

The Impact of Uniprofessional Medical and Nursing Education on the Ability to Practice  
Collaboratively

by

Kiran Veerapen  
M.B., B.S., Punjab University, 1975  
MMEd, University of Dundee, 2008

A Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in Interdisciplinary Studies

© Kiran Veerapen, 2012  
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy  
or other means, without the permission of the author.

## **Supervisory Committee**

The Impact of Uniprofessional Medical and Nursing Education on the Ability to Practice Collaboratively

by

Kiran Veerapen  
M.B., B.S., Punjab University, 1975  
MEd, University of Dundee, 2008

### **Supervisory Committee**

Dr. Mary E. Purkis, (Department of Nursing)  
**Co-Supervisor**

Dr. Oscar G. Casiro, (Division of Medical Sciences)  
**Co-Supervisor**

Dr. W. John C. Walsh, (Department of Educational Psychology and Leadership Studies)  
**Committee Member**

Dr. Geraldine H. Van Gyn, (School of Exercise Science, Physical & Health Education)  
**Committee Member**

## Abstract

### Supervisory Committee

Dr. Mary E. Purkis, (Department of Nursing)

Co-Supervisor

Dr. Oscar G. Casiro, (Division of Medical Sciences)

Co-Supervisor

Dr. W. John C. Walsh, (Department of Educational Psychology and Leadership Studies)

Committee Member

Dr. Geraldine H. Van Gyn, (School of Exercise Science, Physical & Health Education)

Committee Member

Patient centred collaborative practice between nurses and physicians is currently being promoted worldwide. There is increasing evidence that post licensure interprofessional educational interventions improve patient outcomes but similar evidence for pre-licensure interprofessional learning is lacking. The impact of contemporary nursing and medical education on graduates' ability to collaborate in the workplace is also unclear. To address this gap, an interview based qualitative study underpinned by hermeneutic phenomenology and informed by the theoretical lens of social identity was designed. Eleven junior registered nurses and eleven junior residents from a single healthcare jurisdiction each, in Canada and the United Kingdom (UK) were interviewed to explore how the processes that lead to socialization, professional identification and identity formation in professional schools are perceived to influence collaborative teamwork upon graduation. Data were analyzed through iterative naive and thematic interpretations aligned with the hermeneutic process, to arrive at a comprehensive understanding.

The impact of contemporary undergraduate nursing and medical education on the ability to practice collaboratively was found to be obfuscated by internal contradictions and overshadowed by the contingencies and demands of the workplace, during residency and early nursing practice in both locations. In medical schools, the intense socialization

described in literature was replaced by individual reflection and a struggle to maintain work-life balance. Values internalized were of a sense of responsibility and hard work. Students espoused an attitude of collaboration but lacked training in enabling competencies and practical application. Exposure to interprofessional learning and its impact was variable and inconsistent and formal assertions of collaboration were not consistently modeled by faculty. In nursing schools, the value of caring, self-awareness and assertiveness was promoted. Training for collaboration with physicians was largely transactional and teaching about the status of the nurse vis-à-vis the physician was mired in contradictions.

Residents and the nurses could not rely on their experience of professional school as they transited to the workplace. Initiation was frequently precipitous and contingencies of the workplace determined how they acted. For residents the community of clinical practice was fluid and repeatedly new. Both residents and nurses were overwhelmed by unpreparedness, workload, and responsibility and acted to get by and get the job done. Residents learned to preface doing *the best for the patient* and not *compromising patient care*, while nurses became proficient at routine tasks and found fulfilment as *the patient's advocate*. There was a propensity for conflict when unprofessional roles and values collided. In busy wards each group had interdependent but competing priorities which lead to adversarial expressions of unprofessional identity and consequent derogatory out-group stereotyping. In contrast situations demanding urgent focused attention, such as a cardiac arrest, lead to the spontaneous formation of a collaborative team which briefly expressed an interprofessional identity.

Complex cross-generational and gender based interactions were sometimes adversarial and provoked resentment. Consequently junior nurses retreated to derive fulfilment as the patient`s advocate while residents looked forward to collaborating with other health professionals on their own terms, in the future. Neither contemporary professional education nor the hospital environment sustained consistent collaborative practice.

## Table of Contents

Supervisory Committee .....	ii
Abstract .....	iii
Table of Contents .....	vi
List of Tables .....	ix
Acknowledgments.....	x
Dedication .....	xii
Chapter 1 .....	1
Introduction: A Sense of Dissonance.....	1
Chapter 2.....	2
Critical Literature Review: Scanning the Landscape.....	2
Introduction.....	2
Interprofessional collaboration: antecedents and definitions.....	2
Issues that surround collaboration between physicians and nurses. ....	9
The changing landscape of medical and nursing training.....	10
Socialization and the development of professional identity.....	13
Nurse-physician conflict.....	21
Conclusion.....	33
Chapter 3.....	35
The Research Question: A Quest.....	35
Objectives of research.....	35
Purpose of the research.....	35
Chapter 4.....	37
Theoretical Lens and Methodology: From Conception to Execution.....	37
Introduction.....	37
Why study identity and identification?.....	37
The process of identification and the construction of identity.....	39
Construction of professional identity in the workplace.....	46
Perspectives to underpin research.....	48
Qualitative methodology – Hermeneutic phenomenology.....	51
Qualitative interviews and analysis of texts.....	55
The purposive selection of participants.....	61
Researcher’s situatedness.....	66
In preparation.....	68
Along the way.....	70
Rigour and trustworthiness.....	75
Chapter 5.....	77
Interpretation of the Texts: The Lives of the Inhabitants .....	77
Introduction.....	77
Residents’ Stories: Naïve Interpretations.....	79
Residents’ Thematic Interpretation: Unravelling the Text	
Themes, Subthemes and Mega Theme .....	94

Residents' Thematic Interpretation: Unravelling the Text .....	98
Before becoming a medical student.....	98
Understanding the role of the physician.....	98
As a medical student.....	100
Understanding choices.....	100
Identifying with the profession.....	101
Comprehending interprofessional team work and IPL in medical school.....	103
Working as a resident.....	109
Transitioning from a medical student to a resident.....	109
Being overwhelmed by work and its demands.....	114
Working as a resident, with nurses.....	117
Feeling <i>othered</i> by nurses and seeing nurses as the <i>other</i> in turn.....	117
Finding it difficult to communicate with nurses.....	120
Learning to get by.....	122
Understanding the role of power, gender and generation in nurse-physician relationships.....	124
Understanding what makes a team and what doesn't.....	128
Reconciling experiences.....	132
Finding support and identifying with physicians.....	135
Life after residency.....	137
Looking ahead.....	137
Mega theme.....	141
Negotiating an identity to live with while getting the job done.....	141
Nurses' Stories: Naïve Interpretations.....	145
Nurses' Thematic Interpretation: Unravelling the Text	
Themes, Subthemes and Mega Theme .....	160
Nurses' Thematic Interpretation: Unravelling the Text.....	163
Before becoming a nursing student.....	163
Seeing nursing as caring.....	163
As a nursing student.....	164
Preparing to become a nurse.....	164
Working as a nurse.....	166
Being new.....	166
Finding a role and enacting it.....	169
Dealing with the structures at work.....	171
Working as a nurse, with medical staff.....	175
With residents: wishing to work together as equals.....	175
Coming up against barriers in dealing with consultants.....	177
Making sense of intersections in nursing, medicine generation and gender.....	181
Looking ahead.....	185
Reconstructing identity.....	185
Mega theme.....	188
Reconciling professional fulfilment.....	188
Chapter 6.....	190
Comprehensive Understanding: Arriving and Returning .....	190
Introduction.....	190

Congruence of naïve and thematic interpretations.....	190
The data and the research question. ....	191
Professional school: self and the other.....	192
The workplace: self and the other.....	202
Conclusion .....	212
Chapter 7.....	215
Original Contributions, Limitations and Recommendations: Looking Back and Looking Ahead.....	215
Introduction.....	215
Original contributions. ....	215
Limitations. ....	218
Recommendations.....	218
Future research.....	223
Post script.....	223
References.....	224
Appendices.....	234
Appendix A Sample Interview Questions.....	234
Appendix B Consent Form Canada .....	235
Appendix C Consent Form UK.....	240
Appendix D Invitation to Participate Canada .....	245
Appendix E Invitation to Participate UK.....	249
Appendix F UBC Certificate of Approval Minimal Risk.....	254
Appendix G UVic/VIHA Joint Research Ethics Sub-Committee Certificate of Approval .....	256
Appendix H National Research Ethics Service .....	257
Appendix I UBC Certificate of Approval Minimal Risk Amendment.....	258
Appendix J Modification of Approved Protocol .....	259
Appendix K Residents Naïve Interpretations: Remaining Stories.....	260
Appendix L Nurses Naïve Interpretations: Remaining Stories.....	278

## List of Tables

Table 1 .....	94
Table 2 .....	160

## Acknowledgments

My journey through this doctoral study has been filled with adventure and excitement. This is because of those who travelled with me, encouraged me, challenged me, worried about me, were kind to me and most of all believed in me. Some of you have helped me in more ways than I can recount, here are my foremost thoughts.

### My Supervisors, Committee Members and External Examiner

Dr. Mary Ellen Purkis: This study and my thinking evolved and took shape in the intellectual spaces you so generously nurtured. I cannot imagine it otherwise.

Dr. Oscar Casiro: Embedded in reality and action, your guidance grounded this study and reassured me that the research was relevant to the medical world that I came from. This was the safe place from which I went forward.

Dr. Geraldine Van Gyn: Your kindness and your enthusiasm in directing me at the very beginning is responsible for this study becoming a reality, without which it would have remained between dust covers.

Dr. John Walsh: Your gentle probing kept me on my toes and your curiosity about the qualitative paradigm spurred me to give a good account of it and is responsible for the rigour of this study.

Dr. Blye Frank: Thank you for prefacing the complexities of the research topic and for your infectious enthusiasm for looking further. You have given me permission to be excited and to keep pushing the boundaries.

Dr. Alan Bleakley: Thank you for accepting the role of my host supervisor in the UK and following this up with your unfathomable intellectual generosity. You made it possible for me to value my work as unique and special.

### Those Who Made it Possible

Rose Wilson: You are intimately part of every written word of this dissertation. It was a privilege for me to share the data with you as you transcribed. Your sense of awe and respect reinforced my own.

Dale Piner, Heather Keenan, Pat Blonde and Mycroft Schwartz: Thank you for adopting me and giving me a home at the Dean's office in the Department of Human and Social Development. I always felt welcomed and cared for.

The managers, nurses, and others through whose kindness I was able to get permission to conduct this study and recruit the participants: Thank you for your kindness to me and for the many times you went beyond the call of duty to help me negotiate the sharp turns and hairpin bends in this journey.

Participants of the research: Thank you for sharing your life, your experiences and your time. I am honoured by your trust. I hope this dissertation is true to your story.

### My Mentor and My Friends

Dr. Paul Dieppe and Mrs. Liz Dieppe: Thank you Paul for taking on the role of my life long mentor and also for asking the questions to which I had no answers. Liz, your affection and kindness provided me with a home away from home in the UK and from this cocoon I was able venture out.

Sooi Ling, Phyllis, Beatrice, Gail and Sushma: Thank you for worrying about me, for cheering me on, for sharing the painful times and for believing that I could complete what I had started. I could not let you down.

### My Family

Priya, Joe, Roshni and Arin: Thank you for your bemused encouragement, your questions about my research, your concerns about my completion and your tolerance for the times when I was preoccupied. Your acknowledgement that it was a good thing was very important to me and it helped me persevere.

Richard, my husband: I could not have even started, let alone completed this study without your support. Thank you for working while I studied, for cooking us meals when I could not, for looking after the family and the pets when I was away and most of all for believing that it was a worthwhile project.

Finally I acknowledge and thank the Canadian Institute of Health Research for funding this research through the Frederick Banting and Charles Best Canada Graduate Scholarships Doctoral Award.

## **Dedication**

Dedicated to my granddaughter Maya Isabel Hickey, born December 12, 2011.

# Chapter 1

## Introduction: A Sense of Dissonance

A growing sense of dissonance resulting from the disjuncture between my experience of interprofessional team work and the contemporary discourses that surround its teaching in medical school have led me to explore the impact of nursing and medical education on the ability to collaborate. The current focus on working together is encased in terms of collaboration, such that regardless of its dynamics, *working together* is frequently seen as collaborating. Present trends in medical education emphasize the *collaborator role* of the physician and this role has been adopted as an exit competency for residents by the Royal College of Physicians and Surgeons of Canada (Chou, Cole, McLaughlin & Lockyer, 2008).

Based on my own experience of the complex dynamics involved in nurse-physician interaction, initially as a trainee and then as a specialist physician, I am concerned about how a medical faculty that has not practiced collaboratively with nurses will invest itself in teaching this role sincerely and effectively. Conversations with physicians, medical students, practicing nurses, and lay persons has led me to believe that the understanding of collaborative practice and commitment to it was widely disparate, thus accentuating my sense of dissonance. This dissonance has become the point of departure from which I have examined the literature related to this topic, crystallized the research question, identified a theoretical lens, developed a research framework, and conducted research in this field.

## Chapter 2

### **Critical Literature Review: Scanning the Landscape**

#### **Introduction.**

In this chapter, I examine the historical antecedents of the collaborative practice movement and look beyond the rhetoric of healthcare directives at the complex issues which impact the perception of collaboration between physicians and nurses. It considers the conflict and tensions between the professions and its professionals which are said to prevent collaborative team work, through the lens of the social identity theory. Furthermore, it critically explores the literature about the process of socialization and the development of professional identities in the course of uniprofessional nursing and medical education, with an aim to grasp the probable influence of such socialization on the ability of recent graduate physicians and nurses to work together. This will form the basis of understanding from which I will proceed to adopt a theoretical lens and congruent methodology to conduct this research.

#### **Interprofessional collaboration: antecedents and definitions.**

Collaborative team work between health professionals has been promoted through small and independent initiatives since the mid-20<sup>th</sup> century. Until the 1990's, there was little interest or support from governments and most initiatives died a lonely death. In the last two decades the impetus towards economic rationalization of health services, in the face of diminishing healthcare human resources, higher costs of health care and a more demanding public has thrust collaborative practice, as a solution, to the forefront of health policy across the world (Commission on the Future of Health Care in Canada. Romanow, 2002; Health Canada, 2008; World Health Organization, 2006). Bolstered by

government funding and upheld by healthcare policy in Canada the drive for collaborative practice, followed by that for interprofessional education (Curran, 2004; Health Canada, 2004) has gathered momentum and is now an unstoppable juggernaut. The evidence base for these initiatives has been weak, as most studies have been unable to meet stringent inclusion criteria of reviewers. In 2000, the Cochrane review (Zwarenstein, Reeves, Barr, Hammick, Koppel, & Atkins, 2000) found no studies on post-licensure interprofessional education or prelicensure interprofessional education which met their inclusion criteria; in 2008 the same review (Reeves, Zwarenstein, Goldman, Barr, Freeth, Hammick & Koppel, 2009) reported a heterogeneous group of six studies in post-qualifying interprofessional education which met their criteria and demonstrated a range of positive outcomes; they conclude that generalizable inferences are premature. In between these two reports, in 2005, Zwarenstein, Reeves and Perrier reported on a non-Cochrane survey which found that 14 of 419 retrieved studies met their inclusion criteria. All of these studies were of post-licensure collaborative interventions as well. In this heterogeneous group nine of the 14 trials showed benefit in terms of patient outcome. Although they found no evidence for effectiveness of prelicensure interprofessional education on patient outcome, they recognized that this may reflect the difficulty in conducting acceptable trials rather than the effectiveness of interventions. Despite lack of demonstrable evidence, the expectation that interprofessional education will lead to collaborative practice which will constrain healthcare costs through additive, synergistic or substitutive functioning of healthcare personnel continues to fuel enthusiasm for it.

Voices from the professions (Bailey, Jones, & Way, 2006; Freeman, Miller, & Ross, 2000; Hall, 2005) speak of the difficulties encountered in working within the proposed

integrated framework and cite the barriers posed by the traditional hierarchical framework of health care, diverse and divisive cultures of the individual professions, uniprofessional interests, boundary issues and liability concerns. All of these difficulties are juxtaposed against the dynamic healthcare landscape where provider limitations and user expectations and needs are being constantly negotiated. Such a complex milieu underlines the need for a considered, deliberate and contextual process of negotiation and reconciliation between the professions, so that the fabric of new alliances is strong and durable, the user is better served and the professionals are rewarded and fulfilled.

Hugh Barr (2002) notes that in the area of interprofessional education “definition has been lacking and semantics bewildering” (p.6). This is true of collaboration and collaborative practice too. The terms *professional*, *interprofessional* and even *collaboration* yield a spectrum of interpretations, even among healthcare providers, whose perceptions are coloured by diverse world views, professional identities and the nuanced use of language. The following is an attempt to capture the essence of contemporary interpretations of these terms in relation to the current trends in healthcare delivery. The term professional was originally reserved for members of professions which had an exclusive body of knowledge, were self-regulating, required a long period of study and apprenticeship and were bound by a common code of ethics. Interprofessional, consequently alluded to interaction between professionals from different backgrounds. In keeping with this a widely accepted definition of interprofessional education is, “Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (Barr, Freeth, Hammick, Koppel & Reeves, 2006, p. 75). However, with reference to the current

developments in health care, as Leathard (2003) notes, “Where managers, health and welfare professionals, administrative and reception staff, carers and cared for are all involved, the *interprofessional* begins to lose clarity other than all who seek to work together for the service user” (p.6). While the background of the workers or professionals is becoming blurred, the centrality of the patient as the user is crystallizing. There is a definite thrust for healthcare delivery to shift from being *physician centred* to being *patient centred* as is made explicit in the collaborative patient-centred practice model being sponsored by Health Canada through the Interprofessional Education for Collaborative Patient Centred Practice (IECPCP) (Herbert, 2005). While recognizing the participation and contribution of the workers mentioned and of organizational structures at the macro level, this review will restrict itself to the interprofessional interaction between nurses and physicians who make up 50% of the healthcare workforce in Canada (Canadian Institute of Information, 2007).

Understanding what is meant by collaboration and collaborative practice with its many shades and facets is even more problematic. Way and Jones’ (1994) definition has been adopted and accepted widely and defines collaboration as, “An interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of healthcare providers to synergistically influence the patient care provided” (p. 29). Although this definition is fairly recent and collaborative practice is hailed as a new initiative of the late 20<sup>th</sup> and early 21<sup>st</sup> centuries, the concept is not new and was elegantly encapsulated by Szasz in 1969 in his seminal paper, in which he wrote:

It appears that, among other problems, the health professionals employ their talents inappropriately, and as a consequence, scarce human resources are wasted. Evidence also indicates that fragmentation and compartmentalization,

both of scientific investigation and the approach to human problems, and of poor communication between those who provide different components of the health services. (pp. 449-450)

How then does the current trend differ from earlier calls to work together? Why do the objectives of collaborative practice today seem so onerous and formidable? Perhaps, the answer lies in the fact that while earlier exhortations came from within the professions and were likely to preserve their interests and boundaries, and possibly the hierarchal relationships between the professions, the current trend is mandated and driven by forces outside the professions, the pace and extent of which is beyond the immediate control of the professions. A palpable danger of erosion of professional boundaries may be felt by those who have been in control, in particular the medical profession (Whitehead, 2007).

The exigencies of health care that have brought collaborative practice to the forefront of health policy in much of the developed world have been alluded to. Between the 1960's to the 1990's health care and policy was directed towards "care and cure" within institutions; healthcare teams were led by physicians and teamwork was based largely on task allocation under physician leadership. The extent of collaboration and shared decision making varied across teams and specialties, but boundaries tended to be rigid and allegiances were along professional lines. In the 1990's, a combination of neoliberal individualistic ideology and the pressures of cost containment led to a major shift of healthcare delivery out of institutions and into the community, where patients, families and communities were expected to take a central role as partners in health care. This policy underscored the need to shift the system from an episodic orientation to illness towards better planned care. Primary health care was to become the foundation of the healthcare system, as well as the first point of contact people had with the healthcare

system which could be through a doctor, nurse, and another health professional, or phone or computer-based services (Canadian Health Services Research Foundation, 2007). With the delivery of health and social services being mediated through the variety of independent and diverse agencies the need for collaboration was obvious. The move towards increased collaboration, blurring and indeed substitution of roles between agencies gathered strength from World Health Organization (2006) directives which urged the use of scarce health human resources more effectively. At this time the shortage of healthcare workers, especially of nurses and physicians across the vast rural regions was being acutely felt in Canada (Canadian Institute of Information, 2007). Projections of the increasing numbers of chronically ill and ageing made renewal of primary health services urgent. The Canadian Health Services Research Foundation (2007) records the following:

In September 2000, the first ministers' meeting resulted in the agreement that "improvements to primary health care are crucial to the renewal of health services" and, in 2002, the Government of Canada established the \$800-million Primary Health Care Transition Fund to support primary healthcare changes. In addition, the 2003 Health Accord and the 2004 10-Year Plan reaffirmed the first ministers' commitment to primary healthcare renewal and support for interprofessional teams as a central component of renewal. In 2004, the commitment to interprofessional teams was reiterated with the statement that "significant progress is underway in all jurisdictions to meet the objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011". (p. 1)

Around this time, several high profile cases involving medical errors and the volume of adverse events in hospitals were highlighted in the UK (Teasdale, 2002) Canada (Baker et al., 2004) and the USA (Kohn, Corrigan & Donaldson, 2000). There were outcries for better regulation by an informed public, the government and regulatory bodies. Poor

communication between health professionals and silo practices within healthcare delivery shared the blame. Collaborative practice was seen as a fundamental part of the remedy and a shift from physician centered to patient centered care was mooted by policy and regulatory documents in UK, Canada and the United States (Department of Health, 2000; Health Canada, 2008).

Despite the changes in policy and some evidence to its effectiveness the interprofessional collaborative model of care and delivery in primary healthcare settings, remains in its infancy in most of Canada (Canadian Health Services Research Foundation, 2007). In the context of physicians and nurses, who together constitute 50% of the healthcare workforce, the ideals of collaborative practice are at odds with the background of uniprofessional education, separate and sometimes conflicting professional identities and make its implementation difficult, nonlinear and not necessarily additive.

As noted, the scant evaluation of collaborative practice has focused largely on experimental models and their outcomes in terms of patient and provider satisfaction, little is known of the processes by which a team of diverse healthcare providers arrives at collaborative arrangements and works through the complexities and obstacles implicit in this situation. While in remote and understaffed regions, collaborative practice with shared decision making and substitutive functioning is clearly likely to be beneficial for the patient and attractive for healthcare workers, it is unclear how this model is accepted in larger centers and hospitals which may have entrenched hierarchical cultures, where all medical residents and many young nurses cut their teeth. The gap between the traditional hierarchical practice and the ideals of collaborative practice is wide and needs to be

bridged by a deliberate process of dialogue and negotiation, without which hastily formed liaisons may be seen as *conspiring with the enemy*, an alternative meaning of collaboration.

### **Issues that surround collaboration between physicians and nurses.**

A critical look at the issues and interests that impact the negotiation of collaboration between physicians and nurses is a prerequisite to understanding its complexities and considering the ways for approaching it. The professions of nursing and medicine are like Siamese twins joined at the hip. They must walk together, if they are to walk at all. Undeniably, they do work together in the interest of the patient, and to the unobservant or uninvolved the wheels of teamwork appear well oiled. However scratching beneath the surface of the well starched exterior, one uncovers startling and simmering conflicts, which stem mainly from the traditional power differential between the professions and its many ramifications.

In the traditional model, the role of the nurse was subservient to that of the doctor, both in hospitals and in primary care. Their worth was measured by the proficiency with which they carried out the doctors' orders rather than how they cared for the patient. This model has its roots in the historical origins of the nursing profession, and dates back to when Florence Nightingale persuaded army physicians that nurses could be helpful to them and nurses were accorded tasks that the physician saw fit for them. This power differential was perpetuated by the gender distinctions and roles of the era, with nurses being cast in the passive caring role and medicine, which was almost exclusively a male domain being in the more powerful curing role. Until the last quarter of the 20<sup>th</sup> century nursing education and employment was also controlled by physicians who decided what

*valid knowledge* was for nurses and who was to be hired or fired (Keddy, Gillis, Jacobs, Burton, & Rogers, 1986). Nursing, as a profession is now self-regulating and autonomous but the shadow of tradition is long and dark, while change is slow and variable.

### **The changing landscape of medical and nursing training.**

Today's students in medical and nursing colleges will become tomorrow's professionals in the dynamic landscape of health care, with fluid demographics, disease patterns, ideology, and funding. As proposed, while changes within healthcare delivery are contingent upon the negotiations between provider limitations and user expectations and needs; those in education are motivated by issues related to enhancing professional status and accommodating an expanding knowledge base. The two organizations intersect in the persons of nurses and physicians when upon graduation they transit from one to the other. It is anticipated that in spite of their uniprofessional education, they will find ways to collaborate and work seamlessly. It is assumed that the way they work together will reflect the sum total of their priorities, loyalties, and self-concepts molded initially within the context of their professional education.

Medical education remains rooted in training students in the mold of healers, equipped to diagnose and treat the sick. In response to the strident calls for accountability, medicine as a profession is attempting to renew its social contract, restore society's confidence, and retain its privileges through a call to teach and inculcate "professionalism" (Wear, 1998; Wear & Kuczewski, 2004). Medical schools have embraced this call by revising their curricula and focusing on the social dimensions of medicine. Students receive lectures on professionalism and learn about their social

obligations in a variety of learning formats. Interestingly medicine's contract with its co-workers still remains undefined and undeclared.

Other healthcare workers recognize the lack of the recognition of those behind the scenes, who facilitate medicine's image of professionalism (Shirley & Padgett, 2006). In the face of diminishing healthcare human resources, higher costs of health care, and a more demanding public, healthcare policy across the world (Health Canada, 2008; Romanow, R. J., 2002; World Health Organization, 2006) is being rationalized and medicine is being pushed to participate in more collaborative practice.

The impetus for interprofessional learning (IPL) has proceeded from the assumption that learning together will facilitate working together. Prequalification interprofessional educational courses (Curran, 2004; Health Canada, 2008) have been developed and are seen as remedy for the deficiencies in collaboration. Despite its champions and the support such incentives have received from the state, they are usually located outside the practice setting and remain short, sporadic, and optional, since the evidence that they change workplace interaction and collaboration is sparse. In this context, Finch (2000) from Keele University in the UK posed a question that remains pertinent a decade later. She asked if:

The NHS [National Health Service] wants students to be prepared for interprofessional working in any or all of the following senses:

- To 'know about' the roles of other professional groups
- To be able to 'work with' other professionals, in the context of a team where each member has a clearly defined role

- To be able to ‘substitute for’ roles traditionally played by other professionals, when circumstances suggest that this would be more effective
- To provide flexibility in career routes: ‘moving across.’

Which of these does the NHS really want? (pp. 1138–1139)

She went on to suggest that IPL should take place in the clinical settings during clinical placement and pointed out that beyond *knowing about* and *working with* each other, education was not equipped to lead these initiatives and would be attempting to prepare “students for a future that might never exist” (p. 1140).

While medicine struggles to respond to external pressures through changes in medical training, nursing education has undergone a more dramatic transformation from vocational training under the direction of physicians (Keddy, Gillis, Jacobs, Burton, & Rogers, 1986) to independent, autonomous professional education in the 1960s, now increasingly based in universities. Graduates of nursing schools now expect to operate within the framework of equal decision making and autonomy only to discover that the playing field is not yet leveled and medical domination remains a fact of the health care landscape (Coombs & Ersser, 2004).

In the last three decades advanced nurse training has been preparing nurses to take on expanded roles, such as that of nurse consultants, nurse practitioners, and clinical nurse specialist. The rhetoric of nursing education emphasizes its distinction from the biomedical model of medicine (Purkis, 2007); paradoxically its specializations bring it closer to the medical model in substitutive or complementary roles. These contradictions in nursing education have led to a lack of homogeneity within nursing, such that nursing as a profession lacks a common voice and nurses from different educational backgrounds

have different skills and expectations. This heterogeneity may be responsible for a paucity of recent literature on the construction of nursing students' identity as compared with that about medical students.

### **Socialization and the development of professional identity.**

It is within the complex and fluid landscape described above, that nurses and physicians are socialized into their professional identities. I suggest that it is through understanding their identities, how they develop, the values that they foster and those that they inhibit, that the dynamics of conflict played out by nurses and physicians in the workplace can be better understood. Consequently I will examine the process of socialization and nurse physician relationships through the lens of the social identity theory. The concepts invoked are those of (a) social identity; the process of socialization, internalization, and commitment; the perception of in-groups and out-groups and intergroup interactions (Ashforth & Mael, 1989; Henderson & Atkinson, 2003; Hewstone, Rubin, & Willis, 2002; Stets & Burke, 2000); (b) role identity (Stets & Burke, 2000) and; (c) personal identity. These concepts were developed within the literature on organizational behavior and to grasp their meaning I will return to the seminal writings in this domain.

“According to the social identity theory self-concept is comprised of a personal identity encompassing idiosyncratic characteristics and a social identity encompassing salient group classifications. Social identification therefore is the perception of oneness with or belongingness to some human aggregate” (Ashforth & Mael, 1989, p. 21). Ashforth and Mael (1989) claim that factors which predispose to a strong sense of social identity that includes professional and group identities are distinctiveness, prestige of the group, and

its proximity to one's personal identity. Additionally awareness of out-groups reinforces awareness of one's in-group. The stronger the sense of belonging or identification, the more likely it is that the values of the culture are internalized and commitment to the group's goals developed, such that its successes and failures are experienced personally and membership is maintained. Conversely, if the professional culture is weak and identification is not seen to boost self-esteem, an individual may search for an identity through other life roles or nonprofessional social identities. If the professional culture is fragmentary and lacking in cohesion, professional identity may remain unformed and become subordinated by other role or social identities. The proximity of one's personal identity to the professional culture is reflected in the congruence of values and beliefs imbibed through one's life experiences and influences, with those actually held by the profession. If these are incongruent, an internal conflict can be anticipated and either one or the other identification may prevail, leading to rejection of the professional identity or submergence of the personal one. Ashforth and Mael (1989) note that social identification is not an *all or none* phenomenon and identities may compete for expression and salience. If professional identification is weak, individuals may conform to cultural norms without adopting them and experience internal conflict and stress in doing so. In the extreme case, continuing to remain within the fold of the profession may become detrimental to the self and the individual may choose to leave the profession. In contrast, once a strong sense of identity is developed, the individual usually proceeds to internalize the profession's values and culture, regardless of its status and even its negative characteristics are cast into positive distinctions (Ashforth & Mael, 1989).

When group or professional identity is dominant or active, out-groups take on an adversarial dimension and lead to the in-group being judged positively and the out-group being devalued such that comparisons become self-enhancing (Stets & Burke, 2000). This results in stereotypical casting of both. "Groups have a vested interest in perceiving or even provoking greater differentiation than exists and disparaging the reference group on this basis" (Ashforth & Mael, 1989, p. 31). This tendency is further accentuated when the in-group perceives a threat to its domain or its resources. If physicians and nurses see each other as the out-group, conflict and contention in the workplace can be expected.

Ashforth & Mael (1989) note that hostility is more common between groups than between individuals. In-group and out-group relations may be marked by competition and hostility even in the absence of objective sources of conflict. Tajfel (1982) writes that a high status group may feel less threatened than a low status group, which may go to great lengths to differentiate itself. As such, the indifference of the high status group becomes a threat to that of the lower status group, as its identity remains socially invalidated.

The vast literature about nurse-physician relationships in nursing journals, as opposed to only a smattering of articles on the topic in medical literature probably reflects the threat and frustration experienced by nursing as the lower status group, now attempting to close the status gap. Interestingly also, the literature about nurse-physician conflict has proliferated within the last thirty years, at a time during which nursing status has advanced and boundary issues have become contentious. This is in keeping with the observation of Ellemers, Wilke, and Van Knippenberg (1993), that members of the lower status group show bias when status differentials are perceived as unstable. To aggravate matters high status groups are also more likely to show bias when the status gap is

perceived to be closing (Bettencourt & Bartholow, 1998); it waits to be seen if this will be reflected in medicine becoming more involved in the debate as the status gap narrows.

In contrast with identifying with a group, individuals may identify more closely with roles and in role based identities they are more likely to express interconnected uniqueness with less contention and conflict. Unfortunately when group identification is strong, actions and behavior tend to proceed from group rather than role identity (Stets & Burke, 2000). In health care such role identities can only be constructed in the workplace, while it is assumed that educational institutions continue to socialize students into their organizational culture which are later enacted in inter group conflict within the organization of the workplace. The process of socialization is well encapsulated by Jacox (1978): “Professional socialization is the complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession” (p. 10).

Ashforth and Mael (1989) assert that the socialization process is accentuated in professional schools through a process of *divestiture*, in which the individual’s incoming identity is supplanted with an organizational identity.

Such organizations often remove symbols of newcomers previous identity; restrict or isolate newcomers from external contact, disparage newcomers status, knowledge and ability, impose new identification symbols, rigidly proscribe and prescribe behavior and punish infractions while rewarding the assumption of the new identity. (p. 28)

The sections that follow examine the process of socialization and identity formation in the contexts of nursing and medical education.

