the research process, relativist orientated research "must start with the presupposition that social reality is relative to the individuals involved and to the particular context in which they find themselves" (Lincoln & Guba, 2013, p. 39). In addition, Denzin and Lincoln (2008) identified the researcher as being inside the research process, deploying a range of interpretive methods, often over time, to better understand the experiences of those being studying. Researchers, however, do not enter into research contexts as objective observers, rather "observations [are] socially situated in the worlds of, and between, the observer and the observed" (Denzin & Lincoln, 2008, p. 29). Consequently, researchers engage in subjective interaction with the research context; from an interpretivist epistemological orientation they cannot position themselves as being detached from the research process.

Although researchers aim to get as close to their study focus as possible, they frequently observe and interpret the lives of others vicariously. Stake (2010) stated that

when researchers "cannot see for themselves, they ask others" (p. 32). Whether through first hand observation or through vicarious means, the researcher aims to capture aspects of human experience and, through interpretative processes with and of participants, come to understand the various meanings attributed to individual and social lives. In keeping with an interpretive epistemology, a researcher can only ever interpret what has already been experienced and interpreted by another, and as such, "share in constructing what we define as data" (Denzin & Lincoln, 2008, p. 206). Further, Denzin and Lincoln suggested that developing understanding of an issue, through analysis of data, involves subjective interpretation by the researcher; with no claim beyond "theoretical analyses [being] interpretive renderings of a reality, not objective reporting of it" (2008, p. 206).

Criticism is levelled at this epistemological perspective about what constitutes knowledge, described as unscientific or fiction by those "who presume a stable, unchanging reality that can be studied with the empirical methods of objective social science" (Denzin & Lincoln, 2011, p. 46). The main criticism appears over the legitimation of reason and truth. Countering this criticism is their view that knowledge of the social world is multi-faceted and constructed by persons, in and of their world (Lincoln & Guba, 2013). Furthermore the focus of research undertaken from this epistemological stance is not in establishing knowledge truths, but in understanding human experience and construction of meaning. Hence the primary research question regarding graduates' understanding of their practice is appropriately situated in an interpretive epistemology that values subjectivity.

Specific questions of interest regarding graduates' understanding of professionalism, collaboration and professional identity focused on their experiences and the meanings they attributed to a sense of evolving identity in a specified field of health care practice and through interprofessional collaboration. The intention in asking

these questions was to draw on graduates' experiences, sense-making—or perceptual awareness—and construction of meaning in their work context. This, I suggest, was best achieved through conversational interaction between researcher and graduates.

3.2.3 Axiological position

The focus of this study concerns humans as social beings. Specifically, the research centred on health science graduates in their first year of practice as health professionals. Van Manen (1997) described studies of humans as investigations of "persons, or beings that have consciousness and that act purposefully in and on the world by creating objects of meaning that are expressions of how human beings exist in the world" (p. 4). From this perspective, people consciously interact with their world and construct meaning to their experiences (Lincoln & Guba, 2013). This contrasts with viewing humans dispassionately as research subjects for the purposes of experimentation, manipulation and measurement, and when the aim of the research is towards verification or falsification of hypotheses (Denzin & Lincoln, 2011). The language and intent differs markedly between the two distinct approaches to studying humans.

Research undertaken from a positivist approach, underpinned by objective epistemology, aims at explaining human responsiveness or behaviour. In contrast, a researcher approaching a study with the purpose of understanding humans, as they experience and interpret their world, aims to explore the complexities of being human; the purpose being to gain insight into how persons and groups construct meaning to their lives (Denzin & Lincoln, 2011). The premise underpinning this view, or orientation, presupposes that human reality, in a social world, is subjective. Additionally there is no absolute perceived reality; rather persons construct "multiple realities, or interpretations, of a single event" (Merriam, 2009, p. 8).

Accordingly, a researcher working from a phenomenological position delves into the actions, thoughts and emotions of persons and groups as they conduct their

lives, and the meanings they attribute to the events they experience; either individually or through social interaction. In doing so, the researcher is within the research: hearing, observing, noting, isolating and comparing experiences as portrayed by participants in the study, while valuing the subjective nature of interpretation (Denzin & Lincoln, 2008). Through this orientation, research is constantly interpretive, with the aim of constructing new, revised or extended understandings in an area of human interest (Lincoln & Guba, 2013).

This contrasts with a view of reality as fixed and waiting to be discovered; a positivist perspective that forms the basis of conventional scientific research where detached objective methods are employed and where the underlying reality claims are to discover the truth of existence (Denzin & Lincoln, 2011). The intent in undertaking research from a positivist perspective is to test theory in an area of interest, with the view to falsify or add to what is currently known. Furthermore the positivist researcher expects to remain detached from the research, retaining an objective stance in the research process. In positivistic social research, the use of surveys and questionnaires for collecting research information from humans may be used to gather sufficient data from which to make general claims regarding human activity. Researchers' paradigmatic, or worldviews on knowledge claims will influence whether social research is viewed as an objective or subjective activity. As important are the research questions that are asked, as these presuppose specified lines of enquiry (Creswell, 2009).

When the aim of research is to develop understanding of how humans experience their social world and the way they construct meaning to their experiences, then an interpretive research approach is preferred. Lincoln and Guba (2013) argued interpretivist research does not deny a physical world exists or the value of objectively studying the physical world. Interpretivism is focused, however, on a social world, and

how persons experience and construct meaning to their social world. I chose an interpretive research approach that draws explicitly on human experience and the meanings people attribute to their experiences. The research question, of how graduates understand their professional work in interprofessional contexts, was oriented towards exploring the development of graduate practice, as experienced by graduates themselves in their practice contexts.

The focus of this enquiry—graduates' experiences and understanding of developing identity—has drawn on hermeneutic phenomenology as a research methodology; combining philosophical tenets on experience (phenomenology) and interpretation (hermeneutics). Van Manen (1997) explained the study of experience, or phenomena, as a process of "gaining a deeper understanding of the nature or meaning of our everyday experiences" (p. 9). Furthermore hermeneutics, the art of interpretation, addressed the interpretive nature of delving into how graduates make sense of, and construct meaning to their experiences of working as professionals in contemporary health care contexts (Lincoln & Guba, 2013). These philosophical tenets, phenomenology and hermeneutics, are explained in greater detail in the following section, separately and in combination as a theoretical lens through which the research methodology developed.

3.2.4   Theoretical lens

The theoretical lens, through which a researcher addresses research methodology, is founded on the question of how best to acquire knowledge or understanding in the area of inquiry (Lincoln & Guba, 2013). Although many research approaches seek to be objective, interpretive research approaches view subjectivity as embedded in the research process. Furthermore, from an interpretive perspective, Higgs, Horsfall and Grace (2009) viewed knowledge as "an internal construction, where meaning is individually assigned to events, ideas and experiences" (p. 19). Similarly, Lincoln and

Guba (2013) considered the mechanisms of knowledge as created or constructed in social contexts, rather than discovered. This may be achieved through exploring the meaning attributed to experiences, from the different perspectives of those who contribute their own constructions of those experiences.

Hermeneutic phenomenology provided the methodological framework for addressing the research question of how graduate health practitioners understand professional work in an interprofessional context. As the basis of the research question has drawn on both graduates' experiences in the area of interest and their constructions of meaning attributed to the experiences, hermeneutic phenomenology was favoured as a sound methodological position on which to undertake the research (Lincoln & Guba, 2013). Additionally, the purpose in undertaking the research was to develop understanding of the phenomena of interest, i.e., the process of developing professional identity at the intersection of professional practices. This, I suggest, was best achieved through dialogic interpretive interaction with those who were experiencing the phenomena in the defined social context (Laverty, 2003; Sharkey, 2001). Sharkey described the dialogue between the researcher and research participants as "getting lost in the conversation's subject matter in authentic conversation, and it's getting lost in the subject matter that leads to genuine understanding and interpretation" (p. 16).

In addition, Laverty (2003) stated that although dialogue between researcher and research participants "is concerned with the life world or human experience as it is lived" (p. 24), the focus of hermeneutic phenomenology is to draw on aspects of experience "with the goal of creating meaning and achieving a sense of understanding" (p. 24). This implies that, from an interpretive research approach, researchers act in both a conversational role with respondents and as an interpreter of information, with the aim of creating connections between perspectives (Lincoln & Guba, 2013). Furthermore, the researcher expects to think deeply on the complexity interwoven into the perspectives

for the purpose of producing text, or other communicative forms that illustrate and illuminate new understanding to an interested reader. Essentially the researcher is engaged in an ongoing iterative process between transaction and interpretation (Crotty, 1998).

Methodologically, phenomenology and hermeneutics are traditionally viewed as distinctly separate (Laverty, 2003). Phenomenological research focuses on studying the essence of human experience, its structure and the "organizing principles that give form and meaning to the [human] life world" (p. 27). Hermeneutic research, in contrast, focuses on human ability to decipher meanings of experiences, encompassing "historical meanings of experience and their developmental and cumulative effects on individual and social levels" (p. 27), primarily through language use and written text.

Combining the philosophical assertions of each approach befits an interpretive enquiry into social research, when the researcher is concerned with coming to understand not only phenomena, but also the construction of meaning associated with the phenomena and related context in which the phenomena occurs (Van Manen, 1997). Thus, when considering an appropriate research methodology for the current study, it was important to explore graduates' experiences of early professional practice in a health care context. Specifically, enquiry into how graduates developed professional identity at the interface of professional and collaborative practices was contextually bound in clinical work situations, and therefore hermeneutic phenomenology provided the theoretical lens that informed the current study.

Phenomenology—the study of phenomena or human experience—was historically concerned with viewing human experience in ways other than scientifically. Edmund Husserl (d. 1938), a philosopher in the early development of phenomenology, focused on studying human experience as an intentional conscious activity between the self and something. From this perspective Husserl believed human subjectivity could be

bracketed, or set aside, in order to focus on the essential essence of experience, with no attempt at interpretation. It appears that although Husserl's phenomenology was theorised as a break from objectivist thought, the focus on bracketing subjectivity aligns with scientific tenets of seeking ultimate truths (Laverty, 2003). Martin Heidegger (d. 1976), a student of Husserl, questioned the ability to view human experience, without related meaning, as anything other than abstraction and theoretical, with limited practicality (Smith, Flowers & Larkin, 2009).

Primarily Heidegger believed that the study of phenomena was significant because of the human capacity to interpret experiences and make sense of the world. Thus, Heidegger's phenomenological perspective created a link between human experience and interpretation. Importantly, Heidegger recognised intersubjectivity was inherent in people's engagement in their social world and could not be bracketed out of sense–making and interpretation. Thus, from Heidegger's perspective the human world can essentially only be experienced through an interpretive process.

Hermeneutics, or the art of interpretation, provided a further theoretical lens through which to view the iterative, recursive process of constructing meaning. In particular, hermeneutics is viewed as "a rich way of thinking through and approaching …meaning-making that is an integral part of human activity" (Higgs et al., 2009, p. 63). Hans-Georg Gadamer (d. 2002), a student of Heidegger, proposed a philosophical hermeneutics, which was concerned with uncovering the many and varied ways that human meaning unfolds. Gadamer believed that meaning to experience is contextual, and understanding cannot be separated from the historical and cultural contexts that shape human social existence. Furthermore, from this perspective hermeneutics does not lay claim to solving problems, rather to illuminating complexity, and communicating "layers of meaning" humans attribute to their lives (Gadamer, 1991).

Methodologically, Gadamer viewed hermeneutics as a process of mutually constructed interpretation, or a "fusion of horizons" (1995, p. 388) between researcher and participants' contextual understanding in an area of interest. Here Gadamer was referring to the sharing of texts, or perspectives, between author and interpreter through dialogue, whereby "something is expressed that is not only mine or the author's but common" (1995, p. 388). This, Gadamer contended, opened the possibility for new understanding to take place "as a fusion between the horizon of the interpreter (always in a process of formation) and the horizon projected by the life expression being interpreted" (Sharkey, 2001, p. 28). The hermeneutic dialogic process is aimed at producing more than the sum of parts from the contributors to the dialogic. The researcher also acts intentionally to apprehend, comprehend and interpret the combined sums of the parts towards new understanding or insight in an area of interest.

My intention in enquiring into how graduates develop professional identity in interprofessional contexts was premised on the notion that understanding this phenomenon was best achieved through direct dialogue with those who were experiencing the phenomena. The essence of experience was not, however, the primary interest. More important was the graduates' understanding of the process of developing identity in the defined context. Methodologically, a combination of phenomenology and hermeneutics provided a theoretical lens from which to explore the experiences of others, and the meanings constructed to those experiences. Drawing on Gadamer's hermeneutic approach to research, by way of explaining the researcher-participant engagement as a "fusion of horizons", provided a useful metaphor for signifying an iterative interpretive process that enabled me, as the researcher, to interweave the parts—from multiple perspectives—towards new, altered or more sophisticated understanding of an area of interest, pertaining to a specified phenomenon and context.

3.3 Research strategy

Linking a researcher's philosophical and methodological orientation to research activity requires alignment between theory and practice. Denzin and Lincoln (2011) suggested research activity be viewed as an inquiry strategy, referring to "a bundle of skills, assumptions and practices that researchers employ as they move from their paradigm to the empirical world. Strategies of inquiry put paradigms of interpretation into motion" (p. 14). From an interpretive orientation, case study provided a research strategy to gain insight into the "sequentiality of happenings in context" (Stake, 1995, p. X11); namely evolving professional identity, as perceived by graduates during their first year of working in health care practice, and where the development process was embedded in a social context. Stake (1995) recommended the use of case study as a research strategy when a "bounded" process is of interest, and where context and process are inextricably interwoven. Further, Yin (2014) considers case study research addresses "contemporary" phenomenon in "real-world" contexts, where "the boundaries between phenomenon and context may not be clearly evident" (p. 16).

The purpose of this research was to explore how graduates experienced and constructed meaning to professional identity and notions of professionalism in contemporary health-care practice. A particular focus was on understanding professional identity intersecting with the knowledge and practice boundaries of other health professions in provision of effective health-care service. This was an exploratory study, concerned with understanding developmental processes happening in naturally occurring social contexts. There was no intention to observe or to be present in the practice context, akin to ethnographic research (Creswell, 2013). Rather, the research was conducted primarily through dialogue with participants and relied on their experiences, perceptions and views of the process of developing professional identity in the context of their professional practice.

Essentially the study, utilising case study as a research strategy, was undertaken from an interpretive perspective, underpinned by a subjective epistemology, which views individuals as seeking to understand the social world in which they live and work (Creswell, 2009). Case study provided a research strategy for exploring key areas of interest, over time, in a defined naturally occurring context. The advantage of case study, in preference over other research approaches, was utilisation of a specifically defined and bounded context that focused attention on the area of interest (Creswell, 2007; Stake, 1995).

3.3.1 Case Study

In keeping with an interpretive perspective, gathering information from those embedded in the process of navigating their early professional practice in naturally occurring contexts was pivotal to the study (Lincoln & Guba, 2013). Case study design aligns well with interpretive methodologies (Creswell, 2007; Lincoln & Guba, 2013; Merriam, 2009; Yin, 2009). Creswell (2007) defined case study as "a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information" (p. 73). Additionally, Merriam (2009) advocated use of case study to seek meaning and understanding of an issue, suggesting a distinct advantage over other research strategies for exploring phenomena that are embedded in everyday contexts (Yin, 2009). More recently, Lincoln and Guba (2013) support case study as a research strategy through which experiences and related meaning may be shared vicariously between persons.

The aim of this study was to understand how graduates make sense of, or come to understand their professional identity within the intersections of working with other health professions. The experience of developing professional identity was therefore the specific phenomenon being explored. Case study research enabled the researcher to

come as close as possible to naturally occurring contexts related to a specific phenomenon, and provided opportunities to view the lived experiences of others vicariously (Lincoln & Guba, 2013; Merriam, 2009); particularly when the phenomenon of interest was embedded within a "real-life context, [and] when boundaries between the phenomenon and context are not clear" (Schwandt, 2007, p. 28). Stake (1995) stressed the aim of the case researcher is to "understand how the actors, the people being studied, see things" (p. 12). In doing so, the researcher draws from the 'multiple realities' of others, often vicariously, in order to gain insight into what is happening (Lincoln & Guba, 2013). Ultimately, the researcher aims to provide an interpretation of the case but preserve the various views of those who contributed in the form of rich, descriptive excerpts. Furthermore, Merriam (2009) suggested one of the special features of case study research is the ability to "illuminate the reader's understanding of the phenomenon under study" (p. 44), through discovering new meaning or confirmation of what is already known.

Graduate practice, defined as the first year of employment in a clinical health care context, provided a time-bounded context. Hence, case study provided a general research strategy that was centred in the graduate year of clinical practice. Specifically, Stake (2010) advocated the use of instrumental case study if a particular bounded case is examined, "mainly to provide insight into an issue" (p. 123). He rationalised the use of instrumental case study when "the case is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else" (p. 123). Instrumental case study frequently includes a number of cases, chosen because the researcher believes "that understanding them will lead to better understanding, and perhaps better theorizing, about a still larger collection of cases" (Stake, 1995, p. 123) in the area of interest. Further, Stake (2010) emphasised interactivity between the researcher's reporting of a case study and the readers' subsequent interpretations, drawn from

personal experiences in relation to the study context. Thus interpretive case study is of value in capturing a complexity of multiple perceptions, constructions, meaning and understanding.

Furthermore Lincoln and Guba (2013) stressed the importance of offering a vicarious experience for readers, by providing sufficient richness of detail so the reader could form a sense of personal construction. In support of providing a vicarious experience for readers, Stake (1995) recommended the use of vignettes, or brief descriptive exposés that are drawn from the context, timing and experiences of others. It is worth noting the audience who read the case may understand findings differently to the researcher, and thus findings from a case study can never truly be generalised (Merriam, 2009). However, in keeping with an interpretivist perspective, the research intent was not to seek answers to questions that could then be generalised.

The primary aim in utilising instrumental case study, as a research strategy, is to develop an in-depth understanding and interpretation of a phenomenon embedded in the case (Yin, 2014). Furthermore, by paying careful and thoughtful attention to a case, over time, and utilising a number of methods for collecting data relevant to the area of research interest, the social researcher allows leeway for following unique, unexpected and sometimes unanticipated avenues within a social context from which the phenomena of interest arises. Flyvberg (2011) suggested that case study "can close in on real-life situations…as they unfold in practice" (p. 309).

Taken from this perspective, a case study research strategy supported exploration in the area of interest—the development of professional identity and professionalism—to add meaning to the developing general knowledge in the area of collaborative health care practice. Specifically the use of case study enabled a clearly defined focus on the interaction between phenomena, context, and time, in relation to collaborative health care practice. Furthermore, utilising case study as a research

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strategy provided structure early on in the research concerning key decisions on participation, duration of research process, and appropriate methods for collecting data that were relevant to the phenomenon, context and process being explored.

3.4 Ethical considerations

Approval to undertake the study was granted by a New Zealand university ethics committee in October 2011 (Appendix A). Ethics relates to the moral conduct of people. Specifically ethics is concerned with what is deemed morally right, or correct in the way people behave as individuals and towards others (Merriam, 2009). In research there are ethical issues that extend across the duration of research activity. The conduct of the researcher towards those being studied must, at all times, be respectful, transparent, and protective of the interests of those who participate. In interpretive research where participation is sought from persons who are able to offer insights that may contribute to new understanding in an area of interest— and where the researcher is viewed as inside the research—further ethical concerns relate to the protection of participants; protection from deception, exploitation and identification.

As this study relied on seeking the experiences and perspectives of others, there were a number of ethical issues concerning my role as a researcher that I anticipated. Issues of power relations, disclosure of information, and research beneficiaries were formally disclosed to potential participants during the recruitment phase of the research (Appendix B). Furthermore, throughout the research process I was vigilant in maintaining participant privacy through nondisclosure of identifiable information in text. This included the identity of participants and their places of work. Pseudonyms, picked by participants, replaced actual names and workplace names were generalised. In addition, prior to commencing data analysis, participants were sent the transcripts from their individual interviews to assess for accuracy, and the opportunity to provide any additional information or deletions to the text.

This procedure was not however followed with the transcripts from focus groups, due to the number of participants in each of these group interviews. Focus groups posed a breach to participant privacy, as a number of those in attendance knew each other. To limit this risk participants were called by their actual name during the group interview. Once transcriptions of focus group interviews were complete, all actual names were replaced with corresponding pseudonyms so there was no connection made between real and assumed participant identity.

Importantly, the researcher was the only person who had access to participants' personal and workplace details throughout the research process and abided by ethical standards and procedures as required by the institutional ethics committee who approved the research (Appendix A). Of equal importance, those who participated in the study did so willingly, in the knowledge that they could withdraw from participation at any stage if they chose to (Appendices C & D). In addition, on request, any or all of their contributions would be removed from the data collection prior to completion of the project.

3.5   Participants

Participant is the term generally used in interpretive research to signify persons being studied (Merriam, 2009). This term is used to indicate research participation as being informed, inclusive and voluntary. Furthermore, participants are viewed as integral to the enquiry process in an area of interest, through interpersonal subjectivity with the researcher (Lincoln & Guba, 2013). Therefore the selection of appropriate participants into an interpretive research project is important. This contrasts with the selection of subjects into research where objective information is sought. The term subject, in contrast to that of participant, denotes a detached relationship between researcher and those being studied, and where subjects may be uninformed of the aims of research activity in order to further promote objectivity devoid of human subjectivity.

The type of enquiry and the research questions being asked will determine whether participants or subjects are sought. Enquiry into the experiences and perceptions of graduates during their first year of professional practice was best achieved through conversational dialogue with participants, who were graduates. In addition, a decision on the number of participants, their location, and recruitment strategies must be established (Creswell, 2013). Creswell referred to this decision making process as a purposeful, or purposive sampling strategy, in contrast to probability sampling strategies employed in scientific research. Furthermore, Patton (2002) argued the need for purposefully seeking information-rich participation, which Merriam (2009) reinforced, "based on the assumption that the investigator wants to discover, understand and gain insight and therefore must select a sample from which the most can be learned" (p. 77).

3.5.1 Selection criteria

Creswell (2007) proposed the use of a purposeful sampling strategy in selecting participants when a specific issue is being researched. Smith et al. (2009) concurred, stressing the importance of ensuring those participating in a study have experience of the phenomenon being investigated, and are able to offer insight into their particular experience. Utilising purposeful sampling strategy (Creswell, 2007; Merriam, 2009), participants for this research were sought from Bachelor of Health Science (BHSc) programmes at a large university in New Zealand. The reason for this was that the Bachelor of Health Science is the requisite undergraduate degree for a large number of health professions practicing in the New Zealand health care system. Specifically, participation was limited to persons completing their final semester of undergraduate study at the end of 2011. Limiting the time frame to a specified graduation period enabled early structural boundaries to the case study. Additionally, persons graduating at the end of 2011 were expected to transition into professional practice in 2012 and this

provided a temporal boundary to the research time frame of a single graduate year of practice.

Further consideration was given to whether one profession or a number of professions would be recruited into the study. The development of professional identity in single professions has been a focus of previous research (Black et al., 2010; Clark & Springer, 2011; Fenwick et al., 2012; Kelly & Courts, 2007; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001). Furthermore, recent research of nurse graduates working in specific interprofessional contexts has been conducted (Schwartz et al., 2011). However, the aim of this current study was not to understand identity development specific to one health care profession. The aim was to understand the process of developing professional identity within the working context of collaborative practices among professions. Therefore the selection of participants from a range of health professions was appropriate with a research focus into how emerging health practitioners constructed meaning to professional practice in the context of collaboration with other health professions (Creswell, 2013).

Furthermore, the inclusion of a number of health professions was favoured in providing multiple perspectives from within specific and across different health care professions (Merriam, 2009). This is referred to as maximum variation sampling (Glaser & Strauss, 1967), and although associated primarily with grounded theory, Creswell (2013) advocates the use of maximum variation sampling if multiple perspectives are sought on a phenomenon or process. As the purpose in undertaking the current research was to add to the knowledge and practice field of interprofessional health care, inclusion of participants from a number of health professions was viewed favourably in drawing on potentially different professional perspectives. The choice of six distinct professions was rationalised on the basis that the graduates from these professions would transition into clinical practice roles following succesful completion of an

extensive professional education programme. Other professions may have been included; for example, dental, pharmacy and medical graduates also transition into professional practice roles (Sheehan, Wilkinson, & Bowie, 2012). However, the intention of the current study was to explore a temporal developmental process that was not dependent on an all-inclusive respesentation of health and allied health professions. Rather, the intention was to draw multiple expereinces and perspectives from a number of health and allied health professions. Hence, the six professions selected for inclusion were deemed diverse enough to ensure multiple perspectives in the area of interest were captured (Creswell, 2007).

Recruitment of participants was therefore sought from six health and allied health programmes. The criteria for selection of the six specified disciplines was based on the reasoning that graduates from these disciplines would transition into clinical work contexts where they would encounter interprofessional collaborative practices. The disciplines included midwifery, nursing, occupational therapy, and physiotherapy; chosen because these health disciplines are endorsed as professional degrees in New Zealand, with registration councils or boards governing professional accreditation and practice. Recruitment was also sought from two further health disciplines, podiatry and oral health. Although these disciplines are not endorsed as professional degrees in New Zealand, practitioners are registered to practice through regulatory boards that determine adherence to scope of practice boundaries and codes of conduct. Underpinning the registration council or board for each of the six health professions is the Health Practitioners Competence Assurance Act (2003).

The purpose of the Act, under New Zealand legislation, is to protect both the safety and health of members of the public, through provision of mechanisms to ensure the competency of health practitioners to practice their professions. Further, under the Act, scope of practice requires that practitioners have gained a qualification following

extensive formal education, and are registered to provide specified health services commensurate with their qualification. Hence, selection eligibility required completion of a relevant tertiary qualification that enabled a graduate to work as a registered health practitioner from the end of 2011.

It was important to ensure research participants were anticipating a practitioner role in health-related employment following their graduation from tertiary study and that individuals expected to be gainfully employed for the full year following graduation. Original selection criteria required participants to be employed in the greater Auckland area of New Zealand so they were available to participate in focus groups and individual interviews during 2012. This criterion was later expanded to encompass all of New Zealand, once it became evident that many graduates would not gain employment, in Auckland, in 2012.

Final selection did however depend on the availability of participants to contribute to extensive data collection over a defined period of time (from November 2011–December 2012). This created later challenges regarding data collection methods, but afforded a larger recruitment pool from which to select participants. Criteria for final participant selection did not include specificity of genders, ethnicities or ages across the health professions. Additionally, specific working contexts were not sought, other than participants securing employment in their respective professions. Rather, the stage of transition into graduate status was deemed relevant to the aims of the study, and furthermore the expectation of a practitioner role throughout the research period from 2011–2012. Thus, participants were sought from a number of health and allied health professions to provide multiple perspectives from a range of health orientations, in naturally occurring professional work environments (Creswell, 2013; Stake, 2010).

3.5.2 Recruitment process

In keeping with ethical requirements (Appendix A), recruitment procedures were not initiated until ethics approval was given. Following an invitation from academic staff to meet with relevant student groups, I met personally with each of the specified health disciplines, where I detailed aims and the purpose of the research, provided participant information sheets (Appendix B), and answered questions. Additionally, academic staff members of each discipline were willing to post an electronic advertisement (Appendix E), inviting research participation, to a secure online university webpage accessed by students enrolled in each of the nominated disciplines. Through utilising several communicative modes, I aimed to reach as many prospective participants as possible. Although prior to the recruitment process I had not determined a requisite number of study participants, I was optimistic that from among the six disciplines, there would be enough persons willing to participate.

Equally, I was realistic that the selection criteria was specific and requested a lengthy time commitment from those who participated. I therefore commenced the recruitment process being unsure of numbers of prospective participants, particularly as I was inviting participation from students who were near completion of their undergraduate study, already focused on transitioning into graduate practice and possibly uninterested in a research commitment. I was, however, encouraged by the interest shown by people that resulted in 18 participants, from across the six disciplines, being selected into the study.

3.5.3 Selection of participants into the study

When considering case study research Patton (2002) advocated the need to determine the purpose of an enquiry and the context within which the study will occur. Additionally, it is important to establish the case prior to determining the number of participants involved (Merriam, 2009). In this case study participants were viewed as

single cases (within a collective) and the case being explored was the evolving understanding of professional identity and notions of professionalism in contemporary health care practices by graduates in their first year of practice. As previously explained, multiple perspectives were sought from six health professions, through selection of participants who would experience a common phenomenon and irrespective of their definitive workplace context in health and allied health care practice.

Although Creswell (2007) advocated an upper limit of four to five cases within a collective case study when a common phenomenon is to be explored, Patton (2002) appeared less constrained by actual number of cases required in case study research; emphasising instead the need to establish whether breadth or depth of understanding an issue is important. The intention of this research was to provide in-depth understanding of a temporal developmental process; therefore, in keeping with an instrumental case study design (Stake, 1995), participation was sought from a number of health professions, to provide different perspectives and therefore insights into the issue; health science graduates transitioning into contemporary health care practice (Stake, 2010).

A number of people who met the selection criteria showed initial interest in the study, through email responses or by taking a participation pack (containing participant information sheet [Appendix B], copies of consent forms [Appendices C & D] and stamped addressed envelope for ease of return the researcher). Nineteen individuals returned signed documentation, of which 18 were selected to participate in the study, having met the inclusion criteria for selection (Appendix B) and voluntarily providing consent to participate (Appendices C & D). One person was not selected due to confirmed work opportunities outside of New Zealand in 2012. To maintain confidentiality of participants' identities throughout the research, individuals self-selected a pseudonym that replaced their personal identity on all documented texts.

3.5.4 Participant profiles

Eighteen participants contributed their experiences and understandings of clinical practice in this study. All participants commenced and retained employment in their chosen professions during the research period of 2012. Additionally they were all located in New Zealand across a number of different cities and provincial centres. Some were employed in private revenue-generating practices—notably Physiotherapy, Podiatry and Oral Therapy—while others were employed by District Health Boards and worked in public hospitals. One midwife worked independently, although was able to access public hospital facilities as required. Thus, from among the six professions, spanning diverse locations and work contexts, participants shared multiple experiences and perspectives that combined to create a wealth of information related to developing professional identity in interprofessional practice contexts. A breakdown of the participants' pseudonyms, their profession and employment information follows, but to ensure participant privacy and workplace anonymity, employment location and specific details have not been divulged. The 18 participants were:

Aimee (Physiotherapist) was employed in a private clinic, where her work colleagues provided procedural support and practical assistance if and when needed. In 2012 Aimee was registered to practice through the Physiotherapy Board of New Zealand (NZRP). Aimee was also a registered member of Physiotherapy Acupuncture Association of New Zealand (PAANZ) and licensed to perform acupuncture as part of a treatment plan with clients.

Allam (Occupational Therapist) was employed in a city public hospital, where she worked in one ward for the entire graduate year. During 2012 Allam joined a new graduate support group whose members met on a casual basis. Allam was registered to practice as an Occupational Therapist through membership to the Occupational Therapy Board of New Zealand (OTBNZ).

Amelia (Occupational Therapist) was employed by a district health board, and worked in a city public hospital. During 2012 Amelia gained clinical experience through rotational changes among medical, cardiac and orthopaedic wards. Colleagues provided procedural support and practical assistance when requested. Amelia was registered to practice as an Occupational Therapist through membership to the Occupational Therapy Board of New Zealand (OTBNZ).

Cathline (Podiatrist) was employed as a podiatrist in a public hospital in a main city in New Zealand. During 2012 Cathline was provided with procedural and practical support from her employing organisation and colleagues. Cathline was registered to practice as a podiatrist with the Podiatrists Board of New Zealand and holds a current annual practicing certificate.

Charlotte (Physiotherapist) worked in private practice in a provincial New Zealand town. In 2012 a senior physiotherapist in the practice provided mentorship during Charlotte's transition into the workplace. Charlotte was a registered member of the Physiotherapy Board of New Zealand and holds a current practicing certificate.

Elizabeth (Occupational Therapist) was employed in a city public hospital. During her graduate year she undertook rotational changes in clinical placements, providing practice exposure to a variety of client groups. In 2012 Elizabeth was well supported by Occupational Therapist preceptors and supervisors. Elizabeth was registered to practice through the Occupational Therapy Board of New Zealand.