Socialization and the construction of professional identity in nursing education.

As elaborated above, the impact of socialization and the extent to which professional norms and values are internalized and the professional identity personalized are contingent upon the coherence and strength of the professional culture on the one hand and the congruence of such values with the individual's values, goals, and perception of the idealized profession on the other. To gauge and understand this process one needs to grasp both these dimensions.

As mentioned earlier there is a paucity of scholarship around the topic of nursing student's professional identity in recent years. Mindful of the changes in nursing education this review leans heavily on an extensive exposition of the profile of nursing school entrants in Cohen's book, "The Nurse's Quest for Professional Identity" (1981) which though 30 years in print, rings true today and is one of the most comprehensive texts available on the subject. At the time of its writing nursing had already become an independent profession and undergone its most significant change.

Cohen found that girls make the decision to enter nursing at a young age, without deliberately considering other options and do so in the belief that nursing is nurturing and feminine, additionally nurses from both diploma and degree courses scored lower for self-esteem than other college students. Cohen assumes that the choice of nursing may be an attempt to provide and fulfill their quest for an identity. It would appear that these traits are more in keeping with an idealized nurturing and subservient nursing role and probably result in a sense of insecurity and dissonance in the student when they are confronted by the assertive role promoted by contemporary nursing faculty.

Nursing students, particularly in the universities are exposed to two different sets of teachers; academic faculty who are involved with teaching alone and the hospital staff

who guide them in the wards but are primarily practitioners. It is not difficult to envisage that the perspectives and priorities of these two groups may be divergent, especially, as Cohen notes many young instructors are dissatisfied ex-practitioners. In this milieu, it is not difficult to imagine that values emphasized by faculty may be contradictory or ambiguous, depending on individual perspectives and their own identification or lack of it with the reforms in nursing. Clearly both faculty and practitioners are themselves struggling with tensions between values associated with nursing's historical role and its new professional one, such as obedience versus autonomy, involvement with the patient versus detached concern, and holistic versus task orientation.

The students are therefore socialized into a culture of contradictions and even as they may develop a sense of identity and belonging to nursing, it tends to be weak and diffuse (Carpenter, 1995; Cohen, 1981). It does not appear to equip them to navigate the exigencies and diverse demands of the workplace with confidence and boldness. The resulting multiplicity of priorities and weak professional identity imply that there is no stereotypical contemporary nurse. Ironically, no matter how the nurses view themselves or which role identity they favor, perhaps as a team leader, a coordinator or an advocate for the patient, their healthcare colleagues and employers see them as a "nurse", and cast them back into the mold they may have tried to break free of. This can cause further confusion as conceptions of the self are formed through the interpretations of others (Van Maanen, 1979).

Based on these accounts, in-group solidarity founded on in-group characteristics is difficult to achieve for student nurses; but identifying the out-group seems to provide meaning and a sense of cohesion. Medicine, as a professional group is the natural out-

group for nursing. This is not difficult to understand, given that historically nursing has labored under medical domination and has now emerged as an independent and autonomous educational institution, only to find that in the workplace its autonomy and expertise is still thwarted and constrained by medicine. The strength of negative feeling for medicine is palpable throughout nursing literature; what is remarkable is that such negative sentiments are also expressed by nursing students. As Henneman (1995) puts it, “Nurses have a tendency to believe that they alone are concerned with the welfare of the patient. One can imagine the new graduate nurse’s shock when she first realizes that the physician ‘cares’ about the patient too” (p. 360).

Socialization and the construction of professional identity in medical education.

The reports of the socialization process in medical school aligns it to the divestiture described earlier more than in any other professional school. Literature documents the myths, stories, and symbols of the profession (Crues & Crues, 2006; Genn, 2001a; Genn, 2001b; Hafferty, 1998; Reynolds, 2007; Stern, 2000; Suchman et al. 2004; Whitehead 2007). Medical students quickly become aware of their uniqueness, of the distinctive knowledge that they will acquire and of the status they will achieve. They do not yet know how this will happen but are nonetheless clear that the destiny that awaits them is that of the *healer*. Initially through exposure to cadavers and later through encounters with disease and death students learn that expressions of anxiety, uncertainty, and emotional discomfort are considered “extraneous to the medical education and not welcomed by instructors” (Conrad, 1988, p. 325), so they learn to put on a mask of self-assurance in difficult situations. This cloak of competence and confidence hides a kernel

of self-doubt and insecurity which is seldom evident to outsiders and may even remain hidden from other students (Pitkala & Mantyranta, 2003).

Through the clinical training and the informal curriculum the student learns that the medical culture prizes some values over others. In a life burdened with knowledge acquisition, responsibility and depersonalization, priorities are reorganized to meet the demands of the culture. Students learn about the centrality of responsibility as the cornerstone of professional character and “potentially the framework around which all other professional expectations are built” (Stern, 2000, p. S28). They adopt the “notion that a doctor is most fully a doctor when the patient is in trouble” (Weinholtz, 1991, p. 157), thus distancing themselves from areas of health promotion and psychosocial wellbeing, fields that nursing has occupied as representing its unique professional turf. All the while they strain to create a good impression through grueling clinical rounds, not infrequently feeling humiliated. Weinholtz (1991) notes that “while difficult for students, this status is tolerable because they know that as they progress through internship and residency they will acquire the competence and authority necessary to more fully legitimize their team membership” (p. 172). He also notes that values which are not emphasized become devalued and inhibited. Interprofessional respect and interprofessional relationships are inevitably the casualties.

According to Weinholtz (1991):

Medical students learn that physicians perform separately and above their fellow health care workers. The knowledge they acquire legitimizes their claim to authority, but knowledge acquisition remains their central focus. They generally do not work on developing the interpersonal and team skills necessary to collaborate effectively with either their patients or other health professionals. (p. 173)

In a study commissioned by the Association of American Colleges, Ways and Engel in 1982 (as cited by Weinholtz, 1991) reported that through the process of clinical clerkships students' lives are diminished, they become fearful, anxious, and depersonalized and disinterested in whole persons, focusing instead on disease states.

As members of their generation, are the current students in medical school different from their forebears? Has the diversity and change within medicine impacted their socialization and identification? A recent paper from Sweden (Diderichsen et al., 2011) reports, "Today's medical students expect more of life than work, especially those standing at the doorstep of working life. They intend to balance work not only with a family but also with leisure activities" (p. 140). In what other ways are they different? Will they be better team players? These questions are pertinent to collaborative practice and need to be explored. Additionally the reports of nurse-physician interaction have largely failed to distinguish between different generations of professionals. Consequently, to understand the current generation of young professionals, studies must be designed with these distinctions in mind.

### **Nurse-physician conflict.**

Socialized into their individual professions, nurses and physicians enter the workplace; while physicians undergo further mandatory training in service as residents, nurses are considered to have completed their training. It has been assumed that each views the other as a member of the out-group with implicit hostility, evident through disparaging discursive constructions of the other (Reynolds, 2007).

The milieu of healthcare delivery, particularly in hospitals is complex, dynamic and multidimensional. How the nurse functions, is dependent to a large extent on the

organizational structure of the area and on the tacitly understood role boundaries. Nurses have to collaborate with physicians, with lower grade staff and with the administration, while performing in the interest of the patient. Competing priorities inherent in educational socialization are reinforced by a system which “demands that they produce as professionals and take responsibility for their judgments while maintaining subservient attitudes” (Cohen 1981, p. 68). While they try to adapt to the demands of the workplace, they usually gravitate to adopting the *patient advocate* role as the primary one (Joudrey & Gough, 1999), yet they have also been socialized to believe that they are autonomous professionals, so they try to assert their independence with variable success. Their fragmented and diffuse identity is juxtaposed against that of the physicians, who have been socialized into a formidable profession, are sure of their roles as leaders and decision makers of healthcare team and are largely unaware of the nurses’ knowledge, paradigms or priorities. As such, it is often the physicians who stand between the nurses and the realization of their objectives; they have been socialized to see the physician as the oppressor and work experience accentuates this perception. Compassionate communication between the two is difficult because the physicians see all other healthcare workers as separate. They have been taught to bear responsibility and appear confident and competent in the face of uncertainty; their persona of invulnerability and aloofness make such communications rare (Haas & Shaffir 1987; Whitehead 2007).

The impact of perceived conflict on the nurses’ level of stress and dissatisfaction has been extensively described in nursing literature but largely ignored in the medical one. Indeed a poor nurse-physician relationship has been shown to have a deleterious effect on

nurses' health and has been cited as one of the reasons for nurses leaving the profession prematurely (O'Brien-Pallas, Hiroz, Cook, & Mildon, 2005).

Does this imply that only nurses experience this conflict or at any rate experience it more acutely? This appears to be true, as most studies of nurse-physician relationships document a much greater degree of dissatisfaction on the part of the nurse and frequent oblivion on the part of the physician (Devine, 1978; Thomson, 2007). Can this asymmetrical perception be termed *conflict*? If one adopts the definition of conflict by Thomas (1992), it is clear that one party's perception of conflict is sufficient for it to be so. Thomas states the conflict is "the process that begins when one party perceives that the other party has negatively affected, or is about to negatively affect something that he or she cares about" (p. 653). Using this definition, conflict may arise in many areas of operation within health care, which, though interlinked, are distinct.

Conflict related to the nature of knowledge.

Knowledge is shared by physicians and nurses against the background of power politics, mistrust of motives and role disparities. While the medical student is taught to place ultimate value in knowledge that is accountable and verifiable, the nursing student places value in contextual, personal and intuitive knowledge. The dominant discourse on both sides is one of distinct and separate professional knowledge; both professions express their knowledge in a language best understood to them and in terms most acceptable within their profession (Kvarnstrom, 2008). While a nurse may speak of intuitive knowing, a physician speaks of pattern recognition and so on. By virtue of their paradigms they are unable to relate to each other's inner logic. Physicians constantly express frustration at the inability of nurses to defend their arguments in clinically

explicit language (Coombs & Ersser, 2004); while nurses feel that their knowledge is disregarded and ignored. Baggs et al. (1997) reported that physicians see nurses' knowledge as an important antecedent to nurse-physician collaboration, yet physicians are largely ignorant of the content of nursing education and are unable to know or tap nurse's knowledge. It is not difficult to imagine that nurses become frustrated and resentful when they experience disregard for their *ways of knowing* but are unable to express it any other way, while physicians' reinforce their perception of nurses' knowledge as being inferior. The exigencies of practice and identity do not allow for deep dialogue accommodating both perspectives.

Conflict related to value systems and world views.

A common area of conflict relates to issues pertaining to patients' treatment where nurses view interventions from the perspective of the patients' dignity and comfort (Coombs, 2003; Fagermoen, 1997), while physicians strain to apply their knowledge to treat the disease and prolong survival. Such conflicts are described repeatedly, especially in the treatment of the elderly, terminally ill, and otherwise frail (Uden, Norberg, Lindseth, & Marhaug, 1992). Deriving from their professional identity, nurses view the situation as advocates for the patients. Although this is not the only value prioritized by current nursing education, it is certainly the one which best coincides with the nursing student's personal goals and the one that offers a distinctive paradigm. On the other hand, although patient centrality is not lost in medical education, it is seen in terms of using one's knowledge to cure and prolong life and this subjugates all other considerations. In these situations both the nurse and the physician act out their identities; their actions

reflect the values that they have internalized, there is no other way they can act.

Mannheim (2002), described this phenomenon eloquently in 1936:

We belong to a group not only because we profess we belong to it, nor finally because we give it our loyalty and allegiance, but primarily because we see the world and certain things in the world, the way it does. (p. 19)

What creates conflict is not just the difference in priorities and perspectives but the pejorative stereotyping of the out-group and devaluing of its intent and intellect. The inability to see the other in a positive light upholds Mannheim's explanation about being located within one's group in a way that prevents an alternative positive perception, at least as the initial reaction. This is illustrated by Lindseth, Marhaug, Norberg, and Uden (1994), who described perceptions of nurses and physicians in difficult ethical situations:

Physicians were mentioned as the source of ethical conflict in many stories related by nurses. The physicians only see the patient as someone with a disease and cannot accept death and therefore continue meaningless treatment leading to poor quality of life for the patient. The physicians thought nurses were too eager to stop treatment because of insufficient medical knowledge. (p. 248)

Interestingly when Lindseth et al. returned to the same group of nurses and physicians and asked them to reflect upon the content of the previous interview and elaborate it further, they found that both groups expressed similar personal experiences of giving and receiving care. Had reflection allowed them to evaluate their experiences in a new light? Is it possible that time taken for compassionate communication can break through the walls erected by group affiliations? Truly collaborative environments may hold the answer to these questions.

Conflict related to team dynamics.

Health care has always been considered team work, this team used to be composed of the physician and others, the physician was always the leader and was typically male, he gave directions, received information, taught if the impulse struck him, while others carried out his orders and reported back. Clearly this undemocratic model of medical domination is no longer acceptable, at least theoretically. A new ideology of teamwork has been envisioned and propagated by nursing educators and healthcare policy makers. Medical education too, pays lip service to it. As already described, new constructs are based along the lines of a Way and Jones (1994) definition which focuses: "... decision making that enables the separate and shared knowledge and skills of healthcare providers to synergistically influence the patient care provided" (p. 29). Tellingly, the addition of *equal contribution* and *shared decision making* in definitions of team work are found more commonly in nursing literature.

If teamwork is measured against this standard, it becomes clear that healthcare teams are remiss; change has been slow and shades of the old model are found everywhere. In hospitals team work is usually accomplished through ward rounds and the patients' records. It is at the ward rounds that the patient or *case* is discussed, decisions made and tasks allocated. It is here that hierarchy is expressed and the salience of group versus team identity can be observed. Literature documents the frustration of nurses, who indoctrinated in the new ideology of teamwork, hope to participate equally but find themselves on the fringes of the round, seldom asked to contribute or express their opinion. Often intimidated by the authoritarian stance of the senior physician, and the superior and relatively exclusive clinical knowledge of the medical team, they fail to share what they perceive as significant intimate knowledge of the patient (Busby &

Gilchrist, 1992; Caldwell & Atwal, 2003; Coombs & Ersser, 2004). Instead, with simmering resentment they may resort to a passive-aggressive posture and play the *doctor-nurse game* (Stein, 1968), in which the “nurse is to be bold, have initiative and be responsible for making significant recommendations while at the same time appearing passive” (p. 101). Although nurses increasingly claim that they are being assertive in their interactions with physicians, observers report otherwise (Coombs & Ersser, 2004) and the doctor-nurse game continues to be played.

Is marginalization of the nonmedical members of the team and devaluing of their knowledge a deliberate attempt to maintain the superior status of medicine, especially in the face of a narrowing status gap? Or is it just business as usual, reflecting the mantle of leadership ingrained in the medical identity? Whichever it is, nurses perceive that their contribution has been denied and experience conflict without the medical counterpart being aware of such feelings at times.

Teams work differently and some are more democratic than others. It is suggested that members of teams that work synergistically have subordinated their group identities to either a new team identity or have adopted a role identity, through which other members can be seen in complementary counter roles and positions can be negotiated in the best interest of the patient. This transition is clearly difficult for groups whose self-esteem is boosted through operating out of their superior group status. However, should such a transition take place, the dynamics of the team will become more integrative, with greater attention to team players and mutual learning (Freeman, Miller, & Ross, 2000). This is not the norm yet, in healthcare teams. Sadly, Allen and Hughes (2002) surmised that

doctors' support of teamwork amounts to marking out "an arena for nurse decision making at the periphery that leaves medicine's core intact" (p. 73).

Conflict related to shifting boundaries and changing roles.

The blurring of role boundaries and ability for substitutive functioning is very attractive at the *macro* and *meso-levels* of policy makers and administrators, who need to constrain costs and accommodate workforce shortages. It is a much publicized refrain in healthcare policy. However, in specialized areas, a depth of knowledge and skill is required and such substitution is not straightforward. Physicians, grounded in the sanctity of their distinctive specialized knowledge and fearful of legal liability are reluctant to divest their specialized tasks to others, but unmindful of a similar need for autonomy in specialized areas in nursing, and acting out their ingrained leadership role, they frequently intrude into areas, in which the nurse could well perform autonomously.

Undeniably boundaries have shifted and nurses are now performing more skilled tasks and a new grade of staff are performing the traditional nursing tasks; the problem lies in establishing where the lines are drawn and explicitly underscoring the autonomous core of each profession. As Friedson (2001) asserts:

Without boundaries, nothing could be appropriately called even an occupation, let alone a formal discipline, could exist. These boundaries create mutually reinforcing social shelter within which a formal body of knowledge and skill can develop, be nourished, practiced, refined and expanded. (p. 202)

This brings us back to the socialization in each profession, which has led both physicians and nurses to believe that they are autonomous professionals without clarifying boundaries. Without clarity about boundary lines, it is difficult to comprehend how the two can simultaneously function autonomously.

However when nurses are prevented from becoming equal partners and decision makers as they expect and boundaries are not clearly demarcated, they express their independence through pointing out to physicians when their diagnosis or treatment is wrong (Cohen, 1981). Such an attitude although cathartic for nurses, is likely to strike at the very heart of physicians. Clearly the idea of autonomy needs to be considered within the context of professional boundaries and not as a professional prerogative; in the first instance it is likely to facilitate interprofessional sensitivity, in the second it could destroy it.

The conflict associated with a quantum shift in role boundaries is best exemplified when a nurse practitioner joins a general practice. As the nurse practitioner struggles with dual roles and has to decide when to behave as a *nurse* and when to put on the mantle of a *physician*, the physician finds it very difficult to relinquish the care of *their* patients; a relationship, which is the very heart of medical practice. Additionally as the nurse has been trained in this new role within a different system, the physician has little confidence in it. Bailey, Jones and Way (2006) describe the experience of newly appointed nurse practitioners and general practitioners at four Canadian primary care agencies, where no formal strategies had been instituted to familiarize participating professionals with issues of interprofessional practice. “Nurse practitioners described their expectation of automatically functioning in collegial partnerships with family practitioners. However, nurse practitioners suggested that in reality in these practices they actually worked in more traditional hierarchical relationships” (p. 386). Physicians consistently talked of being unsure of what the nurse practitioner role involved and expressed concern about competency in relation to medicolegal liability, while nurse practitioners had to

repeatedly defend themselves and prove their competencies. Legal issues related to collaborative practice and the expanded roles of team members remain a concern. Clearly there is a move in regulatory law to become more congruent with the blurring of role boundaries envisaged in collaborative practice but the fluid and inconsistent nature of change is a cause for concern and confusion. The area of professional malpractice and liability is even more problematic. As Lahey and Currie (2005) point out “In malpractice law, clarity of role, of function and of clinical decision-making is key to assessing whether a provider has met the standard of care” (p. 209). Physicians fear that in the face of lack of clarity of roles and function the courts will “continue to impose a level of accountability on physicians that is disproportionate to their roles as members of clinical teams” (p. 211). Change in the way liability is allocated by the court within the context of interprofessional team work will take time, as the legal process goes through a learning curve, while focusing on the individual circumstances of each case. In the meantime physicians fear that they will be held accountable for the mistakes of others and be more likely to be named the defendant, being the most heavily insured. These issues are likely to reinforce the maintenance of the hierarchical model where the physician is most comfortable as leader and decision maker.

While physicians are trained to document and express their competencies explicitly such as, the conditions they can treat, the procedures they can perform, nurses are trained to care holistically and tend to express their competencies only within a given context. Other conflicts related to the emphasis on treatment of disease versus health promotion are a direct consequence of their professional priorities (Bailey, Jones & Way, 2006).

It is evident that when boundaries are crossed in a way without adequate preparation that nurses take on roles and functions, which form the core of medicine, resistance from physicians is strong and immediate, as one would expect based on intergroup dynamics considered above. The physician as the more powerful is able to revert to an authoritarian stance and dampen the nurse's execution of the new role. In contrast, when nurses take on roles which the physician regards as peripheral and nonthreatening, they are usually supported.

#### Structures, settings, and conflict.

Nurses and physicians work together in diverse settings, such as general wards, intensive care (Coombs, 2003), palliative care, community outposts, and general practice (Blue & Fitzgerald, 2002), to name a few. Each setting has its unique demands and structure (Caldwell & Atwal, 2003); they are expected to adjust, not just to the demands of the setting but also to each other's variable roles, jurisdictions and levels of experience. This requires flexibility in functioning and an understanding, both of the situation and the competencies of the other.

As we have seen, uniprofessional education does not provide them with either the flexibility or such knowledge. Although physicians are ingrained in deferring to authority within the medical hierarchy, they have little understanding of nursing hierarchy and do not know what to expect of them. This leads to higher levels of conflict in situations where there is high staff turnover and junior doctors encounter experienced nurses transiently; failing to appreciate the nurses' greater experience and trained to appear confident, they are unable to admit their own inexperience and enact their prescriptive role independently. Conflict proceeding from this dynamic has been documented

repeatedly, in studies of intensive care (Bucknall & Thomas, 1997; Coombs, 2003; Coombs & Ersser, 2004; Thomas, Sexton, & Helmreich, 2003). On the other hand in situations where junior physicians and nurses work together in stable settings and develop personal working relationships, such as in general wards, nurses perceive them as allies and as buffers between themselves and senior physicians. “On specialty wards where the structure was such that there were no ‘buffer’ roles [residents] there was more conflict, more disagreement and less understanding between nurses and physicians” (Devine, 1978, p. 291).

Conflict between the two groups is least palpable in settings which demand bio psychosocial skills and nurses are able to enact their nonbiomedical role. In these settings, such as in palliative care (Carpenter 1993) nurses and physicians come closest to being a team. As we have seen physicians are indoctrinated in the “notion that a doctor is most fully a doctor when the patient is in trouble” (Weinholtz, 1991, p. 157), and are therefore more willing to share decision making and relinquish authority in non-biomedical areas.

#### Status gap and conflict.

As discussed earlier, the literature dealing with nurse-physician conflict has proliferated in the last three decades in the developed world and corresponds with the improving status of nurses during this time. The question arises: Are nurses just more aware of conflict now or has nurse-physician conflict actually escalated? Undoubtedly, the hierarchy in health care that was previously accepted as a norm is now being increasingly challenged. And now with higher education, emphasis on publishing, and more avenues for expression, the voice of nursing as a profession is better expressed but

it is unclear if it is better heard outside the nursing profession, as there is little sharing of scholarship between professions. Based on intergroup dynamics, both physicians and nurses can be expected to express increasing bias as the status gap becomes narrower. According to Bettencourt and Bartholow (1998) a high status group is more likely to show bias when they perceive the status gap to be closing, likewise the low status group, in this case, the nurses are also likely to show more bias when status differential is perceived as unstable and boundaries become more ambiguous (Ellemers, Wilke & Van Knippenberg, 1993). A study by Hojat et al. (2003), demonstrated that there was less nurse-physician conflict in Mexico and Italy where traditional hierarchical roles are maintained and the status gap is wider than in the USA and Israel, thus corroborating this dynamic.

**Conclusion.**

The close working relationship between nurses and physicians, ostensibly as a team, is fertile ground for conflict, as group identities, developed through socialization in uniprofessional education collide and interact. These conflicts are felt more acutely by nurses, who are unable to shake off the historical image as a physician's assistant and close the status gap, in spite of their professional training and hopes that it has inculcated. They are unable to actualize the objectives and values their identity symbolizes, as physicians continue to have the final word. Physicians, on the other hand are less aware of the conflict and are able to enact their priorities autonomously. Nonetheless, they contribute to the conflict by simply enacting their ingrained identity as the invulnerable leader and final arbiter in matters pertaining to the patient, while remaining ignorant of the nurses' competencies, experience and world view. Their self-esteem remains buoyed

by their super ordinate professional identity and they are unable to adopt a team or role identity, which would make for more collegial relationships.

Clearly both educational institutions and those who organize healthcare delivery have been pursuing their independent agendas and have placed unrealistic expectations upon nurses and physicians. They have espoused high sounding models of teamwork and collaborative practice without attention to details of autonomy, decision making and role boundaries, which perpetuate frustration and conflict within the realities of practice.

All of this begs the question—is it sufficient to teach nurses to be more assertive and physicians how to resolve conflict? Are a few weeks of interprofessional education within years of professional training sufficient to change the way physicians and nurses interact? And even more fundamentally, do we know how professional education in its current incarnation intersects with values and ideals of this generation to influence students' identification with their professions and interprofessional perceptions? These questions have not been answered convincingly. They are important because the answers can serve to guide professional education, healthcare structures and health policy towards grooming professionals and creating environments which favor collaborative team work. It is hoped that the proposed research will advance knowledge in this area and fill a palpable gap.

## Chapter 3

### **The Research Question: A Quest**

How do the processes that lead to socialization, professional identification, and identity formation in nursing and medical schools influence talk about collaborative teamwork upon graduation?

### **Objectives of research.**

To explore:

1. The construction of professional identity in students attending medical and nursing schools.
2. The impact of uniprofessional medical and nursing education on the perception of self versus the *other*.
3. The impact of professional medical and nursing identity on the ability to work as a team.
4. The shift in interprofessional perceptions after transiting from professional school to professional work.

### **Purpose of the research.**

This research seeks to inform contemporary medical and nursing education about the impact of the socialization processes and the formal, informal, and hidden curriculums in professional schools, on the construction of students' interprofessional identities and values, which in turn influence their ability to work collaboratively. These findings will inform the dialogue between nursing and medical faculties in search of mutually acceptable goals for educational curricula, to prepare students for collaborative practice. The need for congruence between educational objectives and workplace realities will also

implicate dialogue between educators, healthcare administrators and policy makers.

Through a shared vision of collaborative practice and congruent medical and nursing education, patient outcome, practitioner satisfaction, retention of healthcare personnel and cost of effective delivery of health care will be positively impacted.

## Chapter 4

### Theoretical Lens and Methodology: From Conception to Execution

#### Introduction.

The role of intergroup dynamics in nurse-physician conflict has been explored through the lens of the social identity theory in the “Critical Literature Review” chapter. In this chapter I proceed to examine the processes of identification and identity formation within the context of social identity theory, which will be invoked to interpret the influence of professional education on the way recent graduates of nursing and medical school work together. I will then examine the functional, interpretive and postmodern perspectives with a view to identifying a perspective to underpin this study, which is compatible with the theoretical lens of identity. Following this the selection of a congruent qualitative methodology will be discussed, leading on to the rationalization of the method for analysis of texts, choice of participants and locations for research. Finally, as the author I will locate myself in terms of my *situatedness* and preparation for this research and then outline the measures taken to ensure rigor and integrity in this study.

#### Why study identity and identification?

Within the shifting landscape of healthcare practice, there is an attempt to flatten hierarchies and focus on collaborative teamwork. However, this is problematic, as professionals enter the workplace with expectations and meanings derived from their training in professional institutions, which do not subscribe to this concept uniformly. Students learn to identify with their schools and professional institutions or organizations rather than the organizations of health care, such as hospitals. Educational institutions tend to be holographic (Albert & Whetten, 1985), where individuals share a common

group identity and the body of medical and nursing students develops shared identities with its peers and faculty respectively. On the other hand, institutions of health care, such as hospitals tend to be ideographic where diverse groups are thrown together and individuals enact their group specific identities instead of a common organizational identity. The transition from a holographic to an ideographic setting is a challenge, which requires physicians and nurses to work together while they hold on to preformed allegiances and remain identified with their own profession. In this new and challenging environment, it is a natural response to retreat behind professional lines; this brings with it the potential for implicit intergroup hostilities. The extent to which individuals subscribe to intergroup dynamics depends upon the solidarity that they feel with their own group. Since such solidarity and identification for a novice physician or nurse develops within the framework of a professional school, we need to return there to understand its meanings, strength and construction.

As argued, an individual's response to intergroup interaction is related to the individual's strength of identification with their own group. However, it is not just this sense of "belongingness" that determines attitude and actions. It is also the juxtapositions of values, goals, and interests that are internalized with those represented by members of the other group that come to the fore. To some extent the values and goals associated with a profession are commonly held by all members but how they are prioritized and internalized by an individual is informed by that individual's perceptions and the congruence of these with previously held values. Although social identity literature speaks of multiple social identities and of the enactment and salience of one identity over another, it admits that new identities are mediated through congruence with previously

held identities (Ashforth & Mael, 1989). It follows that even within a professional group, especially one that is composed of increasingly diverse groups of people, some variation in how professional identity is adopted and enacted can be expected. Thus far a case has been made for studying first how identification comes about through meanings attached to this sense of belongingness and second how professional identity is incorporated, constructed and realized by an individual.

**The process of identification and the construction of identity.**

The concept of identification is derived from organizational literature. The notion that “organizational identification occurs when an individual’s beliefs about his or her organization become self-referential or self-defining” (Pratt, 1998, p. 172) encapsulates the essence of the many definitions offered. In extrapolating this organizational concept to professional institutions and schools, some differences between the two must be kept in mind. Within work-based organizations, identification and identity formation proceed concurrently in the context of the workplace and are informed both by the individual’s perception of organizational identity and his or her experience at work; in contrast, the student in a professional school identifies with the profession but has no experience of the workplace. Becker, Geer, Hughes, and Strauss (1961) assert “Students do not take on a professional role, while they are students” (p. 420). Therefore, though students are socialized into the culture of the profession and begin to identify with it, the formation of their identities as professionals awaits the assumption of work roles and work related interactions. Another difference between the two is that organizational identification relates to where people work, whereas professional identification is aligned with what they do and transcends work locations. It follows that while identification with

organizations and its impact on identity is likely to change with location; professional identification is usually lifelong and consequently more pervasive.

With these caveats in place, I return to examine the process of identification. Harquail's (1998) report, "Identity in Organizations" points to the holistic character of identification and its effects on the whole person, which involves thinking, feeling, and acting. She goes on to explain the difficulty in untangling the "complex interrelationships between the three elements" (Harquail, 1998, p. 224) and attempts to identify the driver for identification. One may argue that because we are ultimately interested in the behavior of physicians and nurses in relation to collaborative practice, it is sufficient to observe behavior and from there make inferences about the implications of professional identification. In keeping with this line of thinking, sociologists have used detached observation as a method to study both identification and identity; I argue that this results in an incomplete picture and the inferences arrived at may be unsustainable. For instance, an observer studying the behavior of a nurse in the emergency room sees the nurse interacting with a patient with severe abdominal pain. The nurse goes to the patient's bed, inserts an intravenous line and with just a few words retreats to another cubicle. The observer notices the patient's distress and need for comfort and concludes that the nurse is not empathetic. However, without some idea of what the nurse is feeling and thinking, the observer fails to grasp that the nurse has six other equally ill patients who need attention, is distressed by the inability to offer comfort, and has been considering leaving the current post as it does not allow enactment of the nursing role, as he or she sees it. The observer therefore captures the situation but not the essence of the person. With this

caution in place, the circular relationship between emotion, cognition, and behavior are examined, to better understand the process of identification and its implications.

The model arrived at by Harquail (1998) and colleagues, expands on identification at these levels. They propose that emotion is important at several levels and signifies personal attachment to identifying with the group; consequently if a relationship with the group is threatened, individuals experience emotional distress. This was termed *emotional significance* of identification by Tajfel (1978). Furthermore, they claim that emotions are elicited as a response to the individual's or others' evaluation of the organizational identity. This corresponds to Tajfel's (1978) concept of *value significance*. They add that when identification is rewarded by positive emotions the process becomes self-reinforcing and motivates closer identification with the organization or profession. The reverse is true if identification results in negative emotions. They go on to propose that the link between affective and cognitive identification resides in the capacity of emotions to enlist cognitive attention to what it means to belong. This proposition, however appears tentative and fails to explain the leap from emotional attachment to cognitive identification with the organization or profession.

The above explanation linking emotional and cognitive aspects of identification presumes that emotional attachment comes first. However, Harquail and discussants concedes that the choice to join and identify with a profession may be motivated by cognitive congruence of the profession's values and goals with that of the individual's. In this case emotional attachment may come through the process of socialization into the culture of the profession. They claim that emotion and cognition are tightly coupled. In contrast, behavioral identification may proceed from several points of departure; it may

represent identity congruent behavior or a superficial desire to identify. Harquail asserts that affirmation of such behavior reinforces emotional identification.

To further illustrate this circularity, consider the example of a medical student in the early years at school. At the level of feeling, the student's self-image and esteem is boosted by belonging to a prestigious profession, parents and friends contribute to the positive emotions by acknowledging the student's potential, hard work, and sense of responsibility. The student is socialized into the culture of the medical school, develops relationships and camaraderie with other medical students, which increases the sense of wellbeing and bonding within the institution. The student is privy to the awe and respect the teachers are held in. All of these experiences enhance the student's positive feelings and strengthen emotional attachment to being a member of the profession. At the same time or later, the student is motivated to reflect upon the culture of the profession in which they are immersed and of which they will become a member. This leads to thinking and evaluating the values and goals the profession stands for. If these are congruent with the student's self-concept, they are internalized and in turn reinforce positive sentiments. However, if they are at odds with personal goals, there may be difficulty in reconciling emotions with thoughts, leading to a dissonance and weakening of identification. This may happen, if for instance, the student is dedicated to a sporting career as well and is unable to subscribe to the ethic of long and unpredictable hours of work. However, if emotions and cognition are aligned, identification proceeds and the student's behaviors begin to express professional norms.

As illustrated, regardless of whether the cognitive or affective identification comes first, they are internal manifestations of identification and purported to be reinforcing.

Behavior, in contrast, is an external manifestation of identification. It may be spontaneous and reflect internalization of the professional identity; this is likely to be the case when identity is established through work and time spent in the profession. At the level of the student, however, it is likely to be an expression of the desire to identify or a need to conform, or even an attempt to try on a professional mantle for fit.

Alongside the process of identification, development of a professional identity proceeds through internalizing professional values and norms into one's self-concept, so that these are enacted through personal convictions. As Albert, Ashforth and Dutton (2000) point out:

By internalizing the group or organizational identity as a (partial) definition of self, the individual gains a sense of meaningfulness and connection. Identity and identification explain one means by which individuals act on behalf of the group or the organization. Thus theories of identity and identification are infused with motivation and feeling. They help to explain the direction and persistence of individual and more collective behaviors. (p.14)

Adoption of professional identity is not necessarily an all or none phenomenon; its strength may depend on a variety of factors, such as its congruence with simultaneously held identities, other organizational or role identities, the cohesiveness and consistency of the professional culture, and its impact on self-esteem. Moreover, professional identity is not concrete and its meanings and strength change over time through experience, phronesis, and new affiliations (Ashforth & Mael, 1989). To research the meaning of *who* you are through the lens of professional identity alone overlooks the complexity of individual identity and the possibility that some professionals may see themselves primarily as embodying their roles, rather than as members of a group. For instance, a physician working in a rural setting may embrace the role of a patient advocate or healer,

rather than a member of the larger body of the profession. Likewise a nurse whose work is mainly administrative may adopt the role of an administrator. It is difficult to predict which identity will be more active in a given person. However, when the emotional and cognitive rewards of belonging to a profession are deemed to be high, a professional identity is more likely to be invoked (Ashforth & Mael, 1989). Clearly, a study that approaches the field acknowledging that individuals may affiliate more strongly with either a professional identity or a role identity will lead to a more comprehensive understanding of identity dynamics. Stets and Burke (2000) emphasize the need for such binocular vision:

We point out that one always and simultaneously occupies a role and belongs to a group, so that role identities and social identities are always and simultaneously relevant to, and influential on perceptions, affect and behavior. For this reason we cannot easily separate the role from group, either analytically or empirically. (p. 228)

Whether one conceptualizes identity through the lens of identity theory or through that of the social identity theory it is clear that identity situates a person in relation to others as a member of a professional organization or group, or in a role (Stets & Burke, 2000). In both instances such an identity is expressed by the individual through self-categorization in a role or as a member of a group (Albert et al., 2000). “Thus although the basis of self-classification is different in the two theories (group/category versus role), theorists in both traditions recognize that individuals view themselves in terms of meanings imparted by a structured society” (Stets & Burke, 2000, p. 226). Through the lens of the social identity theory, the *other* is the out-group, while through the lens of identity theory; the other is the one in a counter role. The differences in enactment of a professional identity versus a role identity are most apparent in the perception of others.

The consequences of self-categorization as a professional are:

... an accentuation of the perceived similarities between the self and other in-group members, and an accentuation of the perceived differences between the self and out-group members. This accentuation occurs for all attitudes, beliefs and values, affective reactions, behavioral norms. (Stets & Burke, 2000, p. 225).

The relational and comparative basis of social identity means that it is reinforced by distinctions between itself and reference groups, which are self-enhancing for the in-group. The dynamics of intergroup bias have been discussed in the “Critical Literature Review” chapter. Social identity theorists claim that professional identification and identity formation proceed through depersonalization and are motivated through the enhancement of self-esteem.

In contrast, “by taking on a role identity, persons adopt self-meanings and expectations to accompany the role as it relates to other roles in the group and then act to represent and preserve these meanings and expectations” (Stets & Burke, 2000, p. 227). Role identity construction proceeds through “self-verification or seeing the self in terms of the role” (Stets & Burke, 2000, p. 232) and is motivated through affirmation of self-efficacy. Other roles are viewed as counter roles and role performance is achieved through negotiation (Stets & Burke, 2000).

Role and social identities are integrated with person identities. Stets and Burke (2000) define person identity as the “set of meanings that are tied to and sustain the self as an individual” (p. 229). It is recognized that “person identities may influence role and group identities when they are first taken on. Once a role or group identity becomes established, however, person identities may have little impact” (Stets & Burke, 2000, p. 229). This demonstrates the power of internalized group and role identities.

The gaps in the seeming certitudes of identity theories speak of the role of individual agency in conjuring a common yet distinctive sense of identity and reaffirm the need to explore the construction of identity at the level of the individual. At this point I return to develop the earlier assertion that a medical or nursing student may identify with the profession, become attached to it emotionally, internalize its values and enact the corresponding behaviors of a professional student but at this time the student is not yet a professional. As such, the student's professional identity is incomplete and remains to be developed through the exigencies and interactions in the workplace. Because our interest lies in informing change to facilitate collaboration, it stands to reason that we explore the points of further construction of the student's identity in the workplace and tease out how the meanings and expectations of student life have impacted the fleshing out of identity.

### **Construction of professional identity in the workplace.**

Beyond the processes of socialization, identification and internalization, accounts of how identity is constructed are sparse. In this field, the recent work of Pratt, Rockmann and Kaufmann (2006) is illuminating. Their research set out to "build and enrich theory around how professionals construct their own professional identity" (Pratt et al., 2006, p. 236). They "chose to study physicians during their residency, because professional identity formation and change are thought to be most pronounced during this time" (Pratt et al., 2006, p. 238). They used medicine as the prototype of professions for their study; it is reasonable to suggest that the theory built could be applicable to other professions, such as nursing.

Pratt et al. conducted a longitudinal study using semistructured interviews with residents from different specialties within one hospital over six years and developed a

theoretical model of the interplay of work and identity customization. The salient points of their theory are that work results in work-identity-integrity assessments which feed into two related learning cycles. If work-identity-integrity assessments are violated, i.e., beliefs about professional identity are not validated, but the individual is socially validated, the individual proceeds to improve performance. Such violations, they claim, also lead to learning about professional identity and an attempt to change the sense of *who* one is through a process they called identity customization. When violations are minor, sense making results in enrichment of identity but if they are major, they result in patching on the new sense of self or of splinting one's identity by leaning on previously developed identities. Although the authors allude to the importance of previous identification and identities they do not explore how they influence customization of identity.

The suggestion that previously formed identities influence the crystallization of the professional identity through the work-learn cycle has implications for the proposed research. Taking this as a point of departure the proposed study can expand on the influence of identification and identity formation that has taken place during professional education in the focused area of nurse-physician relationships. It can explicate how meanings developed during education influence work and how they are in turn influenced by the workplace.

Up to this point, it has been demonstrated that nurse-physician relationships are fraught with conflict and it has been argued in the "Critical Literature Review" chapter that the basis of conflict resides in their identities, which informs their interactions through meanings about who they are and what they do, in relation to who the other is. The

process of identification and identity construction has been explicated in an attempt to delineate pertinent areas of inquiry and the limited theoretical underpinnings of construction of identity and gaps therein have been considered.

The contradictions and complexities of identity are evident in several dimensions: its construction within social structures through individual agency, its stable yet mutable nature, and its negotiation through past and present influences. Just as there are multiple dimensions of this concept, there are multiple perspectives through which its study can be approached. This realization makes it imperative to examine some of these perspectives and to rationalize their suitability for this inquiry, before proceeding to matters of methodology.

#### **Perspectives to underpin research.**

For the purpose of examining the perspectives through which one can approach the topic of identity, I refer to *The Identity of Organizations* (Bouchikhi et al., 1998) in which a group of scholars and opinion leaders in the field wrestle to define the positions, assumptions, and implications of different perspectives that inform studies of identity within the context of organizations or professions. The discussants identified three perspectives; functionalist, interpretive, and postmodern. Each has different implications for the methodology to be adopted and is scrutinized with a view to its congruence with the objective of the research.

Functionalism reflects an objective and realist paradigm and therefore its ontological assumptions about identity are that it is a relatively stable construct, which exists as an object that can be studied, measured and compared. It can therefore be studied deductively through observation by a detached researcher. The heart of the functional

approach, the authors assert is “the verification or (more importantly), falsification of a proposed hypothesis” (Gioia, 1998, p. 26). Studies from a functional perspective allow one to “characterize identity along comparative dimensions (e.g., what is central, distinctive and enduring)” (Gioia, 1998, p. 27). From this brief explanation it is evident that this paradigm is manifestly unidimensional and captures only those aspects of identity, which are externally manifested, such as some behaviors but misses the essence of identity construction as self-meanings, which is central to the discussion so far. In addition, as argued, behavior is enacted within a context and objective measurements fail to encapsulate its nuances and contingencies. It is therefore clear that the pursuit of understanding identity as self-meanings cannot be accomplished through a functional lens alone.

The interpretive perspective reflects a subjectivist approach to understanding the formation of self-identity, whether as a person or as a professional, and therefore assumes that identity is a “socially and symbolically constructed notion intended to lend meaning to experience” (Gioia, 1998, p. 27). Interpretive inquiry consequently aims to develop insightful understanding of the meaning of identity. The role of the researcher within this paradigm is of one who travels with the informant to discover the meanings of the informant’s words, symbols, and metaphors (Kvale, 1996). At the point of narration or conversation the informant is the interpreter, while at a later stage the researcher inductively develops models and theoretical representations of identity (Gioia, 1998).

The interpretive framework is therefore more congruent with the discovery of meanings and the many tacit dimensions of identity. Pratt et al., (2006) demonstrated that identity is iteratively renegotiated; an interpretive framework would permit the researcher

to capture this dimension through the depth and diversity of narratives recounted. The foundational elements of this approach make it suitable as the core perspective through which this research can be conducted. The question that arises is, if it is sufficient in itself. I will return to this after a similar look at the postmodern perspective.

The assumptions of the postmodern perspective are that identity encompasses indeterminate meanings created through contemporary power relations and discursive constructions. Its objective is to disrupt and disclose these elements and to demonstrate its impermanent and fragmented nature as a product of linguistic construction (Bouchikhi et al., 1998). The constructivist and reflexive elements of postmodern thought have increasingly found their way into contemporary interpretive thinking; as Gioia (1998) notes “postmodernists are subjectivists in the extreme” (p. 28). Emphasis on discursive constructions highlights the plurality of authorial voices that may be encountered, especially in dealing with identity construction. For instance, a nurse may express his or her expectations for autonomy, to give voice to the professional stance, while being personally satisfied with their role in a team that is led by other healthcare workers. Unless the researcher is able to tease out *who* the nurse is speaking for the researcher may lose elements of identity construction or even come to false conclusions.

A critical, though brief exposition of these perspectives leads one to the conclusion that the interpretive paradigm of discovery, which incorporates the constant reflexiveness and vigilance for authorial voices is most appropriate for purposes of explicating the iterative construction of identity as an evolving, mutable, and abstract concept. To the traditionalist this choice may appear as the straddling of two perspectives, but is most suited to this study and is compatible with contemporary thought and increased blurring

of paradigmatic boundaries demonstrated in *qualitative research* literature (Guba & Lincoln, 2008).

**Qualitative methodology – Hermeneutic phenomenology.**

The preceding argument for use of an interpretive framework, as well as the exploratory nature of this inquiry invokes the qualitative paradigm as a choice for research methodology. As noted by Boyd (2001) qualitative methodologies have a holistic approach to the research questions, recognize the complexity of human realities and focus on interpreted experience through research strategies that involve a high level of researcher involvement and the production of descriptive data. If one understands the unit of analysis as that of interpreted reality, it becomes increasingly clear that the focus is on “... discovery, description and meaning rather than prediction, control and measurement” (Laverty, 2003, p. 2). Laverty (2003) points out that “... there is a growing recognition of the limitations of addressing many significant questions in the human realm within the requirements of empirical methods and its quest for indubitable truth” (p. 2).

Although all qualitative methodologies subscribe to a holistic approach, they encompass a repertoire of distinctive methods and traditions which have arisen out of different disciplines (Polkinghorne, 2005). In search of a tradition that will maintain congruity between the research question, the theoretical lens of identity, the interpretive perspective, and the philosophical worldview used to underpin this research, the researcher explored the dominant philosophical traditions in qualitative research. Through this search it became evident that *hermeneutic phenomenology* developed by Heidegger corresponded to the perception of iterative interpretation of experience as

central to construction of identity. Indeed, through Heidegger's concept of the hermeneutical circle, the understanding of interpreted life worlds is advanced and clarified. Heidegger's hermeneutic phenomenology was an offshoot of Husserl's phenomenology and is often confused and used interchangeably with it. Lavery (2003) clarifies this distinction succinctly "While Husserl focused on the understanding of beings or phenomena, Heidegger focused on 'Dasein' that is translated as the 'mode of being human' or 'the situated meaning of a human in the world'" (p. 7). Quite simply a phenomenological account speaks of *what* it is to experience, while the hermeneutical account speaks to *who* one is or becomes in relation to experience. Hermeneutic research is based on interpretation and focuses on historical meanings of experience and their cumulative impact on the individual and social settings. Heidegger's hermeneutic circle has been described as an interpretive process which moves from the parts of experience, to the whole of experience and back and forth again and again to increase the depth of understanding (Koch, 1996; Polkinghorne, 1983). This process corresponds to the researcher's perception of how professionals in training iteratively interpret their experiences and how these interpretations influence identity and furthermore how they proceed to interface with the work environment and reconstruct their identity, yet again (Pratt et al., 2006). This cyclical relationship, embodying the hermeneutical circle is well described by Munhall (1989) "Meaning within this paradigm is found in the transaction between an individual and a situation so that the individual both constitutes and is constituted by the situation" (p. 25).

Another distinction between Husserl and Heidegger was their understanding of the researcher's role. Heidegger understood that people and the world are indissolubly related

to each other, and that one's background cannot be made completely explicit or put aside while Husserl, despite his non-dualist philosophy promoted the concept of *bracketing*, through which a researcher is expected to recognise their beliefs, biases, and assumptions and suspend them, thus consciously excluding them from influencing their understanding of the phenomenon at hand. Lavery (2003) further explains Heidegger's viewpoint:

*Pre-understanding* is not something a person can step outside of or put aside, as it is understood as already being with us in the world. Heidegger went as far as to claim that nothing can be encountered without reference to a person's background understanding. (p. 8)

In Heidegger's view the researcher's pre-understandings, biases and background can neither be entirely comprehended nor put aside and it is critical for the researcher first to reflect upon these and lay them out for the reader and second to remain aware of the researcher's influence while exploring the subject's experience. Remaining vigilant the researcher can attempt to obtain a text in which the dominant voice belongs to the subject. The researcher's bond with the topic, situatedness and horizon will once again come into play when this text is interpreted for analysis.

Gadamer (1960/1998) who furthered hermeneutic phenomenology as a research methodology saw the researcher as someone who has a bond or acquires a connection with the subject matter, as is the case in this research. He viewed interpretation as a *fusion of horizons*, through dialectical interaction between the interpreter's expectations and the text. Lavery (2003) explains horizon as a "range of vision that includes everything seen from a particular vantage point" (p. 10). A researcher's horizon or what they are able to see is therefore delimited by their background, history and, experience. Clearly a researcher's horizon will impact their expectations and if their horizon is

limited, their understanding and exploration of the subject at hand will be correspondingly superficial. At this juncture it is clear that the researcher's background and horizon are intricately and indissolubly a part of this research and will continue to be so through the process of data collection and iterative interpretations.

It has been argued that hermeneutic phenomenology is an appropriate philosophical lens to guide this research, however, it does not provide any guidance regarding preferred methods for data collection or for analysis. Within the plethora of methods available the researcher needs to use one that will allow intensive exploration of experience with the subject. It is evident that to plumb the vertical depth of the subject's experience the researcher will have to probe early understandings to encourage the subject to reflect and arrive at new interpretations and deeper meanings. Such nuanced exploration will only be possible through face to face dialogue and will result in languaged data. This is in keeping with Polkinghorne's (2005) assertion that "People have an access to much of their experiences, but their experiences are not directly available to public view. Thus data gathered for study of experience need to consist of first person or self-reports of participants' own experiences" (p. 138). Clearly then for such an intimate interaction, the dialogue needs to take place in a safe and private place and the researcher-subject relationship needs to be anchored in empathy on the part of the researcher and trust on the part of the subject. Such dialogue can be achieved through one-on-one interviews and focus groups but the implicitly collective nature of a focus group defies the intimate space needed for reflection on individual experience and meaning making. Since individual experience and the construction of identity over time is of interest for this

study, I submit that one-on-one interviews are the suitable primary vehicle for data collection.

### **Qualitative interviews and analysis of texts.**

As discussed above, the milieu of the interview must facilitate reflection and interpretation of experiences on the part of the subject. For this to happen, the researcher must follow the subject's lead. Openness in a qualitative interview has been consistently emphasized (Koch, 1995; Polkinghorne, 2005). Polkinghorne (2005) explains the quality of openness and writes of an interview conversation as consisting of "... a give and take dialectic in which the interviewer follows the conversational threads opened up by the interviewee and guides the conversation forward producing a full account of the experience under investigation" (p. 142). While pursuing openness and being led by the subject as the researcher, I remain conscious of the need to nudge the conversation towards areas of interest for this research. To recapitulate, the areas the research hopes to inform are:

- The construction of professional identity in students attending medical and nursing schools.
- The impact of uniprofessional education on the perception of nurses and physicians in terms of self versus the *other*.
- The impact of professional medical and nursing identity on the ability to work as a team.
- The shift in interprofessional perceptions after transiting from professional school to professional work.

As is evident the areas of interest are related to each other and a question addressing one area may segue into another, such that prepared questions may lose their preeminence and remain a guiding framework. [Appendix A](#) lists the framework of questions developed to guide the interviews. As indicated the impact of professional education on the ability to work together is best examined through the narratives of those who are now in the workplace. As such the questions are structured to elicit the narratives of work, through which the researcher will explore the influences and identities constructed through school. The interviews planned can therefore be considered semistructured, where the researcher will guide the subject in the direction of inquiry, based on a loose structure, in addition to being led by the subject's narrative reflections.

The direction in which the interviewer probes will naturally reflect their horizon, bringing the discussion back to the salience of horizons and *co-construction* of the data. As the researcher, if I have a limited view of the experience, I will fail to probe in directions that I cannot see or misunderstand the implications of events and stories recounted by the subject. With this in mind, I will prepare myself to broaden my horizon through immersing myself in the worlds that I intend to explore. Not only my horizon but also my pre-understandings, biases and assumptions as well as the subject's perception of these will influence what is said, what is revealed and indeed even what is thought. Constant vigilance will be needed to allow the subject to remain the author of the description. Polkinghorne's (2005) caution is pertinent "... researchers need to take care that their expectations do not infiltrate the account. They need to manage their influence and bring focus to the participant's own understandings" (p. 143).

It is anticipated that the interviews will result in texts that are rich in descriptions and stories; as the researcher I will actively encourage these stories and their interpretation. The value of narrative has been repeatedly highlighted; Hiles (2002) encapsulates this well in pointing out that it is through the nuances of narrative that one's tacit knowledge about oneself and that of the world one lives in is revealed. She goes on to emphasize the preeminence of narrative in constructing and maintaining self-identity. Although the use of narratives may lead to concerns about the truthfulness of the facts recounted, this concern can be dispelled through the argument that it is not the accuracy of the facts that determine their authenticity, but the veracity of how they are perceived and how they contribute to the construction of identity. Polkinghorne (1988) notes:

Facts only partly determine the particular scheme to be used in their organization, and more than one scheme can fit the same facts: several narratives can organize the same facts into stories and thereby give facts different significance and meaning. (p. 181)

Through the narrative accounts, it is anticipated that the researcher will obtain an insight into the subjects lived world and how identity is enacted and how it is iteratively reconstructed within and following these experiences. The task of interpretation is implicit in this process at multiple levels. Initially, as the subject brings forward their prereflected interpretations and then as they reflect upon their accounts and bring forward their newly understood interpretations. This is followed by the interviewer's interpretations, which are implicit in their probing, and lead to further interpretations as the account reaches into deeper recesses of the experience. Yet further, in the process of analysis the interpretations arrived at will be subjected to the gaze of the research questions and existing literature and new understandings may emerge. This circular

process is congruent with the hermeneutic circle, however, it appears to be constantly evolving and never finite and I suggest that it is indeed better represented by a spiral.

As already discussed hermeneutic phenomenology is a philosophical stance elaborated by Heidegger and developed into a research methodology by Gadamer (1960/1998), and others. The researcher is expected to maintain congruity with the philosophical underpinnings but is neither confined nor guided by rules for the conduct and analysis of the research. In search for clarity and guidance in the process of data analysis, the author has been guided by the *phenomenological hermeneutical method* for researching lived experience, described by Lindseth and Norberg (2004), who used it in the analysis of several studies in the healthcare field (Ekman, Skott & Norberg, 2001; Lindseth, Marhaug, Norberg & Uden, 1994; Storli, Lindseth & Asplund, 2008). Based on Heidegger's hermeneutic phenomenology and inspired by Ricoeur's interpretation theory they use three methodological steps to arrive at a comprehensive understanding of the transcribed interview text.

The first is naïve reading followed by structural analysis, which leads finally to comprehensive understanding or interpreted whole. Lindseth and Norberg (2004) consider the initial naïve reading the non-methodic pole in which the text is read several times to "grasp its meaning as a whole" (p. 149). This naïve understanding is expressed in phenomenological language that is, expressing the meaning of the experience. The naïve understanding then guides the structural analyses, which is the methodic component of interpretation, to identify and formulate themes described as threads of meaning, which run through parts of the text. At the outset of structural analysis the text is decontextualised and divided into meaning units, which may be of variable length but

express a coherent meaning. The meaning units and later the emerging themes are reflected upon against the background of the naïve understanding. The meaning units are condensed into their essential meanings and further abstracted into subthemes, themes and main themes. The iterative process of validating the themes in the structural analyses against the naïve understanding and constructing both anew is congruent with the hermeneutic circle of interpretation which moves from parts of the experience to the whole experience and back and forth to increase the depth of engagement and understanding of the texts (Annells, 1996; Polkinghorne, 1983). Since the text is multidimensional, such iterative analyses may yield multiple infinite meanings and it appears pertinent to ask: How will the researcher know when to stop? In this context Kvale (1996) provides guidance as he explains “In principle, such a hermeneutical explication of the text is an infinite process, while it ends in practice when one has reached a sensible meaning, a valid unitary meaning, free of *inner contradictions*” (p. 47). Following this process, the naïve understanding, the structural themes and the text are all reflected upon in the light of the research question, the existing literature and the researcher’s pre-understandings to arrive at a comprehensive understanding. It follows that like the naïve understanding this step is also non-methodical. Lindseth and Norberg (2004) summarize the talents employed in this process eloquently “We use our artistic talents to formulate the naïve understanding, our scientific talents to perform the structural analysis and our critical talents to arrive at a comprehensive understanding” (p. 152). Although the researcher has chosen to be guided by Lindseth and Norberg’s phenomenological hermeneutical method which carries forward the congruity between the research question, the research lens and the philosophical underpinnings of the

method used, the researcher is cognizant that each research project and its text poses unique challenges and may require creative approaches in analysis and presentation.

Before moving on, I return to the primacy of a trusting relationship between the researcher and the subject and the need for the researcher to reflect upon their own situatedness. What is the basis of trust between relative strangers and how can it be cultivated? Experts in the field suggest multiple encounters (Polkinghorne, 2005) with the subject to forge a trusting relationship over time, but I submit that the environment of this research, in which one is dealing with extremely busy professionals, precludes this approach. In fact, the very expectation or requirement of recurrent meetings implies a lack of understanding and respect, this became clear to me during early conversations with potential participants and was later confirmed when post-interview contact was made. Clearly this does not dismiss the need for *trust* but calls for gaining it within the constraints of limited interactive time. Working with these limitations, a face-to-face meeting with the potential participants at the time of recruitment has been designed and is to be followed by another meeting for one and a half hours during which the interview will be conducted. ([Appendix B](#), [Appendix C](#), [Appendix D](#), [Appendix E](#)). During the initial meeting, I will convey the research aims and process as well as safeguards related to confidentiality and anonymity and answer queries as they arise, then or later. As both I and the subjects are healthcare professionals, it is hoped that their shared history and experiences will promote mutual understanding and trust. It is also submitted that trust, which allows the subject to open up, may be gained tacitly within the time and space of the interview itself as the subject perceives an *I-Thou* nature of the encounter. Although at the time of designing the study a post interview meeting to verify the interview

transcripts had been envisaged, this was not possible due to logistic difficulties in arranging further meetings and was done through e-mail instead. I will now proceed to consider the choice and selection of subjects, following which I will explicate my situatedness as the researcher in relation to the subjects and topic of inquiry.

### **The purposive selection of participants.**

As the aim of this research is to study the impact of uniprofessional nursing and medical education on the ability to work collaboratively, it may seem reasonable to study medical and nursing students. However, as discussed earlier the student's perceptions of what it means to be a member of the profession is devoid of the experience of actually working as a professional. In particular, the student has little or no experience of working directly with other health professionals and their opinions and impressions are constructed through a combination of observing role models and adopting their largely negative attitudes towards others (Hall, 2005). It is through the juxtaposition between the student's sense of professional self and the demands and interactions of the workplace, that their own professional identity is constructed. With this understanding, it is clear that the participants in this study should be recent graduates of medical and nursing schools, and not students, whose identity is being constructed through the reconciliation of identification with the profession in school and the operative contingencies of the workplace, where they now work alongside each other. The value of studying recent graduates who are at the cusp of becoming professionals and whose identity is being actively forged by their experiences is borne out in the works of Cohen (1981) and Pratt et al., (2006). Speaking of nurses entering the workplace, Cohen writes "The shock comes when they find that the total system reflects the same problems inherent in their

education. The health care system demands that they produce as professionals and take responsibility for their judgments while maintaining subservient attitudes” (p. 68).

Writing about the construction of professional identity among medical residents, Pratt et al., (2006) “emphasized the role of ‘working and doing’ in the creation of self” (p. 238).

Pratt et al., suggest that while all medical graduates hold some values and beliefs in common, “residency represents the initial formation of more permanent differentiated (i.e., specialty) professional identities” (p. 238) and that changes in identity formation are most pronounced during this time. In addition to the *doing*, residents must interact in formative encounters with other professionals. As van Maanen and Schein (1979) assert conceptions of self are constructed through reflections and interpretations of how others respond to one in work or social settings. These arguments lend further credence to using junior residents and correspondingly junior nurses as appropriate subjects for this study. They are at a stage where the impact of professional school is still acutely felt and professional identities are being intensely constructed and are not yet subsumed by years of phronesis and new affiliations. They have experienced what it is to be a professional student and are now experiencing what it is to work alongside each other. In keeping with expectations of purposeful sampling in qualitative research (Polkinghorne, 2005), it is anticipated that junior nurses and residents, within three years from graduation, will provide rich data to refine and clarify the meanings of their experiences.

Most studies pertaining to professional identity have been uniprofessional; only a few have explored both professions in limited ways (Lindseth et al., 1994). Consequently, the two professions have been largely viewed through different perspectives, making it difficult to create a reliable binocular picture. It is hoped that employing the same

perspective and methodology in exploring meanings of identity within mutual contexts will provide insights into how shared experiences are construed and how they impact identity for individuals in both professions. Having made a case for studying recent nursing and medical graduates in settings where they work alongside each other, the next step is to identify the settings in which they will be studied and consider their implication on the transferability of findings.

At the outset, this study was to be conducted on Vancouver Island, British Columbia in Canada, where the researcher is located. During the process of developing a proposal an opportunity opened up to extend and replicate the study at a National Health Service Trust in the South of England. Although intuitively this seemed a remarkable opportunity, it obliged the researcher to make explicit its impact on the study and its transferability. A pertinent question appeared to be: How are the advantages and limitations of conducting the study in one location jeopardized or mitigated by extending it to a second location? The advantages of conducting it in a single location are largely logistic. Its main disadvantage is the assumption that the findings are related to the pervading culture and therefore not transferable. It must however be emphasized that although a single health authority or hospital may imply a uniform culture, individual units, wards and disciplines have distinctive demands and cultures and it may be that only broader attitudes that reflect overarching health policy, professional training and social discourses undergird the commonalities. If the study is extended to a different but comparable jurisdiction, themes that are found to be at the core of both locations are more likely to be accepted as transferable to healthcare contexts, which identify with features of both locations. Clearly then the case for transferability of core themes will be more

robust if they straddle two countries whose healthcare systems, medical and nursing education and training are sufficiently similar to be studied together.

In both jurisdictions medical residents, who are graduates of medical school, are trained in service through rotations in various disciplines for two years, followed by more training determined by their choice of specialty. The length of time spent within one rotation is approximately four weeks in Canada and four months in the UK. In both countries graduates from schools all over the country compete for residency seats. Consequently, a hospital may train graduates from several schools at any time. While most Canadian medical schools require entrants to have a minimum of three years of post secondary education, several medical schools in the UK take entrants after high school. Hospitals in both countries employ junior registered nurses who have either a diploma or a Bachelor of Science degree in nursing. They are deemed to have completed their training and are employed to specific units or wards and are not expected to rotate. Training hospitals have been identified on Vancouver Island and in the South of England. Through the recruitment process laid out ([Appendix B](#), [Appendix C](#), [Appendix D](#), [Appendix E](#)), six residents and six registered nurses will be recruited in each location, 24 participants in all. Residents will be recruited regardless of their current posting and nurses will be recruited from a variety of wards to represent the acute-subacute spectrum of care offered in the hospital.

Although achieving saturation that is, reaching a point where new sources do not deepen or challenge the data is considered valuable, the necessity to recruit busy professionals through limited contact and within a small window of opportunity will not allow theoretical sampling or ongoing recruitment (Glaser & Strauss, 1967). The

researcher has therefore opted to recruit a predetermined number of participants at each site through recruitment efforts over a short period. Based on very limited available guidelines it is expected that 24 participants will provide sufficient data to reach a full and rich understanding of the experience. In a review of sample size and saturation in PhD studies using qualitative interviews, Mason (2010) reports that when hermeneutic philosophy underpinned research the average number of interviewees was 24. In addition to saturating the data it is expected that the accounts of 24 residents and nurses about their experiences will also serve to triangulate the data, reveal multiple facets and add richness and complexity. Polkinghorne (2005) develops this idea as he writes:

By comparing and contrasting these perspectives, researchers are able to notice the essential aspects that appear across the sources and to recognize variations in how the experience appears. In this sense, multiple participants serve as a triangulation on the experience. (p. 141)

For further triangulation, I will conduct three half day nonparticipant observations in areas that represent a spectrum of care within the hospital, such as the emergency unit, an internal medicine ward and an oncology ward in hospital locations from which the nurses and residents in Canada are recruited. Logistic difficulties do not permit a similar observation in the UK. The aim of the nonparticipant observation is to triangulate and complement the information obtained in interviews with physicians and nurses. I will station myself at the reception desks of the ward and observe the dynamics of the ward functions in so far as it is possible from this vantage point. In particular I will attempt to observe the verbal and non-verbal exchanges and movements of the physicians and nurses with reference to collaborative practice.

**Researcher's situatedness.**

Having identified the subjects, their location and the means of obtaining data, it now becomes imperative to situate myself, the researcher along the *detached-involved* spectrum (Doanne, 2003), so that as I interpret the text and as the reader examines the dissertation we are both cognizant of its conceivable influence. While venturing to explore this situatedness, a few questions remain problematic:

- How much of one's own situatedness is accessible?
- How does one account for that which has a bearing but is tacit or hidden?
- How far does one go in explicating situatedness?
- When does this become an exercise in navel-gazing?

It appears that to find a balance one needs to rely on one's own judgment and reflexivity and attempt to remain transparent as the iterative interpretation of the text unfolds. I see my own situatedness as being encapsulated in experiences in my career as a physician.

My experience as a physician in practice and my personal experiences of conflict and collaboration inform my assumptions, biases and expectations and will no doubt influence the research at many levels. I recognize that this influence is already reflected in the questions that I have asked, the literature that I have perused and the expectations and hopes that I hold out. Although I have repeatedly tried to realign my stance to a neutral and empathetic one towards both professions, I find this to be an impossible task. I am constantly drawn back to my experiences as a physician because my cues and concerns were formed within them. In keeping with Heidegger's philosophy I am convinced that it is not possible to exclude one's influence on the research as suggested

by Husserl but the best I can do is to make explicit my assumptions and become aware of them.

My life as a physician began in India in the mid 1970s after graduating from a medical school in Northern India. Life as a medical student was devoid of any influence from nursing and interaction with nurses was limited to gaining permission to access patients or instruments. It was clear that senior physicians were treated deferentially by the nurses but physicians' treatment of nurses was unpredictable and variable. As students we saw ourselves at the bottom of the food chain, but our eyes were firmly fixed on our physician role models and our brains engaged in overdrive; there was no need to reflect upon the hierarchy and structure of health care—it was a fact of life. We got by as best as we could.

Training in residency took me to Malaysia. I was overwhelmed by work and an urgency to accumulate enough knowledge to do right and not look stupid, while being plagued by self-doubt for much of the time. Being *on call* was onerous and in acute care situations, such as the coronary care unit, I found nurses were better equipped to deal with some clinical problems than I was. To ask for help was a matter of shame but nurses tended to hold their counsel until asked. Beneath a veneer of civility, we enacted our roles as we understood them.