Jessica (Occupational Therapist) was employed in a city public hospital, working in a general medical ward facility where she remained for the full 12 months of graduate practice. Jessica was involved in a new graduate group which she and others commenced mid-way through 2012. The group met monthly to discuss practice concerns, and offer each other support and assistance. Jessica was a member of the

Occupational Therapy Board of New Zealand and the New Zealand Association of Occupational Therapy.

Lines (Podiatrist) worked in a franchised private practice in a provincial New Zealand location. During 2012 senior podiatrists in the practice supported Lines' transition into professional practice. Lines was registered to practice as a podiatrist with the Podiatrists Board of New Zealand and holds a current annual practicing certificate.

Lisa (Oral Health and Dental Therapist) combined work in mobile and fixed location oral health and dental clinics during 2012, plus additional work in a provincial hospital. Lisa was well supported in her graduate role, via a three-month mentoring programme in early 2012. Lisa was registered to practice oral health and dental therapy through the Dental Council of New Zealand.

Louise (Midwife) was self-employed, working as an independent midwife. Other midwives—through the midwifery first year of practice programme—supported Louise in her role. Louise was registered to practice midwifery through the Midwifery Council of New Zealand and holds an annual practicing certificate.

Max (Oral Health and Dental Therapist) worked as a dental therapist in a private practice dental centre. Dentists in the practice provided Max with ongoing professional development and support in 2012. Max was registered to practice through the Dental Council of New Zealand.

Mia (Nurse) worked in a city public hospital in a general medical ward in 2012. Mia was initially oriented into clinical practice through a graduate mentoring programme and further supported by clinical nurse educators. Mia was registered to practice nursing through the Nursing Council of New Zealand and holds an annual practicing certificate.

Phoebe (Nurse) worked in a city public hospital in an acute care ward in 2012. As with other nurse graduates, Phoebe was oriented into clinical practice through a structured graduate mentoring programme, and was also well supported by clinical staff in the acute care setting. Phoebe was registered to practice nursing through the Nursing Council of New Zealand and holds an annual practicing certificate.

Serenity (Oral health and Dental Therapist) worked in the public sector in a community hub, providing a dental therapy service to schools. Serenity had no direct, or one-on-one mentorship but could request assistance or supervision from a senior colleague, primarily in the first months of graduate practice. Her regulatory body is the Dental Council of New Zealand.

Sophie (Podiatrist) combined practice in a clinic and public hospital setting; both located in a provincial New Zealand city. Sophie received support and assistance from senior colleagues during 2012. Sophie was registered to practice as a podiatrist with the Podiatrists Board of New Zealand and holds a current annual practicing certificate.

Steph (Nurse) worked in a city public hospital in 2012, in a high dependency ward. Along with other nurse graduates, Steph was oriented into clinical practice through a structured graduate preceptorship programme, and was also well supported from clinical staff in the high dependency care setting. Steph was registered to practice nursing through the Nursing Council of New Zealand and holds an annual practicing certificate.

Sue (Nurse) worked in a city public hospital in 2012, in a high dependency neonatal ward. As with other nurse graduates, Sue was oriented into clinical practice through a structured graduate preceptorship programme, and was also well supported from clinical staff in the high dependency neonatal ward. Sue was registered to practice nursing through the Nursing Council of New Zealand and holds an annual practicing certificate.

Sue-Anne (Midwife) worked in a city public hospital rotating among high dependency acute care, postnatal and antenatal wards. Sue-Anne received support and assistance from both midwifery and nursing clinical staff during 2012. Sue-Anne was registered to practice nursing through the Midwifery Council of New Zealand and holds an annual practicing certificate.

3.5.5   Participant involvement in the research process

Participants commenced employment from early 2012, in a variety of health care practices across New Zealand that reflect the diverse professional practice contexts and therefore add richness to the data. Due to the numerous geographical locations of participants during 2012, research contact was maintained through face-to-face contact with those in Auckland, and through Skype interviews and written responses from those outside of the Auckland region. Although Skype interviews will be discussed later in the chapter, this form of electronic software enabled a secure Internet platform for conducting interviews with participants who were unable to attend interviews in person.

On several occasions, however, participants chose to travel to Auckland for focus group or individual interviews. If participants were unable to commit to an interview at any of the research phases—usually due to an inability to coordinate work and interview times to suit their schedules—they responded to research questions through a written response. Table 1 identifies the data forms and spread of data collection across the phases of graduate practice. Over the duration of one year, participation remained constant (Table 1, p. 106).

A mix of written responses, face-to-face and Skype interviews, plus focus groups provided breadth and in-depth perspectives on the key issues being explored over the course of a year. Individual and focus group interviews were conducted at a university campus, in a meeting room that was situated away from the geographical location of the health disciplines. This was to safeguard participants' privacy when

arriving and leaving the university campus for interviews. Following completion of phase 1 of the data collection, I noticed a marked difference in the quality and depth of information obtained from interviews in comparison to written responses by some participants. Transcripts from interviews contained rich, detailed and reflective recounts of participants' experiences in contrast to predominantly descriptive text conveyed by written response.

Prior to commencing phase 2 data collection, I trialled the use of fixed wire telephony (landline telephone communication) linked to electronic network communication, using computer run Skype software; thus, participants residing outside the Auckland region were given an additional option of landline telephone to Skype interview at a time that suited their work schedule. This worked well, with many participants choosing this mode in favour of a written response. Camtasia, an audio-recording software program, was utilised to capture audio files of the interviews through the computer. This proved most effective, with a Camtasia recording then converted to an mp3 audio file for transcription purposes. To ensure confidentiality of participant information, landline telephone to Skype interviews were conducted in a quiet single room and all information was erased from the resident computer by the researcher. Interviews ranged from 20–40 minutes duration, and focus group interviews lasted a full hour. Throughout the research participants were candid in expressing their perceptions and views, and provided vivid examples of clinical experiences that contributed to their sense of evolving professional identity during their graduate year.

Table 1. Form of participant data collection according to phases of graduate practice

Pseudonym	Profession	Phase 1	Phase 2	Phase 3	Phase 4
Aimee	Physiotherapy	Interview	Interview	Focus Group	Focus Group
Allam	Occ Therapy	Written	Skype interview	–	Written
Amelia	Occ Therapy	Interview	Skype interview	Written	Skype interview
Cathline	Podiatrist	Interview	Written	–	Focus Group
Charlotte	Physiotherapy	Written	Skype interview	Focus Group	Written
Elizabeth	Occ Therapy	Interview	Interview	Focus Group	Written
Jessica	Occ Therapy	Interview	Interview	Focus Group	Skype interview
Lines	Podiatrist	Interview	Written	Written	Written
Lisa	Oral Therapist	Written	Skype interview	Written	Focus Group
Louise	Midwife	Interview	Interview	Focus Group	Written
Max	Oral Therapist	Written	Skype interview	–	Skype interview
Mia	Nurse	Written	Interview	Focus Group	–
Phoebe	Nurse	Written	Interview	Focus Group	Interview
Serenity	Oral Therapist	Written	Skype interview	Written	Written
Sophie	Podiatrist	Written	Skype interview	Written	Skype interview
Steph	Nurse	Interview	Interview	Focus Group	Focus Group
Sue	Nurse	Written	Skype interview	Focus Group	Focus Group
Sue-Anne	Midwife	Written	Skype interview	Focus Group	Focus Group

3.6 Data collection

In keeping with an interpretivist orientation that favours subjective epistemology (Lincoln & Guba, 2013), individual and focus group interviews provided the primary source of research data (see Table 2 below).

Table 2. Form of data collection according to phases of graduate practice

Form of data collection	Phase 1 Prior to commencing graduate practice	Phase 2 2–3 months into graduate practice	Phase 3 8–9 months into graduate practice	Phase 4 11–12 months into graduate practice
Interviews	8	16	–	5
Focus groups	–	–	3	2
Written responses	10	2	4	6

Both face-to-face and focus group interviews were recorded via the use of a digital audio recorder, to ensure that all dialogue was available for later analysis (Merriam, 2009). Recordings were transcribed as soon as possible following each interview. If participants were unable to attend an interview they had an additional option of providing written responses to questions pertaining to a particular phase, which was sent to the researcher via email attachment.

Four distinct phases of data collection spanned the research year, coinciding with time frames of increasing familiarity within graduates' work contexts and drawing on information from previous phases. Each phase had a specific research focus, which will now be explained. Phase one focused on participants' perceptions of professionalism, identity and collaboration between health practitioners prior to commencing work as a graduate. The aim of this phase was to collect baseline understanding of the three key research aspects: graduates' experiences and understanding of identity, interprofessional collaboration and professionalism. As shown in Table 2 (p. 107), eight individual interviews with participants were conducted

in phase 1, and ten participants contributed written responses to the guiding research questions (Appendix F).

Following three to four months of graduate clinical practice, further information was collected, primarily through individual interviews with 16 participants and two participants' written responses to guiding questions (Appendix G). This phase centred on the early months of immersion in a work environment, where the three key aspects were revisited, but within a practice context. Evolving profession identity was the primary focus at this early stage of practice, within a specified professional context and in relation to collaboration, where applicable.

Phase 3 data collection focused on professional identity intersecting with collaborative practices, and coincided with eight to nine months of graduate practice. Three focus group interviews were scheduled, but as these were conducted at one central site, several participants were unable to attend due to work commitments or geographical distance prohibiting their travel. Of the 18 participants in the study, 11 were able to attend one of the three focus group interviews, and a further four participants sent written responses to the phase 3 questions (Appendix H). Three participants chose not to take part in this data collection phase. This was not viewed as problematic as there was a collective sense of purpose and focus from others who attended. Furthermore, each of the three focus groups comprised a mix of participants from the six health professions, which provided a wealth of multiple perspectives among the professions. Focus groups were facilitated by the researcher and conducted at a mutually convenient time for participants across three available time slots.

Towards the end of the graduate year, a final phase of individual and focus group interviews were conducted, with guiding questions centred on drawing participants' perceptions and views on how the first year of graduate practice had shaped the development of professionalism, identity and collaboration in health care

practice. In this final data collection phase all but one participant contributed, either in one of two scheduled focus groups, in an individual interview or through written response to the guiding questions (Appendix I). Data collection methods are now explained further, providing rationale for inclusion in the instrumental case study design.

3.6.1 Interviews

Interviews with participants, either individually or in focus groups, provided the primary source of data in this study (Table 1, p. 106). Through conversing with the participants, by asking relevant questions to the research aims and listening carefully to their responses, I was able to come as close as possible to naturally occurring contexts related to the specific phenomenon (Merriam, 2009). Equally, I was afforded opportunities to view the lived experiences of participants vicariously as these unfolded during interviews (Lincoln & Guba, 2013; Merriam, 2009). Interviews allow a researcher the privilege of entering "into the other person's perspective" (Patton, 2002, p. 341). Through semi-structured questioning, an individual's 'telling' of experiences and related meaning can provide a rich source of human understandings of their reality. Kvale and Brinkman (2009) emphasised the semi-structured interview as coming "very close to an everyday conversation, but as a professional interview it has a purpose and involves a specific approach and technique. It is conducted according to an interview guide that focuses on certain themes and that may include suggested questions" (p. 27). In support of Kvale and Brinkman's' suggested approach, I prepared questions for each phase of the study, for the purpose of addressing key aspects of the graduates' experience (Appendices F, G, H, & I). The questions enabled me to undertake a semi-structured interview approach, focused on the research topics (Kvale, 2007).

In addition, these authors argued the importance of the interviewer approaching an interview with openness to the unexpected. This promotes self-qualities of being

"curious, sensitive to what is said—as well as to what is not said—and critical of own presuppositions and hypotheses during the interview" (p. 31). In this regard, as the interviewer, I operated on several metacognitive levels while interviewing; that of interviewer and observer (of other) and reflective practitioner (on self). In doing so, there was room for perceptions to be expressed, while ensuring that the focus on professional identity and intersecting professional boundaries was maintained (Lincoln & Guba, 2013).

The calibre of specific descriptive, perceptual accounts determines the richness and depth of information (Kvale, 2007). To encourage this, the interviewer may ask elaborating questions in some interviews, while in others this may not be necessary. The skills of the interviewer to determine when to ask such questions and when to sit quietly, listen and observe will determine the openness and flow of monologue from those being interviewed. Radnor (2002) suggested an effective interviewer is an active listener who creates an atmosphere where the person being interviewed is provided with non-judgemental indicators that s/he is being heard. The interviewer is active in mirroring questions for clarification, affirmations and encouragement for expansion of specific points.

These interviewing strategies are "necessary because an interpretive researcher wants rich data from interviews in order to build up a picture of what is happening from the perspective of the interviewee" (Radnor, 2002, p. 61). Radnor elaborated on the purpose of the interviewer's questioning as being a genuine attempt to gauge meanings and practices from the interviewee's perspective and not to lead the interviewee in a specific direction. However, Radnor emphasised the need for the interviewer to listen carefully, to speak little and to ensure that the experience is heard. Grant and Giddings (2002) concur, suggesting the researcher must listen, observe and interpret "data given by the participant" (p. 17).

3.6.2 Focus group interviews

Focus group interviews were chosen as a valid data collection method for phase 3 and 4 of the research, due to the social nature of group interviews, where less structured questions may elicit "more spontaneous and emotional views than in individual, often more cognitive interviews" (Kvale & Brinkman, 2009, p. 150). The aim in conducting focus groups was to allow participants to voice their own perspectives in a socially mediated setting, which also enabled them to hear and consider the perspectives of others (Patton, 2002). Due to phase 3 being centred on collaboration and evolving professional identity, a focus group interview provided an opportunity for participants from a number of professions to jointly discuss their perceptions, views, opinions and clinical experiences on the central aspects. The focus group interviews also acted as a catalyst for participants to draw comparisons among their professional orientations to health care practice, to openly discuss individual perspectives on the experiences of others in the group and to dispel misconceptions where these arose (Patton, 2002).

Organising focus groups was challenging due to the difficulty in coordinating with participants' clinical shifts. Facilitating the focus groups was eased through preparation prior to arrival of participants. This included seating, name plaques and positioning the digital recorder so it would capture voices from all of those present. Offering refreshments prior to commencing the focus group interview enabled the participants to chat informally while waiting to start. All these preparatory activities enabled the interviewer to organise the environment in order to minimise disruptions. Furthermore, offering refreshments and having name plaques visible recognised each participant who was present. This was important, as I wanted to acknowledge each participant for taking time to attend a focus group, usually conducted during weekends.

One aspect of concern that was brought to the attention of participants was the need to maintain confidentiality of participants' involvement, following the focus

group. In addition, all participants were called by their actual name during focus groups and pseudonyms were added following completion of interview transcriptions. At the start of focus group interviews each participant present, myself included, stated their name once we were seated to assist with later identifying names with voices during transcription of the interview. As an additional aid, participants' names were used when addressing them during the interview, for the same reason (Patton, 2002). Furthermore, participants were assured that if they felt uncomfortable at any stage during or after an interview, there was provision for counselling services, offered confidentially and free of charge (Appendix J).

Kvale and Brinkman (2009) suggested that in a focus group, conceptual questions can be used to explore the meanings and understandings of participants on a central theme, including participant positions and "taken-for-granted assumptions about what is typical, normal, or appropriate" (p. 151). This was shown in the focus groups with participants frequently reminded of previous experiences through hearing of similar situations expressed by other members of the group. Additionally questions requesting concrete descriptions related to conceptual understanding aimed to elicit experiences of various group participants. Concrete descriptions provided examples of participant activity that could be presented as illustrative data during the interpretive phase of research.

3.6.3   Written responses

Written responses to research questions enabled a number of participants to contribute their reflections on experiences through written as opposed to spoken text. Primarily, this form of data collection was utilised when participants were unable to attend an interview, in person or via the use of Skype or focus group. The same guiding questions for each of the four phases were utilised and participants were requested to respond through emailed communication to me. As with other forms of data, emailed

information was deleted from a computer once a pseudonym was applied and text stored for later analysis.

3.6.4   Transcribing the interviews

Transcribing interviews was time consuming, but viewed as being pivotal to bridging the research processes between data collection and data analysis (Merriam, 2009). I undertook to transcribe interviews as soon as possible after each took place for several reasons. First, while transcribing I was able to recall the conversational nuances that were less evident during the interview. The nuances included the tone, speed, pauses, emphasis and repetitions of language and this enabled me to develop my early thoughts on where participants emphasised particular experiences or their understanding. I also listened to my dialogue, and noted how I responded in the discussion of key aspects. This assisted me to refine my interview skills to promote more listening than talking on my behalf, particularly in relation to my use of elaborative questioning. Second, while each experience of conversational dialogue with a participant remained fresh this enabled me to write memo notes on my own thoughts and ideas related to what was discussed. This proved useful at a later stage when I compared my reflective notes from each phase of data collection. In particular the reflective memos assisted in personalising the participants within the enormous amount of textual information.

Due to the large number of interviews conducted in the first two phases (N=24), I engaged the services of a transcriber to undertake transcription of the focus group interviews in phases 3 and 4. In so doing, I was able to receive the transcripts in a timely manner and commence coding data. Prior to doing this I read each transcript while listening to the interview recording; to ensure that the transcript was correct, and to replace all actual first names of participants with their pseudonyms. To ensure ethical conduct and to safeguard participants' privacy, the transcriber signed a confidentiality agreement (Appendix K).

Throughout the transcription process, the mechanics of formatting the transcripts and written response texts in a uniform manner enabled the input of transcripts into a computer software program from which the coding phase of the data analysis was conducted by the researcher. Nvivo 9 is a qualitative research computer software program that provides organising structures for storing transcriptions and platforms to support the processes of coding and categorising qualitative data. Formatting of transcriptions included the use of bold headings for research questions and clear identification of participants pseudonyms attached to each phase of data collection. Uniform formatting of all written text enabled ease in identifying and managing data during the analytic process.

3.7 Data analysis

Within an interpretive research approach, data analysis is viewed as an inductive process that progresses through increasingly abstract iterations (Denzin & Lincoln, 2011). The following details the iterative process of coding, categorisation and theme identification undertaken in this study. The iterative process is described by Merriam (2009) as "a complex process that involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning, between description and interpretation" (p. 176). Similalry, Cousins (2009) draws attention to the intellectually rigorous process undertaken by the researcher in dynamically linking the data collection with the analytic process, aiming to, "interpret human behaviour and experiences beyond their surface appearances… to provide vivid, illuminative and substantive evidence of such behaviour and experiences" (p. 31).

To ensure I upheld the authenticity of the participants' experiences and perspectives, I was mindful of my own subjectivity as I moved between the data and inductive analytic process. I frequently referred to my reflective notes from each of the data collection phases during the early analytic process, which served to reacquaint

myself with my developing views and ideas over time. However, in engaging in interpretive research activity, I recognised and acknowledged the participants' ability to reflect on, and report on their experiences of professional practice. Thus, in keeping with a hermeneutic phenomenological research approach, the fusion of perspective horizons regarding the research phenomena, "is understood not in its own terms, nor in the researcher's, but in terms that are common to both" (Sharkey, 2001, p.17).

Commencing with raw data, information was progressively organised, managed, and coded into broad categories from which themes or patterns emerge. Patterns resulted from aggregation of information into clusters that could be conveyed as findings from the research (Braun & Clarke, 2006). Alongside this iterative process is the use of textual glimpses of participants' experiences, the purpose being to invite the reader to enter into the world of the participants (Sharkey, 2001). Essentially the process of data analysis allows the researcher to make sense of the data in answering the research questions (Merriam, 2009).

Specific to an instrumental case study, the researcher focuses on an issue embedded in a case and therefore "forgoes attention to the complexity of the case to concentrate on relationships identified in the research questions" (Stake, 1995, p. 77). More recently, Stake (2005) explained the purpose of an instrumental case study was to provide a supportive contextual role for analysing an issue or process, which Yin (2014) describes as an "embedded" analysis of a phenomenon of interest within a case.

3.7.1   Coding the data

During the familiarisation and early coding phase, Nvivo 9 computer software provided a range of tools for managing and organising the qualitative data and functioned in reporting aspects of data analysis. Primarily, Nvivo 9 was used as a data storage repository and to aid the process of coding units of data (Merriam, 2009). During this process it was reassuring to know that participants' complete transcripts were accessible

alongside extracted units of information. Further, extracted units could be linked back to the situational context, which was helpful during the analytic process.

Coding the data involved extracting meaningful chunks of text, or units of data from participants' transcripts that resonated with the research questions and aims of the enquiry. This required ongoing reading and increasing familiarity with the textual data, as it was collected from each phase of the study. Coding took the form of selecting distinct units of meaningful information that stood alone outside of the collective situational context, but retained relevance to the research question once isolated from surrounding context (Merriam, 2009). This involved an iterative process of moving between the whole of the transcripts and the units of information, as segmentations of the actual language spoken by the study participants (Schwandt, 2007). In this study, coding of data was conducted concurrently with the progressive data collection phases. Merriam (2009) upheld the need for ongoing coding and later analysis while actively collecting data, primarily with the aim of identifying and refining emerging themes that may inform successive data collection. However, early and ongoing data coding are viewed favourably as a means for limiting a sense of being overwhelmed by the sheer volume of data that arises from qualitative research.

3.7.2 Constructing categories

Concurrent with the coding process of extracting units of information from the raw data, an inductive process occurs through looking for recurring regularities; drawing information into increasingly abstract classifications, from which categories derive (Merriam, 2009).

According to Merriam, each category must "be responsive to the purpose of the research" (p. 185) and categories must make sense when viewed together. In the current study, a natural matrix provided a structure from which to construct categories. Since the aim of the study was to understand the process of developing professional identity

over the graduate year, the four phases of data collection provided a natural temporal framework. Further, key research aspects of collaboration and professionalism provided contextual categories related to graduate practice. In addition, participants represented six health professions and these provided experiential categories related to identity. Thus, categories were developed within the constructs of process, context and experience.

3.7.3   Identifying conceptual themes

Within an interpretive approach to data analysis, careful organisation and cognitive processing of data is required through each step of the inductive process; from familiarisation with raw data, through coding and categorising to identifying conceptual themes in relation to the research focus (Braun & Clarke, 2006). This phase of the analytic process is crucial, as conceptual themes must do justice to the earlier steps of coding and categorising data. Furthermore, while conceptual themes must reflect patterns of meaning that reoccur during coding and categorisation (Merriam, 2009), the themes must also result in research findings (Yin, 2014). Drawing on numerous categories within the matrix of timeframe, context and experience, as previously explained, I developed layers of meaning within and across the matrix that resulted in research findings. These findings will be presented (Figure 1, p. 126) and discussed in detail in the following chapter.

3.8   Research credibility

A case study research strategy provided a structured bounded context from which to explore a phenomenon of interest. The development of professional identity, evolving in clinical work practices where varied types and amount of collaborative activity occurred among health professions, was explored through dialogic interaction with graduates immersed in the process of navigating their first year of professional practice. As the

researcher, I was immersed in the process through vicarious means, and can only lay claim to an interpretation based on the interpretation of others (Gadamer, 1991).

Through careful thorough interpretive processes, I wanted to gain new understanding of the issue, but do not profess to generalise due to the qualitative nature of the study. Stake (1995) suggested that research seldom provides "entirely new understanding…but refinement of understanding" (p. 7). Due to the richness of data collected—over an extended period—with significant research participation, findings from this study will communicate patterns of process, as these have unfolded over time. I take responsibility for the interpretations made, knowing that another researcher may have interpreted differently (Denzin & Lincoln, 2011; Fosnot, 2005).

This stance accepts that "the subjectivity of the researcher [and reader] will always be present and the best way of addressing this is to openly engage with it" (Cousins, 2009, p. 35). Through careful and methodical organisation of data sources, and through close attention to the interpretive process, I aimed to produce a holistic account of how others perceive and make sense of their reality (Merriam, 2009). Those who read the account may learn something new that they then add to their own understanding of the phenomenon; that of graduates' evolving professional identity when working in the context of interprofessional collaboration.

3.9 Conclusion

This chapter has outlined the research methodology, from the philosophical basis on which the research was premised, through to details on the methods used to explore the phenomenon of graduates' evolving professional identity in both their chosen field and in collaboration among other professions in contemporary health care contexts. The nature of the instrumental case study dataset, across six professions, provided a broad process trajectory rather than in-depth and experienced by single participants. Thus it looked at ways of understanding a social phenomenon, bounded by experiences and

perceptions of a number of participants (Stake, 1995). Research findings emerged

through an inductive analytic process, resulting in themes that are discussed in the

following chapters.

Chapter Four

Findings

4.1 Introduction

This chapter provides findings from participants as a collective, inclusive of 18 participants' perceptions as they progressed through their graduate year. All 18 graduated with a Bachelor of Health Science in December 2011, and commenced full-time employment in their respective field of health care practice in early 2012. Data were collected from graduates in six different health professions: Midwifery; Nursing; Podiatry; Physiotherapy; Oral Health and Dental Therapy; and Occupational Therapy. The goal for inviting participation from the six distinct occupational groups was to draw on multiple perspectives in the intersecting professional dimensions of identity, collaboration and notions of professionalism.

The descriptive account of the graduates' experiences revealed *their* individual understanding of practice in professional and interprofessional contexts as this developed over time, linking identity, professionalism and collaboration. Participants reported their experiences, thoughts and perceptions of clinical practice as they progressed through the graduate year. In deferring to the participants, collaborative practice was expressed in various ways, through their recounting of experiences in diverse health practice contexts. Hence collaboration practice is viewed from participant's perspective. They showed at various times their reflection, honesty and uncertainty as to their role and identity in their respective occupations; in part interwoven and at times juxtaposed with an interprofessional role and through working collaboratively with other health professions.

The chapter commences with a broad overview of the workplace contexts where graduates—as novice practitioners—commenced their employment in 2012. In addition, the workplace orientations to health care practice, as portrayed by participants, are also described. In doing so, the participants' experiences and perceptions are contextually bound (Stake, 1995) within a complex of health care services that operate both in the public and private health care sector in New Zealand.

Following from the contextual overview four categorical themes are introduced to show the temporal, or chronological development of professional practice during the graduate year of working in contemporary health care practice. This is achieved by drawing descriptive findings into a cohesive account of how the graduates experienced and understood their professional work in an interprofessional context. Each categorical theme provides insight into the participants' evolving understanding of professional dimensions—practice, identity, perspective, professionalism and collaboration—from an initial focus on establishing a role in a defined profession to progressive interprofessional collaboration with other health care professions.

Although identity, collaboration and notions of professionalism were the original research areas of interest, practice roles and perspectives were identified as distinctive professional dimensions that underpinned graduates' understanding of professional work in collaborative contexts. Findings are also presented in a diagrammatic view (Figure 1, p. 1266) to portray the interlinked temporal and developmental elements of graduate practice in contemporary health care contexts, as experienced by participants in this study.

4.2 Overview of workplace contexts

Across the six professions, 11 of the participants were employed in public hospital settings. All nurses and occupational therapists were employed in this capacity. Two oral therapists worked in publically funded clinics providing oral and dental care to

children under the age of 18. One of the two midwives was employed in a public hospital while the other worked as an independent midwife. The remaining seven participants all worked in private practices, including the two physiotherapists, three podiatrists and one oral therapist.

In general those employed in public hospitals perceived their role as that of caring for the health needs of patients. This perspective was also observed in the two oral health graduates working in publically funded clinics. Their work contexts however were distinctly different with one graduate employed in a mobile dental clinic that provides services to a number of suburban schools in a New Zealand city. In this controlled context, the work was viewed as routine oral health care, with any patients requiring more definitive dental attention being referred to a dentist. In direct contrast, another oral health therapy graduate was immersed in a challenging practice setting in rural New Zealand. In this context, the therapist was not only providing necessary oral health care for children but also working with families to develop sustainable oral and dental care in the wider rural community.

Juxtaposed were those working in private health practices, where they perceived their professional role as providing a financially driven service to clients. Specifically, the two physiotherapists believed they were well qualified to orchestrate treatment for the paying public. They were very aware of professional reputations being gained or lost due to the success of their work and their ability to forge relationships with doctors and medical consultants in their specialist area of health care. This also applied to one oral health therapist who worked in a private dental practice. Although the three podiatrists were also working in private practice and concerned that they built a client base, they also focused on developing an understanding of their profession by both the public and other health professions. This led them to actively seek out a wider professional network than physiotherapists over the duration of the graduate year.

The one remaining participant, a midwife, spanned the private and public health care sectors. Working as an independent midwife she expressed a sense of vulnerability at the breadth of her work context. This included professional care and support of pregnant women birthing in the community as well as in hospital when medical intervention was required. In the latter context she perceived her professional role altering from that of an independent midwife into a supportive role only.

4.3 Orientation to health care practice

There were distinctly different approaches to professional practice observed between those employed in the public versus the private sector. Those employed in public hospital facilities were inclined to discuss their professional role as focused on returning patients to optimal health status so they could leave hospital. Their interaction with patients was transitory with variable investment beyond the duration of a practice shift. This was noted in particular from the four nurses and one midwife, and less so from the four occupational therapists. This may have been due to the acute care settings that the nurses and one midwife worked in—located in public hospitals—as compared to the predominantly longer-term medical care settings where occupational therapists were working. In the latter context, occupational therapists interacted with patients over prolonged periods of time due to the rehabilitative nature of their work.

It appears that those working in private practice had a vested interest in developing professional credibility in narrowly defined health fields. For example, physiotherapists focused primarily on assessing and treating muscular–skeletal conditions. Equally podiatrists focused on assessing and treating disorders of the lower limbs. The same could be said of the oral therapist working in a dental practice where clients receive a range of oral treatments. Treating individual clients did not require extending professional knowledge or practice expertise beyond the scope of their practice boundaries. This was in contrast to those working in the public sector where the

complexity of patients' health care issues required a distinctly different orientation to health care and related understanding of professional roles. Here, the close proximity of various health professions working from different health perspectives may have enabled practitioners to approach their work from a wider health orientation.

Into the workplace contexts, as outlined, and the associated healthcare practice orientations that influence, direct and support practitioners' work, graduates entered as novice professionals. Although it was not intended that this study differentiate between the working contexts of graduates, the working contexts influenced the exposure of graduates to, and engagement in, interprofessional collaboration. Equally, the focus on professionalism varied due to the work contexts of participants. Hence, in the following presentation of the categorical themes, general details of work environments are provided at times to position the findings within the context of specific professional practice environments. In addition, graduates' occupations are also identified to provide a further contextual point of reference.

4.4 Professional practice in an interprofessional context: A temporal process

As previously discussed in Chapter Three, these findings relate to four phases of data systematically collected at regular intervals throughout the graduates' year in 2012. The phases commenced in the month of graduation and continued through transition into workplace practice in the healthcare workforce.

In general, prior to commencing work (Phase 1), graduates held an idealised concept of working in their respective professions. Even three to four months into practice (Phase 2), there was a sense of profession-centrality, with collaborative practice viewed as peripheral to uniprofessional work. The intersection of collaboration and identity was clearly apparent at eight to nine months into the graduate year (Phase 3). At this time graduates reflected on experiences of collaborative practices and the effect these practices had on the way they worked. Towards the end of the first year of

practice as health care professionals, participants were able to express their understanding of the intersection of identity, collaboration and professionalism, and what this meant to themselves as practitioners (Phase 4).

Figure 1 (p. 1266) depicts the matrix of categorical themes and subthemes that emerged from the inductive analytical process and provides visual representation of the research findings. Key categorical themes were identified as: Graduates, Novice Practitioners, Collaborators and New Professionals, signifying the temporal developmental elements of the research question (shown as vertical columns in Figure 1, p. 1266). Embedded in each of these categorical themes are the contextual subthemes related to the graduates' practice; synonymous with their transitional experiences and understanding of identity, professionalism and collaboration as they progressed through their first year of professional work (illustrated in Figure 1 as dark vertical columns between the temporal columns).

Equally, intersecting the temporal process are professional dimensions related to the participants' developing identity, perspectives, collaboration and notions of professionalism in the graduate year (depicted in Figure 1 as horizontal rows dissecting the vertical developmental columns). The horizontal rows are presented as questions, which illustrate the participants' reflective awareness of their transitioning through the temporal and developmental phases of graduate practice in contemporary health care contexts.

When referring to the diagrammatic representation, the vertical professional dimensions relate to Graduate and Novice Practitioner's progress from practice through to collaboration. Textual findings proceed in this manner, signifying the graduates' focus on establishing their roles and identity during early professional practice. In contrast, the vertical professional dimensions related to Collaborators and New Professionals are textually recounted in the opposite direction, from collaboration

through to practice. This signifies a shift in the temporal process, whereby graduates' collaborative work influenced their experience and understanding of the other professional dimensions.