Specialization in the UK changed everything. It gave me a sense of confidence and ultimate responsibility for the patient, which was reinforced by the patient, the nurses and the system in general. Within this deferential milieu it was not hard to focus on my own priorities, which I saw as being in the best interest of the patient. I learned to expect and receive unquestioning support. I took for granted that in treating the patient and following my instructions the nurses too found fulfillment. Now nurses were my enablers—

relationships were cordial and even friendly but rested on this uneven table. I do not recall reflecting upon the evolution of this relationship. I was comfortable and it worked for me and for the patient, I thought.

After giving up active medical practice in 2004, I devoted myself exclusively to medical education in Canada. I realized that *team work* and *collaborative practice* had become buzz words and students had learned to use them convincingly when speaking about the management of medical conditions, but had little understanding about how these happened and what they meant in practice. This realization led to a sense of dissonance and curiosity to examine how this understanding was being enacted when students became professionals.

I realize that my situatedness and background will affect not just my perception but also the position the research interviewees adopt; they may identify with me as a physician, as a woman or as a healthcare worker or conversely see me as the *other* and then choose what they will reveal and what they will withhold. For my part the best I can do is to prepare myself to better understand and identify with the backgrounds of those I hope to interview and to honor their trust through respectful and empathic listening and interpretation.

### **In preparation.**

At the conception of this research, I immersed myself in topics related to nurse-physician interactions, both in the literature and in conversations. This led me to a heightened awareness that my empathy for nurses lacked depth and was replete with assumptions and stereotypes. I began to see myself as an outsider to the nursing profession and struggled to get an insider's view into their world. Searching for ways to

gain meaningful contact with nurses outside the context of nurse-physician relationship, I settled on studying three Masters-Doctoral level courses, relevant to this research through the School of Nursing at the University of Victoria, which allowed me to work alongside nurses for the better part of one year. This experience proved to be emotionally charged and challenging. It turned out I was the only physician in these courses and my identity as a physician was no secret. In a distance learning set up, the playing field seemed leveled; we were all students, seemingly unfettered by hierarchical constraints, armed with our thoughts and assumptions and faceless behind computer screens.

Mindful of my unusual situation and perhaps sensitized by it, I experienced a range of emotions. I experienced the dismay of being the other and occasionally even intimidated. On the other hand, I also perceived the restrained regard of nurses who appreciated my interest in nurse-physician interaction and was heartened by gestures of friendship. At first this immersion in a nursing community and the polyphonic voices arising out of the diverse backgrounds of its inhabitants did little to clarify my understanding of nursing as a profession. Over time, however the dominant themes and discourses emerged and I began to understand the essence of a commonly held nursing identity. Foremost, I perceived that they saw themselves as different from other healthcare workers, especially physicians—it is possible that those who held this view strongly were also more vocal. The dominant discourse was that of a holistic, valid, independent and assertive nursing role embedded in a theoretical base, which was distinct from a biomedical one.

As the courses progressed, the strangeness and self-consciousness of my intrusion melted away and I became almost a bona fide member of the group. From the fringes, I experienced their pride and frustration, but mostly a striving for empowerment. I was

enriched by this experience and though I will never be a nurse, studying with them gave me a glimpse into their world, which decades of working alongside had not done. I realized that the nurses in these courses were possibly older and more academically oriented than those who would participate in my research interviews. On the other hand they were likely to represent the instructors or role models who had impacted the minds of my interviewees as student nurses.

**Along the way.**

Thus far, I have described and rationalized the conception of the research and the plan for its execution. I now recount some of the events, encounters and realizations that have made the research journey memorable or impacted its course. Once the proposal was in place, I set about obtaining approval from three ethical jurisdictions: University of British Columbia Behavioural Research Ethics Board and UVic/VIHA Joint Research Ethics Sub-Committee in Canada and the National Research Ethics Service in the UK and was soon met with impediments. One of these was a catch-22 situation where both jurisdictions in Canada required proof of submission to each other, before the application was accepted. As forms had to be submitted online there was no avenue for pleading my case between designated electronic lines. Fortunately, I was able to contact approachable officials on the ethics boards who were willing to help me past this impasse. This interaction and goodwill led to further networking and I was able to invite members of the board to meet with the local medical faculty to guide them through the rules, regulations and procedures for applications to ethics boards. I believe that the obstacles along my way have helped remove some from the research journeys of my peers.

Having negotiated this and other hurdles successfully, I was ready to recruit participants for the research. However from conversations with other researchers it became clear that being armed with ethics approvals and requisite documentation was no guarantee of getting past the gatekeepers who were charged with the responsibility for medical residents and nurses. I learned that this was going to be more difficult in the case of residents who were organized by a single person at each location. Access to nurses was ultimately guarded by the senior nurse in charge of a ward and because several wards could be accessed, one stood a higher chance of finding sympathetic collaborators.

Recruitment procedures in both jurisdictions, Canada and the UK, had been laid out with attention to ethical considerations. Accordingly in Canada, I obtained permission to give an informational talk about my research at an academic half day attended by residents. I assumed that all residents would be present but attendance at these sessions was unreliable and as I was given 5 minutes at the very beginning of the session, I invariably missed the latecomers. It took three such sessions and the limits of my host's hospitality for me to recruit all six residents.

In the UK this process proved to be even more daunting. The centre where I was based had an active interest in medical education research and researchers felt that the Medical Education Manager was becoming very reluctant to allow researchers' access to residents. Clearly, if I had been unable to recruit participants in the UK, it would have defeated the purpose of my journey there and all that it entailed. Fortunately, my local host was able to introduce me to the Manager and arranged for me to meet with her. We met and I expressed my respect and appreciation for her concerns for the residents' time and welfare; she allowed me a single opportunity for delivering an information session.

This was to happen in conjunction with a lecture that residents were expected to attend. I realized that this would be a make or break session. This time I persuaded her to allow me to speak at the end of the lecture—she acquiesced and five residents volunteered to participate. The Manager appeared pleased and looked upon me with favor; my peers told me that it helped to be a physician. She went out of her way to find me a private room for the interviews. One morning a visibly exhausted resident arrived for the interview directly from being on call the night before. As the resident and I walked past the Manager's office to our private room, I lamented that I could not get her any tea or coffee at this early hour. As we were settling down to begin our conversation, minus the much needed hot drink, there was a knock at the door—on the other side stood the Manager with a carefully laid out tray of tea. This image and gesture have become symbolic of the human encounters during my research journey.

As described earlier, the interviews were planned as semistructured conversations based on a framework of questions. Although I anticipated gathering rich and complex data from static purposive sampling, I was not assured of data saturation at the completion of interviews. Also, as interviews were clustered in time, it was not possible to have the transcriptions of all previous interviews available at the time of a subsequent interview and formal analysis and coding was deferred until all interviews were completed. However audio recordings were available immediately after each interview and throughout the process. I listened to these iteratively and made memos immediately after the interview. This led to both tacit and explicit probing of participants to expand the understanding provided by earlier interviews. It became evident that a process of constant comparison was being carried out intuitively and by the time the last nurse and

resident were interviewed, very little new understanding was being added. I had hoped to interview 12 residents and 12 nurses in all but could only recruit 11 in each profession. Thus the fact that the data appeared saturated was very reassuring. This impression was further borne out at the time of thematic structural analysis using the phenomenological hermeneutic method.

While adopting the phenomenological hermeneutic method to analyze textual data, I had a conceptual grasp of the basis for iterative readings of the text to develop an overall naïve understanding of what it was saying and the requirement to find congruence between this naïve understanding and the more formal thematic analysis of meaning units in the text. Despite conducting a pilot interview and examining it through this method, it was not clear how the naïve understanding of each interview would be expressed so that it retained its individuality but was comparable with others. However through the process of iterative reading and listening, it became evident that the naïve understanding of each interview was best expressed as the narrative of how each person struggled to construct a professional identity and cope with its contradictions and conflicts within and without. Each plot invariably led me to a place of beginnings, through to formative and challenging experiences of the subject and onwards to a perceived resolution and expression of identity. It became clear that although described as non-methodic, this understanding also concealed the hint of a method that involved searching for the overarching story in each text. Having grasped the essence of each story and established its consistency with more methodic formal thematic coding derived from the interview, I had to find a written expression for it. Through another cycle of listening and reading it became evident that a person's story was best told in their own words, through selecting

those stories and utterances, which together told the essence of the story. This story would reflect the voice of the speaker, subtly intertwined with the interpretation of the researcher, which was reflected in the choice and order of the texts selected.

Although developed intuitively the representation of the naïve understanding as a story and the interpretation of narratives and prose in the text as methodic themes correspond closely with Polkinghorne's (1995) description of the two types of narrative inquiry.

While the naïve rendering as story corresponds to *narrative analysis*, which he describes as "... studies whose data consists of actions, events and happenings, but whose analysis produces stories (e.g. biographies, histories, case studies)" (p. 6), the thematic analysis corresponds to his *analysis of narratives*, which he explains as "studies whose data consist of narratives or stories but whose analysis produces paradigmatic typologies or categories" (p. 5). Interestingly, using the phenomenological hermeneutic method in line with hermeneutic phenomenology has led to a juxtaposition of narrative analysis and analysis of narrative which appear to cohere and maintain integrity and rigor in an unexpected way.

As alluded to earlier, it became clear during the interviews that it would not be possible for participants to return for another face-to-face meeting to verify the texts. Although the Canadian group had consented to do so, it was clear that they found this difficult. Responding to this difficulty, individual transcripts were sent to each participant by e-mail for verification. They were given the opportunity to withdraw or add to the transcribed texts. A minority responded and none chose to withdraw any portion of the interview text.

**Rigour and trustworthiness.**

Maintaining rigor and trustworthiness in qualitative research is reflected in demonstrating transparency, reflexivity and coherence at every step from conception to execution and further in the interpretation, analysis and the conclusions of the research (Koch, 1996; Malterud, 2001; Mays & Pope, 1995). So far, the relevance of the research question to the healthcare context, the theoretical framework, the research methodology, the method, and the situatedness of the researcher have been discussed and laid bare for the reader. Furthermore the researcher's situatedness and preparations for the research as well as the vicissitudes and insights along the way have also been recounted so that the research process is transparent to the reader.

While qualitative research is contextually situated and therefore not generalizable, it is transferable to settings that identify with the relevant features of the research context. I have deliberately chosen to expose the reader to extensive portions of the transcribed text juxtaposed against my interpretation of these texts. This process maintains both transparency and allows detailed insight into the context of the research. Furthermore, conducting the research in two developed commonwealth countries in the English speaking world and once again juxtaposing the texts generated in the form of transcribed data from each country, throughout the process of interpretation, allows themes to be identified as being either common to both countries and transferable to similar locations or as disparate and possibly related to the local culture and conditions and therefore not widely transferable.

The research question has been explored through multiple triangulations and perspectives. Each resident's or nurse's interpretation is triangulated by others in their profession. Furthermore, the Canadian perspectives are triangulated by those of the

subjects from UK and the nurses' experience of the workplace and interprofessional education is triangulated by that of the residents. Finally the half day observations serve to validate the environments described by the subjects. Through multiple vantage points, I have attempted to create a multidimensional holistic interpretation of the subject of this research.

To verify the interpretation of texts, extraction of meaning units, and development of themes and subthemes, they were iteratively discussed with primary supervisor, Dr. Mary Ellen Purkis and refined until agreement was reached.

Ethical considerations: Approval to conduct the study was obtained from three jurisdictions as described. These were the University of British Columbia Behavioural Research Ethics Board ([Appendix F](#)), the UVic/VIHA Joint Research Ethics Subcommittee, ([Appendix G](#)) and the National Research Ethics Service in the UK ([Appendix H](#)). Approval for nonparticipant observation was obtained from the first two jurisdictions as an amendment ([Appendix I](#) & [Appendix J](#)).

Ethical procedures and safeguards in connection with participant selection and recruitment, confidentiality, anonymity, considerations for risk to the participant, data storage and dissemination were closely adhered to and are laid out in the invitation to participate and the consent forms ([Appendix B](#), [Appendix C](#), [Appendix D](#), [Appendix E](#)).

## Chapter 5

### Interpretation of the Texts: The Lives of the Inhabitants

#### Introduction.

In this chapter the naïve and thematic interpretations of interview texts, first of residents and then of the nurses, are presented. In each instance the naïve interpretation is followed by the thematic or structural interpretation.

The analysis of the texts was guided by the phenomenological hermeneutical method as described in chapter four, “Theoretical Lens and Methodology: From Conception to Execution”. After iterative listening and reading the naïve understanding of each participant was interpreted as the journey along which they learned about their profession, encountered challenges and responded to them and in so doing began to construct their professional self. This is expressed as a story in their own words by using selected portions of the interview text. For both residents and nurses, five representative naïve interpretations in the form of stories are presented here, the stories of the remaining participants are found in appendices [K](#) and [L](#).

The structural thematic interpretations mirror the naïve understanding. The subthemes of the thematic analysis were developed from meaning units which were common to most interviews texts in the group. Related subthemes were coalesced to form themes.

Common threads running through all themes were identified as the mega themes. Texts from participants from both Canada and the UK in each group were analysed together as they were very alike in terms of the meanings they expressed. Any differences found are highlighted in the author’s comments. Exposition of the thematic interpretations is done by laying out texts that capture the essence of the meaning units under each subtheme.

Where possible, quotes from participants in each country are juxtaposed against each other, within each subtheme. These texts are understood to be the first level of interpretation where the participant interprets their experience in response to the author's questions. The author's understanding is presented at the level of the theme, after the participants' interpretation and represents the next level of interpretation. Material from the half day nonparticipant observations has been included only where it enhances interpretation of data. Finally in each section the author exposits the mega theme. To preserve anonymity, only pseudonyms have been used in this chapter. Having developed the naïve and thematic understanding in this chapter, I will proceed to develop the comprehensive understanding in the next chapter.

## Residents' Stories: Naïve Interpretations

Diana's story: UK.

Diana has just completed one month of the first year of residency and is currently posted in the *accident and emergency* unit.

I've just been a doctor for one month. And before doing medicine I actually was a very keen horse rider. That was my original life and originally I was going to be a professional rider, a show jumper. And then I actually did very well in my exams at school and people sort of said that actually you should do something sort of academic and I had to decide what I wanted to do. And I sort of thought being a doctor would be quite a nice thing to do so that's how I ended up becoming a doctor. I don't know if I did it for the right reasons but I really enjoy it now.

Speaking of medical school.

I just changed so much anyway because I just grew up basically and left home, had to learn how to do my washing myself and make food for myself and so you sort of, you grow up and become more responsible I guess but I think doing medicine in particular because you've got to be professional, pretty much all the time if you sort of have to be a little bit more sensible because you're meeting patients and they're expecting a certain sort of person and so you've got to kind of live up to that really.

On being a new resident in the accident and emergency unit.

So [now] I'm going to be doing accident and emergency for four months.... And I chose it basically because I want to be a GP eventually and it helps.... Because I did [an elective placement] here in this hospital as well. So I kind of know the people and I know where things are and stuff which just helps so much.

But, yeah, starting work was still, oh my God, it was so stressful. It was so difficult, because when you're a student you're sort of interested in passing exams and learning as much as you can and everything and then when you're a doctor all of a sudden the roles completely changed. And as a first year resident in accident and emergency, a lot of your job is these kind of pointless jobs. They're sort of like administration jobs that nobody else wants to do. And they make you do it.... [O]nce you've finished all that, you can

see patients ... actually is probably the easiest bit in a way because that's what we've been practicing and what we've been learning to do. So I'm actually, I feel really confident, you know, getting a patient in, taking a history, examining them, coming up with a differential diagnoses, doing some investigations, coming up with some kind of management plan. I actually feel fairly confident in doing that.... You don't make any decisions really. You can't discharge any patients unless you've been reviewed by a senior doctor.... So there's quite a lot of support ... which is really nice, especially for your first job.... [Compared with] the wards [where] there's literally one first year resident and then maybe a senior house officer and then the registrar and the consultant that they never see particularly and they don't, you know, [the first year resident is] scared to call them, really.

I had one case where a really ill guy came in, he crashed his car. It's like a really massive trauma case, it's the first one I've ever seen. And I was really nervous when everyone was getting ready and it was like, oh he'll be here in two minutes and you get all your gloves and your gowns on and everything and I didn't really know what was going on.... I was thinking oh God and it all rests on me if I can get the cannula in. Yeah. [laughs] And I was so scared, but then actually the reality of it was that it was such a serious case that actually the guy came in ... and a registrar ... she literally got the cannula and just whacked it in.... So I think actually that they don't expect you to, they don't give it to you.

One of the hardest things actually since starting is working with the nurses. Because I think their opinion of us, let me start, is a very low opinion of us. So I know we've just become doctors, I mean they [nurses] probably know far more than me, I'm sure they do. They've been working in accident and emergency for years and years and years. But it's so difficult because I mean we're trying our best to do, you know, what we should but they sort of, they think we're idiots.... What they do is they don't, quite often they won't do what you ask them to do. So if you, you know, very politely ask them to, "Can you give this person a collar and cuff [sling] or something so they can go home?" And they just, they just sort of I think ignore it and leave it for ages or say, "Oh, I'm doing this." And they're really not doing anything else. And that's been so hard. It's really difficult to know what to do in that situation. It's not all the

nurses, I can't put them all in the same group really because it is just some personalities, I think. Now I'm starting to know the nurses that actually will listen to me.... It's not that they're questioning what you're doing it's just they think you're low priority.... They just seem to have a very low opinion of F1s [first year residents]. So I don't know why. I don't know why.

It must be annoying for them I'm sure because you turn up and you don't know how the system works and you don't know where anything is.... I'm sure it is annoying for them and then just by the time we know everything, how the system works we're going to move off to our next job so they're going to get a whole new load of people in that don't know anything. So it must be annoying.

I try and I don't know, I try and have a bit of banter with the nurses and try and get along with them. And I think they definitely then respond to you a bit better. And I sort of, I ask them in that way. So I'm like, "Do you do that normally ... ?" And so they're okay with it. It would probably help if I knew a little bit more about exactly what they do.... I mean I was only a student a few weeks ago really. So I mean an F1 isn't much different from a student.

Looking ahead.

I don't want to cause trouble. I'm just trying to, you know, I mean I don't want to try and make it an issue, just try and just forget about it.... I guess when I'm actually a GP see, I would have had quite a lot of experience by then, I would have been working for quite a few years and I think a lot of the other health care professionals that they're working with, so the community nurses and the practice nurses, physios [physiotherapists], all that sort of people, I think they sort of look up to the GP in a way. They're almost like the team leader, really. (personal communication, August 27, 2010)

Jerry's story: Canada.

Jerry is nine months into the first year of residency and is currently rotating through pediatrics.

I had a congenital blocked heart valve. And so I had open-heart surgery at a young age, spent a long time in the hospital, in and out for various reasons. I developed a good relationship with my cardiologist and [she] definitely was a role model growing up ... she also got me involved in things as I got more to the teenage stage there was a support group for younger, five year olds that got the same surgery or similar surgery that I had and they wanted me to come speak with them.... I think she had a big influence on my wanting to go into medical school. Not from the intellectual side but more from the compassionate wanting to care for people side.

Speaking of life as a resident.

It's hard as a resident to find that balance of asserting yourself because you're a doctor now and you have responsibilities for the patients and you have responsibilities just for decision making.... So there's that and you[r] own self confidence but then there's the nurses who know you're only a year out too and they know, they see the medical student next to you and they don't necessarily see a difference between you and that medical student. And so it's hard to assert yourself with nursing staff, doctor staff, every, anyone that's worked at the hospital longer than you have.... So yeah, it's hard to it is hard to find your place in the midst of so much experience.

It's hard because your gut reaction, especially at two or three in the morning is to get angry. The nurse doesn't mean it as direct affront to your ability to perform as a doctor but it is. So your first reaction is to get angry but that's not going to get you anywhere. If you do get angry and at the very least that nurse remembers that you got angry at her and [is] definitely less helpful in the future, if you ever need any help and nursing staff's a great help but if they're not on your side it makes your life a lot more difficult ... I don't think a nurse would ever hold patient care as a ransom for you not being nice to her. I'm not saying that but I'm saying they can definitely make your

life more difficult than it needs to be. Just that rapport with nursing it just makes your job a lot easier too.

I've never had a problem with any nursing staff. That being said, I think I'm a lot more easygoing than a lot of other people. If something happens it just kind of rolls off my shoulders and I'm okay with it. I've heard stories though. Labour and delivery was my first rotation ... and definitely going in you hear stories that it's not going to be a fun time. The nurses up there are protective of their patients and fair enough, the people giving birth are in very compromising positions.... And apparently [it was] much worse than for females than it was for males ... I had a fantastic time and another resident, a female resident was on at the same time as me, we don't do the same shifts but over the six weeks she was on the rotation as well. And kind of after four weeks we finally got together and we were talking and I was saying, "Yeah, I don't know what, you know, what these people were talking about beforehand. I'm having a great time on the ward." And she was like, "No, it's horrible." And she just had problems with nurses, not respecting her but just not liking her presence there I guess.

On working with others.

I don't have a good grip on overall what sort of knowledge the different professionals should have. But I have a good grip on I know this is, you know, just picking a name at random, this is Joe from wherever, Joe from physiotherapy and I know Joe knows a lot about this so I'm going to ask Joe about this.

For example, when I was on house, which basically is just a service that covers the entire hospital at night, there was a patient in the rehabilitation ward that was demented and he had a urinary catheter in that was balloon pulled, [it had] blown up and he pulled it out. So he had a traumatic injury and we had to put a catheter back in as fast as possible but he was in a lot of pain. I know nothing about putting catheters in with the exception of how to put one in but beyond that nothing. And the nurse that was on the ward really didn't know much beyond what I knew. But two floors down is the urology ward and the nurses down there know everything about putting catheters in, yeah. So I went down there and just talked with them about what had happened and they gave me specific lidocaine jelly that I could inject in first, they told me what size of catheter I should try to use and basically got everything bundled up in

a package for me so I could go upstairs and do it. And you know, I'd never met them before and they were more than happy to as long as you explain who you are they're more than happy to help you out. Especially, especially if you go with the attitude of "I want to do this can you show me how to do this?" Not "can you go do this for me?"

Speaking about identity.

I've never been interested in medicine for prestige or anything like that. More, I got interested in medicine mainly for intellectual reasons. I'm interested in the science behind medicine.... But I used to be a cook. I used to be a technical theatre technician; I used to want to be a lighting designer for a theatre place. And all of those options would have been equally good for me as medicine would. And if I decided to go into cooking instead of becoming a doctor, I wouldn't be, "I wish I'd been a doctor. People would respect me more." Or something like that. You know, I'm a doctor because I want to be a doctor. Not because I want prestige from it. (personal communication, April 13, 2010)

Matt's story: Canada.

Matt is nine months into the first year of residency and is currently rotating through internal medicine.

Speaking of medical school.

For the first couple years, preclinical years, not a lot changed. People are, "Oh yeah, you're in med school, you're a doctor." And you're, "No, no, no, I'm not a doctor for a few years, I have lots of stuff to do." And they're, "Oh, okay" and things normalized a bit. You got idolized a little bit but only in certain crowds.... But once I got into the clinical years I did notice a big difference. Maybe it was because I had a few of these stories of my own now.

You know, your guy friends are always, "Tell me about that breast exam, ha ha ha." And some of your friends will be, "What's the nastiest you've ever seen?" And when you're able to pull out some pretty gruesome stuff.... Yeah, they're, "Wow, that's, I could never do that, good for you for doing that." And so once you enter clerkship or whatever they call it here that really builds you up more like a little bit more TV show-esque, right? A little bit more dramatized and you're putting in these 24-hour shifts and people [say], "I don't know how you do that" and it's just people's expectations are very different from the boring reality of it often, right?

Moving on to residency.

It's not too bad for me as a male. And the sex and gender stereotypes of medicine and nursing are very alive and well. From my experience with nurses about half of them flirt with me and about half of them treat me like their son.

Things can escalate sometimes depending on the personalities involved. I've had nurses make what I felt were unreasonable demands. They were saying, "We need an order for this". And I say, "Well, you know, this isn't my patient, I don't really know them." They're, "Well, we need it now, we need an MD to write the order". And I start looking through and I'm, "What's the deal with this patient?" And they're, "Just write the order."

You want to have an enjoyable experience; you don't want to hate coming to work. You want to feel comfortable in your role. And when you change roles every four weeks you're constantly making first impressions. And you're constantly on the defensive essentially. Because you're never, you never have home court advantage. You're always coming into their turf.... And so that's why you have to be overly nice and you have to do your best to get in there. And in order to do your job effectively you need to work effectively with other team members. And if you piss them off then they can bug you all night and you won't get a wink of sleep.

If you didn't respect their knowledge. Or if you came on and assumed that you knew everything, if you're a bit of a, if you're rude to patients or staff or if you're completely incompetent. All of these things are noticed and word spreads quickly and you can become ostracized very quickly. And then your life will be hell and I've seen it happen.

I like emergency medicine where the nurses will have already given the patient with chest pain an aspirin and gotten the ECG [electrocardiogram] done before you even see them. It seems there they're given a little bit more leeway to deal with certain things. I really like that. There's a lot of direct interaction there, because you're not just rounding and then gone, nurse sees that patient, you see the patient, you interact with the nurse. And so it's a lot of one-on-one, direct feedback kind of things. And you can bounce ideas off them. You can say, "Man, that guy looks sick." Or "I wonder if this is going to work".

Looking ahead.

[A]s a family doc I'm going to be more in the team-based approach. You know I'm not a specialist, I'm a generalist and I rely on other members of the medical community to help me with my patients.... You really are, not to glamorize it, but you're like a quarterback directing a team. And you call in the specialist, you call in the running back or the kicker to make a key play but you're kind of controlling the whole game, and looking at the whole picture.

It's part of what draws you into family medicine. You get a little bit of everything. And I went into to family med [medicine], my Mom's a family doc so I saw that as a very

positive role just from growing up. And it always had a certain amount of appeal. I mean getting Christmas cards from patients or we were in a small town so she'd get stopped in a grocery store and people were really appreciative. And yeah, she gave a lot to the community, no doubt, but the community did appreciate it.

I mean right through our medical education being taught by specialists is a pretty negative generalist perspective out there. You hear a lot of, "And then the GP missed this and then I saved the day when I cut out the tumor." There's a very, it's, there's a difference, there's a very big line between generalists and specialists. And they've got different colleges and they've got different lobbying groups and you know we start off all as med students and then we just split into different camps.

So you kind of know a little bit about yourself, who you are going in. And you pick up on the cues of role models and you're "who do I identify with? Do I identify with the surgeon who works 120 hours a week and he's the best of the best and he walks down the hall and people tremble? Is that who you are?" Because some people are. Or are you skipping out of class to go skiing and you're lifestyle focused. That's okay in modern medicine.

Despite everything.

I love it, I'm a geek. And I'm happy to be here, I would rather be doing nothing else. (personal communication, March 8, 2010)

Susan's story: Canada.

Susan is nine months into the first year of residency and is currently rotating through emergency medicine.

Speaking of life as a resident.

I'm currently doing emergency medicine ... I started out my year with pediatrics, then I had ICU [intensive care unit], then surgical subspecialties, family medicine, cardiology and that's been it.

Residency is a strange hybrid as you know of you're a learner but you also have a lot of responsibility. There are some rotations that are very pleasant and you get through them and you quite enjoy them. There are other rotations I count the days until I can get out.

Residency is tough because you have your shitty days and you don't have enough sleep and you've not necessarily eaten properly. Often, God, sometimes you don't have time to pee. You know the most basic elements of self-care you don't get to. So there are those sorts of physical, emotional, intellectual stressors all the time.

I mean every one of my resident colleagues, we've all kind of commiserated.... I'm talking about the women, the men have a different approach but we all go home and have our nights where we just bawl. Just cry, cry and cry because it's hard and it sucks. Anyway, but then you have your days where you're, "Damn, I was good today, I was on, that was awesome."

What's really frustrating is.... At night you're literally getting called about kids who are quite sick and you're being given tremendous responsibility to look after children and in the morning sometimes the nurses will treat you like a child. Or the consultants will treat you like a child, "You make sure you show up to the teaching rounds now, teachings really important." And you're like "What?"

But really it's the nuts and bolts. And medicine can be so much of the little practical things. And they don't tell you that in medicine.... You just annoy enough people and get snarled at enough and feel stupid enough that you

eventually sort of start to sort out this is what so-and-so does. And I personally hate annoying people or getting in people's way or feeling like I'm in some way interrupting the flow of patient care. One of the things I feel I've learned about nurses is their friendliness to you is directly proportional to their need to get something from you. So if they need an order, if they need a patient assessed, if they need to write that a doctor is aware of such and such of thing with a patient, they're sweet as pie. If they don't need you, you're just wasting their air. And some nurses are very sweet. And I've run into some really, really nice people who are just genuinely nice. Most of the time though I find they're kind of bitches some times. You know, like you're just in their way, they would rather not have a learner. They would rather not have to phone you. They would rather just phone the consultant who knows what's going on and knows what they're doing and not bother explaining whatever to you. I mean you are absolutely no help to the nurse, zero help. I find operating room nurses are ... actually the most intimidating and the least helpful and friendly, period.

Everybody kind of develops a thick skin and you also develop I find a real sense of, and very quickly, who the nice people are. And you tend to avoid the people you learn are miserable and deal with the people you know are at least civil. My philosophy about dealing with difficult people and in particular difficult nurses has always been that if I can do something in a way that doesn't compromise patient care but allows me to sort of deal with unpleasant people to the least extent possible, I will do that. I'll basically do anything up to compromising patient care.... My priority is the patient care first and avoiding miserable people second.... Some people just put on this very sort of arrogant, superior kind of front and do treat nurses kind of, [like] they are subordinates, I find it harder honestly as a woman when they're women and they're older women. They're often women who are my mom's age. It's kind of a generation of women I'm sort of used to being ruled over by. How's that? There's a big age difference there. And there's a big knowledge gap. I mean certainly as a new resident and definitely as a medical student, they know a lot more than I do, so it kind of feels a little bit silly to put on a big arrogant, superior air.

Well it [residency] works because not every day sucks; a lot of days are fun actually. And medicine is fun by and

large. It works because in order to become a physician I think you have to be the sort of person who can delay gratification who can intellectually and emotionally understand that it's going to be better.... You know you're going to not always be financially struggling which is also stressful. To know that one day you're going to know a lot and that you're going through this process of learning things and that one day you're going to know enough that you can at least have an approach to every situation.

Looking ahead.

I see myself largely being an office-based physician. And having staff who either I employ or who are employed by the office group I work with. And basically being sort of the leader of that group.... I'm looking forward to it because I'd like to be the, I'd like to control my own destiny, I suppose. (personal communication, March 9, 2010)

Tara's story: UK.

Tara has completed one month of the first year of residency and is currently posted in the general surgery and breast unit.

Speaking about joining medical school.

Some people did look down on me at medical school. So I remember when I met this one girl from X, which is where I went to college, I was like, "Oh, I went to college in X." And she said, "Oh, what college did you go to?" And I told her and she was like, "Oh you poor thing." She said, "Your parents couldn't afford private education then?"

Really a lot of people when they found out that my parents both worked in a paper mill they were a bit like, you know, "Oh, what are you doing here?" But what I always said was, "Well, you know, I got into university just as well as you did."

Of role models in medical school.

I thought I'm never going to do that. I'm never going to stand at the end of the bed in a massive bay and tell the patient they have cancer like one consultant did and just like leave them there and say, "Oh nurse I think they'll need some help or something to deal with this." And then just go off to the next patient. I will never do that.

Speaking on the morning after her second weekend call.

I am actually going to write a letter or complaint to someone. . . . Yeah, I mean that was only my second on call I've ever done. I've never known such stress like it to be honest. And on Sunday I went from eight in the morning and I didn't get home until 11 in the evening and I hadn't eaten or drank anything all day and I felt like I was going [laughs]. It was awful really, but never mind.

I don't mind being busy but the problem was the wards had lots of sick patients and they had lots of jobs that needed doing like INRs [International Normalized Ratio, a blood test] to be checked, fluids to be prescribed and they were bleeping me nonstop but my registrar had told me I wasn't to leave the surgical assessment unit because those were the sickest patients and hadn't seen by a doctor. So I just thought it was completely inappropriate really and

dangerous that I was the only one there and the nurses were getting so frustrated because they hadn't got their jobs done and there were sick patients on the ward that needed to be reviewed and I couldn't leave and I can't be in two places at once.

So nurses were ringing me saying, "We're going to be making a complaint about this and, you know, it's not on." And I completely agree with them it's not right that patients have been on the wards and not had their, you know, *venflons* put in so they could have their IV [intravenous line] antibiotics and things like that but I just, I couldn't get there, I can't be in two places at once and I had specific instructions. And that's when I'd leave if it was an emergency.... And that's wrong because I probably could have prevented some of those emergencies if I'd been there to prescribe the fluids or, you know, but I don't know what the answers were. I think they just needed, it's scary to begin with because you feel like you're not helping people and it's an awful feeling because you don't feel in control and you can hear people getting more and more frustrated with you but you're doing all you can at the same time and you're working solidly. Like I didn't stop at all [that] day but people were still angry with me because I hadn't got to do the jobs and you know I sat on the sofa in the surgical assessment unit at half past four in the afternoon and cried and I never thought I would do that because normally I'm completely in control.

I think I don't think anything I could have done more would have prepared myself.... I did think going through medical school I have to say I always thought I would be more supported when I came out [of university] because I thought, you know, as a student you're all quite protected and you don't have that responsibility, you're not given the responsibility then suddenly as soon as you've got that piece of paper in your hand saying you're a doctor, you're allowed to do whatever, like any, you know, like all these practical things on the wards when really you've got no experience, you've only ever done it on a plastic model before.

I definitely felt isolated ... I felt so much stress [laughs], it sounds silly but I couldn't concentrate when I tried to think logically about problems on the ward I couldn't, like, I couldn't think about it properly because I was thinking I still have all of this to do and I need to make a decision

quickly. And it's quite strange really because especially if you're normally quite a calm person and well I think I am, to be honest. And you suddenly feel yourself getting panicky and you can feel you're heart racing in your chest and I think it's that sense of you're losing control of the situation and you feel like helpless in a way.... Because it's not like it's like a regular job. You've actually got people's lives that you're, you know, responsible for.

They [others] don't really care anything about you and the fact it's your birthday or something you just have to get the job done. It was my birthday the week before last but that day I was posttake [after being on call] and I had a big birthday planned and my husband had organized a birthday party for me in the evening and I couldn't go. Well I was two hours late to it because I was two hours late leaving here. And it's fine. I know I'm not a child anymore. I know that I don't have to celebrate my birthday like that but it's just, you know.

And I can see myself changing and like in a month becoming like more irritable when I go home and I'm just in a really bad mood in the evenings and it's just and you dread, well not, I don't dread it but I don't look forward to work like I thought I'd love medicine and I loved it as a student.

Looking ahead.

I'm thinking, I'm back thinking to myself I've got five years to go until it will be fine because then I'll be, you know, a GP or then I'll be higher up and I'll know, I'll feel like I'll know what I'm doing.

[But] I would always be a wife and a daughter and a sister before I'm ever a doctor. I don't, I mean it would be quite easy to let medicine take over your whole life and let yourself think you're brilliant just because you're a doctor but to me, my family will always be more important to me. That's just the way I've been brought up, really. (personal communication, August 31, 2010)

Table 1

**Residents' Thematic Interpretation: Unravelling the Text Themes, Subthemes and Mega Theme**

<b>Before becoming a medical student.</b>
Understanding the role of the physician.
From the media: as challenging, exciting and commanding.
From physician parents: as important, appreciated, making a difference.
From contact with physicians: as involved and compassionate.
<b>As a medical student.</b>
Understanding choices.
Choosing lifestyles: balancing work and leisure.
Understanding the physician's role and status: the undeclared leader.
To be on or not be: evaluating professional role models.
Identifying with the profession.
Bonding and separating.
Becoming an insider: pride and humility.
Comprehending interprofessional team work and IPL in medical school.
Seeing teamwork as a concept <i>out there</i> .
Hearing about interprofessional teamwork: a forgettable experience.
Experiencing formal IPL out of context: just something to do.
Following professionals at work: developing insights.
Left with nurses: feeling lost.
Watching teams in practice: from respect to disdain.

Experiencing teamwork as a member: developing empathy.
<b>Working as a resident.</b>
Transitioning From a medical student to a resident.
Being new and remaining new.
Transitioning from student to resident: precipitously.
Transitioning from student to resident: ill prepared and not knowing enough.
Transitioning from student to resident: unrealistic expectations of support.
Transitioning from student to resident: unclear about roles and structure.
Transitioning from student to resident: burdened prematurely with so much responsibility.
Transitioning from student to resident: looking stupid and hating it.
Being overwhelmed by work and its demands.
Being scolded in spite of doing <i>my</i> best.
Floundering in apparent contradictions and ambiguity.
Being on call: feeling alone and isolated.
Being on call: stressed, scared and unable to prioritize.
Unable to cope: becoming distressed.
<b>Working as a resident, with nurses.</b>
Feeling <i>othered</i> by nurses and seeing nurses as the <i>other</i> in turn.
Feeling inadequate and incompetent.
Feeling unacknowledged.
Being intimidated or ignored.
Seeing nurses as hostile, unreasonable and inconsiderate.
Finding it difficult to communicate with nurses.

Learning to get by.
Avoiding unpleasantness.
Appearing friendly.
Learning to ask for help.
Learning to be assertive.
Understanding the role of power, gender and generation in nurse-physician relationships.
Understanding hierarchy.
Trying to understand nurses' perspectives.
Comprehending gender and nurse-physician relationships.
Understanding the influence of generation and seniority in nurse-physician relationships.
Understanding what makes a team and what doesn't.
Feeling like team.
Not feeling like team.
Developing interprofessional bonds.
Reconciling experiences.
Realizing that it's not all nurses.
Acknowledging nursing expertise.
Making sense of contradictions and priorities.
Comprehending structures and the way it is.
Finding support and identifying with physicians.
Identifying with the physician's perspective.
Being able to confide and commiserate.
Being supported by the medical team.

<b>Life after residency.</b>
Looking ahead.
Confronting roles and values.
Being in command.
Not wanting to be defined by medicine.
<b>Mega theme.</b>
Negotiating an identity to live with while getting the job done.

## Residents' Thematic Interpretation: Unravelling the Text

### Before becoming a medical student.

Understanding the role of the physician.

From the media: as challenging, exciting and commanding.

*ER* and that kind of thing ... I think they create like a very good positive role model sort of a doctor in sort of a young professional exciting life, sort of respected generally ...  
*Nat, UK.*

I would say the show *ER* was largely responsible ... it was definitely the image of this doctor, kind of cool and collected, in charge, ordering everybody else around ... and the nurses just doing what they've been asked to do and it was all very fast and very dramatic. I came into medicine thinking there was going to be more running around and ordering about and I found medicine so much more quiet and sort of calculated and careful than that show seemed.  
*Susan, Canada*

*ER*, there were always these crazy complex cases and but at the end of the day they always figured it out and it was always successful and it was always very fast paced and stressful but at the end of the day they were fine.  
*Jenny, Canada*

From physician parents: as important, appreciated, making a difference.

It came initially from seeing my father ... I realized that from a young age ... people would actually say, "Your dad's really important here." And the town would have been a very different place had they not had him, the only physician. *Susan, Canada*

And I went into to family med, my mom's a family doc so I saw that as a very positive role just from growing up. And it always had a certain amount of appeal I mean getting Christmas cards from patients or we were in a small town so she'd get stopped in a grocery store and people were really appreciative. And yeah, she gave a lot to the community, no doubt, but the community did appreciate it.  
*Matt, Canada*

From contact with physicians: as involved and compassionate.

... I had a congenital blocked heart valve... I developed a good relationship with my cardiologist and [she] definitely was a role model growing up, not only in the sense that someone that was taking care of me but she also got me involved in things as I got more to the teenage stage there was a support group for younger, five year olds that got the same surgery or similar surgery that I had and they wanted me to come speak with them. And there were things like that so ... she got me involved beyond just being a patient.  
*Jerry, Canada*

For most residents, early and formative images of what it meant to be a physician were located in television serials such as *ER*, *Scrubs* and *Grey's Anatomy*. In these the physician was portrayed as the knowledgeable, respected leader of the team who could deal successfully with the most complex situation while remaining calm and in control. The physician's life was seen as exciting and challenging and he was an enticing role model, who was invariably centre stage, in the lead role.

Those whose parents were family physicians saw the physician as having a highly prestigious place in society, valued and recognised as someone who had made a difference. Any notion of challenges and struggles faced by their parents or attributed to fictional characters in the media were conspicuous by being absent in their narratives.

Those few who had prolonged personal contact with physicians through illness or voluntary work understood the physician's role in terms of being compassionate and responsible. Their own goals for the future were clearer and less ambiguous than those who had no such experience. Regardless of personal attributes, everyone understood that demonstration of academic excellence was the gateway to medical school and for some achieving excellent grades became the point at which they began to consider Medicine as a career.

### As a medical student.

#### Understanding choices.

Choosing lifestyles: balancing work and leisure.

So you kind of know a little bit about yourself, who you are going in. And you pick up on the cues of role models and you're "who do I identify with? Do I identify with the surgeon who works 120 hours a week and he's the best of the best and he walks down the hall and people tremble? Is that who you are?" ... Do you want their lifestyle? Do you want their problems and their rewards? ... For family medicine, yeah, it's the flexibility and the diversity I would say. Because I can constantly redefine my career, I can work from downtown Toronto [or] I can go to Haiti.

*Matt, Canada*

Being in third year and all you did was work and you were unhappy. That was an unhappy time in your life and you don't want that to be the rest of your life, right? Yeah. I think we all want to be good doctors and we all want to give back.... Yeah, but like anything I always think in elementary school we had it right, how we thought, we did classes, we went outside, we did gym, we did art, we did music.... If you just focus on one thing in your life and it falls apart what happens to you? *Nina, Canada*

Understanding the physician's role and status: the undeclared leader.

[I think as a medical student] you sort of have to be a little bit more sensible because you're meeting patients and they're expecting a certain sort of person and so you've got to kind of live up to that really. *Diana, UK*

And it was never said doctors are the boss. Nobody ever really said that but it was always insinuated, right?

*Nina, Canada*

To be on or not be: evaluating professional role models.

I thought I'm never going to do that. I'm never going to stand at the end of the bed in a massive bay and tell the patient they have cancer like one consultant did and just like leave them there and say, "Oh nurse I think they'll need some help or something to deal with this." And then just go off to the next patient. I will never do that. *Tara, UK*

And you see people who, when they leave the room the nurses breathe a sigh of relief or they curse under their breath or whatever and you say I don't want to be that guy. And so you evaluate what he's doing and you take it from there. *Matt, Canada*

Tensions between the demands of a career in Medicine and lifestyle choices became apparent with entry to clinical life. The discourse amongst medical school peers justified the choice of a specialty based on its compatibility with individual lifestyle preferences and stressed the value of a balanced life.

While they forged out values to guide them in their careers, they were keenly aware of expectations of friends, society and patients to behave more responsibly than others in their age group and found this mantle of leadership a premature burden. Even as they saw themselves as imposters at this stage, they tried to adapt their behaviors to live up to the expectations of others and sought out those who would be their role models.

Encounters with negative clinical role models were disturbing and seemed to initiate an immediate personal response in terms of how they saw themselves in similar situations, such as "I will never do that"; "I don't want to be like that person"; "I don't want to be that guy", and so forth. Narratives of negative encounters were vivid and mostly related the model's relational style or lack of empathy and collaborative spirit. Interestingly negative role models were described in terms of their actions while positive ones were described in terms of their attributes. Their narratives spoke of continually negotiating a sense of self through evaluating role models.

Identifying with the profession.

Bonding and separating.

So from the start we ... lived with other students ... by the end of a couple years you were living with medics [medical students]. You sort of socialized with medics, obviously

you worked with them and it's quite, it's not impossible obviously but like your whole life just becomes consumed by medicine .... Then after three years and you leave all your nonmedic friends behind and you're sort of the older people left in the university it's quite ... sort of very mature I think .... When you see other people in their lives and you just feel very different, almost alienated from their life of just sort of going to lectures, going out and that kind of thing and you're going to the hospital every day, working every night. You just feel very separate I think and a bit older. *Nat, UK*

I mean right through our medical education being taught by specialists is a pretty negative generalist perspective out there. You hear a lot of, "And then the GP missed this and then I saved the day when I cut out the tumor." .... [T]here's a very big line between generalists and specialists. And they've got different colleges and they've got different lobbying groups and you know we start off all as med students and then we just split into different camps. *Matt, Canada*

Becoming an insider: pride and humility.

You got idolized a little bit but only in certain crowds. Only in the premed [pre-medical crowd], "How did you get in?" because they just want to be where you're at. But in general, most people didn't care. But once I got into the clinical years, I did notice a big difference. Maybe it was because I had a few of these stories of my own now .... You know, you're guy friends are always, "Tell me about that breast exam, ha ha ha." And some of your friends will be, "What's the nastiest you've ever seen?" And when you're able to pull out some pretty gruesome stuff .... Yeah, they're, "Wow, that's, I could never do that, good for you for doing that." And so once you enter clerkship or whatever they call it here that really builds you up more like a little bit more TV show-esque, right? *Matt, Canada*

Definitely in the first year you're very elated that you got in and ... everybody's very proud of you and you feel you're part of this big picture .... And I think in third year when you get actually in the hospitals ... when you're interacting with other doctors, when you're interacting with other residents, when you actually see patients, when you have patients that die that are sick and don't get better, when you have really frustrating patients, when you work and you're very tired because you're on call all the time those initial

ideas come a bit jaded ... and so I think when I came out of med school I was ... not as naïve to think that going into medicine is this big deal. Yeah, okay it was very, very difficult and I am proud of myself, I'm not going to deny that but at the same time it's very, very humbling.

*Nina, Canada*

Bonding and separating were spoken of within several groupings, but identifying closely with any one group was resisted. Individuals wanted to retain their individuality over any group *belongingness*, but often found themselves consumed by medicine and thrown together with medical students and becoming distanced from others. Amongst peers, those who saw themselves becoming specialists and those who themselves as generalists were drawn apart by values prized in each stream, related mainly to lifestyle preference and self-image.

Regardless of such groupings, progression through medical school jaded the initial pride of being the chosen ones, who would know it all. Experiencing both their own limitations and that of the profession, they expressed the tension between pride in their achievements and humility in the face of the enormity of the task.

Comprehending interprofessional team work and IPL in medical school.

Seeing teamwork as a concept *out there*.

Going into interviews at X, I got asked so much about teamwork.... Yet when I come to do the course there's no emphasis on teamwork at all. It's just, you know, teaching us about all these different medical conditions and, you know, you don't work with nurses or any other [health professionals]. *Tara, UK*

I think as a student ... we're told that it exists, that you will be working as part of a team. But we don't get any formal exposure to working in a team. We don't get any training on how to work within a team, or at least I didn't. Like within a team that we're actually going to be working with.... And so I think as a student you're told that it's there and you will be part of it but you don't see how

you're going to be part of it because you're two steps down the ladder and the folks two steps up the ladder are the ones who are actually doing the interdisciplinary work. And so you don't see it. *Sam, Canada*

Hearing about interprofessional teamwork: a forgettable experience.

I don't think there was ... any interaction between physicians, residents or med students and nurses. It was very separate. We never socialized with them, we never had nurses come and talk to us about what their role was. When I got onto the ward in third year in our clinical year I had no idea what a unit clerk was or what that all meant and what the nurses' role was in terms of their evaluation of the patient and what not and it was something I just learned as I spent more and more time on the wards.... No one ever talked about nurses and doctors working together. *Jenny, Canada*

I can't recall much about it right now so it obviously didn't have much impact on me. And unfortunately I think it's sorry to say that I think a lot of it was thrown together ad hoc. I don't think a lot of it was well planned out.... And in fact our year was the first year to get the course and the next year didn't have the course at all. *Jerry, Canada*

Experiencing formal IPL out of context: just something to do.

We had two weeks of it in our first year, two weeks of it in our second year and two weeks of it in our final year.... We only worked with them [other health professionals] in these artificially comprised groups with these artificially made up projects. We didn't work with each other within our own professional specialty.... So you were just a group of people forced together to do some project that was forced on us. And sometimes the quality of the projects were very poor because they had to come up with about 100 of these projects, you know, to cater for the number of students, some projects were very contrived ... it just looks as if somebody was desperate to think of ... something ... I don't think it did much to increase awareness to be honest. And I think it had potential to be harmful and it occasionally was harmful ... there was a danger and some people did kind of identify the behavior of individuals which might not be very professional with the profession they were supposed to be representing.... So people came back saying, "All the nurses behaved in this ridiculous way." Which is complete nonsense, you know, they were

just 18 year olds, three weeks, four weeks into their first degree at university, they're having a week skiving off.... Whereas placement with experienced practitioners within the professions, we never had that. *Temara, UK*

I think the only real exposure during the first two years was ... what was called interprofessional learning so if I remember correctly, four or five sessions over the first two years which were held in a central student union building on campus and you would go and it's an auditorium full of round tables of about eight people including basically there would be one, somebody from medicine, one or two people from nursing, usually a pharmacist, an occupational therapist, somebody doing medical lab technology, maybe somebody doing dental hygiene and somebody doing dentistry. So from all the professional areas but then basically putting those people together and giving them tasks about brainstorming ideas and coming up with solutions to problems that are more theoretical than practical.... But it didn't really touch on how that was going to play out on a practical basis, complete waste of time. *Sam, Canada*

Following professionals at work: developing insights.

You sort of go and you spend an afternoon with a physiotherapist or an occupational therapist or something like that.... Yeah, and just get an insight basically of what their role is which is really helpful when you come to, actually, your clinical years and also becoming a doctor because I know now, I know exactly what an OT [occupational therapist] does ... because I remember going to see someone's house and they lived in sort of it was a really hilly area and they needed a lift outside to get up to where their front door was and obviously to do that it actually takes a lot of construction work and planning work. *Diana, UK*

I did a few shift with physiotherapists in med school, working with the different professions is helpful. It was set up through our program for during one of my rotations. We could spend a half day with the physiotherapist or what have you ... but I mean you could do that with several different professions if you wanted. *Matt, Canada*

Left with nurses: feeling lost.

We spent a whole ... week at a community hospital, which was mainly nurse run and I think there was a couple of doctors that came in occasionally if they were needed.... It's quite a long drawn out period ... I think some of my experience was that you were there and they didn't really bother with you very much.... Yeah, you were slowing them down; you're not really interested in what they're doing or that kind of thing, I think that came across, I mean there was some that were really keen. For the first two weeks of our clinical blocks of our third year we just spent on a ward purely with nurses. They just introduced us to the work environment I think. So we had no sort of doctor orientated roles or anything ... but I think even when we were there we were mainly doing skills that would be useful to us sort of doing bloods and that. Learning, even then was the doctor's aspect of things ... we would spend two years doing lectures and then the next two weeks were shadowing nurses. It was very hard to sort of link the two ... because after those two weeks we sort of went back and then did more lectures and then when you go back onto the ward you're mainly with doctors not nurses so ... it was very much sort of a token gesture sort of thing I suppose.  
*Nat, UK*

Watching teams in practice: from respect to disdain.

On that ward I think it is individual.... [In X], they are a set unit for a long time ... so the consultants have been there for years, most of the nurses have been there for years. They all respect each other ... very publically as well. So when we started there, the consultants made it very clear how much they respect the nurses and how good they were and that kind of stuff, in front of the nurses. *Nat, UK*

I recall very clearly my surgery senior ordering the med students to go to fluff rounds which was multidisciplinary team, "You go do it med student, I don't care, it's just a waste of my time." He called it fluff rounds.  
*Susan, Canada*

Experiencing teamwork as a member: developing empathy.

I completely understand their point of view I mean I did, I was doing my first, second year at university I worked as a nursing auxiliary ... I know how frustrating it is when you need something simple done like fluids prescribed or

paracetamol [analgesic] prescribed for a patient and a doctor won't come. *Tara, UK*

Amongst the stories of medical school that were told spontaneously, those of interprofessional contact were conspicuous by their absence. When impressions and experiences were deliberately sought it felt as if an engaging story had been interrupted and forgettable experiences were recounted without enthusiasm. Students narrated a sense of dissonance between the need to recant the importance of teamwork against a glaring lack of experiencing it in practice or understanding its dynamics, especially in early years in medical school. Some of them however participated in structured IPL, mostly, in later years.

Experiences of formal IPL and the strategies used were inconsistent in both countries and seemed to be school specific and experimental. Three residents, two in Canada and one in the UK, had attended structured IPL with other professional groups, outside the context of work. Two of them were strident in their criticism of these courses, seeing them as unreflective of the real world with a propensity to cause harm, when students from one profession saw unprofessional behavior in others as representative of their profession. They chafed against the contrived nature of the course and questioned its application and value in the workplace. Accounts of these interprofessional courses and projects were devoid of the involvement of medical teachers and role models. Students drifted in and out of these experiences without the guidance or involvement of their own medical teachers whom they respected and wished to model.

Others, two in Canada and two in the UK, had followed a variable number of allied health professionals over half a day or more. One resident from UK had spent a total of three weeks in a ward largely supervised by nurses in a rather unstructured way. Those

who actually spent time with practicing professionals did acquire some insights if the professional was keen to have them on board, but this was by no means consistent. Once again the mention of involvement of medical teachers was lacking. Of those interviewed, two residents had worked in the role of another health professional, one as an auxiliary nurse volunteer and another as a qualified physiotherapist, prior to joining medical school. Both of them spoke with empathy and understanding of those roles and of their intersections with physicians, in those roles.

Overall students were unclear of the relevance of IPL experiences, particularly those that were situated outside the context of the workplace. Much of the actual interprofessional interaction that takes place in the course of work was invisible to them and they were unclear about roles and how they would be enacted; as such learning with other professionals outside the workplace failed to dispel confusion and sometimes added to it. However their most memorable and formative experiences of interprofessional interaction were located in the respect and disdain modeled by their teachers in clinical settings.

Interestingly IPL in medical schools emphasized all allied health professionals equally, making no distinction between those with whom physicians would work sporadically and those with whom they worked side by side, such as nurses. Residents questioned the interests of those who constructed such programs and felt the involvement of so many stakeholder professions diluted the interests of individual professionals. They attributed the gaps and deficiencies in their IPL experiences to vested interests, lack of cohesion and tokenism. Tacitly it appears that such indifferent teaching conveys the profession's indifference towards collaborative practice.

## Working as a resident.

Transitioning from a medical student to a resident.

Being new and remaining new.

So I know we've just become doctors, I mean they [nurses] probably know far more than me, I'm sure they do.... It must be annoying for them I'm sure because you turn up and you don't know how the system works and you don't know where anything is and you couldn't say, "Where do you get this?" and "Can you do this?" and asking them annoying questions. I'm sure it is annoying for them and then just by the time we know everything, how the system works we're going to move off to our next job so they're going to get a whole new load of people that don't know anything. *Diana, UK*

Because you're changing so much, you don't know their names and they don't know your names. They stop caring and you stop caring because you're working with them for a half day or week.... [I]t's friendly when you do work together and I charm and they tease. And it goes back and forth. But it's never going to be that good until you know someone.... And when you change roles every four weeks you're constantly making first impressions. And you're constantly on the defensive essentially. Because you're never, you never have home court advantage. You're always coming into their turf.... And so that's why you have to be overly nice and you have to do your best to get in there. And in order to do your job effectively you need to work effectively with other team members. And if you piss them off then they can bug you all night and you won't get a wink of sleep. And then you'll hate your work.

*Matt, Canada*

Transitioning from student to resident: precipitously.

[S]uddenly as soon as you've got that piece of paper in your hand saying you're a doctor, you're allowed to do whatever ... like all these practical things on the wards when really you've got no experience, you've only ever done it on a plastic model before. Yet just because you've suddenly got this piece of paper saying you're a doctor, ... you're expected to do it. And, you know, I don't really feel like I have experience to do certain things. But I suppose you have to really. *Tara, UK*

It's hard as a resident to find that balance of asserting yourself because you're a doctor now and you have responsibilities for the patients and you have responsibilities just for decision making. You're past the medical student stage; you're at the point where you have to make medical decisions for people. And you're kind of fighting at the same time because I'm only a year out now I guess, and you're kind of fighting with well do I really have enough knowledge to be making these decisions?

*Jerry, Canada*

Transitioning from student to resident: ill prepared and not knowing enough.

You're not really experienced in acute situations as a med student. Because you're not put in that situation because you don't have the experience to deal with it and then suddenly you graduate and you're expected to deal with really sick patients when you never would have had to do that as a student. *Tara, UK*

But really it's the nuts and bolts. And medicine can be so much of the little practical things. And they don't tell you that in medicine. They say administer this drug, this is the name of the drug we use. What they don't tell you is that it comes in a vial with five milligrams per milliliter and that you have to give it via IV push [intravenous injection] and somebody has to chase you with 20 ccs of normal saline.

*Susan, Canada*

Transitioning from student to resident: unrealistic expectations of support.

I did think going through medical school I have to say I always thought I would be more supported when I came out [of university] because I thought, you know, as a student you're all quite protected and you don't have that responsibility.... [A]nd I always thought that ... by the time I graduated I'd feel ready but I'd still have that support around me that if I needed help I could get it. *Tara, UK*

Transitioning from student to resident: unclear about roles and structure.

I just didn't even know really what a nurse was going to be wanting to do with a patient or was going to want from me for the patient or what the unit clerk did, what the charge nurse did. And so you, it's kind of hard to be helpful or even if you can't be helpful to just not be a pain in the ass, when you have no idea what somebody else is trying to accomplish. *Susan, Canada*

Transitioning from student to resident: burdened prematurely with so much responsibility.

[T]here are certain things when you're assessing a patient who's unwell, that it's really down to you and you can't turn around and say, "Do you think I should do this?" Because that's a medical decision rather than a nursing decision. *Kevin, UK*

The stressful thing probably for me is just this sudden change in responsibility that you don't really have as a medical student but all of a sudden you do as a resident and yet you don't really know that much more. *Jenny, Canada*

Transitioning from student to resident: looking stupid and hating it.

I mean sometimes you're afraid to ask for help because you don't want people to think you don't know what you're doing. *Tara, UK*

That's when you first get exposed to nurses and you come in wet behind the ears and you're just trying to study and not look like an idiot. *Matt, Canada*

The experience of being new was felt intensely by all residents. Being new and the attendant emotions and predicaments were relived with every new placement which had its own culture, structure, people and expectations. The residents were acutely aware of their inadequacies and unfamiliarity and saw these mirrored in the way they were treated by nursing staff, thus reinforcing them.

For the first two years residents rotated through a variety of placements which lasted approximately four weeks each in Canada and three to four months in the UK. The impact of shorter placements in Canada was reflected in a sense of overwhelming fatigue, never getting on top of it and stopping to care while in the UK a second year resident recounted the experience of reaching a reasonable level of competence and comfort for a short while at the end of a placement, before becoming new again. The immediacy of newness was still evident in the accounts of the second year residents at both sites but

abated in the narrative of the third year resident in the UK, now based in his chosen specialty.

Being new was accompanied by a sudden change in responsibility and expectation. The student's role had been of a learner and a performer, devoid of ultimate responsibility and therefore with room for error. The student was accountable for learning to the consultant with whom the student was attached but had no accountability to the medical team and remained outside it. Transitioning from student to resident was like being parachuted from the periphery of the community of clinical practice to its very heart. There was no gradual migration towards the center and although both the resident and other members of the community were aware of the suddenness of this transition, it remained largely unacknowledged, thus giving the nursing staff tacit permission to chastise residents and heightening the sense of inadequacy among residents. In the absence of direct acknowledgement of their novice status, nurses' dissatisfaction with residents' decisions and performance was reflected in passive-aggressive behavior and murmurings, against which the residents felt helpless. In this atmosphere the tension between the need to seek help from the nurses for the patient's good against the fear of looking stupid was constantly palpable. Inevitably the residents negotiated their position as doing the best for their patient and measured and justified their actions against this standard.

Although senior colleagues could be called and consulted, there was little guidance about when this should be done, except in the highly structured environments of acute care such as the Emergency unit, and residents struggled to define and justify their threshold for calling for help. When they did resort to calling a medical senior, it was inevitably in the context of difficulties in medical decision making but never in the

context of floundering with structural issues or dealing with other staff. In these areas they saw themselves alone in the deep end. Their poor understanding and inexperience of roles in the workplace added to their confusion and inability to approach team members with confidence.

At the heart of the team, especially in the wards and on call, residents struggled to appear confident in the face of inexperience and while they chafed at the premature burden of responsibility, they shouldered it nevertheless. They recognized their lack of skills and practical knowledge to deal with the needs of the patient and demands of the extended team and realized that developing a rapport with the ward nurses and staff would help them survive. However, in large wards nurses worked shifts and it was difficult to develop relationships or even get to know their names.

Through working with contradictions and tensions, such as that of being a learner but also a practitioner; of knowing so little but having so much responsibility; of being at the bottom of the rung but having the power to authorize medical orders; of being ostensibly supported but often alone; of working in a multidisciplinary team but often apart, the new resident navigates a way through the inherently unstable environment of hospital practice. Here situations, demands, expectations and priorities change with location, unit, the acuteness of the patient's illness, time of day and the staff on shift, to list a few. Through these polarities they struggle to act upon their own priorities that become anchored in their perception of the *good of the patient*.

Being overwhelmed by work and its demands.

Being scolded in spite of doing *my* best.

Like I didn't stop at all [that] day but people were still angry with me because I hadn't got to do the jobs ...

*Tara, UK*

I mean like on a ward the priority's the sick patient and so if someone's sick I'd spend all my time sorting them out but then ... I got bleeped from ... like very senior sort of matrons that sit in the management offices about why somebody's discharge summaries haven't been done yet and it's unnecessary I think ... I mean, all I do in those situations is sort explain my situation, I mean sometimes they just don't understand that you're looking after a couple of really sick people. All you can do really is just point that out. But most of the time they'll say they don't care and they want it done anyway. And then if you sort of say, well, like last night I stayed until eight o'clock and all this kind of stuff. And they just don't care. *Nat, UK*

Floundering in apparent contradictions and ambiguity.

[I]t's very difficult to have a good, clear picture of exactly what is expected at my level and, you know, am I falling short of it or beating it, it's a bit unclear. *Temara, UK*

Every consultant likes things done differently here. You know, when you're on call, the registrars like things done differently, just little things like how you keep up the patient list.... So, you know ... are you supposed to know what's inside someone's head? *Tara, UK*

But I find that sometimes I get treated like a first year med student by people. It's like, "You just stand there and you don't touch anything because you don't know anything." And then other times it's like, "Go do that central line [insert an intravenous line in the central vein]." I'm, "[Really?] Okay, sure." You know. And it can be very dichotomist. *Susan, Canada*

Being on call: feeling alone and isolated.

I didn't feel part of a team at the weekend if I'm honest ... because you get ripped from your team. Like as my surgical team that I'm with, you know, it's the same me, it's the same SHO [senior house officer], registrar, consultant, every day. And then when you're on call you get ripped

from that team that you are part of and you get into a new team of a registrar, SHO that you've never met before. Because they're on call, they're from different teams and basically you're just a mismatch of different grades from different teams. So you've never met them before and you don't feel like part of a team because you don't know the people, you don't know their expectations and they just sort of give you orders and you do it. *Tara, UK*

When you're by yourself and having really sick patients and being really afraid that you don't know what you're doing and not having somebody right there to kind of bounce ideas off of. That's again ... working with nurses is really important because when nurses are really worried about patients I get really worried because they know if patients are really sick or not.... On call you do feel very, very lonely. Very isolated and.... You can always call your staff doctor, but you want to make sure you've kind of done everything that you can before. *Nina, Canada*

Being on call: stressed, scared and unable to prioritize.

I've never known such stress like it to be honest. And on Sunday I went from eight in the morning and I didn't get home until 11 in the evening and I hadn't eaten or drank anything all day and I felt like I was going [laughs]. It was awful really.... [W]hen I tried to think logically about problems on the ward I couldn't, like, I couldn't think about it properly because I was thinking I still have all of this to do and I need to make a decision quickly.... And you suddenly feel yourself getting panicky and you can feel your heart racing in your chest and I think it's that sense of you're losing control of the situation and you feel like helpless in a way ... if a patient dies when they're supposed to be caring for them. But really it's not that the doctor is incompetent it's just that there's so much pressure and there's not enough time to get to the patients. And it is dangerous and sooner or later ... there's going to be a terrible consequence of it. *Tara, UK*

I've had a couple scenarios where ... there've been cases where they could be, in theory, a medical/legal issue and they make me extra nervous ... you [do] not want to do something wrong and faux pas and yeah, so that's been tricky. *Jenny, Canada*

Unable to cope: becoming distressed.

... I sat on the sofa in the surgical assessment unit at half past four in the afternoon and cried and I never thought I would do that all because normally I'm completely in control. *Tara, UK*

Residency is tough because you have your shitty days and you don't have enough sleep and you've not necessarily eaten properly. Often, God, sometimes you don't have time to pee. You know the most basic elements of self-care you don't get to. So there are those sorts of physical, emotional, intellectual stressors all the time. *Susan, Canada*

The experience of being overwhelmed and even distressed was described repeatedly but felt most poignantly in the context of being on call. In this situation residents frequently felt that they were overworked, unsupported and isolated. When this was compounded by physical exhaustion, lack of empathy, outright conflict or the fear of not knowing or making a mistake, exhaustion escalated to panic and compromised the resident's ability to reason and act. They came to terms with such stress by recalling the high points of residency when they had done well and by looking ahead to when it would end.

In the absence of an acute emergency, nurses and residents were guided by their own priorities in a busy ward. Although ultimately both their actions were enacted upon the patient, their tasks, responsibilities and reporting structures that determined their priorities were different. Yet in order to complete tasks nurses frequently needed the participation of the residents and vice versa, leading to conflict and dissatisfaction when it was not forthcoming or timely. Residents' narratives told of senior nurses' and management reprimanding them, but recounted that they found it hard to vent their frustrations for fear of retribution. While the volume of work itself was often daunting, the residents found the lack of acknowledgement of their work and stress harder to bear.