Figure 1. Graduates' understanding of professional work in an interprofessional context

GRADUATES' UNDERSTANDING OF PROFESSIONAL WORK IN AN INTERPROFESSIONAL CONTEXT

TEMPORAL PROCESS

PROFESSIONAL DIMENSIONS	Phase 1 — Prior to commencing practice — GRADUATE — Self *in* …	Phase 2 — Early Practice (2-3 months) — NOVICE PRACTITIONER — Self *with* …	Phase 3 — Mid Practice (6-8 months) — COLLABORATORS — Self *among* …	Phase 4 — Later Practice (11-12 months) — NEW PROFESSIONALS — Self *as* …
PRACTICE	What are my values and beliefs?	How do I endorse my profession?	Who am I within my own profession?	Am I credible?
PERSPECTIVE	Who am I?	Who am I among others?	How am I contributing?	What I know? What I offer? What is unique?
IDENTITY	What do I know?	How do I communicate my knowledge?	How do I interact at the interface of professions?	How do I want to be portrayed?
PROFESSIONALISM	What will I do? How will I respond?	What is my role?	What are our roles?	How do others perceive me?
COLLABORATION				

Process descriptors (bands):

- CONFIDENT / PROFESSION CENTRIC / BROACHING
- VIGILANT / STRENGTHENING VOICES / BORDERING
- EVOLVING / SHIFTING / EXTENDING / CREATING SPACE
- EXPANDING / VALIDATING / FLEXIBLE
- FORECASTING CHANGE / EXPANDING PROFESSIONAL TOOL KIT

4.5   Graduates

The initial phase of the graduate year drew from participants' perceptions of professionalism, identity and collaboration among health practitioners prior to commencing work in their chosen profession (Figure 1, p. 1266: Prior to commencing practice column). Their initial understanding of professionalism, identity and collaboration had developed over years of socialisation in professional education programmes, which included both academic and clinical practice. At this stage they had successfully completed their undergraduate education and were in a transitional state between student and worker. They had previously observed and worked with role models from their respective professions who displayed behavioural standards they wished to emulate in their own practice: notably empathy and respect towards patients.

Concurrent with these displays by experienced practitioners was their ability to convey specialist knowledge clearly, rationally balancing displays of emotional engagement with clinical detachment. A number of graduates—in this time of transition between student and clinical practitioner—reflected on their previous experiences of being a student in clinical situations when they grappled with balancing both a personal emotional response and a reasoned cognitive response to stressful situations. Participants expected they would rely on their experienced colleagues to assist them in developing their roles as professionals in practice.

4.5.1   Confident to practice

During the transition between completion of extended tertiary education and commencing clinical practice in their respective field of health care, graduates felt well qualified to start a practitioner role. Following graduation, Aimee reflected on her readiness to practice physiotherapy, because she had obtained a qualification.

> Having a degree, getting that education formalised, you're part of a
> network and there's an acceptance in that. It's completely different,
> even from being part way through fourth year [as a student]. You still
> have got the same academic knowledge, but not having that student

label and having become fully qualified, people look at you differently. There's an acceptance and it's not only within members of the public coming in for treatments, it's within and around other physios as well. They automatically say, "You're qualified." (Aimee, Physiotherapist).

Similarly, Lines explained how his years of formal education had prepared him for a legitimate role as a podiatrist.

When you first start [tertiary education in Podiatry] you're trying to piece together everything in your mind and it can be a bit challenging, but I've found that as I've progressed through the years… I'm able to look at someone walking up the hallway and can see almost straight away that there's something not quite right, whereas if I go back to year one I would never have been able to see that that fast (Lines, Podiatrist).

Furthermore, Lines expressed his developing professional perspective, discussed in relation to assessing patient health concerns.

It's just natural awareness; you can do it without thinking about it, whereas when you first start you have to think very hard about what's happening with what muscle, for example. But as you move on its something that comes naturally I suppose. It's probably another attribute of being professional, it's something that just occurs naturally after a lot of training (Lines, Podiatrist).

Following years of formal education, Aimee and Lines appeared confident at the prospect of commencing practice in their respective professions. Likewise, Cathline spoke of her ability as a graduate podiatrist to "follow through with patients, and plan out their treatment so that, "at this appointment we are going to do this and next appointment we are going to do this." Cathline elaborated further, saying, "it's knowing where you're going with your patient." Similarly, Aimee stated that as a graduate, "you've now got a voice and that's who I am."

Participants also expressed confidence in their ability to impart knowledge to patients, suggesting their notion of professionalism at this stage of transition from student to practitioner was in offering patients knowledge and engaging in practices that would benefit the patients' health. When imparting knowledge they felt challenged to pitch language and explanations at an appropriate level for patients to understand.

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Charlotte suggested her ability to communicate specialist knowledge effectively was essential to her practicing physiotherapy:

> To take a complicated matter or topic and convey it in a way that is understandable to the patient shows a level of professionalism because it illustrates the grasp and depth of knowledge you have on the topic (Charlotte, Physiotherapist).

Others shared this view. Phoebe (Nurse) emphasised the importance of conveying "a strong knowledge base and application, and being thoughtful of the patient's experience and mindful that not everyone is health trained." Similarly, Amelia (Occupational Therapist) planned to consciously remove specialist jargon when she communicated with patients regarding occupational therapy. In so doing, she would be able to "get the bottom line across to them, of what they need to be doing, for their current situation." Further, Lisa (Oral Therapist) suggested her duty, as an oral health therapist was to "help patients and teach them new skills and pass on current dental information, therefore motivating patients to take responsibility for their own oral health." Similarly, Aimee stated, "as health professionals we have so much to offer, in terms of somebody's wellbeing. It is not just sorting out one thing; what I can offer a person may impact in many facets of their life."

Participants appeared self-assured in their ability to commence working with patients. Following years of education and obtaining a qualification they believed they were knowledgeable and competent to undertake practices commensurate with their respective professions. Furthermore, their view of professionalism was that of a person who conveyed specialist knowledge appropriately in order to benefit the health and wellbeing of people.

Being knowledgeable was considered integral to being a professional, with Cathline (Podiatrist) suggesting "professional behaviour involves practitioners being confident around their patients and looking as though they know what they are doing; being knowledgeable and performing the job properly." Additionally, Sue-Anne

(Midwife) thought "knowledge and a qualification should make a professional person better, kinder and more honest."

Sincerity and integrity were two qualities that participants attributed to being a capable practitioner. A number of participants referred to role models in their profession who displayed both clear reasoning based on their specialist knowledge and integrity in their communication and interaction with others. Amelia (Occupational Therapist) reflected on her experience of working with such people:

> …just their whole persona. Their natural personality, which I think is uncannily linked to Occupational Therapy, plus their professional knowledge and their standing within the profession. That they were proud to be OTs and to keep up with the current knowledge, right through the way that they dealt with their patients and clients and the family (Amelia, Occupational Therapist).

Similarly Elizabeth recalled her experience of working with a supervisor, whom she viewed as an inspirational role model, and someone who revealed professional qualities she admired:

> The supervisor displayed real integrity in regards to the way she expressed her views around clients. She had this really incredible, client-centred approach where she held them in high regard. Over the time of spending two months with her I got to understand her intrinsic views around things. In regards to communicating with her peers, she always made sure that she was very thoughtful about what she said and how she said it and when she said it (Elizabeth, Occupational Therapist).

Sophie (Podiatrist) was philosophical in her recall of role models who had influenced her future practice, saying "I learnt that if it's bad enough for a patient to come and see you for help, then it needs attention or at the very least reassurance and information on self-care and prevention; but never dismissal." She attributed the concern shown by experienced podiatrists to their genuine interest in patients and their personal needs.

Furthermore Aimee added:

> At the end of the day, or the end of the session with every client that you treat, you need to be able to ask yourself whether you've done the best that you can for that patient. That's something I think is really important and I'd like to carry throughout my practice; that I can

always feel I've done the best that I can for that person (Aimee, Physiotherapist).

Others voiced similar sentiments, expressing a desire to be responsible practitioners. Being responsible involved making informed decisions, based on sound theoretical knowledge and understanding of patients' conditions. Jessica (Occupational Therapist) suggested the difference between professional practice in health care and other professions was the level of responsibility inherent in dealing with peoples' health. Additional to this responsibility was the ability of health professionals to influence peoples' lives and wellbeing. Jessica explained this as:

> because you don't really think about occupations as everything that people do in their lives and now when I'm out in the real world during the day I just see things that people do and the struggles that they have and I look at it from an OT perspective (Jessica, Occupational Therapist).

Lisa (Oral Therapist) described this responsibility as *duty of care* and Louise (Midwife) spoke of the responsibility to promote wellbeing and empowering people in their health. Louise explained this further as, "because I'm working in primary health, it's a lot about working with women and it is really that walking alongside them." In this regard, graduates reflected on the need to understand health situations from the perspective of patients, and setting aside their own emotional responses in order to make clinical judgements commensurate with their respective fields of health care practice.

4.5.2   Profession-centric

The sense of embarking on clinical practice in a chosen profession appeared strong at the transitional stage between graduation and commencing a practitioner role. Participants willingly worked with other health professions but they supported clear delineation of distinct professional roles. Even though they acknowledged the need for collaboration among professions—in meeting patients or clients' health needs—many were quick to establish the centrality of their own profession in provision of care. Steph reflected on this:

> The nurse is there all day every day; that is the big difference as no other professions are. Everyone else gets to go home at end of the day, doesn't have to come on the weekend, but the nurse is the constant one; always there, always making sure that the patient's ok, noticing any changes, reporting any changes and I think that the nurse has the most relationship with the patient and the family (Steph, Nurse).

In this context, nursing participants were exposed to 24 hour care of patients and had experience of working with a number of health professions. Although they expressed the integral role of a nurse as the constant provider of care over a 24 hour timeframe, they recognised the need for maintaining "good relationships with other health professionals to get the job done as well as possible, for the ultimate outcome for the patient." (Phoebe, Nurse). Others expressed the importance of profession-centrality in terms of differing professional perspectives, approaches and goals. Amelia (Occupational Therapist) described the different perspectives in relation to patient care.

> Every profession has a different goal for a patient… if we're in a hospital setting the physician will most likely be wanting to discharge the patient, but the bottom line is, are they safe to go home? That's where all the other disciplines come in. The physio, for instance, would be focused on the mobility of the person, OTs come in particularly with cognitive aspects. The patient might be physically capable but are they mentally and emotionally capable? So we could all be arguing from our corners…as much as there is going to be blurring and overlapping boundaries in roles, there can be quite a definite difference in approaches (Amelia, Occupational Therapist).

Jessica (Occupational Therapist) reinforced the difference in approaches to health care service stating that Occupational Therapists' focus on "occupation" differed markedly from that of other professions. She spoke of occupational therapists attending to people "as a whole and helping them to achieve the occupations they want to do, whatever their disability or illness." Elizabeth (Occupational Therapist) elaborated further on the importance of an Occupational Therapy perspective—or world-view—underpinning the practice of this profession.

> I think that's what makes us unique in our profession. Learning about that [Occupational Therapy perspective] and that becoming part of your world-view or your perspective. I think it's really important that as occupational therapists we don't just talk about that but we truly understand about what that occupational perspective is about, and

seeing occupations as a means for rebuilding health and wellbeing (Elizabeth, Occupational Therapist).

Louise (Midwife) spoke of professional perspectives, or world-views as models of care. She suggested the relationship between medical and midwifery practitioners was often difficult due to different orientations from which each profession viewed obstetric care. Midwifery was viewed as providing holistic support of women's choices during pregnancy and birthing whereas obstetricians were more inclined to initiate medical intervention. Furthermore, Louise explained the orientation of independent midwives— working primarily with women out in communities—differed from hospital-based (core) midwives who were more medically focused:

> You're both [core and independent midwives] working for the woman and baby so that they've got that in common, but often the more medically minded will prioritise medical needs over social, psychological needs. I know the core staff have strived to do that [take a holistic approach] but it is difficult in that environment. And when they don't have a long relationship with a woman (Louise, Midwife).

Aimee (Physiotherapist) also signalled the perceived difference between a bio-medical approach to patient care and a physiotherapy focus on general well-being and coping strategies of patients, suggesting a lack of empathy and understanding expressed by medical staff. She recounted clinical experiences whereby,

> The doctors might come in and say "well how come they're still in hospital?" A reply is "Well because they're in a whole lot of pain and they live on their own and they're not going to be able to get up their stairs". So sometimes it's not about knowing theoretical knowledge, but it's a lack of just actually interacting with the patient that I found was maybe the big difference between physio and some of the other professions.

Aimee elaborated further on her professional perspective, making a comparison to her observations of doctors' interactions with patients.

> I watched the doctors coming in and they just sort of read things and delivered a bit of news and then left. So it wasn't that they actually spent time with the person, or found out what really were problems and where we could help, as opposed to just moving them along (Aimee, Physiotherapist).

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Participants expressed clear understanding of their specific profession's orientation to health care practice. They felt they had a good knowledge base and skill competence to begin working in their chosen field. From this position they were in favour of collaboration among health professions, and most anticipated working in this manner. This was evident in discussing the need to refer patients to appropriate care, when the patient health needs were complex.

4.5.3 Broaching collaborative practice

Although profession-centrality was paramount, participants viewed collaborative options as occurring after a specific profession orientated approach was exhausted or limited. Steph (Nurse) expressed the need to provide holistic patient care through collaborative practices, but was adamant that her years of education had prepared her for a specific role.

> We [Nurses] incorporate principles that they [Physiotherapists] also use, things like deep breathing, coughing, effective positioning and mobilisation. But I haven't studied four years to know those things and they've got way more expertise in that [chest physio], and so they'll know how to do that more effectively. I think nurses work adjunct to that, assisting them with that and do what we know to do, but not try to be a physio (Steph, Nurse).

In contrast, Jessica (Occupational Therapist) took a holistic perspective when reflecting on the types of questions asked of patients by physiotherapists as compared to occupational therapists. She suggested the questions were similar but occupation-focused. Through undergraduate collaboration during patient assessments, Jessica had expanded her understanding of a patient's needs beyond her own professional lens, or perspective. Her experiences had enabled her to position her occupational therapy perspective within a broader health care context, whereby "you understand where you do work together and then the sections or parts where you have your distinct roles." Elizabeth (Occupational Therapist) agreed with Jessica, but supported practitioners from different professions taking time to "understand the roles of the other clinicians

and understand what they can do and what their professional view is." Elizabeth

described her understanding of collaboration among health professions:

> It's about respecting those roles and respecting those professional
> views and, I guess, breaking down that hierarchy and being able to all
> get down on the same level, have an open space to be able to talk
> about your views and bring those together, while recognising the
> importance of the differences (Elizabeth, Occupational Therapist).

Similarly, both Steph and Mia (Nurses) advocated the need to understand and appreciate

the various roles of other professions so that they were able to position their nursing

scope of practice in a broader health care service context. Steph expressed this in terms

of both recognising the limits of her nursing scope of practice and recognising the

practice scopes of other professions, in providing continuous patient care:

> You can't value yourself more highly than them [other professions]
> and you have to have an appreciation for what they do. I think also an
> awareness of your own limits; I can't actually do this for the patient
> and that's why we need these people to do that. I think that's part of
> professionalism, knowing your limits and knowing what to do when
> you are faced with that (Steph, Nurse).

In contrast to nurse graduates, other participants were more tentative regarding

collaboration, expressing concern as to where the boundaries between professions lay.

Cathline's (Podiatrist) undergraduate podiatric experiences of collaborative practice had

expanded her understanding of various facets of health care, but left her uncertain on

scope of practice boundaries, noted in this instance between podiatry and physiotherapy.

> Our practice [Podiatry] looked at more of the joints and how they
> worked by passive movement, where they [Physiotherapy] looked at
> active movement; it was more about the muscles, and it was more
> about how the patients moved themselves rather than moving them, so
> there was a huge difference in practice.

Reflecting on this, Cathline questioned what this meant in relation to her future practice

as a podiatrist.

> I guess it highlighted, possibly, the stuff that we were missing in our
> practice; maybe we should be looking at active movement, but how
> would that affect our practice? How would it benefit it, but then again
> was it crossing over into a different discipline if we were going to
> bring that in? (Cathline, Podiatrist).

Scope of practice boundaries were of concern, expressed variously as points of difference that could be utilised to expand knowledge and enhance patient care, to uncertainty over potential practice overlaps. In the former, overarching positivity levelled at collaboration was related to patient-centred goal setting and implementation, with different health care perspectives taken into consideration in practitioners working towards the same goals. In this context, participants expressed the need to articulate their professional perspective early and often, in collaboration with other professions. Elizabeth (Occupational Therapist) described this as "having that voice and making sure I can be clear in what I say because I really think that's absolutely important."

Others expressed this strengthening sense of professional self, with Amelia (Occupational Therapist) suggesting that working closely with other professions made her more confident in her role as an occupational therapist. In reference to her previous experience of working with physiotherapists, Amelia recounted,

> [a] generally good feeling that we can work together. It just helped with the clarification between the two professions, which are so closely linked, generally, and opened up the opportunities of helping with my knowledge of what to go to a physio for, when to get involved (Amelia, Occupational Therapist).

Conversely, concern regarding scope of practice overlaps between professions was tempered by acknowledging the benefits of understanding "each other as health professionals" (Cathline, Podiatrist). Further to Cathline's earlier concern regarding overlapping practice boundaries between physiotherapy and podiatry, she expressed optimism at working with other health professionals once she became familiar with both "the benefits of other professions practice, knowing what they do," and articulating her distinctive podiatric role.

4.6   Novice Practitioners

Participants' early experiences of working in their chosen field of health care focused on the reality of navigating a practice role in the first two to three months of working in

a health care context (Figure 1, p. 1266: Early practice column). As novice practitioners, they oscillated between finding their job challenging and tiring, and yet immediately stated how much they enjoyed their work. The physical aspects of tasks, e.g., continuous walking, lifting or moving patients and use of equipment, were viewed as unproblematic. This afforded practitioners incremental degrees of building confidence in their ability to function in their new role. The participants, however, reported heightened sensitivity to emotional demands, with an overwhelming sense of responsibility for continually making decisions throughout a day, and of wanting to make the best decisions possible.

4.6.1   Vigilant practitioners

Making decisions regarding the health status of other people, subsequent intervention options and possible or potential implications of those interventions weighed heavily on the shoulders of the graduate practitioners. Steph emphasised her need to remain vigilant in all aspects of her practice as a nurse:

> You have to be so sure in yourself that you are doing the right thing,
> and double-checking for yourself, taking that extra time because
> there's no safety blanket for you anymore, really. So it is you, and it's
> your practice and you write your notes and no one countersigns them,
> so it is you (Steph, Nurse).

Steph elaborated further on wanting to understand the dynamics of her workplace and where she fitted in, so she was then in a position to gauge situations better:

> I think I'm just still trying to understand the full picture of it all. I
> went in [to clinical practice] thinking you just go there and you be a
> nurse, and ideally that is what I would like to happen. The days that I
> go to work and I am a nurse and I do my job; those are the best days
> (Steph, Nurse).

Similalry Louise (Midwife) expressed a sense of being mentally challenged by the uncertainty of her role in birthing situations, particularly when hospital intervention was required and this overrode her independent midwifery relationship with a woman. She recalled her overall experience of dealing with "all sorts of things out of left field so it

has kept me really thinking. It hasn't been normal by any stretch; it's never felt easy.

It's always been, "What am I going to do here, what will I do here?" Louise elaborated

further, on her perceived dual role of partnering a pregnant woman by providing

emotional support while simultaneously maintaining cognitive detachment so she was

able to initiate interventions as necessary.

> It's like part of me is with the woman and very much a part of her
> coping and then part of me is standing back and analysing what's
> happening and anticipating what could happen, or what I'm expecting,
> or trying to stay on top of her care (Louise, Midwife).

Lisa (Oral Therapist) spoke too of responsibility weighing "heavily on my mind and I

am scared of making a mistake" in her work with children. From Lisa's perspective she

viewed everyday as a challenge. It appears that a separation between emotional

demands and clinical reasoning became a coping mechanism to combat the

overwhelming sense of responsibility, thereby allowing practitioners to function

rationally in making decisions and reasoned judgements regarding interventions with

patients. Thus, in the early days of working, participants took active steps to harness

their emotions through an internal dialogue. Mia (Nurse) described the process as:

> very much an attitude of "as long as I'm safe." If I don't feel
> comfortable that means I'm not safe. I get less nervous as soon as I
> accept the fact that it is ok for me to say "if I feel uncomfortable it's
> not safe, therefore I'm not going to do it, but I'm going to organise
> something else." (Mia, Nurse).

In effect, a degree of clinical detachment became apparent from this early stage with

emotions side-lined in order to function effectively. Mia (Nurse) compared her previous

experiences of being a student with her current role, whereby:

> As a student nurse you get kind of overwhelmed very easily because
> you don't know the bigger picture or it's not all your responsibility so
> you can talk to someone if you're missing pieces. And so you just get
> overwhelmed and when you switch to being a nurse, you just say to
> yourself that you have to do it, it's not even a question in your mind of
> getting someone else to do this for me, or can I leave this to next shift,
> it's there, I have to sort it now (Mia, Nurse).

Prioritising interventions in a timely manner produced an additional layer of complexity for practitioners to adjust to. Time constraints were ever present, creating uncertainty and vulnerability in a practice role. In response, some participants detached themselves further from emotional engagement, and focused on skill competency. Sue (Nurse) described this in terms of ticking boxes, and Charlotte (Physiotherapist) described injury pattern-recognition in the same way. In both situations Sue and Charlotte aimed to instil structure into their working day. Additionally, successful completion of tasks assisted them in building confidence to practice in their chosen profession. Phoebe (nurse) rationalised her structural approach as managing her time:

> It makes me feel that I'm being an effective nurse, rather than doing a procedure well. By managing my time well and getting to see all my patients and knowing who they are, and being able to do a good handover, makes me feel that I'm being effective (Phoebe, Nurse).

Similarly, occupational therapists and podiatrists focused on accuracy with referral processes to provide structure to their practice. Amelia recounted that in the first weeks of her work as an occupational therapist she was accepting all patient referrals, feeling she could not challenge that due to her lack of experience and limited knowledge of her working context. Through gradual familiarity of her work context, and mentoring from senior colleagues, she began to prioritise her workload. In order to develop their professional practice it appears that participants had entered a phase of unease, whereby the reality of constant decision-making, rational thinking, judgements, and enacting interventions necessitated a changing approach to their practice. However, sidelining emotional responses to professional responsibility and accountability left many with a sense of uncertainty and questioning the efficacy and worth of their professional work.

During the early months of working as a health practitioner, a shift occurred from participants feeling overwhelmed by responsibility and making "good" decisions to a realisation that they were surviving. Charlotte explained this as:

> when you feel you've made a difference with someone; when you've helped them, when you've had someone come in and they're in a huge amount of pain and you've done something and they just feel miles better (Charlotte, Physiotherapist).

Familiarity with work routines, processes and protocols would have assisted this shift. Once participants gained a sense of control over the structure of their work, they began to question their personal engagement and readdressed their professional focus. Steph (Nurse) described her nursing role as "blurred", whereby she was unable to identify distinct scope of practice elements pertaining to her profession. She questioned the role of nurses in general, stating "nursing seems to be a bit of everything; it's like the little piece in between everyone else". Similarly, Elizabeth (Occupational Therapist) expressed her need to "unravel" aspects of patients' occupations, rather than responding to standard assessment information. Likewise, Aimee reflected on her development in physiotherapy practice moving towards clinical reasoning when working with patient information, rather than assuming she had all relevant information for a particular intervention. She recalled an occasion where she made use of her developing clinical reasoning skills:

> Once I had a bit more experience, it's then saying, "here's a 70 year old lady, I know she's got a pace-maker." Chances are she'll be on some kind of blood thinner. It's taking that clinical reasoning be what's said rather than thinking, "right, well she didn't say anything about these medications, therefore I've got all the information I need." So it's reflecting on that and a real learning curve to think, "don't assume, always use your judgment"; and that just comes with more experience of dealing with patients (Aimee, Physiotherapist).

4.6.2   Strengthening professional voices

Prior to participants questioning their own professional engagement in their practice, they had relied on mentoring from senior colleagues in their professions, who had previously shouldered most of the metacognitive aspects of clinical reasoning and judgement. While this enabled novice practitioners to focus on structural aspects of their work, it appears to have aided in their perception of separation between self and the profession, leading to frustration at "remaining in a student state" (Steph, Nurse).

During this transition into workplace familiarity graduate practitioners were in a liminal state, where they were acutely aware of their work surroundings but—in response to scaffolding from experienced colleagues—they were sheltered from access to a larger "lens" for professional practice. Relief was an emotion expressed by some participants once they progressed out from their mentoring programmes. Sue (Nurse) suggested she was now responsible and accountable for her actions:

> It felt really good that I was trusted enough to be given responsibility and that I could take this on. I didn't need someone else to take care of things for me; I was stepping up to the plate (Sue, Nurse).

Being held accountable for decision-making and being trusted by colleagues was a starting point for participants progressing forward in their professional role. Sue-Anne (Midwife) expressed her understanding of accountability:

> I'm at the point now where if I notice something and I do not act, it's on me and the care of that woman on my watch. Even though I have all these people [colleagues and medical staff] surrounding me, I still need to make sure I do my part properly, that someone doesn't get missed out and then something serious happens (Sue-Anne, Midwife).

Amelia (Occupational Therapist) suggested that she still felt overwhelmed at times "because I don't have someone right there to answer my questions." However this forced her to seek the knowledge she required, and think through possible options in her work with patients. Consequently, she described herself as becoming "stronger and standing on my own two feet."

Definitely the transition into becoming a responsible and accountable member of a profession boosted novice practitioners' confidence in their own ability to cement their professional role perspective. Elizabeth (Occupational Therapist) described this process as "turning a corner" and feeling more able to "articulate what I'm doing." She likened her practice leading to that point as a roller coaster of uncertainty, only seeing parts of a broader occupational therapy perspective. Now being in a position where she felt trusted by her colleagues to make clinical judgements, she equated her expanded

understanding to "a whole new way of thinking" about her profession and her sense of being in the right job.

Being relied on to make sound clinical reasoning was concurrent with an expectation—from colleagues initially—of articulating judgements regarding patients' conditions and proposed treatments or interventions. Having a voice and being responsible for communicating information to one's own profession was viewed positively, due to a sense of supportive community and familiarity with procedures and language use. Amelia (Occupational Therapist) described the ease with which colleagues conversed, whereby "the language is the same and I know what they're talking about and it makes sense to me."

Concurrently, novice practitioners were increasingly expected to communicate their clinical reasoning in a wider professional arena. This occurred in team meetings with a number of professions in attendance, in prearranged or spontaneous conversations and through written communication. Prior to commencing work, participants had expressed openness to working with other professions, albeit in response to observing collaboration while in clinical placements or perceiving the need to maintain open communication channels for effective health care services. Lines (Podiatrist) recounted the difficulty he experienced in maintaining open written communication with other professions due to a mismatched use of language, symbols and terminology in documenting patient's clinical notes.

> We podiatrists would write down our notes; we use a lot of symbols
> that I know are different to what the nursing profession use. Some are
> familiar to physios, but again they use symbols that we wouldn't
> understand. So If I were to pick up a set of notes from a physio and
> read them I would not be sure of what they meant (Lines, Podiatrist).

The reality of articulating specific professional perspectives was challenging, including building and presenting a rational case in justifying proposed actions. Participants spoke of the need to clarify their role in interprofessional team meetings and more specifically

their professional perspective. Allam (OT) described her challenge in refining the role of an occupational therapist to a single sentence that she could "roll out" when required. Amelia elaborated further on her strengthening professional voice in support for Occupational Therapy profession.

> I feel OT is one of the least understood allied health professions and we need to be constantly advocating for the profession, especially for the need of OT's in an acute setting. This goes for the distinction of my role too, being confident that we have a specific niche, especially in completing cognitive and safety assessments (Amelia, Occupational Therapist).

In contrast, this was not evident from nurse participants who expressed disquiet at the complexity of patient care. Sue (Nurse) expressed her sense of overall responsibility for monitoring and responding to changes in the health status of her patients:

> I'm looking at something and thinking, 'This is not quite right, this baby's abdomen is distended, what's going on there?' So I'm reflecting on my own critical thinking, my own clinical background and stepping up from there (Sue, Nurse).

Steph (Nurse) described this as "anticipating outcomes" and learning to respond appropriately. Nurses perceived their professional role as diffuse and hard to articulate, with Steph suggesting nurses filled the gaps between the other professions. Appropriate nursing responses often included involvement with other professions, primarily medical staff, but also communication and coordinating with other professions. Thus, nurse participants felt their professional responsibility was in remaining vigilant to changes in patients' health conditions.

Additionally both Mia (Nurse) and Sue (Nurse) suggested their work as nurses encompassed a range of patient advocacy, intervention and safety activities from other professions that they absorbed into their role. Mia likened her nursing role to that of a "bridge between other health professionals because the nurse is the go-to person for the patient." However, unlike the other professions, nurses did not express a need to clarify their role to other professions, suggesting their sense of entitlement to practice relied on traditional notions of nursing being central to health care provision.

4.6.3 Bordering practice boundaries

Certainly, novice nurse participants were adept at identifying when other health professions were required in the provision of patient care. In fact, nurses were the only professional group who perceived their scope of practice blurring at this stage in their graduate year. Mia described this as "changing the shape of my outline", as her understanding of other professions increased. She recounted:

> I was a nurse, I give meds, I do obs, I provide cares for people, I advocate for people and that's what most people would describe nursing as. And now on this ward, I learnt what physios did and then added that to my knowledge base and I kind of changed the shape of who I was. Now I'm also a mobility and moving and handling person. And then I talk to an OT and suddenly I had this new part of my practice, and I know what questions to ask patients about managing at home (Mia, Nurse).

In contrast, profession centrality was strengthened for other novice practitioners at the borders of professional knowledge and practice boundaries. Sue-Anne (Midwife) stressed the importance of sharing patient information, but from her perspective as a midwife other professionals "fill the gaps that I cannot fill." This sentiment was expressed by a number of participants in acknowledging their scope of practice limitations and the need to build interprofessional relationships. Amelia (Occupational Therapist) described her experience of asking for advice from a social worker on how to communicate with a terminally ill patient. The social worker was able to provide guidance "and I then felt confident that I was saying the right thing." Equally Amelia explained the value of her occupational therapy perspective to nursing staff, regarding the home care of patients with progressive Alzheimer disease. This followed her observation of nurses providing what Amelia felt was inadequate information to patients' families. Amelia explained this as " having the confidence to relate it to an occupational perspective." She added:

> I need to have a sound understanding of my role as an OT to not only ensure the patients have a clear understanding of how I can help them, but to be able to back my OT corner with the medical team, and to be

able to do this in a professional way (Amelia, Occupational
Therapist).

Occupational Therapists were remarkably clear on their scope of practice, possibly due

to their sense that other professions did not fully understand their perspective on

occupations. Elizabeth (Occupational Therapist) had previously provided a definition of

"occupations" as being all activities that build and support self-identity and health.

Additionally, from an occupational therapy perspective, occupations were viewed as "a

means for rebuilding health and wellbeing." From this perspective Elizabeth

emphasised the need for occupational therapists to be strong in their professional views

and articulate their distinct perspective when needed. She described this in relation to

undertaking cognitive assessments on patients, stating "I'm looking at it from a different

perspective to doctors because I'm looking at how they will manage with everything

once they're discharged; so I guess that's where I see myself as an individual within the

team." Amelia concluded that she was the "go-to for any cognitive assessments" in her

work context and this provided her "particular identity."

Identity in a specific field of health care was evidently strengthened through

working at the borders of various professions, because it was at these borders that

practitioners perceived the need to validate the distinctive health perspective and

orientation that informed their practice. One participant suggested that if professions

worked in isolation there would never be a need to articulate their distinctive

perspectives because they would just be getting on and doing what they did; where-as

working with other professions required practitioners to reflect on their distinct

professional contribution to patient-centred care, and further, to communicate this

clearly. Elizabeth (Occupational Therapist) realised the value of occupational therapy

through working with other professions. She described this occurring when,

There might be three different professionals who walk beside each
other and experience a client, watch a client do a particular thing, see
a client in a particular environment. The social worker, the nurse and

the occupational therapist are all going to come away with very different observations about that experience, even though we might all be seeing the same thing (Elizabeth, Occupational Therapist).