The structure of hospital and being on call made the residents work, which involved traveling through various wards, invisible to the nurses, who were located in teams in a single location, thus making it difficult for them to appreciate it.

**Working as a resident, with nurses.**

Feeling *othered* by nurses and seeing nurses as the *other* in turn.

Feeling inadequate and incompetent.

One of the hardest things actually since starting is working with the nurses. Because I think their opinion of us, let me start, is a very low opinion of us. So I know we've just become doctors, I mean they [nurses] probably know far more than me, I'm sure they do. They've been working in accident and emergency for years and years and years. But it's so difficult because I mean we're trying our best to do, you know ... they think we're idiots.... What they do is ... quite often they won't do what you ask them to do.

*Diana, UK*

[T]he nurses who know you're only a year out too and they know, they see the medical student next to you and they don't necessarily see a difference between you and that medical student. And so it's hard to assert yourself with nursing staff, doctor staff, every, anyone that's worked at the hospital longer than you have, hard ... for them to ... take your input as serious input, as valuable input. So yeah, it's hard to ... find your place in the midst of so much experience. *Jerry, Canada*

Feeling unacknowledged.

Sometimes they're very surprised that they see us the next day, right? They're very surprised, "Oh I was here last night and you're still here." And they don't get the concept of we work sometimes 36 hours, right? That we work whole nights and during the day. So they don't understand the kind of the.... [I] think they don't really understand how much training we go through to get to the point where we are and how much we've actually really given up or I can just speak for me personally how much I've neglected my family or neglected other parts of my life because of medicine.... I'm not saying you know, we need to be showered with respect or anything but have maybe more sympathy or more empathy ... *Nina, Canada*

Being intimidated or ignored.

I mean nurses can be very intimidating, especially when you're new and you know you don't know what you're doing and you know you don't know how things work and there are just so many things you start to realize that you don't know.... One of the things I feel I've learned about nurses is their friendliness to you is directly proportional to their need to get something from you. So if they need an order, if they need a patient assessed, if they need to write that a doctor is aware of such and such of thing with a patient, they're sweet as pie. If they don't need you, you're just wasting their air.... Most of the time though I find they're kind of bitches some times. You know, like you're just in their way, they would rather not have a learner. They would rather not have to phone you. They would rather just phone the consultant who knows what's going on and knows what they're doing and not bother explaining whatever to you. I mean you are absolutely no help to the nurse, zero help. I find operating room nurses are very, I find them actually the most intimidating and the least helpful and friendly period. *Susan, Canada*

Seeing nurses as hostile, unreasonable and inconsiderate.

[In the accident and emergency unit], I perceive them to be a little bit more hostile. They weren't as willing to help you. So they'd look after a couple of patients, you'd look after more patients and they'd always say, they'd always be very keen to not do things.... [B]ad things happen ... and it's our fault because it wasn't done but we've asked them to do it. *Nat, UK*

Things can escalate sometimes depending on the personalities involved. I've had nurses make what I felt were unreasonable demands. They were saying, "We need an order for this". And I say, "Well, you know, this isn't my patient, I don't really know them." They're, "Well, we need it now; we need an MD to write the order." And I start looking through and I'm, "What's the deal with this patient?" And they're, "Just write the order." *Matt, Canada*

In interactions with nurses, the resident often felt redundant and inadequate and sometimes disregarded and even intimidated. Although nurses are aware of the learner status of the resident, they have no explicit responsibility for guiding them. They are

compelled to interact with them as the frontline representatives of the medical team who have the power to authorize drugs, investigations and other interventions. In this situation the greater experience of the senior nurse as compared with that of the resident is a glaring contradiction and cause for contrition and conflict. On the other hand the rookie resident's legitimate concerns about patient safety based on medical knowledge are overlooked or minimized in view of the resident's novice status. When dialogue and explanations are limited or absent, nurses and residents have no way of understanding each other's reasoning and resort to seeing the other as unreasonable.

Additionally to achieve the nursing tasks such as discharges or transfers, the resident's involvement in the form of discharge summaries or other paper work is necessary. The same holds true for the resident who requires the nurse to carry out orders, such as to administer drugs to achieve his objectives. Ostensibly both nurses and physicians are responsible for providing care for the patient but their accountability structures and concerns though inextricably linked are different, especially in the subacute setting. As such it is not difficult to see how one or the other retreats behind professional lines and sees the other as obstructive and difficult.

To make matters worse, the residents have very poor understanding of the nurses' scope of training, skill and knowledge and their own work is often invisible to the nurses because it is geographically distributed across the hospital. The resident's sense of isolation and being *othered* is compounded by often being the only medical staff in a ward in contrast to nurses who have each other's support.

In the inherently unstable milieu of the hospital rife with contradictions and ambiguities, the residents have to eschew their frustration and learn to get by without

upsetting nurses; they realize that if reputed to be rude or incompetent, their life will be rendered even more difficult.

An incident that occurred during a half day nonparticipant observation in an emergency ward illuminates the lack of interprofessional responsibility felt by senior nurses for junior medical residents. Observing a new resident in the Emergency ward I became acutely aware of her discomfort; while others knew one and other and chatted amiably, she kept to herself and did not speak with anyone. Finally the senior physician arrived and they sat down to discuss a case; she was visibly relieved. Later the senior nurse who had been laughing and talking with everyone came up to the counter and started a conversation, bemoaning the nuisance of having to deal with new residents who get in the way. I pointed out that the resident looked frightened and uncomfortable. She paused, appeared surprised and then after a moment of reflection responded that she had never thought about it that way. A few moments later she wondered aloud if she could have helped.

Finding it difficult to communicate with nurses.

I don't know where the morphine's kept to be honest.... So I need the nurse to just do that last bit of the thing and so I went and asked one of them to do it and put the thing in the treatment box, which is what you always do. Well, you're supposed to put the piece of paper in the treatment box and they're supposed to come and pick it up but I always just go and ask them as well.... And the nurse sort of, what did they say? Oh yeah, "I'll be there in one second." ... And then she got a sheet and she saw I'd already given him sort of paracetamol, diazepam [sedative], ibuprofen [pain killer] and she's, "Oh, and he's had two cylinders of Entonox [medical anaesthesia gas]." And was like, "Oh he can wait, he's had all this already." ... And she didn't come in, yeah, she didn't come and talk to me. I just overheard her saying that to her other friend. And I was so annoyed because I couldn't assess him until it was done.... Well she sort of

went off and did something else ... probably took an hour and a half, I think.... She's one of the nurses that, she's really good, she's worked in A&E for years and years and years. But she's one of the ones that sort of doesn't like doing stuff for the FIs because she thinks that we're stupid. And most of the time she is kind of, she is right that actually it's not that urgent but it was just in this case.  
*Diana, UK*

This was two o'clock in the morning and so you know you go back and kind of stumble into your bed and fall asleep for a couple hours and you wake up to check on some people and you go back down and the antibiotics still hadn't been done yet, hadn't been ordered.... And the reason the nurse hadn't started it was because she was, "Well this person doesn't have an infection. Why am I starting antibiotics?" So, you know it's touchy.... It's hard because your gut reaction, especially at two or three in the morning is to get angry.... If you do get angry and at the very least that nurse remembers that you got angry at her and [is] definitely less helpful in the future, if you ever need any help and nursing staff's a great help but if they're not on your side it makes your life a lot more difficult ...  
*Jerry, Canada*

Residents experienced barriers to effective communication at multiple levels and in aggregate these account for delays, misunderstandings and conflict. On a personal level the feeling of shyness or inadequacy often led a resident into acting alone rather than approaching the nursing staff. Being ignored or rebuffed had a similar effect and often resulted in direct communication only when absolutely necessary. It is generally acceptable to communicate through physician's orders written in the patient's notes, but in a busy ward, these may be overlooked for several hours. On the other hand nursing notes are generally not included in the main patient file and nursing observations are infrequently read by physicians. In wards in Canada nurses communicated with physicians through pink *attention doctor* slips pasted on patient's notes. Collective rounds and decision making were infrequent in both locations. Since communication was

largely spoken of and executed in terms of *doctor's orders* and *nurses' requests*, it had no room for shared decision making, discussion or explanations and therefore seldom went beyond transactional intercourse. Even when opinions differed and nurses' resisted carrying out doctor's orders, mutual explanations and discussion were unusual. Residents fumed and became defensive while nurses found recourse in undermining the resident through contacting a senior doctor or just ignoring the order or delaying its execution. It was only in rare circumstances where respect and long association between senior physicians and nurses had fostered a culture of shared decision making that meaningful communication was the norm.

Learning to get by.

Avoiding unpleasantness.

[I]f I can do something in a way that doesn't compromise patient care but allows me to sort of deal with unpleasant people to the least extent possible, I will do that. I'll basically do anything up to compromising patient care.  
*Susan, Canada*

And I might not delegate tasks. I might just take it on myself to do everything because I'm too introverted or shy to actually say, "Can you do this for me." And maybe that's because I'm shy. Maybe that's because I don't quite know what the nurses' role might be or what they might be prepared to do. I don't want to offend them and so sometimes I think it'd just be easier if I do it, because I'm able to do it. *Kevin, UK*

Appearing friendly.

I try ... and have a bit of banter with the nurses and try and get along with them. And I think they definitely then respond to you a bit better. And I sort of, I ask them in that way. So I'm like, "Do you do that normally or?" And so they're okay with it. *Diana, UK*

For certain rotations you're absolutely taught to tread lightly around the nurses, for Obstetrics for example

because they have this one on one relationship with the patient. They hold a lot more cards than they do in other rotations.... So you end up, you play a game where you flatter them. If you know about something sometimes you say, "Can you tell me about this?" and you're warned ahead of time, be nice to the charge nurse because she'll make your life good or she'll make your life hell.

*Matt, Canada*

Learning to ask for help.

I never used to feel like that but some of the nurses are so horrible to you when you do ask that you end up thinking, oh God, I'm never going to ask ever again. But then you do ask and I still carry on asking. *Diana, UK*

So, I mean they know amazing things about IV pumps and what solutions.... [E]very time I go into a room and the pump is beeping I have no idea what to do and I always just ask a nurse for help ... and even just how medications can be given and over how long, how they need to be reassessed. *Jenny, Canada*

Learning to be assertive.

As an example, if somebody says, you know they're in a lot of pain; they need more painkillers then, again, if somebody said that to me over the phone or they just gave me a chart and said, "Can you write some up?" It's my responsibility because I'm prescribing the medications to actually say, "Well hang on a minute, they're already on this, that and the other, is there something ... else I should know about? *Kevin, UK*

I think when residents get their toes stepped on by nurses; so to speak, I think a lot of the residents try to react with asserting themselves. Asserting that they're in this position and almost like they are higher in the hierarchy than the nurse. Which is that true? Is that not true? I guess in a sense it's kind of true because the resident writes the orders and the nurse has to carry out those orders. *Jerry, Canada*

Amidst shifting priorities and demands, residents begin to see *getting the job done* and *doing the best for the patient* as their goals and to achieve these goals they frequently need the cooperation of the nurses. It follows that residents try to have the nurses on their

side and avoid conflict. However, there is a palpable tension in choosing strategies to ingratiate themselves with nurses especially if these strategies mean being insincere or compromising their values. In grappling to establish their position vis-à-vis nurses, they search for clarity and certainty and lay boundaries beyond which they will not compromise. Quite consistently they espouse this boundary as the line beyond which the patient is compromised. This understanding becomes the guiding principle for their interactions. While this boundary is conceptually clear, in practice the *good* of the patient can itself be ambiguous and a matter of opinion making it difficult for them to decide when to dig their heels in. Considering the consequences, they pick their battles infrequently and judiciously and reserve being assertive for when other choices are exhausted. The stress of having to resort to subterfuge and devalue themselves results in simmering resentment which is evident in the tone of their narratives and in recounting tales of residents *losing it*, in their interactions with nurses.

Understanding the role of power, gender and generation in nurse-physician relationships.

Understanding hierarchy.

I think sometimes I feel like I'm closer to working for the nurses than for the doctors sometimes because they're the ones that need you to do things like on the wards.... So I'm like really just doing what they tell me to do [laughs].... But I suppose ultimately I'm working for my consultant on my team. *Tara, UK*

I don't think its level. I think residents definitely have a, are higher up in the hierarchy. Let's say if there was a hierarchy with everyone I'd say residents are probably above the nursing staff. But I think nursing staff are more comfortable challenging that hierarchy against residents. And I think in general if there was a hierarchy I think some nursing staff, not all nursing staff, but some nursing staff are resentful of that hierarchy ... I find at least some of the older nurses have that hierarchy in their head. And they're

okay with that hierarchy.... Whereas I think for the younger nurses it's not that they don't believe the hierarchy's there, it's just their not established in a position to feel that hierarchy yet. And so it's just easier to just joke around with them a little more and things like that. Not being unprofessional but just it feels more collegial.... But here [there] is a hierarchy but the nurses are on top of that hierarchy on [the] Labor and Delivery [unit]. *Jerry, Canada*

If the resident's not sure they ask the senior resident. Senior resident's not sure they ask the staff. There's a clear hierarchy there and no one has any problems with that hierarchy because it's in place because they know more than you do. And you're comfortable with that because you know they know more than you do ... so I think that clear established hierarchy and I think it's fine because you all have the same role. There's no comparison between roles. It's hard to establish, I think it's hard to establish a hierarchy between nurses and doctors, even though I think it's there. I think it's hard to establish just because it they do different things. *Jerry, Canada*

Trying to understand nurses' perspectives.

I completely understand their point of view I mean I did, I was doing my first, second year at university I worked as a nursing auxiliary ... and I know how frustrating it is when you need something simple done like fluids prescribed or paracetamol prescribed for a patient and the doctor won't come. *Tara, UK*

On certain units or wards there will be the charge nurse with you interacting a lot more directly and they've got a handle on all the nursing points of view and they're able to speak like equals, ... but it's easy to dismiss some of the day-to-day things. Like, "Mrs. Johnson hasn't had a bowel movement in three days." And you're, "Well, I don't care, her ECG still has changes and we're going to worry about these serious medical things that are going to kill her." While to Mrs. Johnson it might be the stomach pain from constipation that's the most important thing. But it's easier to dismiss some of the nursing [concerns]. *Matt, Canada*

Comprehending gender and nurse-physician relationships.

Yeah, they get by because I think men junior doctors I think they either get mothered by the nurses.... But if they're younger nurses they flirt with them and I think they

[laughs] ... you can see it happening like they'll learn the nurses names which I try and learn the nurses names as well and ... so they'll walk into the ward and, "Oh have you got any of your special biscuits?" Or something like that they'll say to the nurses and the nurse will run off and get one ... I think if he was a woman would the nurse go and make him a cup of tea and a biscuit, you know, I don't know ... obviously that's a big generalization. *Tara, UK*

The way I find I kind of have to play it is to be kind of friendly with the nurses and literally to kind of be their friend, be a chick pal ... and in a very girly way. I find I tend to get along with the nurses better if I have knowledge of pop culture and can talk about *American Idol* or *Dancing with the Stars* or whatever. That whole authoritative demeanor just doesn't work. And I think it's because you're all ladies. It's all kind of, it's not how women relate to one another, to have that power structure, women have this very sort of cozy, friendly, often kind of bitchy but complex female milieu, I suppose that there are always different ways to approach every situation. *Susan, Canada*

Understanding the influence of generation and seniority in nurse-physician relationships.

Yeah, I think [laughs] that the junior nurses are more fun. And we're all new there. We don't have a clue what we're doing. So there's that element of it. And they're just ... a similar age to us.... Yeah, just interests in the same things and they're generally a bit more supportive; a bit more outgoing, you can socialize with them. *Nat, UK*

And when you first meet somebody you can feel if there's hostility towards you or a dismissive nature and definitely with older nurses I found that, I'm not trying to stereotype but more often than not it's older nurse that I find kind of more hostility or more, when you can feel that somebody is doubting you because of where you are in your training. *Nina, Canada*

While hierarchy within individual medical and nursing teams is clearly established and acknowledged, that across the two professions in unclear and full of contradictions.

Based on the logic that nurses and physicians do different things and that residents and nurses see themselves primarily as belonging to the medical and nursing team respectively, and only as an afterthought, if at all, to the interprofessional team, they

cannot be in a hierarchical relationship with each other. Although this is the reasonable conclusion residents arrive at, their observations and experiences tell of a fluid and constantly negotiated pull and tug of power and hierarchy. Multiple factors determine who has the upper hand at any given time, such as power to authorize versus the power to resist, the medical knowledge versus the practical skill, experience versus inexperience, personal knowledge of the patient versus medical judgment, and *bureaucratic* power versus medical decision making. To add to the complexity, personnel of different seniority and statuses within their own professions interact across the professional divide. The ambiguity and fluidity of the line of command creates a tension in which the resident is constantly negotiating a space.

The interaction between the residents and junior nurses holds the promise of collegiality and collaboration. Residents find a connection in terms of their common interests, especially the media, and their inexperience. Residents profess little need for hierarchy in their interactions with junior nurses and prefer just to get the job done together.

Junior nurses feel that senior nurses, on the other hand accept the nurse-physician hierarchy in which the physician is higher up but find it difficult to accord this status to inexperienced residents. Such a conflict within their own conceptual framework is reflected in residents feeling resented and judged. Interestingly both research locations had a paucity of middle grade nurses and thus there was a hiatus between the junior and the senior nurses.

While there were almost an equal number of male and female residents in both locations, nurses were mostly female. Women residents anticipated feeling more

comfortable with nurses than their male counterparts, but discovered that although they got along comfortably with junior nurses, the male doctors received more empathy and attention from them. Although female residents did not encounter competitiveness from junior nurses, many felt intimidated and *othered* by senior nurses. Male residents on the other hand were often mothered by them. Those male residents who saw themselves as outgoing and confident were clearly aware of their advantage with nurses and used their charm to get by.

Understanding what makes a team and what doesn't.

Feeling like team.

[In the accident and emergency unit], in resusc [resuscitation] and in the majors area they're actually a lot more helpful and willing, they just get on with it because ... the patients are sicker ... actually you don't have a problem over there, it's really just in the minors area [where patients are less sick] where it's things like getting a dressing or a sling or something similar to that. Those are the really difficult things where I guess the patient's not really going to suffer that much if they wait a bit longer but it's.... I mean you can have a nurse where 20 minutes ago you're in minors and they wouldn't do a sling for you but then if a sick patient comes into resusc and you'll have the same nurse will come in.... [T]he team actually works really well. So I think it can work really well when it needs to. *Diana, UK*

Emerg [the emergency unit] is actually I think one of the best places for the collaborative nature because you're sort of standing shoulder to shoulder with people all the time. You have more of an opportunity to sort of get to know them or just chat.... Sometimes not even that much but just joking and you know it's more everybody's kind of standing in the same place, literally. So I would say the teamwork certainly facilitates communication when everybody's sort of sitting together and you can just easily ask people or so on ... I was impressed you didn't get the feeling like we were tripping over each other trying to fulfill our own little agenda, everybody kind of had little things and they were helping other people with their little

things to speed things up basically. Everybody knew what everybody else needed. *Susan, Canada*

Not feeling like team.

I suppose if the ward is very busy but there's not a specific single thing that's making it busy, there's lots of things, you're trying to get lots of discharges going, you've got a couple of patients that need fairly intensive looking after but they're not necessarily rapidly deteriorating or anything and maybe the consultant's turned up and wants to do a ward round and, you know, there's a lot of different reasons for it to be busy and everybody's kind of being pulled in different directions. It's probably when it works the least well. And then people with different priorities are prioritizing different tasks more urgently. *Temara, UK*

Yeah, nurses communicate via those attention doctor pink slips.... I'd be sitting on the floor [ward] dealing with another patient and they'll kind of come up to you and again, often very nice and very friendly because they want something from you, "Can we have some, you know, a morphine order for so-and-so?" Or whatever, morphine's a bad example. But they'll often ask for, "Can we have a Gravol order on so-and-so, he's been pretty nauseous." *Susan, Canada*

Developing interprofessional bonds.

Well it's quite good on night shift ... and one of the nurses gave me a half a bag of sweets to carry around the wards for the night while I was doing my night shift [laughs] which is really nice and you know, the other one's that I'd worked with during the day and we hardly spoke. *Temara, UK*

But it's [team night out] quite sort of structured ... it's not very spontaneous.... Yeah, yeah, they're a lot of fun. I think, yeah, to see people out of work is ... you see people out of their uniforms ... it's a lot more relaxing.... It's nice; it's better for the team I think. *Nat, UK*

The experience of working as a team with nurses was narrated as good and wholesome and remembered with a sense of pleasure and security. It was remembered as the times when everyone acted together to avert an adverse outcome for the patient; when the

patient's immediate problem was the focus of attention and professional priorities coalesced. At these times individuals were members of the larger team and functioned according to their level of competency towards a common goal. In a resident's words they *stood shoulder to shoulder*. Such teams emerged organically during emergencies both in the wards and in acute care settings and it was the experience of this *teamness* and cohesion that gave residents an alternative sense and vision of interprofessional identity.

Such coming together and collegiality dissolved rapidly upon resolution of the emergency and the team members retreated behind professional lines, to complete their professionally determined tasks with competing priorities. Once again they saw each other in utilitarian terms, and communicated in transactional ways. While the experience of team was one of pride, belonging and satisfaction, residents realized that it was also fickle and short lived in the face of pressing professional priorities and that constant renegotiation was the norm.

Some sense of team was experienced when the interprofessional team got together to focus on patients' problems such as in a ward round. This was not a regular or consistent feature either in the UK or in Canada and when it did occur, the sense of *teamness* was largely dependent on the style of physician leadership which either welcomed everyone's input at one extreme or stifled it at the other. Even where nurses were confident and vocal they learned that the lead physician was in the driver's seat. In the presence of the medical consultant, the resident felt protected and respected but learned that this respectful atmosphere was subject to change and was renegotiable when they were alone with the nurses in a busy ward.

The sense of team was lost when the workload for both nurses and the residents was high or overwhelming and although all work was related to or enacted upon the patient, it was fragmented and divided, requiring little collaboration but significant cooperation to meet targets and goals. In these situations, either inadvertently or intentionally a nurse or a resident could subvert the other without feeling that the patient was being harmed.

Power games were played within these boundaries and assumed to be short of *compromising* the patient. Clearly, judgments about absence of harm were subjective and it is unclear how the patient would perceive them if included in such decision making.

In the residents estimation, this lack of *teammess* could escalate to passive aggressive behavior on the part of the nurses or even direct confrontation if a senior nurse chose to apprehend the resident for not meeting nursing requirements or if the resident decided to dig their heels in. Residents explained clearly why they chose to dig their heels in certain circumstances, but probing their accounts revealed that these impasses were a consequence transactional communication. As noted, nurse-physician interactions seldom went beyond the transactional and in the absence of explanations and discussion, ill will and resentment had the propensity to spiral up. The new resident's sense of inadequacy and powerlessness was at times further exploited by experienced senior nurses who knew the medical consultant well enough to contact him directly and subvert the resident's orders, leaving the resident undermined and alienated.

Interestingly the issues which led to conflict and confrontation were few but recurrent. Frequently these were related to sedation, pain relief and restraint; it would appear that clear and collaboratively developed guidelines would have been useful.

When the workload for both the nurses and the residents was not heavy, pleasant social interactions, empathetic exchanges and attempts at getting to know each other were remembered with pleasure and gratitude by residents. These exchanges occurred most commonly between residents and junior nurses who had common interests and saw each other as learners in stressful situations, both trying to get a job done. They had little need for hierarchy and could communicate across a level table.

Reconciling experiences.

Realizing that it's not all nurses.

It's not all the nurses, I can't put them all in the same group really, because it is just some personalities I think. Now I'm starting to know the nurses that actually will listen to me.

*Diana, UK*

And just at least in terms of this last rotation I've been on I think just generally ... the nurses seem to have a pretty good rapport and just being able to ask questions but then also joke around and get to know everyone else so I think it's been, there's been a lot of collegiality. I don't think that's always true on every ward, I think it depends on the personalities and the particular mix but on the most recent ward ... today I was talking to a nurse and they were too busy or maybe way more experienced than I was and I felt that my questions weren't, you know, well received or were blown off or that sort of thing ... it wasn't as collegial, it just wasn't as you know "I'm the resident can we just chat about this?" sort of way. And I think that maybe stems from just they were really busy at the time and they just didn't really have time to deal with me... [Y]eah there's definitely been some times where I've felt a bit kind of brushed aside. *Jenny, Canada*

Acknowledging nursing expertise.

If the nurses weren't there I'm sure the whole place would fall apart to be honest ... because they've been working in A&E for years and years and years and so yeah, they sort of know. They've seen, you know, they've seen thousands of patients and they know the normal thing of what happens. *Diana, UK*

Some of the cardiac nurses have been working there for 30 years. They know way more about managing, pick something in cardiology, anything and they know more about managing it than I do. I've probably have more specialized knowledge. You know, something weird and wonderful comes up but as far a day-to-day patient management they know way more than I do. *Jerry, Canada*

Making sense of contradictions and priorities.

On ward rounds with the consultant there and the senior physicians I think they obviously have known the nurses for a long time and the nurses know they don't want to mess around.... But then when you're on your own with the nurses they're all always very respectful but ... when it's much more pressured you lose that ... people don't always listen to what each other are saying. Like the nurses don't necessarily listen to your input and you don't always listen to theirs because you're thinking, you know, the nurse thinks I just want them to prescribe the fluids. *Tara, UK*

I find the agitated patient is a difficult one because the nurses have to sit there all night and listen to so-and-so howl and scream and carry on. And that's one where sometimes they're trying to make themselves more comfortable and fair enough but giving a bunch of antipsychotics to some frail little 95 year old lady who's demented out of her skull, you know. It's not necessarily best for the patient; it's best for the nurses. But that's the minority of the time. *Susan, Canada*

They don't need us there; they can deliver babies no problem. And so for us to come on in a very knowledge inferior position and to be giving them orders is a very backwards system. *Matt, Canada*

Comprehending structures and the *way it is*.

And it's quite well supported in A&E as well because ... just the structure over there because they've got so many senior doctors.... It's definitely well supported because I know a lot of people on the wards, there's literally one F1 and then maybe an SHO and then the registrar and the consultant that they never see particularly and they [are] ... scared to call them, really. And I think it's quite, you're on your own a little bit. *Diana, UK*

Basically our interaction with the nurses is getting a report from how the patient did overnight and then if they had any concerns and then we make management plans. But it doesn't really feel like they're part of kind of the overall assessment I would say it's more.... [D]efinitely they're more the patient care and they see the patient more than we would. But definitely the kind of the final decision making is by the residents or the staff doctor basically.

*Nina, Canada*

Despite being impacted by the tensions in nurse-physician relationships and often smarting from difficult encounters, residents were quick to admit that the worst behaviors could not be generalized to all nurses. They demonstrated a constant struggle to remain reasonable and objective and reconcile their negative experiences with the nature of the working environment. Although they chafed at being minimized, they understood how their unfamiliarity with the structure of work environments and their itinerant status could be a source of annoyance and how they could be seen to be getting in the way by nurses.

Recalling adversarial situations, their initial reaction was to ascribe self-serving motivation to nurses' actions such as considering their requests for sedation or physical restraint of an aggressive patient as being driven by a desire for personal comfort. However, having vented their frustration they usually conceded to the possibility of a more patient centered motivation for nurses' action. Upon probing and reflection, the ambivalence and polarities became evident and residents' further reinterpreted such misunderstandings as a consequence of transactional, noncollaborative relationships in the workplace.

Stepping outside their personal affronts, they invariably acknowledged the expertise of experienced nurses and their contribution to patient care and organization. Although they appreciated the holistic and more intimate approach nurses took to the patient, this was often lost in the urgency and primacy of medical issues for which they were personally

accountable. Once again they admitted that alternative priorities, defensive stances and poor communication precluded collaborative conversation but empathetic understanding lay just below the surface. Residents clearly interpreted their interactions at several levels; the most obvious was that which guided their action and justified it but alongside it was a more reflective interpretation that was more conciliatory, leading to implicit ambivalence and tension as they went about their work.

With time spent in residency, they also understood the implicit and explicit influence of the structure of work on how physicians and nurses collaborated, cooperated or conflicted. The placements that made them recurrently new also exposed them to different structures whose distinctive demands promoted or prevented collaboration. Most residents envisaged for themselves a structure that would lend itself to their understanding of collaborative practice.

Finding support and identifying with physicians.

Identifying with the physician's perspective.

But, you know, for the first time I see the doctor's point of view as well because before, you know, as a nurse [having worked as an auxiliary] ... you think the doctor's probably sat in the mess somewhere just drinking coffee and being lazy and not coming to do this patient's discharge summary but I was completely, you know run off my feet. *Tara, UK*

Not to get too dollars and centsy [*sic*] but ... when you look at the responsibility when it comes to a lawsuit, the vast majority of the responsibility will always fall on the physician. And it's not necessarily because they make more money, but because they do make more money they're perceived as having a higher degree of [responsibility].  
*Matt, Canada*

Being able to confide and commiserate.

There are a few girls that I know I would say to them, "I'm not really sure about this." But the people I don't know

very well I wouldn't, I probably wouldn't admit it, I'd just go home and read about it that night. *Tara, UK*

I mean every one of my resident colleagues, we've all kind of commiserated about how we, I'm talking about the women, the men have a different approach but we all go home and have our nights where we just bawl. Just cry, cry and cry because it's hard and it sucks. Anyway, but then you have your days where you're, "Damn, I was good today, I was on, that was awesome." And so, you know, sorry [cries]. I think everybody has shitty days at their work. *Susan, Canada*

Being supported by the medical team.

But I had to pass one [nasogastric tube into the stomach] on a man who just had a duodenal [upper intestine] ulcer repaired ... because I didn't really feel like I knew what I was doing, so I thought if I do it wrong I could tear open ... an anastomosis [sutured organ] inside of him.... [T]here was no other doctors on the ward I was on but I went to the next ward and got one of the SHOs and said, "Can you just be around. I'm doing this procedure, can you stay, you know, stay in the vicinity so that if I need some help you're there?", you know. And she was really nice. So she came and waited on the ward until I'd done it ... I mean sometimes you're afraid to ask for help because you don't want people to think you don't know what you're doing. But I quickly came to the conclusion when I started that I was just going to have to ask for help. *Tara, UK*

Residents entered residency with an expectation of support from the system and from all other workers. They discovered that support from nurses is sporadic, uncertain and unreliable, being contingent upon a variety of factors such as the volume of work, the culture of the ward, individual dispositions and biases as well as the mix of individuals in a given team. When nurses were seen to be supportive, such support took the form of collegial conversation, empathy for shared pressure of work and occasionally assistance with a task. This support was received and remembered with gratitude but they also knew that it was tentative, fickle and superficial. They could not take it for granted.

On the other hand, support from medical peers, although it was always accessible due to the structure of work in which residents were spread out across the hospital, it was more predictable and certain. With trusted peers, they could let their guard down, admit fears, confide and commiserate at a level that exposed their vulnerability and was not possible outside this circle. Here they could share their trials at the hands of the nursing staff and develop mutual strategies for survival. From senior medical colleagues they could usually expect support in difficult clinical situations. They clearly valued the superior knowledge and experience of senior colleagues and accepted their own junior status. Within this support system they accepted correction or even reprimand and identified closely with the medical goals of the team. While acknowledging other roles, they enacted the medical expert role and saw it as their prescribed and overarching mandate, at this stage.

Shared responsibilities and vulnerabilities became the bonds through which they identified with each other and with the profession. Both the responsibility and the vulnerability were linked through the understanding that as physicians they were the *most* responsible and the *most* culpable if something went wrong. Through this dominant discourse, their struggle and stress to make ethically and legally justifiable decisions placed them in a unique place which separated them from others and joined them with those who shared this burden.

### **Life after residency.**

Looking ahead.

Confronting roles and values.

But I think at this point when you're so focused on, okay is this person going to die ... you're just really focused on the medical aspect and then when you refer out to social work,

OT, PT [physiotherapist] you kind of just leave it. In your mind it's just kind of gone.... It's very segregated I would say. *Nina, Canada*

Yeah expectations are different and you're in this more elite group of people but I don't think, at least me and the people I've talk to don't feel like that's actually the case. We just feel like we're, it's almost like we're imposters.... [S]ociety expects us to feel that way but we just feel the same. *Jenny, Canada*

I hope I will always be like that sort of caring person but a lot of senior doctors I've seen lose it ... a patient will start crying but the doctor will keep on talking and get done what they need to get done. Whereas, you know, I would probably sit on the bed and hold their hand and give them a moment or say I'll come back or you know, and I hope I never lose that really. *Tara, UK*

But I think a lot of the residents nowadays don't need the hierarchy. It's not important. Yeah. I don't, I'm the doctor, and I have specific roles that I'm responsible for, medical management and things like that. And I have things that I can't do and I'm not responsible for and I don't think that the things that I'm responsible for are any more important than the things that say nursing is responsible for. *Jerry, Canada*

Being in command.

I mean I guess when I'm actually a GP see, I would have had quite a lot of experience by then I would have been working for quite a few years and I think a lot of the other health care professionals that they're working with, so the community nurses and the practice nurses, physios, all that sort of people, I think they sort of look to the GP in a way. They're almost like the team leader, really. *Diana, UK*

I have learned that I really don't like working in the hospital, not in a big team ... it's just the structure. When you are the person that the patients are coming to see and you're the one who has ... office staff who are employed to facilitate [what] you are doing ... so you have to be the leader then.... I see myself largely being an office-based physician.... And basically being sort of the leader of that group ... not even because I want to be the leader and the boss of things, I'm looking forward to it because I'd like to

be the, I'd like to control my own destiny, I suppose.  
*Susan, Canada*

I do see, as a family doc I'm going to be more in the team-based approach.... You really are, not to glamorize it, but you're like a quarterback directing a team. And you call in the specialist, you call in the running back or the kicker to make a key play but you're kind of controlling the whole game, and looking at the whole picture. So that's a good role for me, I like that kind of stuff. I like to think of myself as a bit of a leader. And so that comes pretty naturally but things change. I change my mind on what I want every couple weeks. *Matt, Canada*

And it's nice to know that at the end of the day that you're going to be doing something that you enjoy and of course you have to rotate through a bunch of different things and they may not be things you always enjoy but they're hopefully making you a better physician at the end of the day. So it's a nice carrot to hold at the end. *Jenny, Canada*

Not wanting to be defined by medicine.

[But] I would always be a wife and a daughter and a sister before I'm ever a doctor.... I mean it would be quite easy to let medicine take over your whole life and let yourself think you're brilliant just because you're a doctor but to me, my family will always be more important to me. That's just the way I've been brought up really. And you know, I don't necessarily just think of it as a job because I think it is a vocation, it is your life but at the same time, you know, I would ... it doesn't define me. *Tara, UK*

I mean I'm definitely not defined by the profession. I haven't lived in residences, I don't, you know, carry on with the things I was interested in before. *Temara, UK*

I don't really want to be a doctor outside of work. I just want to be a, like a person.... Oh no, I still very, I live with doctors still socialize with doctors and [here] apart from nurses and doctors I have no other friends. So I still ... live in their life they live in my life but when I'm meeting new people .... I just want to be a, like a person. *Nat, UK*

I don't think my work defines who I am.... I'm a doctor because I want to be a doctor. Not because I want prestige from it. *Jerry, Canada*

... I didn't like the idea that we were going to be some elite part of the society or that we were going to have special privileges that other people didn't have.... And so I think I've been fortunate to work with, especially some of the psychiatrists here.... [W]e're just members of a society and ... we hold no special powers or special privilege. And they go home and get up in the morning and put on their pants one leg at a time like everybody else and they know that.  
*Sam, Canada*

And I think it is, that's a huge part of who I am and I am very proud of it. I'm not going to hide that. But at the same time, there's a bigger part of me I think ... I think it's the fact that ... there was a time where medicine wasn't a part of my life. That medicine has shaped who I am but at the same time if I lost it, I would still be myself. *Nina, Canada*

The first and second year residents found their trials and difficulties tolerable only as they saw *the light at the end of the tunnel*. They all saw residency as a necessary journey and even those who had best learned to negotiate it, did not see it as a desirable destination. During residency they repeatedly confronted their roles and values and renegotiated them in the light of new experiences and role models and future plans. They projected these roles and values as the substrate for the future, but for now they found themselves focused on *getting the job done*.

They conjured up a future for themselves that would put them back at the helm and allow them to recapture the enjoyment of work. Even as they looked ahead contradictions were hard to escape. While they appreciated the contribution of others in the healthcare team and wanted to be and appear to be collaborative, their experience in residency led them to desire collaboration only within the context of their medical leadership. Although such contradictions were evident to them, for now they justified a benevolent medical leadership and relied on their personal style to make this collaborative.

Looking ahead they also saw themselves recapturing their roles and identities outside medicine. While they identified with their peers and with aspects of the medical profession, they saw themselves as unique individuals and the profession as too diverse, to be defined by it. Amongst peers, the struggle to plan their lives based on lifestyle choices versus perceived obligations to the profession was considered perfectly valid, with only the extent to which one deferred to one or the other remaining a matter of debate.

**Mega theme.**

Negotiating an identity to live with while getting the job done.

Physicians' nascent identification with medicine as a profession begins even before they enter medical school and is based on images and perceptions which attract them and resonate with their self-image. These impressions are put to the test in medical school and reevaluated against their personal experiences of the profession; the struggle for negotiating an identity congruent with personally held values and the practice of medicine ensues. Before long students who had been distant observers of the community of practice are catapulted to the centre as new residents. Here they find themselves in the deep end, a place of contradictions, instability and ambiguity and are forced to make choices, draw boundaries and concretize values, thus actively negotiating an identity.

As new students, they are idolized by those hoping to join medical school and built up by their school and by their parents as tomorrow's leaders. While they are initially buoyed by this admiration, before long they are confronted by the complexity of medicine, the heterogeneity of role models and the diversity and divisions within the profession. It is difficult for them to identify with the profession as a whole because it is difficult to pin down its values and principles. It is easier to identify with positive role

models and internalise the values they espouse, while distancing themselves from the negative models. Regardless of negative models, they recognize and speak of the centrality of the patient, the need for being responsible and behaving responsibly at all times and valuing the contribution of others, as core values.

Both as students and later as residents, they reveal a constant struggle between their lifestyle expectations and the demands of the profession. Their choices determined which group or specialty they identified with. For many shared hardships and struggles resulted in bonding with other medical students but others chafed against assumptions of elitism and denied any bonding.

For medical students the construction of professional identity was largely an emotional and cognitive exercise. Residents on the other hand needed to make choices and decisions constantly and were formed by these as they rationalised and reflected upon them. While at the beginning they saw themselves as individuals acting in the interest of the patient, the contingencies and contradictions of the workplace forced them to retreat behind professional lines. This was most evident in their interaction with nursing staff, especially senior nursing staff. While both nurses and residents ostensibly worked in the interest of the patient, their tasks were different but interdependent; they wished for collaboration but often had difficulty even cooperating and resorted to seeing nurses as the other or out-group. In this milieu, their feelings and actions were at variance with their values of collaborative practice and this caused them considerable distress which could only be resolved by envisioning another reality. For most this was in the future, when they would be in charge and as benevolent leaders would run a collaborative service. Regardless of

the current disconnect from this value, it was one they held onto and projected into the future.

The daily work of the resident forced many other choices such as when to ask for help and when to not to; when to be assertive and when to acquiesce and others. Having made these choices they rationalised them and incorporated the values they stood for. They learned to define their boundaries and limits in their attempts to get by and get the job done. For most the value that remained central was that of *doing the best* for the patient and not compromising patient care. However, even this was not free of contradiction, as they learned that the *best for the patient* could be conceived in a variety of ways.

Holding on their core values, they rotated through multiple units with their individual demands and cultures. Such instability did not allow for any identification to concretize and as different capabilities were prized in different units, identities remained tentative. As residents they were at a cusp where the effects of being both a learner and a practitioner with its implicit uncertainties and stresses were being woven into the fabric of their identity. For now they conformed to the requirements of the rotation, while they projected who they would be and how they would function to a time in the future and examined their current status in the light of the future. Residency was mercifully not a destination.

As they emerged from residency, they expected to claim back their lives and exercise their leadership and competency. Although the profession had been formative to their identities, they could not be defined by it, instead they would negotiate its practice to fit the values they had internalized and those that they had brought with them to medical

school. They would decide how to best practice the profession while honouring their obligations as they perceived them and *doing the best* for their patients.

## Nurses' Stories: Naïve Interpretations

Abe's story: UK.

Abe graduated one year ago and has been working in the renal unit where he rotates between the dialysis ward and the general renal ward. Currently he is in the renal ward.

Speaking of his choice of career.

I had had a lot of personal sort of troubles when I was growing up. Got to probably about 16, 17 and started working in a nursing home, still very low in confidence.... I decided to do A level drama and nursing at the same time ... and then they called me and they said to me I had to decide now between nursing and acting.... [T]he thing ... that kept me thinking about drama as well on the side was we had to do a role play and I had to write and perform it about autism and I got 89% for it and the woman said, "You should be doing acting." You know she was like, "What the hell are you doing." So I've had that in my mind ever since, still. I mean it's not something I'm looking at the in short term but, you know, I'm in an acting group now so I can do that.

Of nursing school.

It was a hell of a hard course to get through. I was doing the work, I was still, I mean I have a huge focus problem. When I was doing assignments I had to have 15 teas, I had to have breaks every two hours to keep myself focused. So that was the big thing for me as well as the confidence because I had a lot of problems when I was growing up. I was mentally bullied for about ten years, ten to 11 years.

Of being a new graduate.

The first year I had here was very hard for different reasons because, you know, we came into the hemodialysis environment first instead of the ward based [one]. I was on dialysis, which shocked me to death because when you get trained you're never near a dialysis machine. You've never even seen a dialysis machine so in six weeks I got trained but I was struggling I had six weeks training with a mentor watching, training me and watching me. Now, in October I was off by myself but I had some very hard ones in the first week. Not because I couldn't help it but because it was just like that at that time. The problem was that it got to November, December and people were going off sick as

they do ... at the same time so we lost the staff ... but we had too many patients at the time ... lots of them come in at Christmas on renal you know, with depression and everything like that. And I was me and another nurse who was just started were shoved into the limelight way too quickly.... It wasn't very safe but some days I was [the] coordinating in charge by myself and had only been there four months, you know ... that hit me and this other nurse for six pretty much and it's been sorted out now. But we were hit for six, it wasn't anyone's fault it was just the way it was. We got pushed into a situation that although it was wrong it couldn't have been avoided because we shouldn't have been with those patients. We shouldn't had been in there.

I never lost my values I just, I mean ... there was a point where I wasn't eating very much because I was so stressed, you know, about January, February time. But there's only the one time I said something it was when I had six or seven patients, I think it was six patients which [when] you're only allowed three, or even two if they're acute.... I sat down on the desk, got very stressed around six people and said, "Look, I can't remember if I've given [medicines] or not to three of four patients. I'm too stressed, I don't [have] a clue of what I'm doing and if somebody doesn't sort this out now I'm gone."

And then things started happening from there but the point was ... that these things ... should have been looked into way earlier. And we never really recovered ... even when we came on to ward because we both with very low confidence [*sic*]. There is teamwork here.... Yeah. I'll say up here, there's a very fantastic support. Because you've got the coordinator and you've got all the nurses all continue to ask you how you're doing, you know, and in dialysis it's kind of your machine, your patient, do your thing.

Still it's hard.

The worst time with teamwork is on the big ward rounds [large group of physicians] ....And then they come around to each bay and they give you, they go to each patient, they say they want all these things done so it could be like five, six things done and you've only got two hours as well as your job to do it. And then you have to run around like a loopy chicken so there isn't that support after that because you're too busy trying to do all these jobs.... [A]nd you're

just hoping when they come in they're not going to say, "Discharge." Because if they say to you discharge, you only got an hour to get everything done, transport booked ... you know.... [D]octors always say to patients, "You can go home." Yes. They always say, "Go home".... And they forget we've got to do the discharge and the summary and ... everything else. We've got to look at the OT, physio and everybody else and make sure everybody's all happy. Well doctors think we badger them all the time, that's what they always think on this ward because we do.... [T]hey're so rushed as well they don't go out they're rushed off their feet as well.

Striving to get by.

For me at the moment it's just getting the job done hoping that every shift I don't get told something at the end or told on the next shift that I should have done something. That's what the thing is for me at the moment. (personal communication, August 31, 2010)

Ann's story: Canada.

Ann graduated one and a half years ago and then worked in a cardiology unit in eastern Canada. Currently she is based in a cardiac short stay unit in British Columbia.

Speaking about nursing school and the nurses' work.

I would have liked to have gone into med school. I really, really, really would have. But by the end of nursing I owed \$36,000 and ... I didn't think ... reapplying for another degree would have been an option.... Nursing school was kind of this fairyland that doesn't exist in the real world. It's just silly.... [A]iry fairy, getting to know the patient and getting to know their life story and you'll be making these nursing diagnoses based on your assessment of [*sic*], you can't say that the patient is dehydrated ... because that's a physician's diagnosis, but you can say impaired skin healing due to inadequate intake of fluids and nutrition and it just went to these mind boggling mental gymnastics that you had to write to stay within your legal limits. And in real life nobody does that. Nobody does that.

It seemed like the most important thing in the world that you made these nursing diagnoses and doctors would read your charting and based on your nursing diagnoses they would act upon them. And it was just silly ... it doesn't happen, it doesn't happen at all. And then all the microbiology that we had to learn, we don't use anything ... like nothing is just acknowledged.

In nursing school we weren't taught any collaboration with other healthcare professionals. We were barely taught how to work with other nurses. That was a big change too. I would like to have that changed as well.... There was no togetherness.... We weren't taught anything. We weren't taught how to communicate with physicians or any kind of teamwork.... No and like I said even the teamwork between nursing was very limited too. I was pretty much legalities.... A lot of it was communicating with the patient and confidentiality and speaking about your coworkers properly. It wasn't about communicating in the real world.

I see now that we're treated as worker bees and I'm just not really happy with that end of things. I'm really happy with the care that I'm able to give and the personal side of it but

I think that the bureaucratic side of institution of nursing I'm not happy with it.

You're given a piece of paper and it says *attention doctor please* in big letters and then this blank sheet for you to put your thoughts on it and how silly is that? ... I barely write sticky notes to my boyfriend if I want something important done. Why would you do that with somebody's life? You know, it's just silly to me.... We have stacks and stacks of these pink things.... So I think that generally the doctors and residents know how I am because I'm probably the only one who puts happy faces on those little notes. I don't put anything important. If there was anything important it would not go on a sticky note.

I'm just unclear of my role too ... I've made requisitions for psychiatrists and geriatric teams, the gym [exercise] team and physio and apparently I'm not allowed to do that, only a doctor is able to do that. So I get call backs from that unit and say, "Really appreciate your request for this but you need a doctor's order." So I think okay, I'll call the doctor.... Right, because it's some silly legalities in place. And I have no clue what most of them are so I think I just kind of overshoot things.... It makes me laugh more because I just kind of roll my eyes and think, oh God this is going to have to change one day because how sustainable is this, it just seems silly to not utilize the knowledge of so many employees because ... you have to go ask a different employee that has this title.

Of working with residents.

I think that nurses were taught to be guided by your patient as a person and not a diagnosis and I think that the residents, this is having absolutely no knowledge of what they're taught but just kind of what I gather.... From hovering around their circles and chattering with them I think that they're a little bit more concerned with the diagnosis and trying to figure it out rather than the patient as a person.... I'd just like to know what, if they have just as little an idea of nurses as we do of them. And I would like to know if they feel comfortable around us as a team. If they see us as this distant tight knit group and if they see some of the junior nurses as reaching out to them as much as I like to think that we do. Because I really want them to.

[When] it's their first couple of nights and they're in charge of emergency and our unit and they've been up for so long

and their pager might not be working or something might be happening or they have six consults to do, six admissions to do ... they just sit down and you look over at them and it's on nights so we've got a few extra minutes to chat with them and they'll start crying. Or they just look so flustered and they're just so angry and they don't want to listen to you. So you ask them if they want a cup of tea or an apple or a sandwich that you've got in the fridge and they'll break down.

Of priorities and dilemmas.

My current priorities and aspirations are that patients who don't want to receive a certain kind of surgery don't get talked into getting it.... I've spoken with a few doctors and said, "The patient doesn't want to sign a consent form. They're not sure if they want to go for surgery. I don't think that personally they're ready for it. It's happening too fast or this or that and they have some questions." And they kind of smile and take the consent and said, "Give me five minutes." or, "I'll get it signed." And then they walk in and they're chatting with the patients for a few minutes, they come out, they put [the consent form] down in front of me, "It's signed.".... [G]oing to the clinical nurse leader ... has just been completely useless.... [She] told one nurse in a similar situation that your job as an employee is to get this done and if you don't like it and you're ethically upset you can go work somewhere else.

I'm caring. I know that I'm a caring person. And I know that I'm a smart person. I know that I think a lot. I watch people and I watch situations and I take that all in. I have a strong personality. And I strive for balance between doing what's right and doing the right thing I'm going to be 30 this year so my life didn't start with four years of nursing and it didn't end with four years of nursing so ... I became a nurse. Ann became a nurse, but you know, I'm not *Nursing* [emphasis added]. (personal communication, March 29, 2010)

Karen's story: UK.

Karen graduated one year ago and has been working on a respiratory ward since.

I was quite caring, like compassionate person and ... it was my mum who suggested ... what about midwifery, what about nursing?... [I] didn't like university very much. And I used to come home quite a lot actually because I missed being at home, so I made myself finish my degree and then I decided to come back and work here ... I lived with people that weren't doing nursing.... But that made me miss home more I think. Because they weren't very nice people, if you know what I mean ... they didn't consider me, consider the fact that I needed to go to bed ... I didn't feel I belonged.

On being a new graduate.

When I started it was all [a] big mess ... we didn't have our PIN numbers ... it was a complete mess.... So I remember me and this other nurse, we had these seven patients and we had somebody quite unwell and I remember changing her sheet, we were changing the sheet and we'd forgotten to take like a skip you know to put the dirty sheet in so we put it on the floor. And I remember the matron just shouting at us, she was horrible.... The matron was stressed and I remember her turning around to us and saying, "So how do you think you're getting on?" And we said, "Oh, we feel absolutely hopeless. Like we can't do anything." And she said, "Oh that's exactly what you are".... But that's her, that's just our matron. And she said, "Oh well you're either going to sink or swim on this ward." Which made me just think right, well I'll show you lady.... But it was just terrifying. And you just felt hopeless, helpless.... Well it didn't get better for a few months. We then got our PIN numbers so we were band five [a payscale grade] and we were working properly. And we had, you know, proper shifts and but the staffing was terrible.... It was a good job that the nurses on my ward are lovely because nothing was too much trouble for them. But it wasn't fair on them either, it was unsafe on the patients ... there was ten of us started at the same time ... it was so stressful and just blooming hard work and yeah, it was frightening.... Some older nurses are sort of "I'm the nurse, that's the doctor, that's the nursing auxiliary." Some of them don't get their

hands dirty if you know what I mean and they can be quite, I found when I was newly qualified some of them very unhelpful ... there's just a few of the older nurses, they're very set in their way and you know they won't help. But then I think part of that is not just the fact that they've been nursing for several years, it's part of their personality as well.... And obviously the matron ... doesn't lower herself to certain, you know to talk to certain people. But it's better now ... I would never wish like that experience on anybody else ... but I'm the type of person who just took it in my stride. It takes six months to find your feet really and to get to know things and you know be able to think ... you know.

Of finding her role.

I know when say, my dad has been in hospital, quite often I think the patients get forgotten about really and the nurses and the doctors talk and they know what's going on but they forget to tell the patients. So I try and make sure they know what's going on.... [B]ut nobody ever tells you exactly what you're supposed to be as a nurse. You find your own you know, yeah and ways of doing things and routines and stuff.

We've had some F1s start on our ward recently and they do look terrified and ... I had this incident the other day where the F1 had prescribed a certain antibiotic and he prescribed a really odd dose.... And rang him and I said you know, "Are you sure you've prescribed this right because I've never seen it given like this." And he said, "Oh I looked on the policy, blah, blah, blah.".... So anyway they came to the ward, him and the F2 [second year resident] ... it's a good job I questioned it because what he'd actually done is printed the neonatal policy off the computer. So he'd ... done the dosing for a baby.... I was giving it to a 60-year-old man, you know. So it was a good job I questioned him because it was wrong.... He's lovely ... he said to me when he first started his first day as an F1 he clung onto a nurse and asked her, "What shall I do?"

Sometimes when we have female doctors the older nurses find they ... don't seem to get on with them as well and they'll say, "Oh I don't like that doctor blah, blah, blah." I don't know whether it's an age thing but I never have any problems with any of the doctors really. Sometimes the consultants but the junior doctors are often you know very

nice.... And the other day at lunch one of them came and sat with us which doesn't often happen but she's lovely.

#### Learning to be assertive.

[But] even now some of the consultants talk to you like you're a piece of rubbish. Like on my ward there's one particular, he's horrible.... [T]he staff nurses will say ... it's because he thinks, you know, social class wise, he thinks he's better than us.... There was this gentleman I was looking after and he was nil by mouth, kept pulling his nasogastric [stomach] tubes out so hadn't been fed for about ten days. And I said to him [Consultant] you know, "What are we doing? Has anybody spoken to ENT [ear, nose and throat specialist]? You know he's not been eating, he hasn't eaten for ten days." And he turned around to me and said, "Well what exactly do you suggest I do about it if he keeps pulling his tubes, you know, his nasogastric tubes out." And I said, "I don't know but you're the consultant".... Yeah, well I was like, "I'm not sure, I don't know but that's why I'm asking you. Because I don't have any, I don't have a solution to this, you know I don't have time to put down a nasogastric tube every hour when he's going to pull it out. But you need to speak to somebody about what we're going to do to feed him." And he's just so unhelpful but that's just him. As a student when you work on the wards I never understood how communication between sort of the doctors and nurses worked. But I think you only find that out when you're actually a staff nurse you know.

#### Finding meaning.

I think for me my life is about like my friends really and my family. But I like my job.... And I like helping but it's not my life ... like I could never be a matron because I just have to spend too much time you know at work. Yeah, I love it.... This sounds morbid but when people do die ... we had this particular gentleman.... His dying wish was that he wanted to see his dogs and we managed to get ... the dogs to come in and like literally as he was taking his last breath. And I was like crying, it was horrible but you know, we did that for him and that's important I think.  
(personal communication, August 26, 2010)

Kathy's story: Canada.

Kathy graduated nine months ago and has been working in a medical respiratory unit since.

Speaking about working in the wards.

I find most of the senior nurses are getting a little burnt out and are a little less willing to help the new grads, it's just sad to see but I've seen that a lot actually where you go to ask for help and they're too busy or they just don't have time to answer that question. But I find the newer nurses are so supportive, we've used each other for physical tasks and also debriefing if we've had an incident, they're really good that way. I find that way with the doctors it's challenging ... you do get to create that bond with the doctor or the nonbond, which makes it challenging but overall it's pretty good.... I just find that either the really cocky nurses, or the older nurses will come in and be, "You didn't order this, we need this, we need this and I want this." and that would put me off as a physician.... Some of them do not like suggestions at all. I find a lot of the senior doctors are still in that hierarchical you are my nurse and I think a lot of the younger nurses are making it more of you are my coworker, you know it's not such a you're not my boss.

The ones that see you as a coworker I find it's so empowering because you're more willing to suggest things or even just ask the rational. I find it's easier with younger doctors to say, "I don't understand why did you order that? I'm just not sure for my knowledge." and they'll go on and explain things and you'll learn so much more from them which is great ... I think what's missing with a lot of our communication is the verbal dialogue.

There's been quite a few doctors that I've seen. There's one doctor in particular that I enjoy thoroughly and I know him on a personal level because I am friends with his daughter, so when I phone him he always says, "What do you think?".... Whereas there's an older physician that's quite cantankerous and he's been known for some anger management issues and management is aware of this he has been ... disciplined on multiple occasions. And I phoned him for an order one time for a sleeping pill. It wasn't

obviously a dire necessity but when a person hasn't slept in a long time you know for them that is a key piece right there. And I was told to "f-off" and hung up on. So I find legally just charting [wrote it into the records] the responses [*sic*] and then he was quite upset that I charted that response. So it's challenging that way when you're met with such disdain over any time you phone.... I phoned one doctor three times before he finally gave me an answer and an older nurse [goes], "Oh I can't believe you're doing that." and I think there's this odd respect for them.... It puts you in a horrible dilemma because you want to provide for this patient with whom you built a huge relationship ... and you want to be able to help them but you're hitting that barrier.

I find as a new grad too and I know a lot of the younger nurses will do this we'll grab the nurse that has the best relationship with them [physicians] and get her to talk to him and she'll get what she wants because they have that different relationship for sure.... I find that one of the largest barriers for sure is time ... I don't have time to sit with the doctor the whole time and explain all my concerns and they don't have time when they have 26 patients and an ER to go to you know.

Of being appreciated.

If I've made a difference for positive benefit in somebody's care or they've said that to me, "Thank you, you've been so attentive." Or, "You've really met my needs." Or a coworker even says, "Wow that was a cool thing you did I've never seen a nurse do that." That's the stuff that gets me. A physician can say, "You don't know what you're doing blah blah blah." but if I'm supported by the patient and my manager and my coworkers I'm finding it's easier to discredit the physician. But on a whole it's nice to hear the physician say too, "That's great, awesome job, we did a good job as a team." I find that happens most frequently when there's a death or something or a good code or something I find the physicians are really good about saying, "Way to go team that was a good effort on all our behalves."

Of working with residents.

I don't know what their capabilities are and I don't know where I should interject. Maybe they do know about that and they're just not saying anything or maybe they missed

that piece. It's hard because we don't know where to interject and I find that a lot even with the residents I find it so much easier just to scowl at them because they missed something but maybe they haven't hit that piece yet.

Of preparation in nursing school.

Honestly the general curriculum ... it focuses a lot on interpersonal communication but it doesn't focus on physician/nurse communication. It's almost an implied thing. The way you read an interprofessional team that looks so cohesive beautiful thing that's going to work out well but in reality it is very much like pulling teeth a lot of the time to get what you need for this patient or what nurses feel we need for the patient.... And I think it's just possibly something that's the elephant in the room, we all know it exists you can talk to any nurse or maybe any doctor.

Of transition from school to work.

The thing that I've found most trying coming from nursing school to nursing is just you have a lot of ideals and they slowly get broken away I'm already finding that slowly I'm kind of just pulling back more on things that I know that in the past I would have been more passionate about.... A lot of it is so challenging because even stuff to help with sleep or anything to do, simple things I know were allowed I know it's hard to get.... So I know it's something a patient would benefit from and something they need but I won't phone the doctor at 3 o'clock in the morning for a Ventolin nebulizer when by law I should. I'd just give it to them. But [now] I'm less willing to do that and just wait it out until I can get a physician. (personal communication, March 9, 2010)

Kim's story: UK.

Kim graduated one year ago and has been working on a respiratory ward since.

Speaking about choosing nursing as a career.

I decided to go into nursing after my dad was poorly and it really sparked an interest in me. The nurses really helped our family through that and I really saw myself doing something like.... I've got a really keen interest in medicine and conditions and ... I worked with learning disabilities in the community but I wanted to do more acute medicine.

Of being a new graduate.

We started with 11 newly qualified nurses onto quite an acute ward and it was very, very difficult for us ... the ward had expanded into a double ward so they were also very short staffed and in particular the more senior nurses they're obviously under a lot of stress and they couldn't really support us as well.... We definitely felt not very supported because it was a stressful time with the acuteness of patients and the short staffing.... So we didn't know when the doctor's rounds were, who the doctors were, what breaks were happening, any of the nursing documentation, we didn't know how to fill that out. We didn't know any of the protocols of who to contact in an emergency or ... how to contact the senior nurse on call or anything like that. So things were often not getting picked up and when somebody would follow up from me it would be, "Oh you haven't done this, you haven't done that." And it was difficult and very stressful.... I definitely felt like maybe nursing wasn't for me because I was always leaving like an hour late because I was still doing my writing and nobody was thanking me for staying late [laughs] to help other people.... I felt lost and the newly qualifieds that I started with they were probably my biggest support because we were all in the same situation. We'd all had terrible, terrible days where.... I had a family who are with the lady who was in the Liverpool care pathway, a pathway for the people who were dying. And she'd been on this pathway for a week, which is a long time really, they don't intend people to stay on for a week. They expect them to have passed away by then. And it wasn't a nice death at all, she was very rattly and chesty and we were giving her all the medications to try and dry up the secretions but it wasn't

working and we'd repositioned her and it was still, she sounded ghastly.... The family were annoyed ... we couldn't control her pain very well no matter how much we were giving. I had [another] lady who then had a profuse PR [per rectum] bleed and that was an emergency and it was dealing with that at the same time. And one of the family members said, "Can I use a particular mouth care pack for this patient?" And I said, "Yes that was fine." And then the matron came in and saw that this particular mouth care pack was on the table and it was apparently one that was banned from our ward but not from the trust. And she took me outside of the bay in front of all the doctors and consultants.... Yeah and she shouted at me for using it and said that it was an inappropriate use and said that I shouldn't be using that on that patient. And I explained that that was what the patient wanted and what the family wanted. She said that it wasn't a good enough reason. And then she left and then I cried because it was in front of everybody.... [I]t was winter period and winter in respiratory is very difficult heavy work, very acute.

Moving on.

Well my relationship with the matron has got much better. It's the same person. It's weird, I don't know like just recent[ly], over the last few months she's definitely had more time for me and she's been much nicer to me.

Of dealing with consultants.

One of the issues is some of the particular consultants; they are very set in their ways.... One in particular he is frightening [laughs]. His presence, well actually last week he was the consultant on call and they come on a Saturday and a Sunday, they come in for three hours from about eight to about 12 or 11 and they come and see any of the poorly patients.... And then there was a patient who'd come in overnight with a exacerbation of COPD [chronic obstructive pulmonary disease] and nobody in respiratory had seen him so the consultant needed to see him as well. And I asked, "Would you mind seeing him?" And his phrase was, "Well you better bloody have a good reason for me to see him because the patient's I've seen this morning haven't been necessary for me to see them." And he said, "Why do I need to see this patient? Give me a reason?"

Of medical residents.

Although sometimes they're just as busy as we are and you can ask them for something really small like a cannula and it's just, you'll get a reply like, "It will just have to wait." And sometimes you feel, I wished I could cannulate [laughs] just to help them out a bit. And then you're waiting for like six hours for a cannula and that person needs fluids or IV antibiotics.

We're always like, "I wonder who we're going to get?" Recently we've just had the first intake of the residents that have left medical school and are now doing their first ever placement ... as an F1. It's difficult [laughs]. And I really feel for them because I remember, I was probably in the same situation a year ago and you can see them being bogged down with all this work ... you can see them as yourself.

Reflections.

I used to want to do everything and now I have realized that I'd be there for hours ... so I have to be more assertive in saying, "Well actually no I can't help you wash that patient. Are you able to get your other nursing auxiliary to do that." Or, "I actually need to do this first before I can do that."

I thought sometimes I wished I'd actually been a nursing auxiliary because I prefer the hands on care ... the responsibility that comes with being a registered nurse, I was not prepared for that as a student. ... That it obviously comes down to the nurse a lot of the time. Doesn't it?

I'm so used to doing things that the doctors want but actually I've got to tell them actually maybe sometimes the patient does not want this or they would like this instead. And to let the medical team know what the patient wants and to help the patient make that clear, to support the patient with their time in the hospital. ... I wish the doctors would understand the amount of stress that we're on if we have got to look after 16 patients instead of the usual eight, because somebody's gone sick. ... No, I don't think the stress is understood that we're under. (personal communication, August 23, 2010)

Table 2

**Nurses' Thematic Interpretation: Unravelling the Text  
Themes, Subthemes and Mega Theme**

<b>Before becoming a nursing student.</b>
Seeing nursing as caring.
Being cared for.
Being caring.
<b>As a nursing student.</b>
Preparing to become a nurse.
Becoming disconnected from reality but aware of <i>myself</i> .
Being confused and uncertain about physicians and also a little afraid.
Practicums: doing the nursing thing, still disconnected.
<b>Working as a nurse.</b>
Being new.
Being afraid.
Being unprepared.
Being overwhelmed.
Being supported by fellow nurses.
Not being supported by senior nurses.
Finding a role and enacting it.
Proving my competence and gaining confidence.
Becoming a patient advocate.
Learning to become assertive.

Dealing with the structures at work.
Protecting my turf.
Being busy and what it means.
Being short staffed.
Enjoying working in collaborative structures.
<b>Working as a nurse, with medical staff.</b>
With residents: wishing to work together as equals.
Seeing residents as learners.
Identifying with residents.
Empathizing with residents.
Coming up against barriers in dealing with consultants.
Having difficulty communicating.
Finding ways to <i>bell the cat</i> .
Being undervalued and underused.
Failing to advocate for the patient.
Being intimidated: being yelled at but seeing no justice.
Making sense of intersections in nursing, medicine, generation and gender.
Not being part of medical team.
Distinguishing nursing from medicine.
Understanding hierarchy.
Recognizing generational differences.
Observing gender based interactions.
<b>Looking ahead.</b>

Reconstructing identity.
Discovering that ideals were unrealistic.
Reflecting about myself.
Finding my passion and my role.
Being my own person.
<b>Mega theme.</b>
Reconciling professional fulfilment.

## Nurses' Thematic Interpretation: Unravelling the Text

### Before becoming a nursing student.

Seeing nursing as caring.

Being cared for.

The oncology nurses were amazing. And I don't know if it's just Oncology. That's how come I went into nursing ... from the nurses that I had received care from [for cancer].

*Mary, Canada*

I decided to go into nursing after my dad was poorly and it really sparked an interest in me. The nurses really helped our family through that and I really saw myself doing something like that. *Kim, UK*

Being caring.