Elizabeth elaborated further on how her identity as an occupational therapist was strengthened through having to articulate her professional perspective to others.

I'm finding that, working with them [other professions] we do have so much role overlap, but that really demonstrated to me how my perspective is quite different. It makes me hyper aware of holding onto that and I'm constantly thinking, "what's my view on this, why have I got this view?" I need to ensure that I never lose my occupational perspective, or the importance of making sure that I'm aware of my clients' occupational needs (Elizabeth, Occupational Therapist).

4.7 Collaborators

During the first half of the year, graduates' professional focus was firmly located in their chosen field of health care practice. In contrast, in the second half of the year, viewed chronologically as mid practice (Figure 1, p. 1266: Mid practice column), participants expressed their work in terms of "working relationships" that intersected knowledge and practice skills among professions. Although they continued to work predominantly with members of their own profession, they were developing collaborative practices. Hence this categorical theme focuses exclusively on the participants' experiences of working collaboratively with other health professions, and aims at providing insight into how novice practitioners develop their professional identity in contexts where they intersect knowledge and practice boundaries with other professions. This categorical theme is distinctly smaller than others as key findings of graduates' experiences of collaborative practice have been discussed previously, and form a foundation from which to focus on key findings that emerged as the graduate year progressed. For example, prior to commencing work, graduates had encountered various collaborative practices as students, in learning contexts and in practice settings. Additionally, as novice practitioners, they communicated and increasingly worked with

others at the borders of the respective professions. By midway through the graduate

year participants were routinely intersecting professional practice boundaries.

4.7.1   Creating collaborative spaces

During the second half of the graduate year, participants became increasingly familiar

with their working environments, and in the main they had ascertained a distinctive

professional voice in their interactions with other professions. There was less need to

continually clarify and justify specific perspectives to others, as participants became

known and trusted in their work contexts. Participants were more confident in their

practice and generally viewed collaboration as a working relationship. Elizabeth

(Occupational Therapist) described her experience of working with other professions:

> Being in the team, working with the other disciplines, having to
> actively put up my hand and say 'I think this client needs this' has
> really helped me to become more confident in articulating what my
> own profession can bring to that Elizabeth, Occupational Therapist).

Elizabeth compared this way of working to her earlier experience of interprofessional

work, which she likened to "pieces lying on the table and you don't know what they

mean or how they fit together…once that starts to make sense, it's much easier to

navigate that relationship." Sue-Anne (Midwife) agreed, stating she had often felt lost in

her early days of practice but persevered in her observation of clinical practice and

slowly started making sense of how the various professions worked together. She

suggested this was partly due to increasing familiarity with her work environment and

partly due to her developing confidence in her own practice ability.

> You soon start picking up on, "ah, they're [Doctors] going to order
> this, this and this and they're going to say this, this and this," and that
> knowledge becomes a part of my knowledge. In a way it's outside of
> midwifery because it's a very medical model, so therefore I'm getting
> the doctor's input of what will be needed for this kind of a situation
> that we're facing. So that increases my knowledge. And it increases
> my understanding of their profession and what they bring to me (Sue-
> Anne, Midwife).

Elizabeth (Occupational Therapist) likened collaboration to working in the "space in between a number of professions where we all contribute our own specialised area." She described the process of creating space, whereby practitioners learned when to step forward and contribute and equally when to step back because another person's contribution had greater traction regarding patient care.

In order to create space among professional perspectives, Elizabeth highlighted the importance of having a strong professional identity and similarly an understanding of other professions, stating, "I think it's about owning your own profession and knowing what it is that you do but also respecting what the others bring to that." Understanding other professions included increasing awareness of alternative perspectives, described by Sue (Nurse) as "seeing the bigger picture" in nursing and by Sophie (Podiatrist) as "broadening my take on things" in podiatry. In qualifying this perspective Sophie explained that she now questioned her motives before referring patients to other professional services, whereas in the past she would act in accordance with set protocols. Specifically, she questioned the benefit to patients of being referred back to their general practitioner (GP) following successful podiatric treatment.

> When you send a patient back to the GP, what's the GP actually going to do? Are they going to do anything? Should I ring them and ask? Rather than just looking at the patient and sending them off, actually think about, "well, what are they [patient] going to get out of that?" (Sophie, Podiatrist).

As with the nursing practitioners who had previously spoken of blurring their scope of practice with other professions, participants from other fields were noticing their knowledge and practices extending beyond what they perceived as clear scope of practice demarcation between professions. Sophie (Podiatrist) recalled her experience of working with nurses, resulting in a broadening perspective:

> I've asked a thousand questions of the nurses that I work with at a few of the out-clinics. They ask me lots of questions and I learn so much from them and hopefully they're learning a bit from me. It's definitely changed the way that I approach a few patients because I wasn't really

sure of what the nurses were doing. But now I kind of know their thought processes, with a few of the things that I see in conjunction with them. So it's changing the way that I treat them [patients] (Sophie, Podiatrist).

Similarly, Sue-Anne (Midwife) reflected on her broadening theoretical and practice orientation resulting from working in a hospital environment where patients required both obstetric care and advanced medical treatment:

If I'm going to have to work in this environment I want to know what to do. I'm not going to just plead ignorance and plead it's outside my scope. If I'm here and this is what's happening and this is where women are at now, it's not going to change (Sue-Anne, Midwife).

Even perspectives were altering as understanding of different health perspectives influenced the "lens" through which participants viewed their work.

4.7.2   Shifting professional orientations

Although forging a professional identity in a distinct occupation remained an overarching priority for participants, some participants began questioning the perceived ideal of profession-centricity to the reality of working interprofessionally. Mia (Nurse) described her experience of working collaboratively in her nursing role as altering her scope of practice.

I find myself being a dietician, being a physio, being a speech language therapist automatically; just adjusting things because I've talked to them and they've educated me, and just worked together on things before during previous experiences (Mia, Nurse).

From Mia's perspective she was extending her knowledge and practice boundaries in a responsible ethical manner. She realised that she could either discount the perspectives of other professions as peripheral to her own practice or adjust her practice boundaries to include additional knowledge for making clinical judgements and acting upon this. She chose the latter, but she later qualified her earlier statements by stating her unease regarding collaboration when "there are too many voices telling you too many things." When she felt overwhelmed she retreated into her scope of practice and best practice guidelines for nurses.

Sue-Anne (Midwife) had similar experiences in her expanded role as a midwife working in an antenatal ward. Her work spanned nursing and midwifery and she sensed she was becoming increasingly medically orientated in her practice. She reflected on her unexpected dual role and the need to consciously extend her knowledge and practice boundaries.

> I don't have the luxury of just being a midwife. I'm not a holistic midwife in the sense that I'm into only the natural; I'm ok with taking on medical. But I'm just realising that I cannot just stay in my blinded midwifery; I've actually got to expand now and up-skill myself to become this very knowledgeable, clinical sort of nurse-midwife (Sue-Anne, Midwife).

Sue-Anne continued to explain how she could reconcile her professional identity with her expanded practice role.

> Midwifery will be how I partner with the woman and maybe the breastfeeding and the baby. But the nursing part is blood transfusions, heparin transfusions, stuff that we were never taught because it's highly medicalised for women having babies; women that normally wouldn't have been having babies except for the medical technology that now gives them that window, which is great for that part of it but it's way outside our [midwifery] scope (Sue-Anne, Midwife).

It seems likely that shifting practice expectations created potential for destabilising identity in a specific profession. A number of participants suggested they were working outside their prescribed scope of practice boundaries. Elizabeth (Occupational Therapist), who was anticipating a change in her practitioner role, reflected on this:

> Is it right that someone [who] trained three, nearly four years in my profession is going to be attending to a person's medication? Well, I only know what I've learnt just recently about somebody's medication (Elizabeth, Occupational Therapist).

She reflected further by stating, "Am I operating outside the scope? I am really." However, Elizabeth reconciled her need to increase her knowledge and practice beyond her regulated scope of practice in order to "remain safe and accountable, and for my clients to remain safe." Participants appeared resigned to the reality of practicing in new ways, with a number of participants facing changes to their occupational role. Sue-Anne

(Midwife) offered her view on expanding professional foci beyond a single health care profession:

> We're going to miss out on some opportunities if we are that way [profession only focused] because this is the reality in our world in New Zealand. You might go to a bigger country and be able to stick to your chosen profession but I just feel times are changing and we just need to diversify (Sue-Anne, Midwife).

However, tension had surfaced; tension related to reconciling professional identity with current or projected interprofessional practice, and the perceived need to extend knowledge and practice boundaries in order to work in an ethical and safe manner.

4.7.3 Extending practice boundaries

Extending practice boundaries was perceived as a way forward in meeting practice role expectations. In one respect nurse participants were reconciled to this way of working, having learnt to incorporate—from early in their graduate year—the perspectives of other professions into their on-going monitoring of patients' health status, and relaying information appropriately. Additionally, as their familiarity with the specific interventions associated with other professions increased they extended their practice to include these, when appropriate.

Mia spoke of extending beyond her nursing scope of practice because she "was doing things that you don't necessarily tick off under the nursing council competencies." She described her experiences of working alongside other professions in assigning appropriate responsive interventions to complex patient-centred care.

> You start taking on their views, because once you see what their point of view is, you approach someone and think, "I should probably think about this as well; I can't just think about that. Then you have a set of skills that you didn't know you had before, that you automatically just start using (Mia, Nurse).

From this perspective, Mia rationalised extending her practice boundaries to ensure patients received continuity of care, rather than discontinuous interventions related to

variable access and availability of other health professions. She elaborated on the need to ensure continuity of care.

> It's just knowing it is the right thing to do and implementing it when they're not there. On the weekends we don't have the MDT [multi-disciplinary team], it's just us nurses. And so you can't stop rehabilitating people on the weekend just because they're [MDT] not there. You'll have people say "oh no, we need the physio to get this day one knee up" and I reply "no, because then the patient will be here for a week instead of four days". If you have the knowledge, and act safely, you can do it (Mia, Nurse).

Not only was continuity of care shown in this example. Mia was also conscious of extending her practice boundaries to support the economic constraints of her employing organisation, through optimising patients' health status in a timely manner so patients spent minimal time as an inpatient in a public hospital. Other nurse participants shared this perspective, viewed as tension between medical and nursing staff in "freeing up hospital beds" (Phoebe), or "moving patients from acute wards" (Steph).

Conversely—due to this perceived tension—nurse participants were strengthening their patient advocacy, similarly evident in occupational therapy. Elizabeth (Occupational Therapist) questioned the efficacy of undertaking cognitive assessments on patients without clearly identifying the purpose, specifically in regards to elderly patients being discharged from public hospitals to either their own home or a residential care facility. Elizabeth stated her focus differed to other health professions, "because I'm looking at how they will manage with everything once they're discharged."

From an extended health practice orientation, nurses and occupational therapists adamantly opposed discharging patients if their clinical reasoning indicated otherwise. Sue, for example, in her nursing role of working with ill infants, questioned doctors' decisions to discharge these patients if she sensed potential deficiency in a home environment. She attributed this to her extended knowledge from working with a number of allied support workers, who bridged hospital-community health care. Sue

likened her extending practice boundaries to a "sponge" whereby she was absorbing

knowledge from others and being cognisant of this knowledge when making clinical

judgements.

> My title is still a nurse but I do follow-up care; I see what happens
> when people go home. That's technically not my job. That's a
> homecare referrer's; it's their job but I anticipate it now. When I
> started my job I anticipated my 12 hours and that was it. I couldn't see
> the follow through, the long-term, whereas now I can (Sue, Nurse).

This meant Sue was now anticipating areas of concern that she was previously unaware.

She described this as part of her evolving role as a nurse.

> I've learned from working with the social workers. They see things
> that I didn't but now I know the signs. I know how to sometimes ask
> those difficult questions… I did not want to go there… [now] I'm
> going there. Things like asking about domestic violence and things
> like that. I would not go there. I just did not think it was in my scope
> of practice whereas now I know how to be tactful around some
> questions. I've learnt from the social workers and other people (Sue,
> Nurse).

4.7.4 Evolving practice roles

Sue-Anne agreed. In her evolving practice as a hospital-based midwife, she realised she

was working outside the prescribed scope of practice for her profession. She explained

her quandary in caring for women who were pregnant but also had a multitude of other

medical conditions impacting on their pregnancy.

> I'm realising that I cannot just stay working from my midwifery
> perspective. I've actually got to expand now and up skill myself to
> become this very knowledgeable, clinical sort of nurse/midwife…in
> order for me to know I have a future job and not be an independent
> midwife, I will consciously up skill myself (Sue-Anne, Midwife).

In the circumstances recounted by Mia, Sue-Anne and Sue, role expectations were

evidently expanding beyond their professions' scope of practice regulations. As

previously mentioned, this was in part due to situational circumstances in their work

environment; namely expedient patient discharges from public hospitals. Equally,

through continual communication at the knowledge and practice borders between

professions, novice practitioners were incorporating aspects of other professions'

practice jurisdictions into their work. Elizabeth—working in her role as an occupational therapist—likened her expanding practice perspectives to that of a "toolkit" that she was continually adding to. This wasn't necessarily through choice, but becoming a necessity as Elizabeth described a potential change to her occupation description.

> In the area where I work they now advertise for positions as a clinical team member and you are just a clinical team member and they will employ a psychologist, a social worker, an occupational therapist or a nurse. And so in that position, you have these sorts of skills that are just quite broad and I need… the exposure to those other clinicians at the beginning to be able to go 'what do you do?' because I need to do that in order to be able to function in that role. So it's kind of scary (Elizabeth, Occupational Therapist).

This was a similar situation to that encountered by Sue-Anne in midwifery practice. In both contexts the novice practitioners were purposely extending their practice boundaries to accommodate changing role expectations with Elizabeth suggesting she needed to "step up" and Sue-Anne stating she did not want to "miss out on opportunities" to further her career opportunities. However, both Elizabeth and Sue-Anne were adamant they did not wish to compromise their chosen professional orientations, or their professional identities. Sue-Anne stated she would orientate her interaction with patients, first "in partnership as a midwife" and then attend to other concerns. Equally, Elizabeth suggested she would hold on to her occupation perspective in one hand, while "juggling" new skills in the other. In doing so, they anticipated retaining their professional identity while broadening their practice orientation.

4.8   New Professionals

The fourth categorical theme—New Professionals—concludes the temporal process of participants' development and understanding of professionalism, identity and collaboration in health care contexts in the graduate year of working as health practitioners (Figure 1, p. 1266: Later practice column). It draws on the interwoven professional dimensions of practice roles, experienced by graduates as they proceeded to work as New Professionals, in their respective health professions and in collaborative

work with others. Findings from this later phase (Phase 4) identified the significant influence of interprofessional collaborative activity on graduates' practice boundaries, professional identity and health care perspectives.

4.8.1 Flexible working relationships

The latter part of the graduate year was a critical phase for participants in the development of their professional practice. It became evident that regardless of where their practice was located—in a public hospital or in private practice—participants had established a flexible understanding of their role in clinical practice. Charlotte (Physiotherapist) described the multifaceted nature of her work, saying,

> it's never black and white when you're treating someone. There are all sorts of different pieces to the puzzle and your communication with other professions helps you put those pieces in the puzzle together and it helps you deliver a better package of care to the patient (Charlotte, Physiotherapist).

Overlapping knowledge and practice boundaries among professions was viewed positively in creating space for discussion on practice possibilities. Additionally, although participants remained centred in their chosen profession, they recognised the value of interprofessional collaboration, specifically related to broadening professional perspectives on health care provision. Sophie (Podiatrist) expressed her view of working collaboratively with other professions as:

> If only one person looks at a problem, they can miss things really easily but if you have different points of view on the same client, then you can get a better outcome; usually with different points of view (Sophie, Podiatrist).

In addition, some participants provided experiences of how they worked collaboratively with others and what this meant in relation to professional perspectives in their respective health profession. Amelia (Occupational Therapist) described her experience of working with a physiotherapist in assessing a patient's home environment prior to the patient's discharge from hospital.

He [patient] lives in a council flat, up a flight of steps, and that was quite a big challenge from the physiotherapy perspective. So she [physiotherapist] was quite concerned with getting him up to speed on that number of steps. That was her main focus, but for me, it not only had to incorporate the steps, which she was working on, but that was crucial to him being able to access his home environment, for me to do my assessment (Amelia, Occupational Therapist).

Amelia clarified that in this situation, the physiotherapist's focus was on a patient's physical ability to climb stairs, whereas Amelia was focused on the patient's ability to cope in his home once he climbed the stairs. The stairs were important but for different reasons. Amelia reflected on this, stating:

As I've developed my understanding of their roles [other professions] that also helps to clarify my role, because there are overlaps and I think there will always be overlaps. But, it's becoming clearer in my mind as to where the lines are drawn and how much of an overlap there can be (Amelia, Occupational Therapist).

Similarly Mia (Nurse) reflected on her experience of assessing patients when they were admitted to a hospital ward and on how understanding the perspective from another profession assisted in her nursing assessments.

When a patient comes in, I do an ADT planner [assessment] and say, "hold on, do you have stairs at home; do you a high seat in your toilet; do you have care at home?" After talking to the Social Worker and identifying what a social worker focuses on compared to a nurse I can approach a patient and think 'oh yes, they're an elective so they're going to need the needs assessment coordinator'. So I know what to ask, I know what to look for, I go in prepared, but at the same time open (Mia, Nurse).

Mia suggested her professional shape was altering, whereby "the more health professionals I meet, the more I add to my knowledge and implement." Hence a shift was evident from earlier profession-centricity, to maintaining a credible professional persona in a broader health context. Credibility was linked primarily to being portrayed as a good clinician.

4.8.2 Validating professional identity

Intersecting or "blurring" professional practice boundaries continued to strengthen professional identity in a specific field. From an occupational therapy orientation, both

Allam and Amelia perceived their professional identity strengthening in this way. Allam proposed that, in working with other professions she was able to understand her scope of practice within a broader health context, resulting in her developing confidence "to voice my professional perspective and justify decisions". Here she was referring to her experiences of advocating for patients' delayed discharge from hospital following her assessment of potential safety risk factors in patients' home environments.

Equally, Amelia described her strengthening identity as an Occupational Therapist resulted from her knowing when to interact with others, including her ability to identify roles and where these blurred or overlapped. Having this knowledge allowed her to make clinical decisions determining when she "could step in" for another practitioner and undertake procedures that did not normally fall within her jurisdiction but provided seamless patient care. Amelia explained how, as she became more familiar with the roles of others she also developed greater confidence in her own role. She stated, "It's created a strong identity for me as an Occupational Therapist as those boundaries have been further clarified."

Conversely, overlapping occupation jurisdictions had been common practice for nurses for much of the year with Mia and Steph previously questioning a specific role for nurses, other than 'filling the gaps' among the other professions. At the end of the graduate year, however, Steph was clearer on her identity as a nurse, particularly when she compared her role to that of the doctors she worked with. She described this as "surfacing" from a medically driven workplace "where you get slightly lost because you don't get to make important decisions." Over time she realised the importance of her patient advocacy role, stating, "I know there are options for my patients and voice those, from a nursing perspective, to the medical staff."

Steph shared clinical experiences of preventing medication errors, responding to alterations in patients' physiological vital signs, and of becoming increasingly confident

at speaking empathetically to families of ill patients. Further, she felt able to challenge actions of other professions—notably doctors—if she judged the health status of patients under her care was at risk of being compromised. Steph summed up her actions as providing good nursing care, "where all the pieces finally start to fit and you finally see how important the nursing role is."

Similarly, Elizabeth took a view that, with a potential role change from working as an occupational therapist to a generic clinician role, she would uphold her distinct occupational therapy perspective, as this was the driving force that informed her practice. Further, she reasoned that holding onto her "identity as an occupational therapist" would enable her to practice in a legitimate manner, in a changing role.

> Working collaboratively makes me have to define my identity and touch on that and explore it. Thinking about doing the generic role next year, I really am sitting in my identity and trying to form that around me because I want to make sure that that is really strong and drives me for the rest of my career. You know, I'm happy to be a [specific title omitted] clinician but I want to be first and foremost an Occupational Therapist (Elizabeth, Occupational Therapist).

Elizabeth and Steph looked to be validating their professional identity. Both participants had expressed their self-awareness of working collaboratively with other professions and had reflected on this, concluding an evolving relationship between their strengthening professional identities and expanding professional role perspectives.

4.8.3   Expanding professional perspectives

Extending practice boundaries through collaborative work with other health-care professions was linked to participants' perceptions of strengthening identity with one's own profession. Participants appeared to accommodate an expanded perspective beyond their own profession, concurrent with a strengthening sense of their own professional identity in a distinct field of health care. Jessica (Occupational Therapist) clarified the meaning she attributed to her expanding perspective through,

> taking little aspects of every different discipline and it just becomes part of who you are in your role. You don't necessarily do it

intentionally but just the way you talk or the way you write things… I think everything about what you do, just tiny little parts of it, is part of another profession but you've still got your hat on as your profession (Jessica, Occupational Therapist).

Additionally, increasing understanding of perspectives from other professions altered participants' practice boundaries as they became familiar with the work of others. Amelia explained that in her practice as an Occupational Therapist she was not opposed to undertaking tasks that fell under the jurisdiction of other occupations if she was competent to do so.

> If the physio doesn't have time to assess transfers, then I know I can do it and vice versa. I can talk to a patient about a suitable package of care for housework or personal cares and I can get that process underway for the social worker (Amelia, Occupational Therapist).

From Amelia's recount it appears she was working at the overlapping borders between three professional groups. This wasn't unique to Amelia's experience, as other participants stated they were also working outside their regulated scope of practice. However, an overriding desire to be good clinicians in providing patient-centred care meant participants were aware of the need to work collaboratively with other professions or indeed extend one's own scope of practice to action effective care. Louise expressed relief at sharing workloads with other professions:

> As a midwife you do so many things and I think if I can identify that someone would be better off seeing a physio, rather than me advising them, then it's a relief to be able to share that responsibility (Louise, Midwife).

Equally Sophie spoke of her confidence in expanding her patient injury assessments beyond a specific podiatric focus as she became more familiar with the perspectives of other professions she referred patients to. She reflected on this, recounting conversations she had with other practitioners.

> Talking to physios, GP's and nurses, I learn all sorts of things; it's just a different way of looking at things. You get a different perspective from someone who sees slightly different things every day; it can be something quite simple but you just never thought of doing it that way before (Sophie, Podiatrist).

Indeed, Sophie concluded by saying, "most of our scopes of practice will overlap in some areas." Lisa recounted similar experience in her role as an oral and dental therapist, where working primarily with child patients, she relied on the perspective of other professions—notably teachers, public health nurses, and dentists—in developing her own understanding of oral health in communities. Expanding her professional perspective allowed her to function effectively in a rural health context. From Lisa's personal perspective, she wanted to be portrayed as a therapist who made a difference in the lives of people she treated:

> Dentistry is traumatic, people hate being there and so you try to make it stress free. If I see patients [out in the community] and they still greet me with a smile, then I think "well I couldn't have done such a bad job. They're still happy to wave at me." (Lisa, Oral Therapist).

4.8.4 Being a good clinician

Had participants' views on what constituted professionalism and being professional altered during their graduate year? When participants discussed their understanding of professionalism at this stage they spoke of the importance of how they were perceived by others. Jessica (Occupational Therapist) noticed positive reactions from the public when she was in her uniform. She recalled occasions when she wore her uniform away from her work context:

> I definitely notice a difference out in the community; the way people treat me when I'm in my uniform just after I've finished work and I might need to go to the supermarket or something like that as opposed to walking around in my everyday clothes. I definitely get a different interaction with people; it's almost as if they do respect me more (Jessica, Occupational Therapist).

Jessica explained that people showing her respect made her proud of her professional role as an Occupational Therapist, and "having a role that people do see as important." At this later stage in the graduate year, Max (Oral Therapist) also took pride in her role, stating, "it's a sense of knowing a skill and implementing that skill in a manner that can enhance other people… I think it's really about being valued for what you do." Further, there was general consensus among participants that, in their practice they wanted to

portray human interest in the people whose lives mattered to them. This was evident in Lisa's (Oral Therapist) recount of being acknowledged by patients in her community, which she equated with a sense of integrity at "having helped someone." Equally, in a hospital context Sue-Anne (Midwife) voiced a similar desire to be portrayed as a good clinician, as someone who displayed integrity:

> I'm trying to make sure I still stay true to who I am with my professional cap on because I feel you can get so professional that you can put a wall up and be only a professional…I'm very aware that I can want to be more involved in people's lives because that's what I'm used to and that's not who I can be now (Sue-Anne, Midwife).

Sue-Anne elaborated on her understanding of practitioner-patient relationships:

> They're human, we're human and I acknowledge them. We're professionals in one role and yet we are people. It's like a rolled up ball; we're rolled up and pieces are professional, pieces of ourselves, and it depends on which one we need to be, which way we hold the ball (Sue-Anne, Midwife).

Sue-Anne appeared to be grappling with the complexity of combining her personal self with her professional self. Serenity (Oral Therapist) expressed a similar perspective. In her work with school age children, she aimed to "do the best I can in the job, while being true to myself." Likewise, Sue (Nurse) described her experiences of "walking a fine line" between her subjective responses of caring as a human, and distancing herself emotionally from patients so she could function objectively in her role as a nurse. Sue recounted her experiences of caring for ill children, where her personal disposition of nurturing a child conflicted with her professional role of clinical efficiency. Recalling an occasion when she was unable to provide any treatment for a terminally ill child other than physical touch she stated, "my knowledge failed me. I felt there was something more I should be able to do and that was not right." Reflecting on these experiences Sue described how she reconciled her professional and personal self:

> You can be as friendly as you want during the day, during the night, but that's it; that's where it ends. When you go home, you might have spent 12 hours with a patient but you're leaving the patient there (Sue, Nurse).

It appears Sue was reconciling her professional or "duty of care" boundaries with her personal responsiveness to patient needs. Both Sue and Sue-Anne recounted experiences of when they felt unable to draw exclusively on their professional knowledge and skills, and displayed affection and compassion towards patients and their families. Similarly Lisa (Oral Therapist) had grappled with her emotional response to patient conditions that she viewed as avoidable—namely extreme tooth decay—and perceived her need to infuse her professional practice with genuine concern for the holistic wellbeing of patients and their families.

Lisa recalled:

> There have been some awful days. I've had some very aggressive patients or very aggressive parents and they blame you. "Why does he [patient] need that many fillings? Why does that tooth have to come out?" They're aiming it all at you and you can't aim it back at them (Lisa, Oral Therapist).

Lisa felt she was becoming less judgmental in her views and more empathetic towards the wider implications of community health inequities on people's lives. Equally, her interaction with members of her wider community, in providing patients' treatment and education, was aligned with her being acknowledged as a therapist who cared. She stated, "It's hard, but as a professional I feel I've made that little difference." Evidently at this later stage of the graduate year, participants were establishing a sense of how they wished to be portrayed as professionals. This was not only at work but also in their personal lives. It appears participants perceived a fusion of personal and professional attributes, thereby interlinking internal and external manifestation of personal self as a professional.

4.9   Conclusion

The ability of participants to navigate their graduate roles in a variety of health care settings was initially premised on clinical reasoning and judgements from profession-centric perspectives. Although there was some variation across the practice

environments, noted specifically between those working in public as compared to private practices, all participants initially viewed professionalism as encompassing sound decision-making and subsequent tasks that endorsed their competency to practice in their chosen field. This view of professionalism was further reinforced through mentoring programmes and support from experienced colleagues who scaffolded graduates' early months of practice. It appeared that in interprofessional team meetings the need to articulate a professional perspective forced participants to clarify a distinct professional role and associated scope of practice. In doing so, participants' sense of professional identity strengthened as they become adept at communicating a distinct professional perspective to others.

Concurrently, participants found that in order to work effectively in collaboration among professions, they also needed to understand the perspectives of other professions. Understanding these other perspectives allowed participants to prioritise and action clinical interventions beyond their own clinical perspective. This required them to communicate and work at the borders of professions, with increasing overlap or blurring of distinct roles. In doing so, participants extended their knowledge and practice boundaries when they worked collaboratively.

Consequently, scopes of practice breaches occurred. So, while professional identity was strengthened through communicating a distinct professional perspective to other health occupations, practice boundaries appeared increasingly permeable through interprofessional collaborative health care. Additionally, through extending knowledge and practice boundaries, participants expanded their professional perspectives and scopes of practice.

Therefore it appears there was professional discord between strengthening professional identity and loosening epistemological orientation to a profession, compelling graduate practitioners to question how others perceived them as

professionals. Taken from this view, graduates appeared to enter professional practice with distinct practice orientations towards patient or person-centred care. Although they began their transition into practice idealising professions and their prospective roles, their respective underlying health perspectives drove their actions towards focusing on persons in their care. Thus duty of care priorities overlaid self-interest across all professions. It also appears perspective sharing among professions enhanced learning and confidence to practice in new ways, through graduates forming flexible working relationships. Equally, professional identity strengthened as a result of working at and beyond distinct knowledge and practice boundaries.

Chapter Five

Discussion

5.1 Introduction

Health science graduates entering the workplace are confronted by many practice challenges. Complex and uncertain health care contexts have led to calls for changes in the way health professionals work (WHO, 2006, 2009, 2010). Where once health professions primarily worked independently of each other, there is a need for more flexible working relationships among health professionals. Research on the graduate year of working in health care practice indicates that novice practitioners' primary focus is on developing their ability to integrate into their respective professions; towards becoming competent and valued members of the profession with which they identify (Black et al., 2010; Camilleri, 2008; Cowan & Hengstberger-Sims, 2006; Toal-Sullivan, 2006; Tryssennar & Perkins, 2001). These authors provided insight into the graduates' experience of establishing both an identity and a credible role in a profession. However, unlike previous research, this current study has extended the focus on graduates' practice beyond their single profession. It has examined how graduates—from six health professions—experience and construct meaning to professional work as they navigate the first year of professional practice, both in their respective professions and in collaborative practices with other professions.

This chapter will discuss the findings of this study in consideration of the literature reviewed in Chapter Two. The collection of data, over time, has offered an opportunity to understand the process of graduates developing their identity and professionalism in work practices that intersect professional and collaborative boundaries. Specifically, it is through navigating a professional role and negotiating collaborative roles that graduates develop their capability to work in dual practices that

are shown to complement each other. The key findings from this study relate to graduates' adaptive nature of learning to become a professional in contemporary health-care practices that require professional and interprofessional capability. For the purpose of the discussion, the findings of this study are grouped into three convergent themes representing the graduates' temporal trajectory in relation to professional dimensions of practice, perspectives, identity and professionalism in collaborative work contexts. Each of the convergent themes, depicted in Figure 2 (p. 1688), intersects the horizontal professional dimensions and the vertical temporal processes; drawing together the key developmental changes identified in the findings (Figure 1, p. 126)

The first convergent theme, *Emergent Dual Practice*, discusses findings related to graduates developing understanding of their practice roles in collaboration among professions, and encompasses their expanding professional perspectives or orientation to health and health-care practices. This theme relates primarily to the values and beliefs that underpin and develop during graduates' enculturation into professional practice.

Second is the convergent theme, *Strengthened Professional Identity*, which discusses findings regarding the graduates' strengthening perceptual awareness of themselves as members of a particular profession, through communicating distinct and negotiated practice roles at the interface of professions. This theme encompasses the ontological dimension of becoming a health care practitioner, in and among professions.

The third and final convergent theme, *Evolving Notions of Professionalism*, focuses on graduates' shifting notions of professionalism, resulting from extending knowledge, skills and roles during collaboration among professions. This theme relates to the epistemological dimension of graduates' sharing knowledge in collaborative practice contexts.

Although the convergent themes are discussed separately, they cannot be viewed in isolation from each other, as the development of graduates' perspectives, identity and

professionalism are shown to follow a circuitous, or indirect trajectory (Webster-Wright, 2013) that weaves contextually between professional and collaborative practices. It is however at the intersection of professions' practices where this study is primarily focused, and therefore the themes centre on the development of graduates' understanding of their work in, at and beyond the borders of their respective professions.

Figure 2. Convergent themes identified in graduates' developmental trajectory related to role perspectives, identity and professionalism in collaborative work contexts
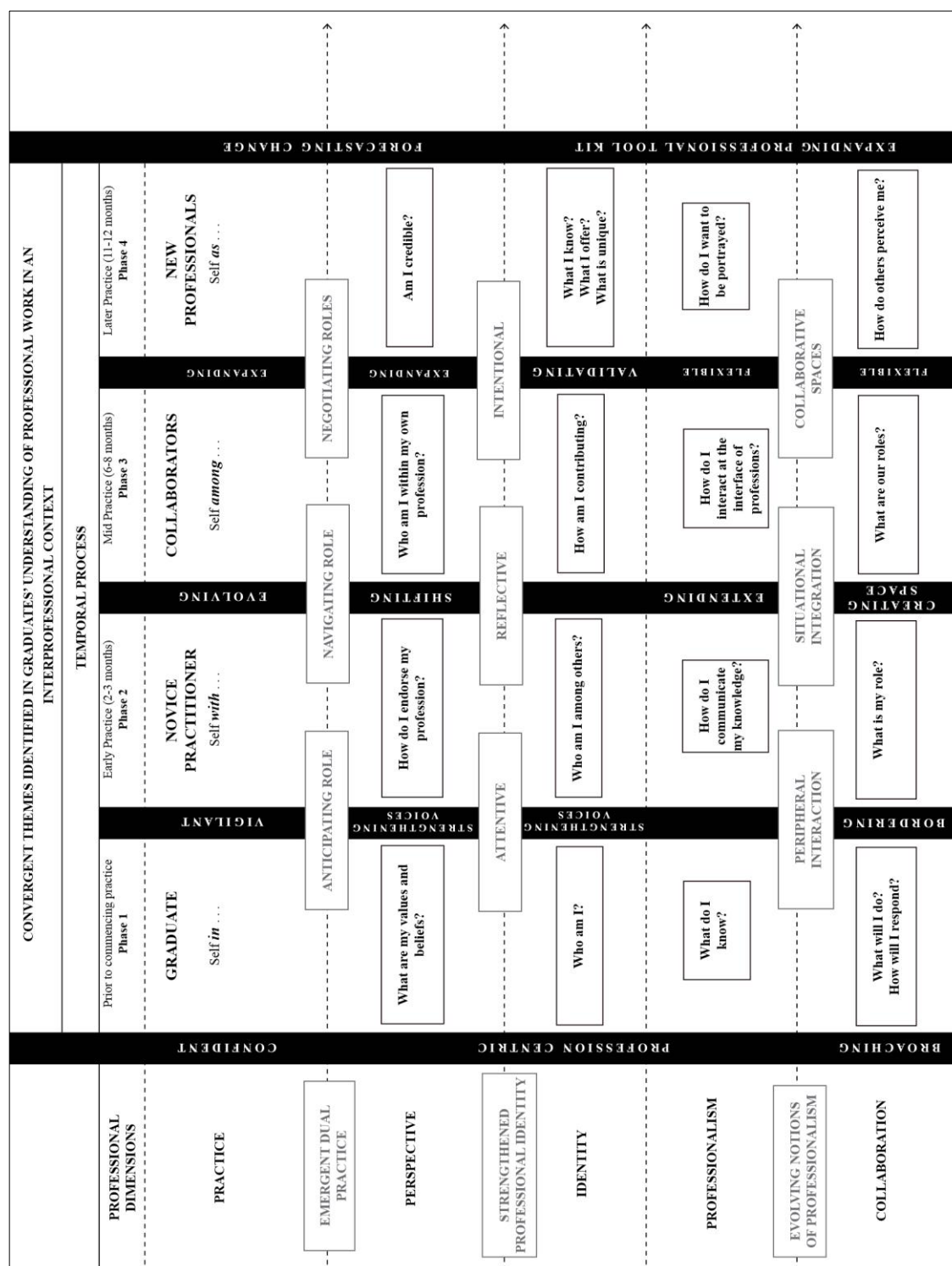
5.2 Emergent dual practice

The first convergent theme indicates graduate practice is characterised by a dual

practice, in contexts where professional and interprofessional work intersect. Here

graduates learn to navigate a professional role while concomitantly negotiating role

relationships at the interface of other professions. Their practice is at times situated solely in a particular profession, and at other times borders, overlaps and intersects the knowledge and practice boundaries of other professions, likened to boundary crossing (Akkerman & Bakker, 2011). These authors view boundary crossing as entering onto unfamiliar professional territory that disturbs existing roles and perspectives. In considering the boundaries that professions successfully construct around their specialised knowledge and skill expertise, it is little wonder that the interface of professions is considered an area of uncertainty, due to the multiple number of professionals and perspectives involved (Brown et al., 2011; Suter et al., 2009).

According to the current study, graduates, as new practitioners, were increasingly engaged in sharing perspectives and working contexts with a number of professions other than their own. Furthermore, as the year progressed, graduates adhered less to distinctive professional role boundaries in favour of developing flexible working relationships in their provision of health care services. It is at the borders of their professions that graduates engaged interpersonally and interprofessionally in developing, refining and expanding their perspectives and role relationships; through the increasingly competent use of boundary objects (Star, 1988) that were jointly constructed, or shared during collaborative activity.

Although work contexts influenced the nature of practice activity, the process of becoming a professional in practices that include collaboration among professions followed a similar circuitous or indirect trajectory. The term "indirect trajectory" is used to define learning situations that include both effort and intention on behalf of the learner, but which are characterised by uncertainty, doubt and possibilities. The term aptly describes graduates' progression from an early focus on establishing a practice role in their particular profession, to purposefully engaging in collaborative practice. Until they developed a degree of confidence in working within their respective

professions, they struggled to function interprofessionally, as they possessed only limited ability to decipher communication channels that operated at the intersecting practice boundaries of professions.

Communication channels included communal access and documentation in patients' clinical progress notes plus the use of colloquial professional language during team meetings in public hospitals. In the private health care sector, particular professional jargon and symbolic language was used in writing referral letters among professions. Star (1988) refers to the communication channels as boundary objects, which inhabit several intersecting practices and act to fulfil a bridging function. Furthermore, boundary objects, which Star (2010) conceptualises as including both material artefacts and processes, reside in workspaces that are ill structured due to the indeterminate nature of collaboration (Akkerman & Bakker, 2011). For example, a participant in the current study expressed the challenge confronting graduates in the construction and use of boundary objects, which in this situation refers to patient's clinical notes:

> We podiatrists would write down our notes; we use a lot of symbols that I know are different to what the nursing profession use. Some are familiar to physios, but again they use symbols that we wouldn't understand. So If I were to pick up a set of notes from a physio and read them I would not be sure of what they meant (Lines, Podiatrist).

Boundary objects are prevalent in clinical environments concerned with provision of patient-centred care. They serve to provide a centralised source for communication and action among professions. Additionally, boundary objects reduce duplication of information and miscommunication between persons involved in the provision of health and social care for an individual patient or client. Although a valuable resource, boundary objects are open to professional interpretation and may be contested, or ignored in work contexts where collaborative activity among professions is limited (Hall, 2005; Hall & Weaver, 2001). Yet findings from the current study have shown

that, through collaboration among professions, graduates develop their ability to construct and maintain a range of boundary objects, in order to function in a dual practice. Boundary objects are in the form of both material and personal artefacts and serve to "capture multiple meanings and perspectives" (Akkerman & Bakker, 2011, p. 141) of those engaged in collaborative work. In discussing findings from this study, collaboration is being viewed as any occasion when graduates interact at, or beyond the knowledge, skills and perspective boundaries of their particular professions.

5.2.1 Anticipating a role in professional practice

Discussion proceeds with the experience of graduates prior to commencing work in their respective professions. This provides a starting point from which to discuss how graduate health practitioners developed professionally, as they progressed through their first year of practice. Findings from the current study indicate graduates remain on the periphery of professional practice during their formal education, as noted by Lave and Wenger (1991). From this position graduates espouse ideal qualities they aim to emulate in their practice; qualities they have observed in role models working in practice (Robertson & Griffiths, 2009; Schwartz et al., 2011). In the current study, this translated into dialogue on the requirements of a professional in abstract terms. Examples of "You have to know… You have to make up your mind… You have to be able to gauge…" indicate the intensity of graduates' perceptual understanding of what professional practice entails.

Argyris and Schön (1974) described idealised professional practice in terms of practitioners possessing espoused or procedural theories of action that frequently have limited relevance to the actual work contexts where practitioners enact their knowledge and specialised skills with and among others. Espoused theories are the theories-of-action practitioners communicate to others, encompassing what ought to happen in certain situations and under specific circumstances. This often differs with what actually

happens in practice where unintended conditions and unpredictable situations rely on enacting theories-in-use (Argyris & Schön, 1974). Theories- in-use are seldom articulated verbally but may be observed in the actions of practitioners. Multiple theories-in-use interlink any number of actions, inferences, and judgements made by practitioners, in an effort to solve problems, make decisions and action responses.

Taken from the perspective of these authors, graduates exit formal education with strong allegiance to the knowledge claims and related skills of their respective professions, which they anticipate will convert smoothly into practice (Bisholt, 2012). In addition, espoused theories-of-action foster the ideology of a profession and are developed during initial socialisation into professions when students are inducted into distinct ways of viewing health. This results in their adopting distinct perspectives on what constitutes health care practice (Hall, 2005; Shulman, 2005).

Graduates in the current study held firm views on their distinct health perspectives, expressed as, "a natural awareness…that occurs after a lot of training", "of knowing where you're going with a patient", and "having a voice, and that's who I am". They appeared supremely confident in their ability to commence working in their respective fields of health care practice, in the belief they were knowledgeable and ready to practice as a member of their profession. This finding is shown in other studies where students have graduated with the expectation they are prepared for a functioning practice role, likened to entering the real-world, after years of being sheltered as students (Fenwick et al., 2012; Mooney, 2007; Robertson & Griffiths, 2009). In each of these studies, graduates had retrospectively compared their espoused theory—developed during their formal education—of working closely with patients in optimising their health status, with the real-time practice of workload requirements. Mooney (2007) reported graduate nurses compared the manageable number of patients they encountered as students with the workload requirements of a registered nurse, with 11 of Mooney's

12 study participants reporting "nursing students seemed to have a better rapport with patients and learned more about them than staff nurses" (p. 844). This report suggests graduates reflected on their previous experiences, as students, of clinical actions that aligned with their professions' espoused theory of practice. In comparison, the reality of task oriented patient workloads possibly led graduates to a default theories-in-use (Argyris & Schön, 1974), observed in the actions of more experienced colleagues and imitated by graduates when under pressure to comply with workplace requirements.

Similarly, in a study of graduate midwives' perceptions of their transition from student to practitioner, Fenwick et al. (2012) identified a mismatch between how graduates anticipated working with patients and the reality of task oriented work contexts in public hospitals. These authors reported that "having been educated to put the woman at the centre of care, participants struggled when they perceived women to be treated as 'commodities' and 'just another part of the routine'" (p. 2058). This may have been due to a perceived misalignment between espoused models of holistic person centred care and the real-time theories-in-use evident in practice. Equally, graduate midwives may have sensed their professional ethics were undermined, leading them to abandon their espoused models of practice to a default task oriented mechanistic practice. Research into occupational therapy graduates' perceptions on their preparedness for practice identified similar misalignment between anticipated roles and the experience in practice (Robertson & Griffiths, 2009). Occupational therapists, working primarily as sole occupational therapists in hospital wards, experienced difficulty in expressing their particular role in team meetings and making sense of their knowledge in practice contexts.

In accordance with findings from these other studies, there appears a disconnection between socialisation-for-practice, which occurs during initial education away from the workplace, and socialisation-in-practice once graduates enter the work

context as qualified practitioners. Socialisation-in-practice is described by Argyris and Schön (1974) as "real-time conditions" (p. 157), and refers to situational learning that occurs during the act of practice. Situational learning eventually becomes so routinised, the practitioner adopts this as tacit behaviour that ensures " a smooth and uninterrupted sequence of responses" (p. 13) or interconnected skills. In the context of graduates transitioning into existing practice contexts, where they observe and attempt to imitate the tacit behaviours of more experienced colleagues, they experience practice discord between espoused and real-time models of practice. The transitional phase into professional practice is therefore troublesome if graduates exit programmes of study with a strong sense of being prepared for a practitioner role that may differ from real-time conditions (Argyris & Schön, 1974).

5.2.2   Navigating a practice role in a professional context

The transition from graduate to credible practitioner is troublesome as it occurs in unpredictable working contexts and requires the ability to familiarise and adapt to the fast pace of clinical practice. Previous research on transition into practice identifies the discord graduates experience when they transition from undergraduate education into the workplace (Clark & Springer, 2011; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001). Tryssenaar and Perkins' findings from a small study of Occupational Therapy and Physiotherapy graduates' experience of transition identified a disconnection between prior expectations and the reality of practice environments where the pace and demands of work were stressful. Similarly, Toal-Sullivan (2006) signalled a mismatch between Occupational Therapy graduates' theoretical preparedness and their ability to contextualise theory in practice. This impacted on graduates' ability to determine how to proceed with patients, challenging their clinical reasoning skills in practice contexts.

More recently, Clark and Springer (2011) identified similar findings from nursing graduates' experiences of their first year of professional practice, suggesting

graduates strive to make sense of perceived practice chaos in order to function effectively in their role. These authors described practice chaos in terms of the pace at which novice practitioners were expected to work, "with limited clinical experience, clinical judgement, organizational and prioritization skills, and critical thinking" (p. 5). Participants in the current study, who had anticipated an ideal professional role prior to commencing practice in a work context, share this depiction of practice role confusion. Their early practice was punctuated with the various administrative and procedural tasks associated with their role, while they also attempted to function in unpredictable and frequently unfamiliar clinical contexts.

The uncertainty regarding patient assessments, making decisions and answering questions was likened to moving from a previous state of being able to fade into the background as a student, to becoming highly visible as a novice practitioner. The heightened self-awareness experienced by graduates suggests they had shifted from focusing on espoused or ideal theories to developing theories of practice during practice (Argyris & Schön, 1974). These authors argued that practitioners learn to construct their own theories of practice through interaction with others in the work they do. Furthermore, Argyris and Schön attest to the need for a professional to "attempt to see the perspectives of those he encounters…[and] somehow construct for himself their ways of looking at the world, at least insofar as their perspectives will affect his performance" (pp. 158–159).

According to the findings of the current study, graduates were acutely aware of their position as novice practitioners and relied on the scaffolding into practice from both experienced colleagues and through mentoring programmes. Other studies have indicated the importance of this form of support in assisting graduates to become members of the profession (Black et al., 2010; Clark & Springer, 2011; Fenwick et al., 2012). Existing members of a profession have an invaluable role in guiding graduates

through an apparent quagmire of functional aspects of professional practice, the observable aspects of practice. As important is their role in modelling the values and beliefs that underpin the profession's distinct orientation to their practice, described by Black et al. (2010) as modelling what it means to be a practitioner in a particular profession.

A participant in the current study expressed her developing understanding of a professional role occurring through working with colleagues from her profession where "the language is the same and I know what they're talking about and it makes sense to me" (Amelia, Occupational Therapist). Other participants learnt their roles by observing their colleagues in real-time conditions (Argyris & Schön, 1974), usually in situations where they, as novice practitioners, felt out of their depth and unable to proceed with making decisions. The importance of ongoing role modelling from colleagues in the profession is vital for novice practitioners as they progress through their first year of professional practice (Black et al., 2010; Clark & Springer, 2011; Fenwick et al., 2012). Socialisation that occurs within the boundaries of a profession provides a strong foundation from which graduates construct their theories-in-practice (Argyris & Schön, 1974).

For newly graduated workers—intent on integrating into a profession—the additional layering of practice demands to work collaboratively appears onerous. Hall (2005) suggests socialisation into a profession "serves to solidify the professional's unique world view" (p. 190), shown through the roles they enact in practice. Furthermore, through the process of being mentored in the early months of graduate practice, novice practitioners develop approaches to make decisions, solve problems and understand health concerns from a distinct perspective (Hall & Weaver, 2001). These assertions are validated by the findings in the current study, where participants expressed their "strengthening voices" in articulating their distinct professional

perspective. Communicating particular perspectives and roles did not, however, occur during practice in the professions. Rather, it occurred at the boundaries of professions.

Unlike previous studies that centre only on graduates' transition into practice in their respective professions, the focus in the current study is on novice practitioners' experience of navigating professional practice and negotiating interprofessional practice concurrently. Findings show novice practitioners, across a range of professions, conceptualise collaborative work among professions in terms of negotiating roles at the border of one's own and other professions, where they communicate and practice separately to their own professions. Furthermore, this current study identifies graduates—working in a variety of work contexts in either the private or public health care sector and progressing along different collaborative paths—increasingly interact at and beyond the borders of their respective professions. This finding supports the need for interprofessional education in preparing graduates for collaborative practice.

Brooks and Thistlethwaite (2012) proposed collaborative practice may conflict with the normative behaviours of a profession, and undermine the "established values, goals and protocols" (p. 409) on which the profession is premised. Watling (2004) concurs, suggesting the unsettling nature of interprofessional collaboration is due to disturbing "the security of fixed positions" (p. 21). Yet, findings from the current study indicate it is at the borders of professions where graduates learn to articulate their profession's distinct health perspective to others. Establishing a practice role situated in a particular profession also enabled graduates to venture into collaborative activity with a degree of confidence they had something to contribute from their profession.

5.2.3 Negotiating roles at the boundaries of professions

As health practitioners increasingly engage in collaborative work activity, they need to communicate their role, perspective and actions to a wider audience than their own profession (De Vries, 2012; Schwartz et al., 2011). Currently there is very limited

research into the experience of new graduates working at the interface of professions (De Vries, 2012). DeVries undertook doctoral research into the perceptions of practitioners (N= 376) from a number of health professions on interprofessional collaboration and utilised posted surveys as a research method to obtain data. In reporting on the results from the study, De Vries recommended future exploratory research into both the impact of interprofessional working on the socialisation of new graduates into their respective professions and "changes that may occur through the socialization process" (p. 71). This, De Vries suggests, would provide insightful information on practice competencies that develop through practices among professions.

The current research has addressed this aspect of interprofessional collaboration, through the exploratory study of graduates' perceptions and experiences of transitioning into professional practices are situated in both distinct professions and in collaborative contexts. Findings show communication of professional perspectives is challenging for novice practitioners, as this involves personal understanding of the values, beliefs and associated knowledge that underpin a particular profession's orientation to health care. Equally, the ability to clearly express one's perspective and role is not a skill required of graduates when working with colleagues from the same profession, where the increasingly familiar use of colloquial language and routine practices become familiar and routinised.

As newcomers to established practice communities, graduates in the current study were initially identified as observers, or on the periphery of interprofessional practices while they developed confidence to practice in their primary role in a particular profession. Yet increasingly, collaborative practices impacted on their daily work. Collaborative practices included constructing boundary objects that cross boundaries (Star, 1988), in the form of patient referrals and networking through

telephonic and electronic mail communication in the private health care sector, and inclusion in team meetings, prioritising health care services and interprofessional clinical notes in the public sector. Each of these practices occurred at the knowledge and practice boundaries of professions, where practitioners negotiate perspectives, roles and identities in the work they conduct together (Akkerman & Bakker, 2011; Wenger, 1998). Thus, graduates needed to develop ways of working concurrently in professional and collaborative contexts, viewed here as following a circuitous or indirect trajectory towards establishing themselves as new professionals in contemporary health care practice contexts.

In contrast to previous studies that report lack of understanding of roles and resultant conflict among members of interprofessional teams regarding scope of practice violations (Brown et al., 2011), graduates in the current study appear more adept at viewing their practice roles in new ways, likened to a sponge whereby "you absorb everything from everyone around you and you evolve in your role" (Sue, Nurse). Additionally, it is through collaboration that these graduates developed their ability to articulate distinct perspectives.

Articulating perspectives occurred at the boundaries of other professions during meetings and increasingly during collaborative activity. For example, one participant compared her interactions with colleagues from her own profession to those she had among other professions:

> If there were just a whole lot of OTs, we'd just be doing our thing. But working with everybody else makes me hyper aware of that and I'm constantly thinking, "what's my view on this, why have I got this view? (Elizabeth, Occupational Therapist).

For some graduates, specifically noted in occupational therapists, the ability to define and communicate their professional perspective appeared common practice. They were adept at foregrounding the importance of conceptualising occupations as those activities that had significance in peoples' lives, and therefore requiring attention when discussing

implications of rehabilitative person-centred care. For others, it was more difficult to specify a distinct professional perspective in the early stage of graduate practice but clarity emerged through collaboration. This was identified primarily from nurses who initially perceived their work as generic and furthermore, their role as filling the practice gaps between other professions. In this group, a distinct nursing perspective or orientation to health care practice surfaced as a result of directly opposing the bio-medical views of doctors on patients' ongoing hospital care and discharge plans but this did not emerge until well into the graduate year.

A further challenge for graduates working at the border of professions involves not only communicating their professional perspective, but also providing a rationale for proposed actions based on that perspective. This is reinforced in a recent study on graduate nurses' experience of working interprofessionally (Schwartz et al., 2011). These authors identify that new graduate nurses assume a passive role of listening and watching during early interprofessional practice as they learn to fit into new work environments. Shifting from a passive to an active role requires building trust and credibility among other team members. For the novice practitioner, this requires time and familiarity with the professional perspective of one's own profession to support any proposed actions.

According to Schwartz et al. (2011), graduate nurses in their study became active participants in interprofessional health teams when they perceived there was critical information related to patient safety that only they were able to convey. This included monitoring and reporting on changes to patients' health conditions. In comparing the findings from Schwartz et al. with those of the current study into graduates' understanding of working interprofessionally, a similar phenomenon was noted with regards to graduate nurses' initial inability to articulate a distinct perspective or orientation to their practice. Specifically this group perceived their role as "filling the

gaps" between the other professions. They failed to recognise aspects of patient care that are integral to the nurses' role but seldom consciously recognised by nurses as their unique contribution to interprofessional practice. This includes monitoring, safety and advocacy roles in relation to patient care and their extended families.

Furthermore, as with the other five professions represented in the current study, nurses developed awareness of their unique role through communication—usually on behalf of patients—at the borders of professions. In contrast, if they were working only with members of their own profession, much of their role and orientation was subsumed into tacit practice knowledge that is enacted but left unspoken (Argyris & Schön, 1974). Tacit practice knowledge is viewed as displaying behaviours that are difficult to explain. Indeed there is seldom need to explain tacit practice knowledge among members of one's profession as the socialisation process is designed to instil distinct values, principles and practices that are adhered to by members (Freidson, 2001; Shulman, 2005). In contrast, practitioners need to articulate their practice role and perspectives at the borders of professions (Coyle, Higgs, McAllister, & Whiteford, 2011). Indeed, findings from the current study show it is at the interface among professions that novice practitioners cement their professional role and health care orientation. Furthermore, each time they are required to articulate this information, they reinforce their affiliation to their profession, which also serves to strengthen their identity.

> Being in a team, working with the other disciplines, having to actively put up my hand and say 'I think this client needs this' has really helped me to become more confident in articulating what my own profession can bring to that (Amelia, Occupational Therapist).

While findings from Schwartz et al. (2012) provide insight into the nursing graduates' experience on working interprofessionally in a specific health care context, these authors join De Vries (2011) in recommending the need for further research in this area

to better understand how graduates develop their practice role during interprofessional encounters.

Previous studies that have examined boundary work among professions identify the difficulty advanced career practitioners experience when they perceive their professional roles are misunderstood, or at risk of being subsumed into generic practices (Brown et al., 2011; Suter et al., 2009). The study undertaken by Brown et al. drew participants from well-established primary health care teams (ranging from between five and thirty five years of working together), whose members experienced ongoing team conflict due to their collective inability to function at the boundaries of their respective professions. Boundaries were perceived as problematic due to entrenched professional roles and a lack of willingness to openly discuss different perspectives.

Similarly, Suter et al. (2009) reported that perspective sharing added to the complexity of collaborative practice, with the risk of professionals blurring roles viewed as a significant disincentive to collaborative among professions. These authors advocated a shift away from profession-centred to person-centred-care, whereby "focusing on the patient's needs helps to reduce professional boundaries and role conflicts" (p. 45). Yet professions have traditionally ensured the ongoing adherence of members to distinct values and spheres of practice to maintain their own authority (Freidson, 2001; Hall, 2005). Furthermore, when working autonomously and independently of other professions, professionals seldom need to articulate their values and perspective, nor negotiate their role boundaries. Their practice becomes myopic, or narrow-focused (Suter et al., 2009).

Findings from the current study of graduates' experiences as new professionals working at the boundaries of professions contrast with those reported from previous studies (Brown et al., 2011; Suter et al., 2009). As a result of boundary work, graduates from the six professions represented in the study expressed their health perspectives had

broadened. For example, nurses who earlier in their graduate year had felt ambiguous about perceiving their role as filling the gaps between other professions expanded their views to incorporate perspectives of others. They accomplished this through working with members of other professions, observing their practice and asking questions. This resulted in their sense of changing professional shape, whereby:

> You start taking on their views, because once you see what their point of view is, you approach someone and think, "I should probably think about this as well; I can't just think about that. Then you have a set of skills that you didn't know you had before, that you automatically just start using (Mia, Nurse).

Those working in private practice also communicated increasingly with other health care providers and expressed their expanding perspective in relation to their duty of service in various ways. This included building confidence in their practice role through developing a broader practice base, suggesting graduates felt better equipped to provide health support for patients or clients not limited to their own profession. Furthermore, a broadening perspective paralleled a sense of shared responsibility for ensuring patients' optimal health outcomes, expressed as overlapping scopes of practice "in some areas" (Sophie, Podiatrist). These graduates viewed working at and beyond professional boundaries as a shift away from clearly defined autonomous roles and related perspectives to more flexible practice roles, including role overlap during collaborative activity.

As novice practitioners become more familiar with the perspectives and practice approaches among professions, it appears they naturally extend their own practice boundaries. Participants described extending practice boundaries as taking on the views of others and incorporating these alternative perspectives into ones' own clinical decision-making and practice. Hence, through learning from each other, across professions, novice practitioners extended their scope of practice, with one participant stating, "if you have the knowledge and act safely, you can do it" (Mia, Nurse).

Mitchell et al. (2011) caution against creation of a collaborative identity that undermines the professional differentiation on which collaboration is premised. The primary reason proffered is that if professional identity is threatened by being subsumed into a social identity commensurate with a team, then members are likely to retrench into their professions. In support of the misgivings expressed by these authors, Thomas and Pattison (2010) argue the importance of understanding better how professional identity forms and consolidates in contemporary health practice, "enabling what might seem like trivial turf wars in practice to be seen in a new and more constructive light" (p. 242). Current findings add to this ongoing discussion, specifically related to the creation of collaborative spaces among professions and how working in these spaces has influenced graduates' perspectives, identity and notions of professionalism.

A difference is noted however, between these graduates' developing confidence in their practice through articulating their professions' perspective and unique contribution during boundary work and more experienced staff expressing role insecurity in similar situations (Booth & Hewison, 2002). Other authors support the findings of Booth and Hewison on role insecurity and also, the risk of destabilising professional identity through interdependent collaborative practices (Baxter & Brumfitt, 2008; Brown et al., 2011; Mitchell et al., 2011). A reason for reluctance to engage in interprofessional collaboration by experienced practitioners involves acculturation into professions, which has encouraged largely independent practice between professional groups (Freidson, 2001).

Graduates' early transition into clinical practice could be viewed as resembling the uncertainty experienced by advanced practitioners when confronted with ways of working that differ from what they are accustomed to. In both situations, practitioners are engaged in new practice contexts for which they are possibly ill prepared. Between the two groups, with graduates on one hand and advanced career professionals on the

other, a difference is shown in the ability to adapt to changing health care environments where person-centred care requires a practice shift away from professions working independently of each other. A finding from this current research into the graduates' understanding of working interprofessionally shows new professionals learning to work in dual practices, at times in their chosen profession, and at other times through perspective sharing and blurring roles during interprofessional practice.

What is shown clearly is the shared sense of responsibility expressed by graduates for person-centred care, which is fostered during collaborative work. Sharing responsibility does not appear to diminish the graduates' role in their chosen profession; rather it brings to their conscious awareness where practice roles overlap and where they are appropriately centred in specific professions. Furthermore, through engaging in dual practice, graduates identity in their chosen profession is shown to strengthen at the professions' boundaries, expressed in the following manner.

> As I've developed my understanding of their roles [other professions]
> that also helps to clarify my role, because there are overlaps and I
> think there will always be overlaps. But, it's becoming clearer in my
> mind as to where the lines are drawn and how much of an overlap
> there can be (Amelia, Occupational Therapist).

Shared responsibility suggests open-mindedness among graduates to working in the pursuit of patient or person-centred goals, as noted by Hobman and Bordia (2006). These authors suggest open-mindedness results from accepting diversity and associated different perspectives in teams. Considered from this perspective, interprofessional openness may be viewed as the extent to which members from different professions are "open to sharing and receiving alternative perspectives from members of different professions and motivated to collaborate across professional boundaries" (Mitchell et al., 2011, p. 1328).

5.3   Strengthened professional identity

Graduates' professional identity strengthened as a result of working collaboratively. While graduates negotiated their perspectives and relevant practice roles at the borders of professions, they consciously devised a broader view on the patient or client complexities confronting them. This was expressed simply as getting "a different perspective from someone who sees slightly different things every day; it can be something quite simple but you just never thought of doing it that way before." (Sophie, Podiatrist). Findings from this study identify graduates' strengthening sense of professional identity was as a direct result of interaction among various professions.

Through perspective sharing, expanding perspectives and overlapping roles during collaborative practice, graduates' professional identities came into sharp focus for them. Indeed professional identities appeared to strengthen through their dual practice, which is contrary to findings from other research (Baxter & Brumfitt, 2008; Booth & Hewison, 2002; Brown et al., 2011; Mitchell et al., 2011). A reason for this finding may be reflective of the current study focus, which has specifically explored the development of graduates' identity at the interface of professional practice boundaries. Other studies have focused on experienced practitioners who viewed collaborative practice with scepticism (Beddoe, 2011; McNeil et al., 2013). Attention is now drawn to the circuitous or indirect trajectory of graduates learning to establish a professional identify while working concurrently in and beyond their respective professions.

5.3.1   Attending to professional roles

When conversing and working with members of one's own profession, graduates became increasingly familiar with the flow of their practice, developing ways of working that provided appropriate care delivery commensurate with the profession's values, beliefs and perspective (Wenger, 1998). Socialisation-in-practice fosters the use of common language, protocols and procedures that fall within the scope of practice

regulations of a particular profession, described by Wenger as a "shared repertoire" (p.

152). Furthermore, through participation in a profession, in real-time conditions

(Argyris & Schön, 1974), competence and identity develop concurrently within specific

communities of practice (Wenger, 1998). In practice communities, Wenger proposes

identity develops through integrating the professional self-concept with the activity of a

profession, whereby:

> We learn certain ways of engaging in action with other people. We
> develop certain expectations about how to interact, how people treat
> each other, and how to work together. We become who we are by
> being able to play a part in the relations of engagement that constitute
> our community…As an identity, this translates into a form of
> individuality defined in respect to a community. It is a certain way of
> being part of a whole through mutual engagement" (p. 152).

Findings from the current study show that through mutual engagement, over time,

familiarity replaced the practice discord graduates experienced as they navigated their

early practice role in a profession. Familiarity was shown in various ways by different

professions. For example, physiotherapists focused on familiarity with injury pattern-

recognition, while podiatrists and occupational therapists focused on attaining accuracy

with referral processes and nurses focused on their time management. Equally, oral

therapists focused on formulating treatment plans and midwives on mechanisms for

supporting women during their pregancy. Competency in these specific areas of practice

assisted in the development of perspective and identity in the respective professions,

expressed as " stepping up", "turning a corner" and "taking responsibility" in making

clinical decisions.

Previous research centred on graduates' first year of practice support the

overarching focus of novice practitioners in establishing themselves as members of their

chosen professions (Black et al., 2010; Clarke, & Springer, 2011; Kelly & Courts, 2007;

Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001). These authors report that novice

practitioners view their developing role as acting in ways that are clearly visible to

members of their respective professions. Furthermore, through their mutual engagement in profession-centric activities, and increasing competence to perform requisite tasks commensurate with their professional role, the novice practitoners develop their identity within their profession. However, it appears that unless the process of developing professional identity is focused on explicitly, it goes largely unnoticed. Professional socialisation occurs in such a pervasive manner that when engaged in activity within the profession, members generally work in a synergistic manner, giving little conscious thought to their practice roles (Argyris & Schön, 1974; Hall, 2005). One graduate in the current study expressed this as her inability to recount what she did during her day at work but knowing she had done a good job.

In comparison to the increasing familiarity of working with members in their respective professions, graduates, as novice practitioners showed a distinct contrast when communicating at the interface of professions. When communicating among professions, they initially had difficulty deciphering the practice repertoires used by others. Learning to unravel the colloquial language, symbols and acronyms used both informally in conversations and more formally in team meetings was challenging. So too was learning to read patients' clinical notes that initially appeared cryptic and difficult to interpret. Social theory of learning identifies professional identity threat when a person is confronted with unfamiliar or foreign territory for which they have limited ability to engage with others (Wenger, 1998). In this situation, they may lack willingness or capability to construct a mutual enterprise, or boundary objects (Star, 1988) and therefore revert to the familiar practice of their own profession.

A number of studies show both subtle and more explicit ways in which protection of professional identity is linked to preservation of professional boundaries (Barrow et al., 2011; Mitchell et al., 2011; Reeves et al., 2009; Timmons & Tanner, 2004). Reasons include a perceived assault on professional identity when linked to

eroding professional boundaries through a change from a distinctive to generic dress code among professions (Timmons & Tanner, 2004). Equally, perceived identity threat is lessened through maintaining formal communication boundaries between professions, thereby monitoring and limiting the amount of mutual exchange of knowledge (Reeves et al., 2009). Barrow et al. (2011) reported divergent views between nurses and doctors on authority in decision-making and leadership roles, and Mitchell et al. (2011) signalled the need for maintaining clearly distinguished professional identities in collaborative teams so professions are acknowledged and valued.

Although reasons for identity threat at the borders of professions vary across the spectrum of health professions, a perceived threat to identity is shown to impact on the willingness of professions to collaborate. This may be due in part to a generational shift from professions working predominantly in an autonomous manner to an increasingly interdependent practice focus, along with a move away from profession-centred to person-centred models of care. However, the research conducted by Barrow et al. (2011) involved more recent graduate nurses and doctors than those in the other studies, leading Barrow et al. to emphasise the pervasive socialisation processes into the professions of nursing and medicine that continue to mould identities, beliefs and values in ways that discourage collaborative work.

In contrast, an important finding from the current study identified novice practitioners' strengthening sense of professional identity as they positioned and negotiated their professions' health perspective among others. Furthermore, it was during collaborative encounters that novice practitioners learnt to articulate their professional perspective as being distinct and worthy of inclusion in joint decision-making processes. Although prior to commencing work graduates were open to working interprofessionally, the reality of concurrently navigating a professional role in a profession and negotiating roles among professions was expressed by one graduate as

"changing the shape of my outline" (Mia, Nurse), by another as learning to "see the bigger picture" (Sue, Nurse) and similarly "broadening my take on things" (Sophie, Podiatrist). Through communicating with others at the borders of professions, through role clarification in meetings and sharing information, they appear to reinforce their identity in a single profession.

5.3.2 Reflecting on practice roles and professional identity

It has been suggested changes in professional identity may occur when practitioners become cognisant of the perspectives and priorities of other professions during collaborative practice (Edwards, 2010). For example, Edwards speculates that as professional practices merge, practitioners may form new identities as collaborators, who operate with the priorities and resources that are offered by others. In addition Brooks and Thistlethwaite (2012) recommend caution in assuming health professions are able to collaborate effectively when the established values and perspectives underpinning each profession are in conflict.

Yet the findings from this current study do not uphold Edward's concern regarding professional identity, or the caution suggested by Brooks and Thistlethwaite regarding conflicting values and perspectives. The process of reflecting on what constitutes one's professional perspective, and equally the ability to articulate the perspective to others, appears to strengthen identity in a single profession. In addition, graduates' construction of boundary objects and practices are shown to further cement professional identity residing in a specific profession. Boundary practices include, extending patient assessment criteria to reduce duplication across professions, role blurring to ensure provision of patient-centred care in a timely manner and importantly, sharing information with each other.

There may be several reasons for this. First, novice practitioners may be less concerned with upholding traditional notions of practice autonomy, in favour of

focusing on patients', or clients' health outcomes as central to their practice. Webster-Wright (2010) suggests such a shift addresses what professionals consider as important in their practice, or what 'matters', and is primarily in relation to their interaction with patients. Edwards (2010) similarly refers to changing priorities in practice may be driven by what professionals 'care about'. This is shown in the following example of a novice practitioner negotiating practice boundaries, with the aim of providing effective care.

> It's never black and white when you're treating someone. There are all sorts of different pieces to the puzzle and your communication with other professions helps you put those pieces in the puzzle together and it helps you deliver a better package of care to the patient (Charlotte, Physiotherapist).

Another possible reason for this apparent anomaly between strengthening identity and expanded perspectives relates to the possibility graduates are unencumbered by notions of individual professions holding distinct health perspectives in isolation of a broader orientation that may be achieved through collaboration. Social identity theory draws attention to the futility of claiming monopoly, or conceptual priority, of one perspective over another in addressing the often ill-defined complex nature health concerns confronting those working in health care practice (Tajfel, 1981). That graduates appear to learn ways of sharing perspectives separate to their sense of affiliation to a particular profession supports this theoretical perspective, expressed by one graduate as "fill[ing] the gaps that I cannot fill."

Furthermore, as graduates focus on developing a professional identity during their first year of professional practice, they may experience greater reliance on identity as a moderating factor between practice roles that are enacted in their respective professions or during collaborative work. Thus, as novice practitioners, they become acutely aware of learning where their practice role fits into a broader organisational structure of health care and why their role is important in relation to the roles of others.

Hence they cite their identity in their profession and from this position they venture into collaborative work.

By way of offering a further explanation on the graduates' strengthening identity through collaborative work, Mitchell et al. (2011) reported a positive correlation between the expression of a strong professional identity by established career professionals and their interprofessional openness to working in teams. These authors also identified the risk of identity threat if advanced career professionals perceived the diversity of a collaborative group prevented them from utilising their expertise, leading to conflict and competition among team members. This led the authors to advocate the value of teams acknowledging professional identities as being important to the teams' function.

5.3.3   Intentional separation of identity and negotiated practice roles

In support of assertions made by Mitchell et al. (2011) on the positive correlation between strong professional identity and interprofessional openness, graduates in the current study present similarly, with a definite link shown between collaboration and strengthening professional identity. Mitchell et al. do not identify the process of developing identity concurrent with collaborative practice. The current study, however, explicates this process, indicating graduates develop a strengthening identity with their profession through their collaborative activity. Indeed, this finding is significant in light of concerns regarding possible disruption to professional identity due to collaborative practice (Adams et al., 2006; Beddoe, 2011; McNeil et al., 2013). Concern has been levelled at early socialisation into professions (Adams et al., 2006), generic practice roles (Beddoe, 2011) and from advanced career professionals (McNeil et al., 2013). In addition, the experiential nature of developing a professional identity as shown by nursing graduates (Camilleri, 2008) implies the gradual process may be interrupted or, at the least, influenced by interprofessional collaborative factors.

These concerns are not upheld by findings from the current study. Indeed, graduates are shown to clearly distinguish between the work they conducted with colleagues in their own profession and the boundary work they engaged in with members of other professions. Boundary work is explained as "space in between a number of professions where we all contribute our own specialised area…owning your own profession and knowing what it is that you do but also respecting what the others bring to that" (Elizabeth, Occupational Therapist).

Social identity theory (Tajfel, 1981) is acknowledged for drawing attention to the comparative nature of belonging to groups, and of intergroup relationships. Specifically Tajfel theorised that interpersonal attributes assigned to members of specific groups reinforce the comparisons between the groups. In addition, members in one group are inclined to view their group favourably in comparison to others. Taken from an intergroup perspective, members from comparatively different groups may view others favourably if they are perceived as possessing complementary values and perspectives. Tajfel explains intergroup relations occur when "behaviour of two or more individuals towards each other is determined by their membership of different social groups or categories" (p. 240).

Relating this theoretical perspective to graduates' experience of working collaboratively, it provides an explanation for strengthening identity in one social group, their chosen profession, as separate to the interaction with members of other groups, during collaborative practice. van Knippenberg, Dreu and Homan (2004) offer a further explanation by distinguishing between social categorisation (Tajfel, 1981), which focuses on similarities and differences between groups and an information-decision processing perspective that centres on harnessing differences in knowledge, expertise and perspectives in a group. From this position, professional groups are viewed as distinctly different but intersect with a common purpose.

A combination of social categorisation (Tajfel, 1981) and information-decision processing (van Knippenberg et al., 2004) supports the emergent dual practice that graduates in this study are shown to engage in. This is shown in collaborative activity, where graduates drew on the perspectives and knowledge of others, while still endorsing their own profession as a worthy contributor to joint practices. Importantly, in doing so they positioned their profession within the collaborative group, which was expressed by graduates as having strengthening voices as they communicated from their professions' perspectives at the borders of the professions. Also important is the realisation that the perspectives of others can enhance collaborative practice roles rather than diminish or dilute those specific to professions (Akkerman & Bakker, 2011). Graduates expressed this as taking on the views of others, while concurrently holding their professional identity as separate to overlapping roles and practices.

> [You] take little aspects of every different discipline and it just becomes part of who you are in your role. You don't necessarily do it intentionally but just the way you talk or the way you write things… I think everything about what you do, just tiny little parts of it, is part of another profession but you've still got your hat on as your profession (Jessica, Occupational Therapist).

So, while identity remains situated in respective professions, combined knowledge of the collaborative team is infused into, and expands professional perspectives towards a broader understanding of presenting health concerns. Furthermore, as perspectives expand, this fosters motivation for engaging in and exploring further collaborative activity, specific to information–decision processing (van Knippenberg et al., 2004). While interprofessional collaboration may enhance professional practice, graduates in this study retained strong affiliation within their chosen professions. Equally, they viewed interprofessional collaboration as complementary to their primary practice role situated in a profession.

> As I've developed my understanding of their roles [other professions] that also helps to clarify my role, because there are overlaps and I think there will always be overlaps. But, it's becoming clearer in my

mind as to where the lines are drawn and how much of an overlap there can be (Amelia, Occupational Therapist).

Interaction at this level of practice brings into question the knowledge realms and associated perspectives of different health care professions (Schwartz et al., 2011). Brooks and Thistlethwaite (2012) suggest collaborative practice may conflict with the normative behaviours of a profession, and undermine the "established values, goals and protocols" (p. 409) on which a profession is premised. They further question whether collaborative practice is in direct opposition to notions of professionalism developed during education and enacted in clinical practice. Yet in this current study, which has focused on graduates' early professional practice in collaborative contexts, it is shown that identity remained centred in distinct professions. Furthermore, identity strengthened in apparent defiance of expanding perspectives and overlapping roles during collaborative activity. This finding adds support to graduates being engaged in dual practices that complement each other without impacting on developing professional identity in a chosen profession. Indeed, working at and across professional boundaries appears to bring professional identity into clear focus for graduates and further validates their sense of belonging to sufficiently different social groups that comprise particular values, beliefs, perspectives and normative behaviours.

5.4   Evolving notions of professionalism

Graduates who participated in this study entered the work force expecting to become credible members of their chosen profession. They had high hopes of making a smooth transition from student to professional worker, and relied on their years of education as preparation for the knowledge and skills required to function in a professional role. From this orientation, graduates' practice may be viewed as progressing from the periphery to full membership in a profession, while concurrently constructing collaborative space at and beyond the boundaries among professions. This third convergent theme focuses on discussion of graduates' evolving notions of

professionalism as enacted in their practice as health professionals. Specifically, discussion centres on graduates' use of knowledge and skills in practice, in their respective professions and through interaction with others; drawing together epistemological threads related to graduates' understanding of their professional practice in collaborative contexts.

5.4.1 Peripheral interaction at the border of a profession

Current findings indicate graduates navigate from a position of peripheral interaction—as previous students and in the early months as novice practitioners—to establishing their practice role in their respective professions. Peripheral interaction in this context is described as practice at the margins of professions; with graduates being given limited opportunities by more experienced colleagues for taking professional responsibility. During this time, graduates' focus is centred primarily on familiarising themselves with their work environment, through working with and observing others in their profession as they conduct their practice. Findings from the current study show graduates' experience a state of heightened self-awareness during this time, as they navigate their professional practice responsibilities. Although they view themselves as professionals—based primarily on attainment of a qualification—their early practice is punctuated with uncertainty as to how they will competently enact a role within their respective professions. Furthermore, while situated on the periphery of a professional practice community, graduates also remain highly visible to their colleagues, through preceptorship and mentoring programmes. Through scaffolding of graduates' early practices, professions ensure novice practitioners develop competency to practice in ways that are commensurate with their scope of practice requirements.

Prior to commencing work, graduates in this study appeared well prepared theoretically to commence work. This included understanding the legal and professional boundaries that would inform and regulate their future practice. This finding is

important as graduates anticipated that from a previous state of interacting at the periphery of their profession—only working on the fringe or outer margin of a profession as students—they were ready to integrate seamlessly into a work environment as credible colleagues (Freidson, 2001). Tryssenaar and Perkins (2001) likened this state of anticipation to that of "great expectations" (p. 22), whereby graduates look forward to the shift from "being on hold for many years as students" (p. 22) to a professional status. In support of Tryssenaar and Perkins' findings, graduates in the current study expressed this sense of great expectations variously as, "being qualified", of "taking a complicated matter or topic and convey[ing] it in a way that is understandable", and conveying "a strong knowledge base and application".

Duchscher (2009) has studied the transitional phase from student to professional and posits that graduates experience transition shock, shifting from a state of heightened practice expectation to the actuality of immersion in work environments. Duchscher describes the transition from the periphery of practice to a professional practitioner as "a channel between what was and what is" (p. 1104), suggesting a process of disconnection experienced by graduates as they anticipate navigating their way "in a world for which they had been prepared but were not wholly ready" (p. 1108). Lave and Wenger's (1991) Theory of Situated Learning explains the importance of adaptability and resilience needed by novice practitioners during this time of uncertainty. During this time, they have partial access to the profession's practice but are not subjected to the demands of full membership. Taken from this perspective, newcomers to an existing practice community must learn to navigate practice terrain they are only partially ready for. The current study found that graduates expressed this sense of preparedness for practice—tempered with uncertainty—as needing to know their limitations and learning from more experienced colleagues.

In addition, they were conscious of learning to moderate a natural tendency to respond emotionally to challenging clinical contexts. This is shown in comments of "learning to take a step back or take a breath" (Phoebe, Nurse) and "having a thick skin but a warm heart in order to remain professional" (Mia, Nurse). The latter comment was made in relation to becoming a responsive practitioner, with the graduate reflecting on how she perceived professionals should behave.

During the transitional phase, graduates are shown to grapple with amending their espoused theories-about-practice into theories-in-practice (Argyris & Schön, 1974), or learning "how to think in the course of 'doing' a practice" (Kemmis, 2005, p. 392). Toal-Sullivan (2006) suggests graduates need to adjust to their changing role from student to practitioner. As students, they may be protected from "setting priorities and managing caseloads" (p. 520) and therefore enter into the workforce unprepared for professional working contexts and associated practice challenges. In support of Duchscher's (2009) notion of transition—of looking back and thinking forward—it is possible the aspirations of graduates related to becoming professionals acts as an incentive, or motivates them to continue in their pursuit of membership into professional practice (Wenger, 1998). From this perspective, peripheral interaction permits graduates transitioning into professions to observe and learn from the margins of a profession.

Yet graduates' eagerly anticipated view of practice frequently creates unrealistic expectations by novice practitioners (Mooney, 2007; Whitehead & Holmes, 2011). Certainly in nursing, which makes up a large proportion of the health care workforce, there is concern graduates are ill prepared for the realities of clinical work (Casey, Fink, Krugman, & Propst, 2004; Mooney, 2007; Morrow, 2009). In nursing, the level of responsibility expected of new graduates, particularly related to patient safety, can leave

novice practitioners feeling inadequately prepared and lacking in confidence and competence.

Other professions note a similar trend. Toal-Sullivan (2006) indicates graduates from physiotherapy and occupational therapy have difficulty transferring their espoused theories into theories in practice (Argyris & Schön, 1974). Furthermore, they have difficulty adapting to complex practice environments where their fledgling clinical assessment and reasoning are often inadequate. Adapting to the demands of a busy clinical environment is equally challenging for midwifery graduates. In particular, midwives working in hospitals struggle with adapting to task oriented medical practice when their primary focus of putting women at the centre of their care is holistic (Fenwick et al., 2012).

The participants in the current study share the challenges identified in these previous studies. During early months of practice, novice practitioners across the six health professions referred to their new sense of responsibility, of having to make decisions and of no longer being on the periphery of practice.

> You have to be so sure in yourself that you are doing the right thing,
> and double-checking for yourself, taking that extra time because
> there's no safety blanket for you anymore, really. So it is you, and it's
> your practice and you write your notes and no one countersigns them,
> so it is you (Steph, Nurse).

The process of transitioning from the periphery of practice into situated integration was likened to "becoming visible", after years of fading into the background as a student. Not surprisingly this state of heightened self-awareness, of being alert to one's own practice limitations, creates uncertainty. Working in unfamiliar clinical situations presents challenges for novice practitioners, expressed by a nursing graduate's experience of admitting a patient into a hospital ward and having to think through the foreseen and possible unforeseen aspects of this procedure.

> When things were unpredictable and I couldn't anticipate what an
> expected outcome would be, or how expected events would be. So I

knew what skills I could bring but beyond that I didn't know. I think it's those [situations], when you don't know what you don't know (Steph, Nurse).

5.4.2 Situational integration into a profession

Preceptorship programmes and support from experienced colleagues insulate novice practitioners from a number of aspects pertaining to their practice; aspects that are described by Schön (1983) as 'messy' indeterminate practice zones beyond technical procedural knowledge. Bisholt (2012) suggests preceptorship may hinder graduates from developing clinical and reasoning skills, as the process elongates their adaptation to professional practice. Equally Casey et al. (2004) describe this state as that of graduates struggling "with the dichotomy of needing to be independent yet continuing to rely on the expertise of others" (p. 307). This view is shared by a number of graduates in this recent study who experienced frustration at "remaining in a student state" during preceptorship.

There is, however, extensive support for preceptorship programmes in nursing literature (Clark & Springer, 2011; Cowan & Hengstberger-Sims, 2006; Ellerton & Gregor, 2003). These programmes are aimed at developing graduates' safe practice, management of workloads and clinical reasoning (Clark & Springer, 2011). With nurses comprising the largest proportion of the health care workforce, preceptorship programmes have been identified as increasing job satisfaction and limiting attrition of graduate nurses in their first year of practice (Ellerton & Gregor, 2003). Nursing graduates in the current study were all mentored in the early months of practice. Although there was a collective sense of relief at progressing beyond mentorship, they were able to ease their way into their practice role. The sense of finally progressing beyond the periphery and into full membership of a profession was expressed as feeling "really good that I was trusted enough to be given responsibility and that I could take this on" (Sue, Nurse).

In the current study, all graduates were supported in their early transitional phase of practice but in less organised structures than nurses. Mentoring was generally undertaken with experienced colleagues who modelled and shaped graduates' practice into the specific knowledge and practice tenets commensurate with their respective professions. A key factor identified in the transitional phase was improved time management, which resulted in graduates gaining a sense of control over prioritising and managing workloads. Managing a workload and increasing independent decision-making was viewed as a positive shift towards becoming integrated into a profession, expressed by one graduate as developing strength to stand "on my own two feet" (Amelia, Occupational Therapist).

A further important function of preceptorship programmes and less formal mentoring from experienced colleagues concerns continued socialisation into the profession. Through close monitoring of graduates' responsive behaviours to real-time activity by experienced practitioners, and continuing provision of reinforcement or censuring in accordance with the profession's knowledge and practice realms, the novice practitioners are inducted into the professions community of practice, as noted by Wenger (1998). During this transitional phase, although graduates in the present study believed they remained in a 'student state', their patterns of practice were developing. The early and ongoing support of experienced colleagues provided a strong foundation from which graduates established their practice perspective and role within their respective professions. Traversing into a profession was likened to passing a driver's licence by one of the occupational therapists. She made a comparison between her theories-for-practice constructed in formal education and her developing theories-in-practice, expressed as:

> You've done your three years at university and then its "on you go". I feel that maybe the practical experience was on the limited side [at university]. It makes me feel like I did when I passed my driver's licence; you get out there and learn how to drive. That's exactly how I

feel now, but I'm actually learning the career of an occupational therapist rather than just being given a box of tools that I now have to set in practice. I feel very responsible (Allam, Occupational Therapist).

Professions have traditionally laid claim to specialised knowledge (Eraut, 1994) and associated expertise in assessing, diagnosing and treating health problems (Freidson, 2001). Furthermore, through the erection of scope of practice boundaries between professions and regulation of members' practice roles within these, health professions have maintained a degree of autonomous practice, independent of each other. Socialisation into the professions, which spans initial years of education and into clinical practice, inducts graduates into distinct ways of viewing health (Hall, 2005; Petrie, 1976; Shulman, 2005). According to the present study, graduates are inducted into their professions in this manner.

A key finding in this study, however, was a progressive shift in professional orientation that occurred when novice practitioners spent increasing amounts of time in collaborative activity among professions. From their perspective, this developed through communicating and working with each other at the interface of their respective professions. Through sharing information, they are shown to negotiate optimal approaches to appropriating effective responsive practices, depicted as 'negotiated professionality' by Edwards et al. (2010) and as 'interprofessional openness' by Mitchell et al. (2011). Petrie (1976) proposed the notion of idea dominance to shift focus from individual professions' perspectives to a broader holistic approach to health care service.

Furthermore, Boreham (2004) suggests teams focusing on collective competence, shift professional thinking from being individualistic and autonomous to a focus on shared activity. Boreham describes collective competence as occurrences when team members jointly understand the reasons for their collaborative work, of "developing and using a collective knowledge base and developing a sense of

interdependency" (p. 9). Crowley (2014) develops the concept of a collective knowledge base through advocating the need for broadening perspectives and revaluating "notions of truth and knowledge" (p. 50) that traditionally underpin professions. Crowley argues the need for professionals to "be open to new ways of perceiving the world…be ready to explore with others from very different backgrounds issues of significance to our professional practices" (p. 50).

These notions of how teams can work effectively have relevance to the ways in which novice practitioners are shown to practice at the interface among professions. According to the present study, novice practitioners working at the interface of professional boundaries create collaborative 'space' among respective professions. Collaborative space may be viewed as "space in between a number of professions where we all contribute our own specialised area" (Elizabeth, Occupational Therapist). Additionally, collaborative space was construed as:

> respecting professional views and, I guess, breaking down that
> hierarchy and being able to all get down on the same level, have an
> open space to be able to talk about your views and bring those
> together, while recognising the importance of the differences
> (Elizabeth, Occupational Therapist).

While there is need for practitioners to initially have an understanding of their own professional perspective when entering collaborative space among other professions (Hall & Weaver, 2001; McPherson, Headrick, & Moss, 2001;Toal-Sullivan, 2006), equally important is the developing understanding of different perspectives and sharing knowledge to inform collaborative health care (Crowley, 2014; MacDonald et al., 2010).

5.4.3   Creating collaborative space among professions

Conceptualising work among professions as practices that occur in collaborative space, provides scope for explaining graduates' understanding of their professional work in interprofessional contexts. According to the present study, graduates are shown to

construct collaborative space through intersecting knowledge and practice domains from their respective professions.

> I've learned from working with the social workers. They see things that I didn't but now I know the signs. I know how to sometimes ask those difficult questions… I did not want to go there… [now]I'm going there. Things like asking about domestic violence and things like that. I would not go there. I just did not think it was in my scope of practice whereas now I know how to be tactful around some questions. I've learnt from the social workers and other people (Sue, Nurse).

Through creating collaborative space, graduates are shown to construct new ways of working at and beyond single professions. This involves navigating a professional role towards situated integration into a profession while concurrently constructing collaborative space to communicate and negotiate practices that intersect professions. Thus, novice practitioners develop complementary or dual practices. According to the present study, working in complementary practices is expressed by graduates as melding the knowledge and skills from one profession into another.

> I find myself being a dietician, being a physio, being a speech language therapist automatically; just adjusting things because I've talked to them and they've educated me, and just worked together on things before during previous experiences (Mia, Nurse).

This contrasts with studies of experienced practitioners, who perceive their professional knowledge and expertise is threatened by working interprofessionally (Baxter & Brumfitt, 2008; Miller, 2004). In addition, there are studies that indicate professional identity threat resulting from collaboration (McNeil et al., 2013; Timmons & East, 2011). Yet, there is neither identity threat nor perceived withholding of information shown by graduates in the current study. While they establish their practice in their respective professions through learning from and with their colleagues, they also draw on the knowledge and skills from other professions in order to respond insightfully to patients or clients presenting with complex health concerns. They appear to delineate routinised practice of their respective professions from more complex indeterminate

health care concerns, which require knowledge sharing among professions in order to make well-reasoned appropriate decisions.

In doing so, they sustain their identity in their chosen profession as their primary social group (Tajfel & Turner, 1986). Similarly, they draw on their profession's distinct perspective, knowledge and associated practice role during early collaborative activity. However it is in the collaborative spaces, or through border work between professions, that graduates are shown to extend their knowledge through sharing information. Furthermore, the unique professions' perspective through which graduates enact their practice is shown to expand in collaborative space, due to their becoming cognisant of different orientations to viewing person-centred health concerns.

In relation to collaborative practices among a number of health professions, a key finding from this study suggests novice practitioners emerge as professionals with a flexible approach to their work contexts, described as altering their "professional shape" to incorporate collaborative space in practice. Consequently, as practice boundaries become increasingly permeable, new professionals construct meaning to their practice in collaborative space with others. Collaborative space looks to extend beyond the confines of specific professional contexts, whereby new professionals—working in both their respective professions and in collaborative practice—validate their identity while working in new ways. Working in new ways appears to shift traditional notions of professionalism. In particular, this relates to expanding health perspectives and extending practice boundaries.

So, while graduates' identity appears to remain embedded in their respective professions, knowledge expansion through sharing information in collaborative space allows new professionals to progressively connect multiple perspectives to inform their practice from being perceived as fragmented to cohesively "fitting of pieces together." As professional practice boundaries blur and progressively extend beyond regulated

scopes of practice, concurrent notions of professionalism appear to shift from a

distinctly profession-centric focus to a more general understanding of professional self

in a broader context, as noted by Crowley (2014). Crowley illustrates a shift from

viewing professionalism as being embedded in single professions to that of a

collaborative work context where professional interdependency is favoured.

> Altruism and expertise are still central to the concept of
> professionalism as is autonomy, but our expertise is not solely
> knowledge-based and cannot be exclusive and it is an autonomy that
> comes from interdependence rather than independence. Professional
> reframing requires a particular understanding of autonomy based on
> informed decision-making whilst recognising that part of the
> informing must come from understanding the diverse perspective of
> others including those whom we serve. (p. 51).

Viewing professionalism in this way, through valuing interdependency along with the

independency of professions' altruism and expertise, is shown to resonate with

participants in the present study. Specifically, graduates seek and share information with

each other at the interface of professional boundaries.

> I feel like I've started again almost with what I realise I don't know.
> So I've started asking all sorts of questions again and it means that
> I'm able to pull on other people's knowledge, whether that is doctors
> or other professions or nurses and find out more and add it to my own
> knowledge (Mia, Nurse).

Equally, through negotiating practice roles across collaborative space, new

professionals are shown to possess an expanding health care perspective that

encompasses not only their own profession but the perspectives of other professions

also. Broadening perspectives, through interprofessional collaboration, is known to

improve communication among professions (Brown et al., 2011; Hall, 2005; Suter et

al., 2009), enhance professional job satisfaction through sharing resources (Holtman et

al., 2011) and improve the safety and health outcomes of patients (Hall & Weaver,

2001; McCallin, 2001; Weller et al., 2010).

In contrast, concerns regarding conflicting professional role expectations and

identity discord appear unfounded. Graduates in this study, working in dual practices by

choice or through necessity, have not compromised their chosen professional field or their professional identity. Rather, through creating collaborative spaces for practice among professions, the graduates are shown to broaden their understanding of complex health concerns, alongside the realisation of how different professions contribute to these. Construction of collaborative space is captured in the following experiential account, revealing the influence of expanding perspective and extending knowledge on a graduate's subsequent practice decisions.

> In my role as a podiatrist, I think there are some things that I do really well and some things I still need to learn. There are things that other people do really well but we can all still learn of each other. Talking to physios, doctors and nurses, I learn all sorts of things…you get a different perspective from someone who sees slightly different things every day; it can be something quite simple but you just never thought of doing it that way before…I've got a physio I talk to quite a lot for different things because sometimes you get tunnel vision with a certain patient and you can't quite get something right…I bounce my ideas off her and she'll say, "Oh why don't you try…" or "have you tried…" and she might suggest one thing that I haven't tried and that might just be the one things that makes all the difference. I know I'm never going to know everything but I think if you get someone else's input on it, then they're going to pick up on something that you haven't thought of and vice versa. Two heads are often better than one and I think I would never have got nearly as far in terms of my learning this year if I had worked in isolation (Sophie, Podiatrist).

5.5 Conclusion

This study has added a unique understanding of graduate's developing professional practice during their early career in contemporary health care environments that intersect professional boundaries. Through their creation of collaborative working space among professions, graduates have shown expansion of their health perspectives, or orientations to health care practice. Concurrently, their knowledge and skills have extended beyond the regulatory scope of practice boundaries during collaborative work.

Significantly, graduates' professional identities are shown to strengthen through their work at the interface of professions. In contrast to the increasingly familiar work contexts that graduates experience in their respective professions, working at the

interface of professions requires them to communicate their distinctive health perspective, knowledge and specialist skills to other members in a collaborative teams. In doing so, they reinforce their professional identity as distinctive in relation to other team members, while engaged in flexible working relationships that traverse knowledge and practice boundaries.

Thus, the intersection of professional knowledge and practice boundaries provides a collaborative working space where graduates establish their roles as professionals through emerging dual practice of professional and interprofessional work. Dual practice capability is essential for graduates working in contemporary health care contexts. Therefore, embedding interprofessional capability in current professional education programmes will better prepare graduates for practice. Similarly, ongoing interprofessional education for graduate practitioners will enhance collaborative capability among professions.

Chapter Six

Implications for Education and Practice

6.1 Introduction

Insight into health science graduates' developing practice in interprofessional contexts adds to the current knowledge in the areas of interprofessional education and collaboration. This study has shown the developmental trajectory that graduates, from a number of health professions, experience during their first year of professional practice in their respective professions. Specifically, the study has identified key features of graduates' practice that are attributed to working at the interface between professions; related to strengthening professional identity, expanding perspective and evolving notions of professionalism.

Although the research commenced with speculation that graduates' identity may be compromised due to interprofessional collaboration, the findings from this explorative study show a strengthened identity resulted from graduates' interaction at the interface of the professions. Through experiences at the interface, graduates learnt to overtly endorse their respective professions, by articulating a distinct perspective and related specialist knowledge and skills they could contribute to collaborative practice. As a result of continually communicating this information, graduates are shown to reinforce their identity as distinctive and situated in a defined profession.

This finding supports continuing socialisation into distinct professions during initial professional education programmes, in order to develop graduate capability for becoming a functioning member of a profession. Concurrent with early socialisation into distinct professionals—during professional education programmes—there is the additional requirement for continuing development of interprofessional education that prepares graduate capability for working in dual practice. Specifically, the timing and

placement of interprofessional education initiatives must be considered, to ensure the relevance of IPE to the developmental stages of student learning.

Knowledge of graduates' emergent dual practice, strengthening professional identity and evolving notions of professionalism has education and practice implications in developing and supporting graduate interprofessional capability. In consideration of education and practice implications to support changes to both undergraduate and continuing professional practice, a concentric model (Figure 3, p. 211). is introduced. This model links the interrelated features of graduates' practice roles at the interface of professional and collaborative practice (represented in Figures 1 & 2). The model draws attention to the multifaceted dimensions of graduate practice in interprofessional work contexts and provides scope for developing interprofessional education (IPE) initiatives supporting the development of graduate capability beyond the requirements of their respective professions.

Each of these features is shown in the concentric model, depicting an ontological axis (identity and perspectives) and an epistemological axis (practice and professionalism) that intersect in the central position of graduates as professionals; working in their respective professions and collaboratively among professions. This emergent model represents the culmination of the exploratory study into graduates' understanding of their early professional practice. In consideration of education and practice implications from this study, the concentric model will support further development of IPE teaching and learning strategies in preparing graduates for dual practice work contexts.

Figure 3. Graduates' emergent dual practice: Interrelated features of graduates' roles working at the interface of professional and collaborative practices
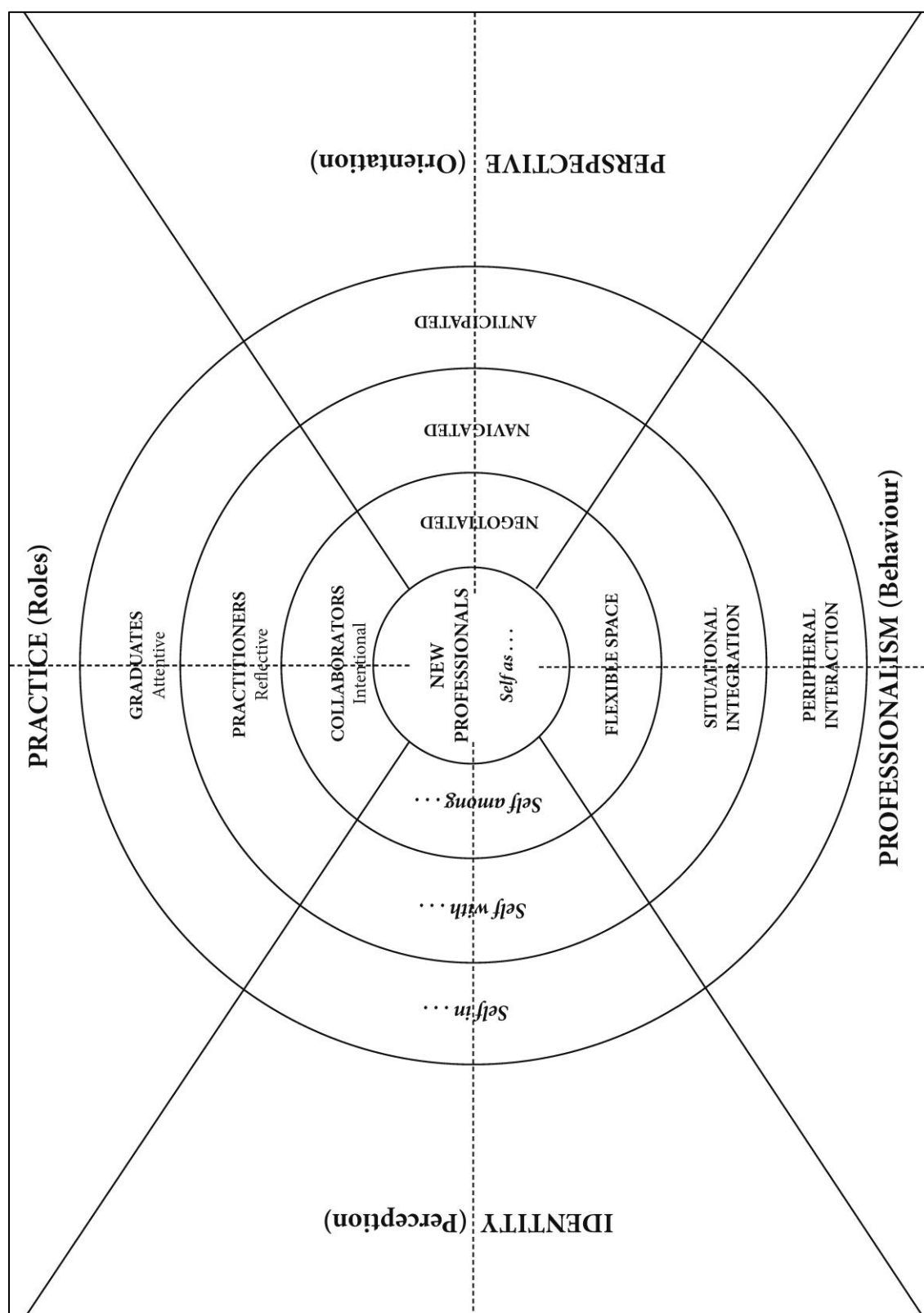
6.2 Developing interprofessional capability for practice

These study findings support the need for students, in professional education programmes, to develop understanding of professionalism that shifts from an ideal notion, to a realistic understanding of practice contexts. Students exiting initial education armed with greater understanding of the historical premises underpinning professionalism may be better able to decipher and respond to professional relationship concerns among professions, as they enter the contemporary health care workforce. Concurrently, an understanding of the socio-cultural influences on notions of professionalism—from organisational, professional, and service users perspectives— will support the development of graduate capability to work in professional and interprofessional dual practice. For example, experiential learning opportunities that challenge students' traditional notions of professionalism, in favour of intersecting professional knowledge and practice boundaries among professions (Dall'Alba, 2009; Schwandt, 2005).

In light of the challenges facing practitioners working in contemporary health care, it is important that, during undergraduate professional education programmes, students collaboratively engage in philosophical debate on epistemological and ontological dimensions that underpin and inform their respective professions. In doing so, students and academic staff may develop "holistic views formed from a synthesis of discourses surrounding knowledge, method, culture, work and so on… manifest in our ways of 'knowing' and 'doing' (thining, speaking and acting in respect to) the practice fields" (Scwandt, 2005, p.315). More recently Dall'Alba (2009) argues the need for students to explicitly address the cognitive constructs that inform practice, viewed by Schön (1983) as reflective practice. Dall'Alba (2009) attests to the situatedness of knowledge, stating that "cognitions are not exclusively individual, but are distributed among people and their surroundings, including tools and artefacts" (p.11). Thus,

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learning situations that explicitly draw on both students' individual and combined understanding of knowledge constructs are favoured (Green, 2009; Styhre, 2011).

Perspective sharing, viewed by some authors as sharing mental models (Burford, 2012; Weller, 2012), is another area students need to engage with on an ongoing basis. Based on findings from this study, professional perspectives or orientations to health expand through direct and continuing interaction among practitioners at the interface of professions. This study identifies the distinct advantage of graduates having a clearly defined health care perspective or orientation when they initially communicate at the interface of professions. For example, occupational therapists quickly learnt when they should intervene in person-centred team meetings with their distinct assessment and intervention priorities and when they should "take a back step" in favour of other priorities. In comparison, nurses had difficulty initially articulating a distinct perspective and therefore considered their practice role as "filling the gaps" between other professions. Therefore graduates from nursing followed a more indirect, or circuitous developmental trajectory in first articulating and then expanding their perspective for collaborative practice.

It is crucial that during professional education programmes, collaboration in "real-time" clinical practice (Argyris & Schön, 1974) is concurrent with time spent in respective professions where perspectives are developed. Graduates are shown to conceptualise the interface of professions as flexible space; a space where they share perspectives and negotiate roles in response to person-centred health needs or support. Although graduates initially grapple with deciphering existing boundary objects that serve as communicative channels between professions, they learn how to co-construct and use these through their experiences of working at and beyond their respective professions.

In preparing graduates for working interprofessionally, there is a need for students from different professions to collaboratively experience real-time learning opportunities for setting and solving complex problems related to health (Argyris & Schön, 1974). Ideally, provision of opportunities for collaboration should be ongoing during practice, and include overt communication of perspectives and roles among students. As previously mentioned, timing and placement of IPE interventions in professional education programmes is important. Students must possess an understanding of their respective professions' health perspective and practice roles in order to communicate effectively at the interface of professions. Future research into students' construction of flexible or collaborative space, through their reflection on the experience of working at and beyond the interface of professions, will provide additional insight into development of interprofessional collaborative capability.

In academic settings, students from a number of professions may collaborate in problem solving and problem-setting of complex health related issues. Students' experience of collaborative decision-making, through communicating different orientations to health and health care practice promotes diversity mind-sets (van Knippenberg et al., 2004). Diversity mind-sets may moderate the effects of social categorisation (Tajfel, 1981), which focuses on "similarities and differences" classification in groups. Diversity mind-sets suggest people who value diversity and who draw on the both informational diversity, attain positive group outcomes.

While some writers suggest caution should be exercised over the precise timing of interprofessional education during undergraduate study (Charles et al., 2010; Carlisle et al., 2005), it appears shared interprofessional learning positively correlates with developing professional as well as interprofessional capability concurrently (MacDonald et al., 2010, Verma et al., 2009). This can be achieved through placing learners "in situations so that, together with their peers and through their own practices

and experiences, they can construct the resources that will help them to become competent" (Jonnaert, Masciotra, Barrette, Morel, & Mane, 2007, p. 196) in authentic learning situations that promote development of distributed, collective capability.

6.3 Extending interprofessional capability in graduate practice

Graduates' early interaction at the interface of professions is shown to strengthen professional identity, broaden perspectives and extend knowledge over the first year of professional practice. Ongoing opportunity for graduates to practice at and beyond the interface of professions is favoured in building interprofessional capability for effective responsiveness to the complexities of health concerns beyond the expertise of specific professions. This study has provided insight into the developmental trajectory of graduates' interprofessional practice, adding to a growing body of knowledge on interprofessional collaboration. An area for future study is to explore the influence of interprofessional practice on possible changes to graduates' affiliation to their specific profession beyond the graduate year. Further study could draw on the current findings to investigate longer-term effects of collaborative practice on profession-specific perspectives, specialist knowledge claims and areas of expertise.

According to Social Identity Theory, identities are socially mediated through interpersonal interaction that is meaningful to an individual (Tajfel & Turner, 1986). In support, Social Learning Theory (Wenger, 1998) claims the malleable nature of identities in groups that are sensitive to the changing dynamics of participation from both new and established membership. If professions are viewed in this way, then graduates working at and beyond the borders of a number of professionals groups may, over time, choose to alter their allegiance to established groups, or indeed create new groups that span existing professions. It may therefore be valuable to investigate how professional identity evolves as new professionals continue to practice interprofessionally beyond the graduate year.

6.4   Study limitations

This exploratory study has included a number of health professionals who were all educated at one university and may be viewed as a parochial study. However, the 18 graduates who participated in this study, although primarily educated in siloed professional programmes, were socialised into a faculty that was in the early stages of introducing interprofessional education (IPE) during 2009–2011. These 18 participants had encountered elements of IPE during their professional education programmes. This led a number of this group to express interest in the study because of interprofessional collaborative experiences during their years at university. This may have influenced their initial perceptions of collaborative practice and later impacted on their graduate experiences of collaborative practices. On occasions during the study timeframe, a number of participants voiced their increased awareness of collaborative activity among professions. They reasoned this was due to the research questions they were asked, which inadvertently assisted their developing ability to reflect on their own professional practice and the practice of others.

It is possible participants may have been swayed, through the use of semi-structured interviews, to recount their clinical experiences less candidly than might occur through unstructured interview techniques. Yet, the use of semi-structured questions did not appear to prevent participants from elaborating on their clinical experiences and reflecting on their developing practice as health professionals. So while the use of semi-structured research questions may have resulted in prescribed responses, this was not evident in the recall of thoughtful, richly descriptive experiences from participants in this study.

A further possible study limitation is the skewed number of participants from each profession, with greater numbers participating from nursing and occupational therapy, as compared to the other four professions. This led to increased contribution

from these two professions over the duration of the study but was tempered by coding of data both across and from within the six professions to provide a credible final description of the graduates' developmental trajectory of professional work in interprofessional contexts. It is however evident that one profession, oral therapy, was represented less than the other professions in the findings of this study. This was unintentional, but suggests the work environment of two oral therapists (Max and Serentity) was less conducive to collaborative practice activity external to their immediate work context. Future research focused on phenomenological study of single graduates from each of the professions may develop greater depth of understanding into interprofessional differences among professions. This would build on, and extend the knowledge from this study, which has shown that graduates—from a number of health professions—strengthen their professional affiliation and identity through interprofessional collaboration.

6.5 Concluding comments

The first year of graduate practice in health care professions is crucial to the development of practitioners who are competent and confident to work both in their respective professions and interprofessionally. This exploratory study, which examined the interface of professional and collaborative practice, provides unique insight into graduates' understanding of working in and beyond their respective professions. This reveals an emergent dual practice, whereby novice practitioners navigate a role in a particular profession while concurrently negotiating practice roles at the interface of professions. Dual practice, comprised of professional and negotiated roles, is shown to be complementary but distinct, due to graduates' strengthening identity in their chosen field of health as a result of collaborative work.

Communication at the interface of professions has significant influence on reinforcing professional identity. Graduates' clinical experience of working at the

interface of professions has established a link between communicating professions' unique perspectives at practice boundaries and reinforcing their affiliation to, and sense of identity in a single profession. This finding runs counter to research that has reported the risk of identity threat when working at the interface of practice boundaries (Baxter & Brumfitt, 2008; Brown et al., 2011; McNeil et al., 2013; Mitchell et al., 2011) and those who have cautioned interprofessional collaboration may destabilise professional values, normative behaviours and identities (Brooks & Thistlethwaite, 2012; Edwards, 2010; Hall, 2005).

Participants in the current study, who perceived a positive influence of collaboration on strengthening professional affiliation and identity in chosen health fields, do not share these views. As graduates' early practice focus is reported to be on establishing membership into their chosen profession (Black et al., 2010; Camilleri, 2008; Clark & Springer, 2011; Duchscher, 2009; Kelly & Courts, 2007; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001), it is understandable that introducing collaborative activity during transition into practice may be viewed as weakening graduates' developing identity with their respective professions, in favour of a more generic health practitioner identity. Yet, this study reveals graduates' professional identity is strengthened, due to collaborative practice among professions. When working with colleagues in their chosen profession, graduates may be unaware of their developing identity. Rather they focus on mastering the clinical skills required to competently practice their profession. During interaction with other professions, however, graduates are required to address their affiliation to their respective professions every time they meet others at, or beyond the borders of the respective professions.

Although initially challenged by their workplace experience, these graduates learned to articulate their professions' orientation, priorities and corresponding contribution to collaborative activity through the actual practice of collaboration. In fact

it was at the interface of professions that they became consciously aware of what their distinct perspectives were. This contrasts with the tacit theories-in-use embedded in particular professions, enacted by members and seldom discussed overtly (Argyris & Schön, 1974). Thus, graduates' professional identity is strengthened through explicit and frequent articulation of their profession's orientation to health care, reinforcing the values and beliefs underpinning their practice in a chosen field.

By working as collaborators at the interface of professions, graduates were furthermore shown to expand their health perspective. Expanding health perspectives resulted in a broader orientation to complex health concerns and willingness to engage in joint decision-making around provision of health care support. Work at the interface of professions involved the construction of boundary objects (Star, 1988), both verbal and material, that functioned to intersect professional knowledge and skills, leading to sharing of information and subsequent overlapping roles during collaborative work. Additionally, negotiating roles during collaborative activity influenced notions of professionalism towards more flexible interprofessional relationships.

The flexible spaces graduates constructed during collaboration among professions did not encroach on their identity in their primary practice. Towards the end of their first year of professional practice, as new professionals, the participants in this study *intentionally positioned* their primary affiliation in their chosen profession, while concurrently working in complementary dual practice. So even though graduates develop interprofessional capability through their collaborative work, they orientate their professional practice from within their separate professions. In doing so, graduates *enact dual practices* of professional and interprofessional work, whereby their professional identities are nourished in their chosen profession and strengthened through collaboration among professions.

Concurrently, at the borders of professions, graduates are engaged in ontological development as they reflect on and communicate their distinct and negotiated roles and perspectives. Furthermore, this study has shown that as professional practice contexts vary, graduates extend their epistemological orientations beyond specific professional knowledge and practice borders to function interprofessionally. Graduates' professional work is enhanced rather than diminished through their work at and beyond the borders of their respective professions, through strengthening their professional identity, expanding their health perspective and extending their knowledge.

Interprofessional practice enhances professional practice as well as improving efficiencies related to escalating costs of health systems globally (Frenk et al., 2010; WHO, 2010), and in New Zealand (HWNZ, 2013) to address the challenges of future health service demands. Graduates are unlikely to be subsumed into becoming generic health care workers, when their professional affiliation and identity is drawn to their own attention and to the attention of others during interprofessional practice. Through acts of verbalising distinct practice orientations and related knowledge and skills during collaborative work contexts, graduates further bind their identity in their respective professions.

The graduates participating in this study are adept at working in dual practice in their chosen profession and in collaborative space where they develop flexible working relationships among professions. The work in their respective professions has nourished their developing professional practice. Concurrently, collaborative work among professions has extended their knowledge, expanding their health perspectives to encompass multiple ways of viewing and responding to complex health environments. Working at and beyond professional boundaries has strengthened their identities as health practitioners in their chosen field.

In summary, inter-professional collaboration has multiple benefits for graduates. It leads to enhancement of professional practice, more flexible inter-professional relationships and rather than weaken professional identity, it enriches it. Continuing development of IPE and collaborative practice is required in undergraduate and graduate programmes to promote interprofessional collaboration and graduate capability for dual practice. Attention to the interrelated features of graduates' roles working at the interface of professional and collaborative practice will assist in developing education and practice initiatives to better prepare graduates for dual practice in contemporary health care contexts.

References

Abbott, A. (1988). *The system of professions*. Chicago, IL: University of Chicago Press.

Adams, K., Hean, S., Sturgis, P., & Clark, J. M. (2006). Investigating the factors influencing identity of first-year health and social care students. *Learning in Health and Social Care, 5*(2), 55–68. doi:10.1111/j.1473-6861.2006.00119.x

Akkerman, S. F., & Bakker, A. (2011). Boundary crossing and boundary objects. *Review of Educational Research, 81*(2), 132–169. doi:10.3102/0034654311404435

Amey, M. J., & Brown, D. F. (2004). *Breaking out of the box: Interdisciplinary collaboration and faculty work*. Greenwich, CT: Information Age.

Argyris, C., & Schön, D.A. (1974). *Theory in practice: Increasing professional effectiveness*. San Francisco, CA: Jossey-Bass.

Arndt, J., King, S., Suter, E., Mazonde, J., Taylor, E., & Arthur, N. (2009). Socialization in health education: Encouraging an integrated interprofessional socialization process. *Journal of Allied Health, 38*(1), 18–23. Retrieved from http://www.asahp.org/journal_ah.htm

Barr, H., Koppel, I., Reeves, S., Hammick, M., & Freeth, D. (2005). *Effective interprofessional education: Argument, assumption & evidence*. Oxford, England: Blackwell.

Barrow, M., McKimm, J., & Gasquoine, S. (2011). The policy and the practice: Early-career doctors and nurses as leaders and followers in the delivery of health care. *Advances in Health Science Education, 16,* 17–29. doi:10.1007/s10459-010-9239-2

Baxter, S. K., & Brumfitt, S. M. (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care, 22*(3), 239–251. doi:10.1080/13561820802054655

Beaton, G. R. (2010). *Why professionalism is still relevant*. University of Melbourne Legal Studies Research Paper No. 445. doi:10.2139/ssrn.1545509

Beddoe, L. (2011). Health social work: Professional identity and knowledge. *Qualitative Social Work, 12*(1), 24–40. doi:10.1177/1473325011415455

Benade, L. W. (2012). *From technicians to teachers: Ethical teaching in the context of globalized education reform.* New York, NY: Continuum.

Bisholt, B. K. M. (2012) The professional socialization of recently graduated nurses: Experiences of an introduction program. *Nurse Education Today, 32,* 278–282. doi:10.1016/j.nedt.2011.04.001

Bishop, J. P., & Rees, C. E. (2007). Hero or has-been: Is there a future for altruism in medical education? *Advances in Health Science Education, 12,* 391–399. doi:10.1007/s10459-007-9064-4

Bjorke, G., & Haavie, N. E. (2006). Crossing boundaries: Implementing an interprofessional module into uniprofessional Bachelor programmes. *Journal of Interprofessional Care, 20*(6), 641–653. doi:10.1080/13561820600991801

Black, L. L., Jensen, G. M., Mostrom, E., Perkins, J., Ritzline, P. D., Hayward, L., & Blackmer, B. (2010). The first year of practice: An investigation of the professional learning and development of promising novice physical therapists. *Physical Therapy, 90*(12), 1758–1773. doi:10.2522/ptj.20100078

Bluteau, P., & Jackson, A. (2009). Interprofessional education: Unpacking the early challenges. In P. Bluteau, & A. Jackson (Eds.), *Interprofessional education: Making it happen* (pp. 24-37). Hampshire, England: Palgrave Macmillan.

Booth, J., & Hewison, A. (2002). Role overlap between occupational therapy and physiotherapy during in-patient stroke rehabilitation: An exploratory study. *Journal of Interprofessional Care, 16*(1), 31–40. doi:10.1080/13561820220104140

Boreham, N. (2004). A theory of collective competence: Challenging the neo-liberal individualisation of performance at work. *British Journal of Educational Studies, 52*(1), 5–17. doi:10.111/j.1467-8527.2004.00251.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. doi:10.1191/1478088706qp063oa

Brooks, V., & Thistlethwaite, J. (2012). Working and learning across professional boundaries. *British Journal of Educational Studies, 60*(4), 403–420. doi:10.1080/00071005.2012.729665

Brown, J., Lewis, L., Ellis, K., Stewart, M., Freeman, T. R., & Kasperski, M. J. (2011). Conflict on interprofessional primary health care teams – Can it be resolved? *Journal of Interprofessional Care, 25*, 4–10. doi:10.3109/13561820.2010.497750

Burford, B. (2012). Group processes in medical education: Learning from social identity theory. *Medical Education, 46*, 143–152. doi:10.1111/j.1365-2923.2011.04099.x

Burke, P. J., & Stets, J. E. (2009). *Identity theory*. New York, NY: Oxford University Press.

Cameron, A. (2011). Impermeable boundaries? Developments in professional and inter-professional practice. *Journal of Interprofessional Care, 25*, 53–58. doi:10.3109/13561820.2010.488766

Camilleri, M. (2008). *Becoming a nurse: A process of learning*. (Doctoral thesis, University of Surrey, Surrey, England). Retrieved from http://search.proquest.com/docview /898749810

Carlisle, C., Donavan, T., & Mercer, D. (Eds.). (2005). *Interprofessional education: An agenda for healthcare professionals.* Trowbridge, England: Cromwell Press.

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The nurse graduate experience. *Journal of Nursing Administration, 34*(6), 303–311. doi:10.1097/00005110-200406000-00010

Centre for the Advancement of Interprofessional Education. (2002). *Defining IPE.* Retrieved November 13, 2013, from http://caipe.org.uk/resources/defining-ipe/

Charles, G., Bainbridge, L., & Gilbert, J. (2010). The University of British Columbia model of interprofessional education. *Journal of Interprofessional Care, 24*(1), 9–18. doi:10.3109/13561820903294549

Clark, C. M., & Springer, P. J. (2011). Nurse residents' first-hand accounts on transition to practice. *Nurse Outlook,* 60, E2–E8. doi:10.1016/j.outlook.2011.08.003

Colyer, H., Helme, M., & Jones, I. (Eds.). (2005). *The theory-practice relationship in interprofessional education.* Retrieved from http://repos.hsap.kcl.ac.uk/content/m10143 /latest/occp7.pdf

Cooke, S., Chew-Graham, C., Boggis, C., & Wakefield, A. (2003). 'I never realised that doctors were into feelings too': Changing student perceptions through interprofessional education. *Learning in Health and Social Care, 2*(3), 137–146. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1473-6861

Coster, S., Norman, I., Murrells, T., Kitchen, S., Meerabeau, E., Sooboodoo, E., & d' Avray, L. (2008). Interprofessional attitudes amongst undergraduate students in the health professions: A longitudinal questionnaire survey. *International Journal of Nursing Studies, 45*,1667–1681. doi:10.1016/j.ijnurstu.2008.02.008

Cousins, G. (2009). Researching learning in education: An introduction to contemporary methods and approaches. New York, NY: Routledge.

Cowan, L. S., & Hengstberger-Sims, C. (2006). New graduate nurse concept and retention: A longitudinal study. *International Journal of Nursing Studies, 43*, 59–70. doi:10.1016 /j.ijnurstu.2005.03.004

Coyle, J., Higgs, J. M., McAllister, L., & Whiteford, G. (2011). What is an interprofessional health care team anyway? In S. Kitto, J. Chesters, J. Thistlethwaite, & S. Reeves (Eds.), *Sociology of interprofessional practice: Critical reflections and concrete solutions* (pp. 40–53). New York, NY: Nova Science.

Creswell, J. W. (2007). *Qualitative inquiry & research design* (2nd ed.). Thousand Oaks CA: Sage.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches.* Thousand Oaks, CA: Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* St. Leonards, Australia: Allen & Unwin.

Crowley, S. (2014). (Ed.). *Challenging professional learning*. New York, NY: Routledge.

D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care, 19*(1), 8–20. doi:10.1080/13561820500081604

Dall'Alba, G. (2009). *Learning to be professionals.* Dordrecht, Netherlands: Springer.

De Vries, D. (2012). *Therapists' value of interprofessional collaboration*. (Doctoral thesis, Central Michigan University). Retrieved from http://search.proquest.com/docview /1143223075

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2008). *Strategies of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The SAGE handbook of qualitative research* (4th ed.). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2013). *The landscape of qualitative research* (4th ed.). Thousand Oaks, CA: Sage.

Dombeck, M. (1997). Professional personhood: Training, territoriality and tolerance. *Journal of Interprofessional Care, 11*(1), 9–21. Retrieved from http://www.jripe.org/index.php /journal

Douglas, F. (2010). Sustaining the self: Implications for the development of career practitioners' professional identity. *Australian Journal of Career Development, 19*(3), 24–32. Retrieved from http://www.uk.sagepub.com/journals/Journal202148

Duchscher, J. E. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing 65*(5), 1103–1113. doi:10.1111/j.1365-2648.2008.04898.

Edwards, A. (2010). *Being an expert professional practitioner: The relational turn in expertise.* Dordrecht, Netherlands: Springer. doi:10.1007/978-90-481-3969-9

Edwards, A., Lunt, I. and Stamou, E. (2010). Inter-professional work and expertise: New roles at the boundaries of schools. *British Educational Research Journal, 36* (1), 27–45. doi:10.1080/01411920902834134

Ellerton, M., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3 months. *The Journal of Continuing Education in Nursing, 34*(3), 103–107. Retrieved from http://www.jcenonline.com

Ellis, R. J. (2009). "Problems may cut right across the borders": Why we cannot do without interdisciplinarity. In B. Chandramohan & S. Fellows (Eds.), *Interdisciplinary learning and teaching in higher education: Theory and practice* (pp. 3–17). New York, NY: Routledge.

Engel, J., & Prentice, D. (2013). The ethics of interprofessional collaboration. *Nursing Ethics, 20*(4), 426–435. doi:10.1177/0969733012468466

Eraut, M. (1994). *Developing professional knowledge and competence*. London, England: Routledge-Falmer.

Evans, K. (2001). Expectations of newly qualified nurses. *Nursing Standard, 15*(41), 33–38. Retrieved from http://nursingstandard.rcnpublishing.co.uk

Frenk, J., Chen, L., Bhutta, Z., Cohen, J., Crisp, N., Evans, T., ... Serwadda, D. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet Commissions, 376,* 1923–1958. doi:10.1590 /S1726-46342011000200023

Fenwick, J., Hammond, A., Raymond, J., Smith, R., Gray, J., Foureur, M., … Symon, A. (2012). Surviving, not thriving: A qualitative study of newly qualified midwives' experience of their transition to practice. *Journal of Clinical Nursing, 21*, 2054-2063. doi:10.1111/j.1365-2702.2012.04090.x

Flyvberg, B. (2011). Case study. In N. K. Denzin & Y. S. Lincoln (Eds.). *The SAGE handbook of qualitative research* (4th ed., pp. 301-317). Thousand Oaks, CA: Sage.

Fosnot, C. T. (Ed.). (2005). *Constructivism: Theory, perspectives and practice* (2nd ed.). New York, NY: Teachers College Press, Columbia University.

Fournier, V. (2000). Boundary work and the (un)making of the professions. In N. Malin (Ed.), *Professions, boundaries and the workplace* (pp. 67-87). London, England: Routledge.

Freeth, D., Hammick, M., Reeves. S., Koppel, I., & Barr, H. (2004). *Effective Interprofessional education: Development, delivery & evaluation*. Oxford, England: Blackwell.

Freidson, E. (2001). *Professionalism: The third logic*. Chicago, IL: University of Chicago Press.

Gadamer, H. G. (1991). *Gadamer and hermeneutics.* New York, NY: Routledge.

Gadamer, H. G. (1995). *Truth and method* (2nd Rev. ed.). New York, NY: Continuum.

Gieryn, T. F. (1983). Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review, 48*(6), 781–795. Retrieved from http://asr.sagepub.com

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*(1), 10–28. Retrieved from http://www.contemporarynurse.com

Green, B. (Ed.). (2009). *Understanding and researching professional practice.* Rotterdam, The Netherlands: Sense.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care, 1*, 188–196. doi:10.1080/13561820500081745

Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: A long and winding road. *Medical Education, 35*, 867–875. doi:10.1046/j.1365-2923.2001.00919.x

Hall, P., Weaver, L., & Grassau, P. A. (2013). Theories, relationships and interprofessionalism: Learning to weave. *Journal of Interprofessional Care, 27*, 73-80. doi: 10.3109/13561820.2012.736889

Hammick, M., Freeth, D., Copperman, J., & Goodsman, D. (2009). *Being interprofessional*. Cambridge, England: Polity Press.

Headrick, L., Wilcock, P., & Batalden, P. (1998). Interprofessional working and continuing medical education. *British Medical Journal, 316,* 771–774. Retrieved from http://www.bmj.com

Health Practitioners Competence Assurance Act 2003. Retrieved from http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Health Workforce Advisory Committee (2003). *The New Zealand health workforce future directions – Recommendations to the Minister of health 2003*. Retrieved December 7, 2013 from https://www.health.govt.nz/system/files/documents/publications/hwac-future-directions-recommendations.pdf

Health Workforce New Zealand. (2013). *Health workforce New Zealand: Annual plan 2012–2103.* Retrieved December 10, 2013, from http://healthworkforce.health.govt.nz/system /files/documents/publications/hwnz-annual-plan-2012-2013.docx

Hean, S., Macleod-Clark, J., Adams, K., & Humphris, D. (2006). Will opposites attract? Similarities and differences in students' perceptions of the stereotype profiles of other health and social care professional groups. *Journal of Interprofessional Care, 20*(2), 162–181. doi:10.1080/13561820600646546

Higgs, J., Horsfall, D., & Grace, S. (Eds.). (2009). *Writing qualitative research on practice*. Rotterdam, The Netherlands: Sense.

Hilton, S., & Southgate, L. (2007). Professionalism in medical education. *Teaching and Teacher Education, 23*, 265–279. doi:10.1016/j.tate.2006.12.024

Hind, M., Norman, I., Cooper, S, Gill, E., Hilton, R., Judd, P., & Jones, S. C. (2003). Interprofessional perceptions of health care students. *Journal of Interprofessional Care, 17*(1), 21–34. doi:10.1080/1356182021000044120

Hobman, E. V., & Bordia, P. (2006). The role of team identification in the dissimilarity-conflict relationship. *Group Processes Intergroup Relations, 9*(4), 483–507. doi:10.1177/1368430206067559

Hoerger, M., Quirk, S., Lucas, R., & Carr, T. (2010). Cognitive determinants of affective forecasting errors. *Judgment and Decision Making, 5*, 365-373. Retrieved from http://journal.sjdm.org/vol5.5.html

Holley, K. A. (2009). *Understanding interdisciplinary challenges and opportunities in higher education*. San Francisco, CA: Jossey-Bass.

Holtman, M. C., Frost, J. S., Hammer, D. P., McGuinn, K., & Nunez, L. M. (2011). Interprofessional professionalism: Linking professionalism and interprofessional care. *Journal of Interprofessional Care, 25*, 383–385. doi:10.3109/13561820.2011.588350

Horsburgh, M., Perkins, R., Coyle, B., & Degeling, P. (2006). The professional subcultures of students entering medicine, nursing and pharmacy programmes. *Journal of Interprofessional Care, 20*(4), 425–431. doi:10.1080/13561820600805233

Johnson, M., Cowin, L. S., Wilson, I., & Young, H. (2012). Professional identity and nursing: Contemporary theoretical developments and future research challenges. *International Nursing Review, 59*, 562–569. doi:10.1111/j.1466-7657.2012.01013.x

Jones, I. F. (2007). The theory of boundaries: Impact on interprofessional working. *Journal of Interprofessional Care, 21*(3), 355–357. doi:10.1080/13561820701257383

Jonnaert, P., Masciotra, D., Barrette, J., Morel, D., & Mane, Y. (2007). From competence in the curriculum to competence in action. *Prospects, XXXVII*(2), 187–203. doi:10.1007 /s11125-007-9027-9

Kelly, S., & Courts, N. (2007). The professional self-concept of new graduate nurses. *Nurse Education in Practice, 7*, 332–337. doi:10.1016/j.nepr.2006.10.004

Kemmis, S. (2009). Understanding professional practice: A synoptic framework. In B. Green (Ed.), *Understanding and researching professional practice* (pp. 19–39). Rotterdam, Netherlands. Sense.

King, G., Shaw, L., Orchard, C. A., & Miller, S. (2010). The interprofessional socialization and valuing scale: A tool for evaluating the shift toward collaborative care approaches in health care settings. *Work, 35*, 77–85. doi:10.3233/WOR-2010-0959

Kreber, C. (Ed.). (2009). *The university and its disciplines: Teaching and learning within and beyond disciplinary boundaries*. New York, NY: Routledge.

Kvale, S. (2007). *Doing interviews*. London, England. Sage.

Kvale, S., & Brinkman, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA: Sage.

Larson, M. S. (1977). *The rise of professionalism.* Berkley, CA: University of California Press.

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge, England: University Press.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 21–35. Retrieved from http://www.ualberta.ca/~ijqm/

Lee, A., & Dunston, R. (2011). Practice, learning and change: Towards a re-theorisation of professional education. *Teaching in Higher Education, 16*(5), 483–494. doi:10.1080 /13562517.2011.580840

Lincoln, Y. S., & Guba, E. G. (2013). *The constructivist credo*. Walnut Creek, CA: Left Coast Press.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2013). Paradigmatic controversies, contradictions, and emerging confluences revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (4th ed., pp. 199–266). Thousand Oaks, CA: Sage.

Macdonald, K. M. (1995). *The sociology of the professions*. London, England: Sage.

MacDonald, M. B., Bally, J. M., Ferguson, L. M., Murray, B. L., Fowler-Kerry, S. E., & Anonson, J. M. S. (2010). Knowledge of the professional role of others: A key interprofessional competency. *Nurse Education in Practice, 10*, 238–242. doi:10.1016 /j.nepr.2009.11.012

Manley, K., Hills, V., & Marriot, S. (2011). Person-centred care: Principle of nursing practice D. *Nursing Standard*, *25*(31), 35-37. Retrieved from http://dx.doi.org/10.7748/ns2011.04.25.31.35.c8431

Margalit, R., Thompson, S., Visovsky, C., Geske, J., Collier, D., Birk, T., & Paulman, P. (2009). From professional silos to interprofessional education: Campuswide focus on quality of care. *Quality Management Health Care, 18*(3), 165–173. doi:10.1097 /QMH.0b013e3181aea20d

Masterton, A. (2002). Cross-boundary working: A macro-political analysis of the impact on professional roles. *Journal of Clinical Nursing, 11*, 331–339. doi:10.1046/j.1365-2702.2002.00604.x

Maxwell, J. A. (2012). *A realist approach for qualitative research*. Thousand Oaks, CA: Sage

McCallin, A. (2001). Interdisciplinary practice – A matter of teamwork: An integrated literature review. *Journal of Clinical Nursing, 10*, 419–428. doi:10.1046/j.1365-2702.2001.00495.x

McCallin, A. (2005). Interprofessional practice: Learning how to collaborate. *Contemporary Nurse, 20*, 28–37. Retrieved from http://www.contemporarynurse.com

McCallin, A., & McCallin, M. (2009). Factors influencing teamwork and strategies to facilitate successful collaborative teamwork. *New Zealand Journal of Physiotherapy, 37*(2), 61–67. Retrieved from http://www.physiotherapy.org.nz

McKimm, J., Sheehan, D., Poole, P, Barrow, M., Dockerty, J., Wilkinson, T. J., & Wearn, A. (2010). Interprofessional learning in medical education in New Zealand. *The New Zealand Medical Journal, 123*(1320), 96–106. Retrieved from http://journal.nzma.org.nz/journal/123-1320/4270/

McNeil, K. A., Mitchel, R. J., & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review, 22*(3), 291–307. Retrieved from http://hsr.e-contentmanagement.com

McPherson, K., Headrick, L., & Moss, F. (2001). Working and learning together: Good quality care depends on it, but how can we achieve it? *Quality in Health Care, 10*(Suppl. 2), ii46–ii53. doi:10.1136/qhc.0100046

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Miers, M. E., Rickaby, C. E., & Clarke, B. A. (2009). Learning to work together: Health and social care students' learning from interprofessional modules. *Assessment and Evaluation in Higher Education, 34*(6), 673–671. doi:10.1080/0260293080247185

Miller, J. L. (2004). Level of RN educational preparation: Its impact on collaboration and the relationship between collaboration and professional identity. *Canadian Journal of Nursing Research, 36*(2), 132–147. Retrieved from http://cjnr.mcgill.ca

Ministry of Health. (2013a). *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016*. Retrieved from http://www.health.govt.nz/system/files/documents/publications/health-loss-in-new-zealand-final.pdf

Ministry of Health. (2013b). *Framing the future: Proposal paper from the Health Science and Technical Workforces Working Group (Phase 2) June 2013*. Retrieved from http://www.health.govt.nz/system/files/documents/pages/framing-the-future-phasetwo-report.docx

Mitchell, R. J., Parker, V., & Giles, M. (2011). When do interprofessional teams succeed? Investigating the moderating roles of team and professional identity in interprofessional effectiveness. *Human Relations, 64,* 1321–1343. doi:10.1177/0018726711416872

Mooney, M. (2007). Facing registration: The expectations and the unexpected. *Nursing Education Today, 27,* 840-847. doi:10.1016/j.nedt.2006.11.003

Morrow, S. (2009). New graduate transitions: Leaving the nest, joining the flight. *Journal of Nursing Management, 17*, 278–287. doi:10.1111/j.1365-2834.2008.00886.x

Nancarrow, S. A., & Borthwick, A. M. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness, 27*(7), 897–919. doi:10.1111 /j.1467-9566.2005.00463.x

O'Brien, D., McCallin, A., & Bassett, S. (2013). Student perceptions of an interprofessional clinical experience at a university clinic. *New Zealand Journal of Physiotherapy, 41*(3), 81–87. Retrieved from http://www.physiotherapy.org.nz

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pecukonis, E., Doyle, O., & Bliss, D. L. (2008). Reducing barriers to interprofessional training: Promoting interprofessional cultural competence. *Journal of Interprofessional Care, 22*(4), 417–428. doi:10.1080/13561820802190442

Perkins, R. J., Horsburgh, M., & Coyle, B. (2008). Attitudes, beliefs and values of students in undergraduate medical, nursing and pharmacy programs. *Australian Health Review, 32*(2), 252–255. Retrieved from http://www.publish.csiro.au

Petrie, H. G. (1976). Do you see what I see? The epistemology of interdisciplinary inquiry. *Educational Researcher, 5*(9), 9–15. doi:10.3102/0013189X005002009

Pollard, K., Miers, M. E., Gilchrist, M., & Sayers, A. (2006). A comparison of interprofessional perceptions and working relationships among health and social care students: The results of a 3-year intervention. *Health and Social Care in the Community, 14*(6), 541–552. doi:10.1111/j.1365-2524.2006.00642.x

Professions Australia. (1997). *Ethics resource centre: Definition of a profession*. Retrieved November 15, 2013, from http://www.professions.com.au/definitionprofession.html

Radnor, H. (2002). *Researching your professional practice: Doing interpretive research*. Buckingham, England: Open University Press.

Reeves, S., Rice, K., Conn, L. G., Miller, K., Zenaszchuk, C., & Zwarenstein, M. (2009). Interprofessional interaction, negotiation and non-negotiation on general internal medicine wards. *Journal of Interprofessional Care, 23*(6), 633–645. doi:10.3109 /13561820902886295

Reeves, S., Lewin, S., Espin, S., & Zwarenstein, M. (2010). *Interprofessional teamwork for health and social care*. Oxford, England. Wiley-Blackwell.

Reeves, S., Perrier, L., Goldman, J., Freeth, D., & Zwarenstein, M. (2013). Interprofessional education: Effects on professional practice and healthcare outcomes (update) (Review). The Cochrane Collaboration. John Wiley & Sons. http://www.thecochranelibrary.com

Robertson, L. J., & Griffiths, S. (2009). Graduates' reflections on their preparation for practice. *British Journal of Occupational Therapy, 72*(3), 125–132. Retrieved from http://www.cot.co.uk/british-journal-bjot/british-journal-occupational-therapy

Sargeant, J., Loney, E., & Murphy, G. (2008). Effective interprofessional teams: "Contact is not enough" to build a team. *Journal of Continuing Education in the Health Professions, 28*(4), 228–234. doi:10.1002/chp

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. London, England. Ashgate.

Schwandt, T. A. (2007). *The Sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage.

Schwartz, L., Wright, D., & Lavoie-Tremblay, M. (2011). New nurses' experience of their role within interprofessional health care teams in mental health. *Archives of Psychiatric Nursing, 25*(3), 153–163. doi:10.1016/j.apnu.2010.08.001

Sharkey, P. (2001). Hermeneutic phenomenology. In: R. Barnacle (Ed.), *Phenomenology* (pp. 16–37). Melbourne, Australia: RMIT University Press.

Sheehan, D., Wilkinson, T. J., & Bowie, E. (2012). Becoming a practitioner: Workplace learning during the junior doctor's first year. *Medical Teacher, 34*, 936-945. doi: 10.3109/0142159X.2012.71784

Shulman, L. S. (2005). Signature pedagogies in the professions. *Daedalus*, 52–60. Retrieved from http://www.mitpressjournals.org/loi/daed

Skorikov, V. B., & Vondracek, F. W. (2011). Occupational identity. In S. J. Schwartz, K. Luyckx, & V. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 693–715). New York, NY: Springer. doi:10.1007/978-1-4419-7988-9.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, England: Sage.

Stake, R. E. (1995). *The art of case study research.* Thousand Oaks, CA: Sage.

Stake, R. E. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), The Sage handbook of qualitative research (3rd ed., pp. 443–466). Thousand Oaks, CA: Sage.

Stake, R. E. (2010). *Qualitative research: Studying how things work*. New York, NY: Guilford Press.

Star, S. L. (1988). The structure of ill-structured solutions: Boundary objects and heterogenous distributed problem solving. In L. Gasser & M. Huhns (Eds.), *Distributed artificial intelligence* (pp. 37–54). San Mateo, CA: Morgan Kaufmann.

Star, S. L. (2010). This is not a boundary object: Reflections on the origin of a concept. *Science, Technology, & Human Values, 35*, 601–617. doi:10.1177/0162243910377624

Styhre, A. (2011). *Knowledge sharing in professions: Roles and identities in expert communities.* Surrey, England: Gowe Applied Business Research.

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role clarification and effective communication as core competencies for collaborative care. *Journal of Interprofessional Care, 23*(1), 41–51. doi:10.1080/13561820802338579

Schwandt, T. A. (2005). On modeling our understanding of the practice fields. *Pedagogy, Culture and Society, 13*(3),313-332. doi:10.1080/14681360500200231

Tajfel, H. (1981). *Human groups & social categories: Studies in social psychology*. Cambridge, England: Cambridge University Press.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup conflict. In S. Worchel & L. Austin (Eds.), *Psychology of intergroup relations* (pp. 7–24). Chicago, IL: Nelson-Hall.

Thomas, H., & Pattison, S. (2010). Health care professions and their changing values: Pulling professions together. In S. Pattison, B. Hannigan, R. Pill, & H. Thomas (Eds.), *Emerging values in health care: The challenge for professionals* (pp. 229–245). London, England: Jessica Kingsley.

Thistlethwaite, J. E., Forman, D., Matthews, L. R., Rogers, G. D., Steketee, C., & Yassine, T. (2014). Competencies and frameworks in interprofessional education: A comparaitve analysis. *Academic Medicine, 89*(6), 869-875. doi: 10.1097/ACM.000000000000249

Timmons, S., & East, L. (2011). Uniforms, status and professional boundaries in hospital. *Sociology of Health & Illness, 33*(7), 1035–1049. doi:10.1111/j.1467-9566.2011.01357

Timmons, S., & Tanner, J. (2004). A disputed occupational boundary: Operating theatre nurses and operating department practitioners. *Sociology of Health and Illness, 26*(5), 645–660. doi:10.1111/j.0141-9889.2004.00409.x

Toal-Sullivan, D. (2006). New graduates' experiences of learning to practice occupational therapy. *British Journal of Occupational Therapy, 69*(1), 513–524. Retrieved from http://www.cot.co.uk/british-journal-bjot/british-journal-occupational-therapy

Tryssenaar. J., & Perkins, J. (2001). From student to therapist: Exploring the first year of practice. *American Journal of Occupational Therapy, 55*(1), 19–27. doi:10.5014 /ajot.55.1.19

van Knippenberg, D., De Dreu, C. K. W., & Homan, A. C. (2004). Work group diversity and group performance: An integrative model and research agenda. *Journal of Applied Psychology*, 89, 1008–1022. doi:10.1037/0021-9010.89.6.1008

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. Ontario, Canada: Althouse Press.

Verma, S., Broers, T., Paterson, M., Schroder, C., Medves, J. M., & Morrison, C. (2009). Core competencies: The next generation of a common framework for multiple professions. *Journal of Allied Health, 38*(1), 47–53. Retrieved from http://www.asahp.org /journal_ah.htm

Vignoles, V. L., Schwartz, S. J., & Luyckx, K. (2013). Introduction: Towards an integrative view of identity. In S. J. Schwartz, K. Luyckx, & V. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 1–27). New York, NY: Springer.

Watling, R. (2004). Helping them out: The role of teachers and healthcare professionals in the exclusion of pupils with special educational needs. *Emotional and Behavioural Difficulties, 9*(1), 8–27. doi:10.1177/1363275204038258

Webster-Wright, A. (2010). *Authentic professional learning: Making a difference through learning at work*. London, England: Springer. doi:10.1007/978-90-481-3947-7 978-90-481-3946-0

Weller, J. (2012). Shedding new light on tribalism in health care. *Medical Education, 46,* 132–142. doi:10.1111/j.1365-2923.2011.04178.x

Weller, J., Barrow, M., & Gasquoine, S. (2011). Interprofessional collaboration among junior doctors and nurses in the hospital setting. *Medical Education, 45*, 478-487. doi:10.1111 /j.1365-2923.2010.03919.x

Weller, J., Thwaites, J., Bhoopatkar, H., & Hazell, W. (2010). Are doctors team players, and do they need to be? *The New Zealand Medical Journal, 123*(1310), 109–117. Retrieved from http://www.nzma.org.nz/journal

Wenger, E. (1998). *Communities of practice: Learning, meaning and identity*. Cambridge, England: Cambridge University Press.

Whitehead, B., & Holmes, D. (2011). Are newly qualified nurses prepared for practice? *Nursing Times, 107*(19/20), 20–23. Retrieved from http://www.nursingtimes.net

World Health Organization. (2006). *Working together for health*: *The world health report 2006.* Retrieved from http://www.who.int/whr/2006/whr06_en.pdf?ua=1

World Health Organization. (2009). *Global health risks: Mortality and burden of disease attributable to selected major risks.* Retrieved from http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report _full.pdf

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice.* Retrieved from http://whqlibdoc.who.int/hq/2010 /WHO_HRH_HPN_10.3_eng.pdf

World Health Organization. (2013). *Protecting health from climate change: Vulnerability and adaptation assessment.* Retrieved from http://www.who.int/globalchange/publications/reports/9789241598880/en/

Wright, A., & Lindqvist, S. (2008). The development, outline and evaluation of the second level of an interprofessional learning programme – Listening to the students. *Journal of Interprofessional Care, 22*(5), 475–487. doi:10.1080/13561820802210968

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: Sage.

Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage.

Zwarenstein, M., & Reeves, S. (2006). Knowledge translation and interprofessional collaboration: Where the rubber of evidence-based care hits the road of teamwork. *The Journal of Continuing Education in the Health Professions, 26*(1), 46–54. doi:10.1002 /chp.50

Appendices

Appendix A: AUTEC Committee approval letter

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Dale Furbish
From: **Dr Rosemary Godbold** Executive Secretary, AUTEC
Date: 10 October 2011
Subject: Ethics Application Number 11/259 **Intersecting professional boundaries: An exploratory study of emerging health practitioners' understanding of professional practice in an interprofessional context.**

Dear Dale

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 26 September 2011 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 31 October 2011.

Your ethics application is approved for a period of three years until 7 October 2014.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 7 October 2014;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 7 October 2014 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902.

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Jane Morgan

From the desk of …   Private Bag 92006, Auckland 1142   Tel: 64 9 921 9999
Dr Rosemary Godbold   New Zealand   ext 8860
Executive Secretary   E-mail: ethics@aut.ac.nz   Fax: 64 9 921 9925
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Appendix B: Participant information sheet

Participant Information Sheet

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Date Information Sheet Produced: 10 October 2011

Project Title

Intersecting professional boundaries: An exploratory study of emerging health practitioners' understanding of professional practice in an interprofessional context.

An invitation

Hi, I'm Jane Morgan and am currently a Doctoral student at Auckland University of Technology (AUT). I would like to invite you to participate in my research related to professional identity and working in collaborative health care practices. The study will focus on the first year of graduate practice; how new graduates work in their chosen field of health-care and how they work with other health professions in providing effective health-care services.

What is the purpose of this research?

The aim of this research is to explore how new graduates understand their work as health practitioners. I am interested in studying the development of professional identity in the first year of graduate practice, and how this relates to working with other health professions. This research project is part of my Doctoral studies, with successful completion of the project leading to the award of an Ed.D. Findings from the research may be used to help prepare students with graduate skills they need to work collaboratively with other health professions. Research findings may also be presented at conferences and used for publications.

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

You have been invited to participate in this research because you are completing a BHSc degree at the end of 2011 and will be commencing work as a health practitioner in 2012. Further to this, you are graduating into Midwifery, Nursing, Occupational Therapy, Oral Health, Podiatry or Physiotherapy. You have secured employment in a related field of health care practice, in the greater Auckland area, in 2012. You are also over the age of 20 years. Following my personal contact with each health discipline to introduce and discuss the research aims and purpose, or in response to the advertisement, you have indicated an interest in participation. Participation is voluntary and you may choose to withdraw from the study at any stage during the year from 2011-2012.

What will happen in this research?

Your participation in this research will involve me interviewing you four times over the next year. This includes an initial interview before you graduate in 2011, and then a further interview three months after you have started working as a health practitioner in your chosen field. Midway through next year (2012) I will ask you to join one focus group interview with other participants to discuss your work as health practitioners in collaborative situations. A final individual interview will be conducted towards the end of your first year as a health care practitioner. Each interview will take approximately one hour, requiring a total of four hours over the year from November 2011-2012.

As I will not be physically observing what you do in your work and how you interact with members of your own and other health professions, I am asking you to provide informal written accounts, each month, of your work in providing health care services. This may include description of specific situations, your involvement and reflection on how you responded. I would like you to journal these accounts and send them to me on a monthly basis during the year (from when you start working until November 2012), to inform me of your working environment and how you interact with other health practitioners in that

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environment. I am providing guidelines to help you construct your written accounts and anticipate you spending no more than half an hour each month in this completing each written account. All details regarding your identity or your work place will remain confidential, although your health discipline may be identified in the final written report.

Individual interviews may be conducted at AUT, or at your workplace if more convenient for you. Focus group interviews will take place at AUT, North Shore Campus. I will be conducting all interviews, where I will audiotape your responses to semi-structured questions that relate to the research purpose. Audiotape recordings will be transcribed into text for later analysis. Throughout the research process your identity will remain confidential, through the use of pseudonyms (false names) to protect your privacy. Following each interview you will receive a transcribed copy to check for accuracy before I begin the process of data analysis. At this time you may want to add further information to the transcript before replying. If you do not reply within ten days of the transcript being sent to you, I will assume your acceptance of the transcript as a true and accurate account of your interview, and I'll commence data analysis. All data collected will be used only for the purpose of this study.

What are the discomforts and risks?

You may feel discomfort at being interviewed, and your thoughts being audiotaped. Talking about aspects of your work as a new practitioner may also be unsettling. However I will be conducting interviews in a friendly manner, respecting and valuing your contribution. Any information you provide, oral and written, will be treated confidentially and your identity will be protected at all times.

How will these discomforts and risks be alleviated?

You can choose whether you answer questions during interviews, you can stop an interview and you can withdraw from the research at any time. Counselling is available if requested, through AUT Counselling Services, at no cost to you for up to three sessions.

What are the benefits?

As a participant in this study you may benefit from focusing on your work as a health professional during your first year of graduate practice; how you work in a specified field and through collaboration with other health professions. As the researcher I may benefit from this research through receiving an EdD and through contribution to knowledge in the area of interest.

How will my privacy be protected?

Your identity and any details of your workplace will remain confidential at all times during and following this research. This will be achieved through safe storage of your personal details and consent forms, kept separate to research data. In addition, your name will be replaced with a pseudonym following transcription of all interviews and upon my receiving your reflective accounts. You may choose your own pseudonym. Throughout the research project all email communication with you will be copied and transferred to a secure external hard drive that only I have access to. Inbox copies will be deleted from my AUT address, to ensure your privacy.

What are the costs of participating in this research?

In terms of time, I am asking you to participate in four interviews (three individual and one focus group) from October 2011 to November 2012. Each interview will take approximately one hour.

The phases of data collection are:

- October-November 2011: Phase one (Interview = one hour)
- March-April 2012: Phase two (Interview = one hour)
- August 2012: Phase three (Focus group interview = one hour)
- October-November 2012: Phase four (Interview = one hour)

If you have time, I am also asking you to reflect on and informally document accounts of professional and collaborative working situations you have experienced during the preceding month. I suggest you spend a maximum of half an hour a month on your written account. This documentation can be emailed to me or sent via post, at the end of each month.

What opportunity do I have to consider this invitation?

If you would like further information regarding the study, please email or call me (details provided

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below). Please consider this invitation and if you would like to participate in this research, return signed consent forms within ten days of receiving the information pack. Your participation throughout this study is voluntary and you can choose to withdraw at any time prior to completion of the data collection (November 2012). Written withdrawal from the study will be required and all data from you would then be removed and destroyed, with no adverse consequences for you.

How do I agree to participate in this research?

If you agree to participate, please complete and send the attached consent forms (for interviews and focus group) to me via email or by post within ten days of receiving your information pack. If sent by email, I will provide a paper copy for your signature when we meet for the first interview. Once I receive your signed consent forms I will contact you regarding a convenient meeting time for your initial interview (Phase one).

Will I receive feedback on the results of this research?

If you would like to receive feedback on the results of this research, you can indicate this on the consent forms. You may also verbally indicate an interest in receiving results of the research at any time during the study. I will forward information to you, through email or via post, once the research is completed.

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, Dr. Dale Furbish, dale.furbish@aut.ac.nz, 09 9219999ext 5557.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz*, 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Jane Morgan, Rm. AF409, Faculty of Health and Environmental Science, Auckland University of Technology. Email: jane.morgan@aut.ac.nz, Telephone: 921 9999 ext 7023

Project Supervisor Contact Details:

Dr. Dale Furbish, Rm. AR406, Faculty of Applied Humanities, Auckland University of Technology. Email: dale.furbish@aut.ac.nz, Telephone: 09 9219999 ext 5557.

Approved by the Auckland University of Technology Ethics Committee on *10 October 2011*. AUTEC Reference number *11/259.*

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Appendix C: Consent form for interviews

Consent Form: Interviews

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project title: **Intersecting professional boundaries: An exploratory study of emerging health practitioners' understanding of professional practice in an interprofessional context.**

Project Supervisor: **Dr Dale Furbish**

Researcher: **Jane Morgan**

○ I have read and understood the information provided about this research project in the Information Sheet dated 10 October 2011.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand interviews will be audio-taped and transcribed.

○ I consent to the use of my written accounts in the research study (please tick one): YesO NoO

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one): YesO NoO

Participant's signature: ....…………………………………………

Participant's name: ....…………………………………………

BHSc Qualification : …………………………………………………………………………….

Participant's Contact Details :

Email : ………………………………………………………………………………….

Mobile : ……………………………………………………………………………….

Date: ……………………………

Approved by the Auckland University of Technology Ethics Committee on 10 October 2011 AUTEC Reference number 11/259

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

Appendix D: Consent form for focus group

Consent Form: Focus group

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project title: **Intersecting professional boundaries: An exploratory study of emerging health practitioners' understanding of professional practice in an interprofessional context.**

Project Supervisor: **Dr. Dale Furbish**

Researcher: **Jane Morgan**

O   I have read and understood the information provided about this research project in the Information Sheet dated 10 October 2011.

O   I have had an opportunity to ask questions and to have them answered.

O   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.

O   I understand the focus group will be audio-taped and transcribed.

O   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

O   If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

O   I agree to take part in this research.

O   I wish to receive a copy of the report from the research (please tick one): YesO   NoO

Participant's signature: ....……………………………………………

Participant's name: ....……………………………………………

BHSc Qualification :   ………………………………………………………………………….

Participant's Contact Details :

Email : ………………………………………………………………………………………

Mobile : ……………………………………………………………………………………..

Date: …………………………….

Approved by the Auckland University of Technology Ethics Committee on 10 October 2011 AUTEC Reference number 11/259

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

Appendix E: Electronic advertisement

Developing professional identity in health-care practices

Hi, I'm Jane Morgan and am currently a Doctoral student here at AUT. I would like to invite you to participate in my research related to professional identity and working in collaborative health care practices. The study will focus on the first year of graduate practice; how new graduates work in their chosen field of health-care and also their work with other health professions in providing effective health-care services.

- Are you in the final semester of a BHSc in either Midwifery, Nursing, Occupational Therapy, Oral Health, Podiatry or Physiotherapy?
- Do you anticipate working in health-care practice following graduation?
- Are you planning to work for the full year, in New Zealand, in 2012?
- Are you over 20 years of age?

If you answer 'yes' to each of the above questions, and are interested in participating in a research project over the next year (2011-2012) please contact me at jane.morgan@aut.ac.nz or phone: (09)99219999 #7023 for further information. An information pack will be sent on request.

Approved by the Auckland University of Technology Ethics Committee on *10 October 2011*. AUTEC Reference number *11/259*.

Appendix F: Phase one guiding questions

Phase one (First interview)
Conducted prior to participants graduating from undergraduate study, with the focus on providing baseline data related to participants' perceptions of professionalism, identity and collaboration between health practitioners:

Generally

- What does it mean to be a professional?

Q. What does the phrase 'being a professional' mean?

Q. Examples of professional behaviour observed in others, displayed by yourself.

More specifically

- What does working as a health professional mean?

Q. Define characteristics of a 'health professional' and what this means in terms of working in health care practice. (thinking of role models who exhibit characteristics)

Q. Specific characteristics that you identify with.

Q. Examples of experiences over time, encounters with others and/or activities (academic and clinical) that you have had during undergraduate study that have prepared you for work as a health practitioner in a specified field.

Q. Which examples stand out and why?

A focus on your perceptions of working as a health practitioner in a collaborative context

- What does working collaboratively with other health professionals mean?

Q. During undergraduate years, which other health professions have you worked with, either in academic and/or clinical settings? Elaboration on specific encounters / activities (eg who, where, how, why).

Q. Thinking back, how will these encounters / activities influenced your views of working with other professions once she/he is registered to practice in a specified field?

Appendix G: Phase two guiding questions

Phase two (Second interview)

Following three–four months of graduate clinical practice, this interview will focus on participant's work environment in the preceding months. Important to emphasise that the questions will be similar to those asked in phase one, <u>BUT</u> the emphasis is now on the early months of graduate clinical practice.

Generally:

- What does working as a health professional mean?

  Q.What have the first few months of graduate practice been like, working in a clincial setting as a health practitioner? General description of, and personal interaction in the working environment.

More specific to developing professional identity in a specified field:

  Q. Examples of clinical situations where participant felt she/he is an active member of the (named) profession and why? Adverse examples also and why?

  Q.What does this mean to the participant in terms of being 'part' of the (named) profession?

Focusing on participant perceptions of working as a health practitioner in a collaborative context

- What does working collaboratively with other professions mean?

  Q. What clinical situations have required participant to work with members of other health professions in providing health care services? Examples of activities, including the purpose/s, participant's involvement, interactions, outcome/s?

- How does working with other professions influence participant/s understanding of professionalism and developing professional identity?

  Q. How has working with members of other health professions influenced participant's own professional knowledge and practice?

Appendix H: Phase three focus group guiding questions

Phase three (Focus Group interview)
Following eight months of working in health-care practice participants will be asked to take part in a focus group interview. The aim of the focus group interview is to elicit general discussion of collaborative practices among the participants and the relationship between working in a specified profession and collaborating with other health professions. Focus groups will be made up of six-ten participants with a mix of the six health disciplines represented in this study.

The following questions are indicative rather than fixed. Three broad questions may be asked sequentially, providing time for discussion and elaboration by participants.

The first question will focus on participants' perceptions of working as a health practitioner in a collaborative context.

- What does working collaboratively with other professions mean?

  Q. In what ways have participants been working with members of other health professions in providing health care services? Examples of activities, including the purpose/s, participant's involvement, interactions, outcome/s?

The second question will focus on perceptions of professionalism and collaborative practice.

- How does working with other professions influence participants' understanding of professionalism and developing professional identity?

  Q. How has working with members of other health professions, in providing health care services, influenced participants' professional knowledge and practice?

The final question will focus on perceptions of collaborative practice and professional identity.

  Q. How has working with members of other health professions influenced participants' working within their own health field?

Appendix I: Phase four guiding questions

Phase four guiding questions

Towards completion of the first year of graduate practice, questions will draw on findings from earlier analysis, in relation to the previously asked questions. The focus of this interview will be on how the first year of graduate practice has shaped the development and understanding of professionalism, identity and collaboration in health care practice.

- How has working with other professions influenced your evolving **identity in your chosen health profession?** Examples

- How has collaborative practice with other professions influenced your **understanding of professionalism** in a health care context? Examples

Optional
- At the conclusion of your graduate year, what does it mean to be **a professional**?

    - Generally?

    - Specifically in a health-allied health context?

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Appendix J: Counselling support memorandum

MEMORANDUM

TO   Jane Morgan

FROM   ██████████

SUBJECT Psychological support for research participants

DATE   16th July 2011

Dear Jane

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

"Intersecting interprofessional boundaries: An exploratory study of emerging health practitioners' understanding of professional practice in an interprofessional context."

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:
- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website:
  http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

██████████

Head of Counselling
Health, Counselling and Wellbeing

Health, Counselling & Wellbeing   **Tel: 09 921 9992**
Private Bag 92006, Auckland 1020
55 Wellesley Street, Auckland.

Appendix K: Confidentiality agreement

Confidentiality Agreement

AUT UNIVERSITY
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Project title: **Intersecting professional boundaries: An exploratory study of emerging health practitioners' understanding of professional practice in an interprofessional context.**

Project Supervisor: **Dr. Dale Furbish**

Researcher: **Jane Morgan**

○ I understand that all the material I will be asked to transcribe is confidential.

○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ....………………………………………………….

Transcriber's name: ....………………………………………………….

Transcriber's Contact Details (if appropriate):

………………………………………………………………………………..

………………………………………………………………………………..

………………………………………………………………………………..

………………………………………………………………………………..

Date:

Project Supervisor's Contact Details:

Dr. Dale Furbish, Rm. AR406, Faculty of Applied Humanities, Auckland University of Technology. Email: dale.furbish@aut.ac.nz, Telephone: 09 9219999 ext 5557.

Approved by the Auckland University of Technology Ethics Committee on 10 October 2011 AUTEC Reference number 11/259

Note: The Transcriber should retain a copy of this form.

This version was last edited on 13 October 2010