I was quite caring, like compassionate person and ... I think it was my mum who suggested you know, what about midwifery, what about nursing? So I decided to, yeah, give nursing a go. I'd never done any really any care work or anything before. I just thought I'd have a go and see if I liked it. *Karen, UK*

I like people and [have been] interested in the sciences and taking care of my younger sister my whole life; she's been diabetic since she was a baby and quite frail with that.... We're about a year apart, taking care of her and helping out my mom with her and then I knew that I'd be able to make good money as a nurse and also help my mom when she retired. *Ann, Canada*

Nursing was understood as the archetypical *caring* profession. For some this understanding was validated by personal experience, for others it was an assumed association, tacitly nurtured by societal discourses. Joining nursing as a profession was seen as the explicit expression of *being caring*. Caring in nursing was however appreciated in terms of personal relationships and the broader scope of nursing was usually absent from these nascent impressions. Being thought of as compassionate often

initiated the desire to become a nurse and fulfill one's natural proclivities. In addition, nursing as a well-paid and respected profession was attractive to those looking for financial security.

### **As a nursing student.**

Preparing to become a nurse.

Becoming disconnected from reality but aware of *myself*.

Nursing School was kind of this fairyland that doesn't exist in the real world. It's just silly.... [A]iry fairy, getting to know the patient and getting to know their life story and you'll be making these nursing diagnoses based on your assessment of [*sic*], you can't say that the patient is dehydrated ... because that's a physician's diagnosis, but you can say impaired skin healing due to inadequate intake of fluids and nutrition and it just went to these mind boggling mental gymnastics that you had to write to stay within your legal limits. And in real life nobody does that.  
*Ann, Canada*

I remember a lot of first year stuff was useless. I felt sitting in a circle and telling everybody how you felt using words of the weather for two hours ... it just didn't make sense. I felt if you weren't a caring person to care about patients, why are you in this profession? *Sabina, Canada*

Being confused and uncertain about physicians and also a little afraid.

We've had a few specialists on call just come and talk about like oncology but they never do talk about functioning as nurses and doctors. And I think it's just possibly something that's the elephant in the room, we all know it exists you can talk to any nurse or maybe any doctor. *Kathy, Canada*

Once a year I know that they got all the doctors, nursing students, physio students, we all had to get together and do like a week of teamwork type thing. Which kind of reinforced what happens in the hospital.... I don't think it made much difference, to be honest.... It was very much like the doctors sort of kept to themselves and took over the groups and everybody else just did whatever [suited them].  
*Hailey, UK*

Practicums: doing the nursing thing, still disconnected.

In clinical [practicums] you're so focused on learning your own skills and things that there wasn't really much interaction. When you got on the floor there's medical students there but no, they were sort of doing their own thing and we were doing our own thing and didn't really [connect]. *Mary, Canada*

So my first placement was here in minor surgery ... was [in] surgical admissions. So I'd never done things like paperwork, never made a bed, you know, except for at home [laughs]. You know, I've never dealt with that sort of thing before. I was welcomed into the team and I didn't sort of interact with the doctors quite so much in that role. But the nursing team itself, I was welcomed in and it was hugely valuable. *Karen, UK*

Nursing school was remembered as being disconnected from reality. This perception was validated by the realities of the workplace, upon starting work. The atmosphere of nursing school lacked cohesion and consistency and students received mixed and confusing messages transmitted by instructors whose ideas reflected their own experiences and generational views. This lack of cohesion and congruence in nursing courses was reflected in the paucity of tales of belonging and identification with the profession, teachers and peers.

Seeing themselves as bright and capable, students were keen to master scientific knowledge relevant to nursing and chafed against the large amount of time spent developing self-awareness, through seemingly inane exercises. While becoming more aware of themselves, they also became aware of a corresponding lack of insight into other healthcare workers' perspectives. This was particularly evident in the case of physicians. The focus of working alongside physicians was learning how to process and package information that had to be conveyed to them. Since interactions with physicians were to be transactional, there was no real anticipation of collaboration; instead any

understanding of the physician's role was seen in juxtaposition and differentiation from the nursing role. Nurse-physician relationships were viewed in hierarchical terms by older instructors but in more collegial terms by younger instructors. The gaps in understanding physicians' roles and training, the confusing messages about nurse-physician relationships and the emphasis on the correct way to approach a physician resulted in the novice nurse being afraid and often timid when faced with senior physicians, in spite of their training to be self-aware and assertive.

Formal IPL was inconsistent and only three of the 11 nurses interviewed had participated in it. All sessions had been organized out of the workplace and the interviewees conveyed a sense of being lost in large settings and questioned the applicability of such learning. Learning which could be practically applied occurred in practicums.

Practicum placements in the workplace were very useful in teaching students nursing skills but it was the preceptor who determined the extent to which a student nurse interacted outside the nursing team. It appears that being enfolded within the nursing team was a comfortable place for most and experiences outside its confines were happily limited.

### **Working as a nurse.**

Being new.

Being afraid.

Being a new grad you don't approach anybody, you don't talk to anybody because you hear the stories from other nurses, other staff members and you don't approach anybody.... I think one of the worst things was being a new grad and being told on a night shift, "Do not call unless there is an emergency, like a heart failure or a heart attack or someone coding otherwise you don't call." And it was

the fear that the doctor would yell at you or they would hang up on you and you would be wasting their time.  
*Sabina, Canada*

[T]he first six months is the scariest six months of your life. Because you suddenly realize, okay, I've not got someone working with me anymore I have to have this knowledge, I have to know what I'm talking about and if someone comes to me and asks me a question I can't go, "Hang on a sec, I'm just going to ask my mentor." *Sarah, UK*

#### Being unprepared.

We started with 11 newly qualified nurses onto quite an acute ward and it was very, very difficult for us all because [laughs] we weren't, none of us had done respiratory-based nursing particularly so it was an eye opener for us and it was at a time when the ward had expanded into a double ward so they were also very short staffed and in particular the more senior nurses they're obviously under a lot of stress and they couldn't really support us as well.... We definitely felt not very supported because it was a stressful time with the acuteness of patients and the short staffing.... So we didn't know when the doctor's rounds were, who the doctors were, what breaks were happening, any of the nursing documentation, we didn't know how to fill that out. We didn't know any of the protocols of who to contact in an emergency ... how to contact the senior nurse on call or anything like that. So things were often not getting picked up and when somebody would follow up from me it would be, "Oh you haven't done this, you haven't done that." And it was difficult and very stressful. *Kim, UK*

#### Being overwhelmed.

[T]here was a point where I wasn't eating very much because I was so stressed, you know, about January, February time. But there's only the one time I said something it was when I had six or seven patients, I think it was six patients which [when] you're only allowed three, or even two if they're acute and I said, I basically, I shouldn't have done it but maybe I should ... it got things done. I sat down on the desk, got very stressed around six people and said, "Look, I can't remember if I've given [medicines] or not to three of four patients. I'm too stressed, I don't [have] a clue of what I'm doing and if somebody doesn't sort this out now I'm gone." *Abe, UK*

Being supported by fellow nurses.

But I find the newer nurses are so supportive, we've used each other for physical tasks and also debriefing if we've had an incident, they're really good that way.

*Kathy, Canada*

I felt lost and the newly qualifieds that I started with they were probably my biggest support because we were all in the same situation. We'd all had terrible, terrible days.

*Kim, UK*

Not being supported by senior nurses.

They, most of them, I find most of the senior nurses are getting a little burnt out and are a little less willing to help the new grads, it's just sad to see but I've seen that a lot actually where you go to ask for help and they're too busy or they just don't have time to answer that question.

*Kathy, Canada*

I have a couple of times very recently because going to the clinical nurse leader and the nurse educator has just been completely useless.... Because they, the nurse educator specifically told one nurse in a similar situation that your job as an employee is to get this done and if you don't like it and you're ethically upset you can go work somewhere else. *Ann, Canada*

I did feel abandoned definitely, I remember I needed to give her [the patient] some more morphine and that's a double nurse check and we need to sign that out and it was only the matron and myself on duty. I asked the matron to sign it out with me and she said, "No, I'm not giving it to her. That is a way a person breathes if they are going to die. And if the family has a problem with that then they need to speak to me because that is how she is going to be."

*Kim, UK*

The interactions of new nurses with others, particularly physicians were overwhelmingly limited by fear which was based on a mystique created by peers and fuelled by ignorance of the physician role. The fear of saying something inappropriate and being reprimanded was compounded by the realisation of personal responsibility for patients and the danger of staying silent.

The presence of a benevolent mentor or the opportunity to work as a supernumerary made the experience of transiting from a student to a practicing nurse smoother and less stressful. However this was not the case for at least half of those interviewed. In the face of acute staff shortages, some were placed in positions of responsibility for a large number of patients without an adequate understanding of the structure of work or the processes and conventions in place. In such situations the stress and isolation was frequently compounded by lack of support from senior nursing staff that were also stretched.

Even in the absence of staff shortages the support from senior nursing staff was unpredictable. On the one hand it could be highly supportive but on the other bordered on being adversarial. Narratives of being challenged and allowed to sink or swim were not uncommon. Once again, such variability in the attitude of senior nursing staff towards its young spoke of a lack of professional cohesion and direction. In contrast shared experiences *in the deep end* led to bonding and fraternity between junior nurses, who relied on each other to go the extra mile. When in need of support they turned to each other and to the sympathetic senior nurses.

Finding a role and enacting it.

Proving my competence and gaining confidence.

I find that the longer I've been [here] the more I'm becoming familiar with the resources and the less I'm leaving to go to other people to get things done. I can put in my own home nursing care referral; I can do that sort of thing. I can talk to people and make little bits happen more. Which is nice now that, kind of building on a body of knowledge and making it stronger. *Laura, Canada*

I think as time progresses you get confident in your job role and you get confident with your knowledge and your knowledge of your patients and you feel more able to go up

to the doctors and say, “Actually I need you to do this.” Or, “Actually I think you need to come to see this person.” So you do almost in a way get, it’s not bolshie; I’m trying to think of the word. It’s almost like enough confidence to be able to speak your mind, to deal with and to stand firm, yeah. *Sarah, UK*

#### Becoming a patient advocate.

I’ve spoken with a few doctors and said, “The patient doesn’t want to sign a consent form. They’re not sure if they want to go for surgery. I don’t think that personally they’re ready for it. It’s happening too fast or this or that and they have some questions.” And they kind of smile and take the consent and said, “Give me five minutes.” or, “I’ll get it signed.” And then they walk in and they’re chatting with the patients for a few minutes, they come out, they put [the consent form] down in front of me, “It’s signed.”  
*Ann, Canada*

I found recently you know that we had a gentleman who was really unwell and the doctors just wouldn’t stop treating him. And the F1 agreed with us that we felt he should just be left to you know, to die. And they were still you know giving him antibiotics and he was very hypertensive ... and we just felt we were being so cruel to him and they wouldn’t listen. The doctors just wouldn’t listen. And in the end, I think me and another nurse and the physiotherapist just said to him, you know, said to the [physician], “It’s not fair, you have to stop.” And so they did. *Karen, UK*

#### Learning to become assertive.

There was this gentleman I was looking after and he was nil by mouth, kept pulling his nasogastric tubes out so hadn’t been fed for about ten days. And I said to him [Consultant] you know, “What are we doing? Has anybody spoken to ENT? You know he’s not been eating, he hasn’t eaten for ten days.” And he turned around to me and said, “Well what exactly do you suggest I do about it if he keeps pulling his tubes, you know, his nasogastric tubes out.” And I said, “I don’t know but you’re the consultant.... Yeah, well I was like, “I’m not sure, I don’t know but that’s why I’m asking you.”  
*Karen, UK*

Some of the younger doctors are so intent on getting their assessment done and I think they just want to go in there and, “Yes, I did it!” .... So I try to grab them and say, “Okay, this is Mrs. So-and-so. She doesn’t hear very well and this is where she’s coming from so please don’t use medical words.” *Ann, Canada*

For new nurses, the period of being new, afraid, and unsure usually had a finite end, marked by becoming competent at the jobs expected and gaining confidence in speaking up. For most this happens around the six month mark, while being based in a single department. Although junior nurses sometimes shifted location or ward, it was within the context of a department or unit, which meant that the culture of work was very similar to the one they were accustomed to. In some specialised areas such as the renal unit, staff rotated between the ward and the dialysis unit which required unique skill sets but were linked by overarching cultural practices.

While gaining confidence was linked to becoming competent, it was also related to identifying oneself as the advocate for the patient. This was the primary role that all nurses adopted in the brief months after commencing work. In this role the new nurses were acting in the interest of the patient and their conviction bolstered their courage and confidence to speak up, ask or confront without as much fear of conflict and reprimand as they felt earlier. Even in their role as the patients’ advocate some nurses saw themselves as more conciliatory while others saw themselves as more assertive but all wished to stand firm to safeguard the interests of the patient.

Dealing with the structures at work.

Protecting my turf.

I find it’s challenging when I’m in charge ... because doctors try to wiggle their way around the system and get patients to your floor. It’s “well you can’t do that, you have to go through the proper channels” and trying to explain the

channels to the doctors who should know it. They should know it but it's a lot of that "no, you have to go through this road" or talking to people who are pushing you to take patients that aren't appropriate for our floor.... So you're doing a lot of negotiating, a lot of talking and just wiggling back and forth and really advocating for yourself, for your unit, for people that you work with. *Laura, Canada*

Being busy and what it means.

Yeah I definitely felt like maybe nursing wasn't for me because I was always leaving like an hour late because I was still doing my writing and nobody was thanking me for staying late [laughs] to help other people and I still now find it difficult to go home and leave things behind of what's happened during that day.... Yeah I find it really difficult to hand over; things that I haven't done or haven't managed to do. *Kim, UK*

You'll be in the middle of your drug round, [you will] constantly get you know relatives on the phone wanting to know whether Mrs. So-and-so slept well. And our matron makes us take the phone, she says, "You have to take the phone calls." Whereas the sister thinks there should be no phone calls until ten o'clock because then you'll easily make a mistake.... And you know you spend hours on the blooming phone which takes away you know patient contact time. So that's a big stress, phone calls and just generally, yeah phone calls take a long time. It's quite, on our ward there's lots of IVs to do. That takes up a big majority of you know my time and the paperwork as well. *Karen, UK*

Being short staffed.

[I]t was lack of staff on the floor. You got put into situations sooner than you should have.... I was very anxious. I felt very overwhelmed. Because there was a lot of situations I wasn't sure how to handle and there weren't a lot of senior nurses on the floor because they were so short staffed. So it made it really hard trying to learn new skills and transition from being preceptored [taught] and having someone there all the time that you could talk to, to pretty much having [no one]. I think it was my fourth day of being on the floor, I had my own assignment with nine patients. And I was, "Oh my God!" You know you come from nursing school where you have maybe four is your maximum number and then you graduate and all of a

sudden you've got nine patients and no supports there.  
*Mary, Canada*

I wish our staffing was better because I never feel like I give a good enough care to my patients because of time restraints. Because, you know, I'm supposed to know everything about those people, you know the people I'm looking after. If I'm looking after 12 patients I don't have time to know whether they've got a sore bottom or haven't had their bowels opened for seven days. And I should do. So I wish it wasn't as busy and I wish I had more time to give proper care, you know proper holistic care. Because you don't. And I wish I just had time to sit down and talk to them sometimes. But that's just the ward I work on I think, it's just busy. *Karen, UK*

Enjoying working in collaborative structures.

Yeah, after working there [special clinical teaching unit] I felt I could work anywhere. So it was really ... good because a few of them were like, "I didn't know nurses did that." Or, "Do you guys do that?" Or, "Do you know what this is?" Or, "How do I do this?" And so it was you do get a sense of ... how much knowledge residents have to know about everything. They get an idea that we don't just sit behind a nursing station all day long and just hand out pills.  
*Sabina, Canada*

I think in all honesty I think working on the renal ward is like working on no other ward. Because we have quite a big team of doctors and a huge team of nurses and obviously we've got, down here we've got the dialysis nurses and then all the upper level branches that we have within renal and we are sort of like a little family unit because everyone knows everyone and the nurses up on the ward rotate around dialysis and then back up. So we're constantly moving around so we get to know a lot of people. And we're quite close to everyone. *Sarah, UK*

Having grasped the rules, conventions and procedures that governed the functioning of the ward, the nurses saw themselves as its custodians and as enforcers of its culture in the face of encroachment by others. As with patients, here too they saw themselves in the role of an advocate who was to protect the structures and wellbeing of the ward. These *others*, who violated the structure, were usually physicians and managers, and nurses saw

themselves having to *deal* with them, rather than work *with* them. Clearly they were seen as a threat to the status quo and nurses needed to remain vigilant and fend off violations to the structure.

Dealing with structure also meant living and coping with its inadequacies, complexity, and instability. For the nurse this resulted in having to constantly adapt to changing work conditions, struggling with interruptions to prioritize tasks and straining to demonstrate competency through completing the day's work. These capabilities were evidently valued and seen as the hallmark of a capable nurse as such they judged themselves and were judged by their peers against this standard. The failure to measure up caused them distress and pushed them to reconsider their choice of profession.

Their high expectations of themselves were not infrequently pitched against difficulties related to being short staffed, which were repeatedly referred to in both research locations, implying that such shortages are an intrinsic part of the nurses' work environment. In addition to this, poor communication between nurses and physicians and its attendant risks compounded anxiety and frustration. With time and experience they found themselves closer to achieving competency and recognition in negotiating the work environment. However while coping more efficiently in their role as advocates for the structure and executing its tasks capably, they also found themselves distanced from the patient because of lack of time, thus compromising their main role as the patient's advocate.

Working in complex and difficult environments, such as those alluded to provided novice nurses with a vantage point from which to evaluate and appreciate more efficient structures when and if they had the opportunity to experience them. Those units which

were considered more efficient or desirable were more collaborative across professions and/or organized around the patient. In such units patient advocacy seems to have been shared by professions without loss of preeminence by nurses.

### **Working as a nurse, with medical staff.**

With residents: wishing to work together as equals.

Seeing residents as learners.

The residents are always pretty good. It's challenging because they're still learning. So it's difficult to get orders that are very time consuming or near impossible to do. For example ... I think it was a year two resident order [*sic*] urine specs [test] on a lady who was incontinent and he didn't order us an in and out [catheter] so obviously that's not going to be possible, we're not going to be standing there all night waiting for it. It's just the little things like that that are challenging because you have to go from resident two to resident three then they change the order but then the attending [senior physician] comes down and changes all their orders so it's challenging to work with. It's good I understand that they have to go through this process, which I think a lot of the older nurses don't have that patience. They expect you know the orders to be precise because they're used to working with senior doctors so that's challenging working with the residents.

*Kathy, Canada*

[A]nd they're kind of thrown into the deep end and they're already expected to know stuff about dialysis and acute dialysis prescriptions and you know what kind of things are meant to use specific drugs and doses and things so they do turn up and they're a bit kind of like, "I don't know what I'm doing." So we kind of are quite nice to them in that way because we understand that you know that they've turned up and they don't really, they need a bit of support. So we're always quite nice to them and you know we take them under our wing and try and teach them as much as possible. *Sarah, UK*

Identifying with residents.

I think they're a lot of times closer to my age as well. And they're learning too.... And lots of times they'll ask you, "What do you think about this? I haven't encountered this

before.” Or you get talking, because they’re learning too. And when you’re a student you’re learning and a new nurse you’re learning as well. So you kind of work it out together a lot of the times. *Mary, Canada*

Because I think a lot of the junior doctors are quite frightened of some of the consultants and would never want out turn out like them [laughs] if you know what I mean. Because they can see how you know, they don’t communicate very well with the nurses.... Yeah and ... because they hear ... us saying, “Oh he’s a -.” [laughs] you know. *Karen, UK*

Empathizing with residents.

They [senior nurses] just don’t do it or I find a lot of them can be quite manipulative with the residents about like, “Oh well why don’t we just do this, this is normally what so-and-so would do or this is how we’ve been doing this for years on the ward.” You know they’re very confrontational with that or they’ll just ignore the order completely and say if they want urine specs they can just come get it themselves because I’m not going to. They don’t have time and that’s not a priority for them. I think their mentality is if he’s not smart enough to realize that he’s going to have to order an in and out that he wants a urine spec then it’s not my problem. *Kathy, Canada*

Junior nurses identified with residents on several levels. First they saw them as learners like themselves, second they felt a generational bond in terms of interests and values and third they empathised with the unfair treatment meted out to the residents by senior nurses, which some of them had also experienced. Fourth, they felt that residents shared their fear of oppressive senior physicians.

Many nurses across both research locations commented on the uneasy relationship between senior nurses and residents. Junior nurses saw themselves in a collegial, perhaps collaborative relationship with residents but they perceived resentment and manipulation in the behavior of senior nurses towards residents. While junior nurses recognised facing

challenges in working with residents who were unsure and slowed work, they chose to be understanding and tolerant as compared with senior nurses who were often unforgiving.

Junior nurses were usually familiar and competent in their area of operation within a few months of starting work but residents were new to the environment as they rotated through it. As such, even though they were both learners, the nurses who had been in a stable environment were able to guide, question and correct the residents and even be in a position to judge the residents' performance and influence their reputation. This clear advantage was empowering and gave novice nurses a sense of purpose vis-à-vis the residents. Nurses found residents to be friendly, collegial, and collaborative and although there was lack of clarity about their scope of practice, their vulnerability, inexperience and occasional distress evoked empathy. Such empathy was usually expressed through offering comfort in terms of food or a friendly chat; almost an extension of the nursing role.

Coming up against barriers in dealing with consultants.

Having difficulty communicating.

I find especially where we don't have that relationship because we do work with so many physicians I find it's really difficult to even find time to get the communication because for the five minutes they're there it's hard to step away from six to seven patients you know, it's just challenging. It's a lot of like bypassing communication, so you leave a note but did they address it? No, so now you have to phone them and now they're angry that you've phoned them and it's just I find it very backwards when it could be more efficient. I think it really could. And a lot of it is doctor and nurse dependent, it depends on how the nurse approaches the doctor it depends on what kind of mood the doctor's in you know.... Some nurses will approach them in such a manner that I'd be turned off.... But I find a lot of it is just waiting, waiting to see what

happens, waiting to see if they're going to address it waiting to see ... it is ... so not efficient. *Kathy, Canada*

Finding ways to *bell the cat*.

In the morning report we have a daily discussion.... The discussion is, "This patient need[s] this, this and this but how are we going to get it? Who's going to talk to this person [physician]? How are we going to approach this person? Should we just leave a note? Should you go and talk to them? How do we butter it up to be approachable?" So we are always trying to find ways around.... If you say, "The patient wants this, this and this and this is what they told me." Well now you're telling the physician what to do. And he's not having that. That's not going to happen. It's not going to get dealt with ever.... The likely response is, "Who do you think you are?" And "I'm not doing that, that's the stupidest thing I ever heard of and they need to deal with it on their own." Or "They can go to their family physician and deal with it after they're gone, I'm not dealing with it." *Sabina, Canada*

Being undervalued and underused.

They [physicians] incredibly, incredibly underestimate. I think they might have the idea that we're taught to do our assessments from a nursing point of view and we don't pick up on anything else and we give medications and make nursing notes. I don't remember ever a doctor ever reading my nursing notes. I don't know I think that [they are] kind of out of touch with what nursing, younger nurses want out of them.... I see now that we're treated as worker bees and I'm just not really happy with that end of things. I'm really happy with the care that I'm able to give and the personal side of it but I think that the bureaucratic side of institution of nursing I'm not happy with it. *Ann, Canada*

I feel like sometimes they don't quite know all that we do and just assume we do it all. I mean, it magically happens. *Laura, Canada*

Failing to advocate for the patient.

You recognize that something's not right with your patient, you have these wonky vitals are not looking right. And they phone the physician and the physician doesn't give you any direction. You see the patient, you know something's not right with them but you can't get really get any direction from the doctor at all; they kind of brush it off.... Where

you're recognizing something's not right, but they're not going to do anything about it. You can describe your assessments to them until the cows come home but nothing's happening. *Laura, Canada*

Being intimidated: being yelled at but seeing no justice.

I find a lot of the senior doctors are still in that hierarchical you are my nurse and I think a lot of the younger nurses are making it more of you are my co-worker, you know it's not such a you're not my boss. So I think a lot of it is generational how we work with our physicians.

*Kathy, Canada*

[But] even now some of the consultants talk to you like you're a piece of rubbish. Like on my ward there's one particular, he's horrible. And you know, but the staff nurses will say, and like one of them thinks it's because he thinks, you know, social class wise, he thinks he's better than us.

*Karen, UK*

[T]here's an older physician that's quite cantankerous and he's been known for some anger management issues and management is aware of this he has been sent and disciplined on multiple occasions. And I phoned him for an order one time for a sleeping pill. It wasn't obviously a dire necessary but when a person hasn't slept in a long time you know for them that is a key piece right there. And I was told to "f-off" and hung up on. So I find legally just charting the responses [*sic*] and then he was quite upset that I charted that response. So it's challenging that way when you're met with such disdain over any time you phone.... And it's funny here though I find the nurses here ... complain or bring up certain issues but are not willing to take it to the next level.

*Kathy, Canada*

Poor communication with physicians was endemic and hampered efficient and timely functioning. All wards, in which the nurses who were interviewed worked, catered to patients being managed by a variety of physicians, who visited at all times during the day. In most wards daily rounds, where nurses accompanied physicians to the bedside, had been abandoned due to logistic difficulties. Some wards still maintained a weekly board round; where all members of the healthcare team discussed patients' problems

usually guided by the lead physician. As such face-to-face contact between nurses and physicians and discussions about patient care were rare. Most communication took place through orders written in the patients' charts. This had a propensity to marginalise the nurses' input as their notes were not included in the patient's main file and remained in separate nursing notes which were seldom read by physicians. Nurses left their queries and requests posted on patients' files but when these notes were not answered the nurse had to consider calling the physician by phone which was often challenging.

Emboldened in the role of the patient's advocate, and mindful of their responsibilities new nurses were prepared to approach senior physicians with requests and queries. Nonetheless this task was frequently intimidating and had to be weighed against its consequences. The nursing discourse of unreasonable and abusive consultants was a strong deterrent, especially if one had not rehearsed the request or if it was to be conveyed at an inconvenient time, especially at night. Strategizing to approach the physician and using coy, beguiling tactics was not uncommon. Having to resort to these strategies undermined the nurses' sense of professional self and marginalised their contribution as members of the healthcare team. Junior nurses grappled with the contradiction between learning that their contribution was equal and valued and being forced to behave in ways which professed a different reality.

Additionally, the structure of work did not permit nurses to authorize simple orders that they felt equipped to handle and thus undervalued them. In such a structure the physicians remained unaware of nurses' training and their capabilities remained hidden and underused. Their frustration was compounded because as nurses they understood the patients' needs in a holistic and intimate way while physicians saw only part of the

picture or even an inaccurate one, thus misjudging the urgency of the patients need or even misinterpreting the nurses' motivation. Stories of inadequate sedation and pain relief or protracted treatment causing suffering to the patient and conflict about the use of restraints dominated these narratives. Reflecting upon their training nurses realised that much of it was wasted; tiptoeing around conventions and legalities nurses discovered their role as the patient's advocate to be the one that is uncontested, legitimate and fulfilling and become willing to risk being assertive in the interest of the patient.

Most nurses interviewed recounted at least one encounter of being reprimanded and being treated unfairly, if not abusively and most wards boasted of at least one consultant who was *set in their ways*, implying that they were unreasonable and difficult. Such abusive behavior however went unpunished as senior nurses or management were unwilling to take the matter further, leaving the aggrieved nurse unsatisfied and disempowered. New nurses understood the senior nurses' relationships with physicians as different from their own. While they saw themselves as direct and forthright, they saw senior nurses as manipulative, in spite of being more accepting of the hierarchical framework. They interpreted such differences in generational terms and it set them apart from very senior nurses.

Making sense of intersections in nursing, medicine generation and gender.

Not being part of medical team.

I think that sometimes we're quick to say doctors aren't part of the team but a lot of the times we don't look at ... what are we doing to make them kind of feel okay... I feel we're clumped up and, "Oh, we're the nurses, we're having fun, we're doing our 12 hour shift and we're, this is us and then there's you." So ... we're not including anybody else... because we think that they don't want to be included. *Sabina, Canada*

The worst time with teamwork is on the big ward rounds. Because the big ward round comes in. They have a meeting the same day, which means they have the ward round about four in the afternoon, right. And then they come around to each bay ... they go to each patient, they say they want all these things done so it could be like five, six things done and you've only got two hours as well as your job to do it. And then you have to run around like a loopy chicken so there isn't that support after that because you're too busy trying to do all these jobs. *Abe, UK*

#### Distinguishing nursing from medicine.

I think that nurses were taught to be guided by your patient as a person and not a diagnosis and I think that the residents, this is having absolutely no knowledge of what they're taught but just kind of what I gather.... From hovering around their circles and chattering with them I think that they're a little bit more concerned with the diagnosis and trying to figure it out rather than the patient as a person. *Ann, Canada*

I find medicine is a lot different than nursing, it overlaps in so many ways but I just think they are looking at curative, here's that lab [laboratory] values, here's the medications ... and what do we need to ... get this person well? .... You know we ran into a situation like that where there was this lady who was in with her COPD and Ativan can cause respiratory depression as we all know but the cops had just came in and let her know that her daughter had committed suicide and of course she was quite upset and she was in a safe respiratory range to have the drug and the doctor said no she's just seeking. I find sometimes they forget the whole picture. *Kathy, Canada*

#### Understanding hierarchy.

I've never had an issue talking to PT, OT or a social worker about any problem [as compared with physicians].... Wow, yeah, I've never even really realized that. I think that comes ... from just the balance, the hierarchal balance that still exists that we're still breaking down ... because they've had more education or more years of education we automatically assume that they have greater knowledge than us instead of different knowledge than us. *Kathy, Canada*

### Recognizing generational differences.

I find a lot of the senior doctors are still in that hierarchical you are my nurse and I think a lot of the younger nurses are making it more of you are my co-worker, you know it's not such a you're not my boss. So I think a lot of it is generational how we work with our physicians.... Whereas I think even the doctors coming out now, the few that I know even in school, are looking at what do you know that I'm not seeing, how can we mesh this together to give the best possible care. I think we're looking more as a team aspect as opposed to you are doctor I am nurse like I will follow exactly what you say. *Kathy, Canada*

I think what I learned almost in nursing school [that] most of the instructors have been instructors for 20 years sometimes and ... time has changed and evolved and I feel like physicians and their generation now I feel like we're all doing the same thing, they [are] maybe our age and they maybe going out and doing the same things and there's just more to talk about. *Sabina, Canada*

### Observing gender based interactions.

Sometimes when we have female doctors the older nurses find they ... don't kind of seem to get on with them as well and they'll say, "Oh I don't like that doctor blah, blah, blah." I don't know whether it's an age thing but I never have any problems with any of the doctors really. Sometimes the consultants but the junior doctors are often you know very nice a lot of the time. *Karen, UK*

[Female residents] sometimes they try to speak a little bit louder than their normal speaking voice when they're in groups. Or I just see something a little bit different and sometimes I think that they're so used to having to prove themselves that if you tell them your opinion on something they might be a little bit less inclined to listen to you unless you kind of take it down a little bit and sit with them and just be a little bit more sympathetic to them. *Ann, Canada*

When nurses spoke about being part of a team, this team excluded physicians.

Likewise they felt excluded from the medical team. While the *teamness* of the nursing team was forged by working together comfortably, they saw that the *teamness* of the medical team was forged by learning together. Their own peers were clearly the most

proximal in physical terms and it was to them that they first turned for help and understanding. Occasionally when they referred to the team it also included occupational therapists and physiotherapists. With these team members they were able to discuss and solve the patients' problems collaboratively without resorting to subterfuge, preparation or hesitation. Clearly then, physicians' especially senior physicians who were not physically present for team meetings and had to be approached cautiously in transactional interactions could not be considered team.

For most nurses this separation was a natural consequence of the structure of work. Reflecting upon how teams were enacted, they saw how their own comfortable huddle could become uncomfortable for the physician particularly the resident, who was often the lone physician among a group of nurses. Even when junior nurses wished to bridge the divide it was difficult because they were unsure of the resident's knowledge base and goals and based on dominant nursing discourse assumed that while nurses were guided by the patient's needs, physicians were guided by the diagnosis. This was a fundamental divide and wedged its way into any sense of being a team. This wedge is withdrawn when a patient is acutely ill and both nurses and physicians direct their attention to averting the immediate danger and work in unison being guided by the same goal.

Although junior nurses are educated in an ambivalent environment, they have a high expectation of themselves and their role. Whether they demonstrate their value and equality through being assertive or eschew being marginalised, they express frustration and disillusionment. Most struggle to hold on the belief that their contribution to patient care is equal though different from that of physicians. In this they feel endorsed and bolstered by residents of their own generation who seem to have less need for hierarchy,

but are let down by senior nurses who have found ways to work within it. Amongst these contradictions an interesting convention surfaced; all nurses referred to the patient they were looking after as *my* patient in conversation with everyone except with the physician, when they always said *your* patient. This was telling.

Nurse-physician interactions become more complex as gender and generation intersect. Junior nurses describe this dynamic in terms of how they interact and how they observe others interact across the gender divide. Female nurses describe an easy companionship with female residents, while the male nurse interviewed expressed a similar sentiment toward male residents. Although none of the nurses admitted to coyness, they often observed it in others and felt that such nuanced interaction between male residents and junior female nurses oiled the transactions between them. Despite being comfortable interacting with female residents themselves, junior female nurses observed that female residents, had a difficult time at the hands of senior nurses who resented female residents but often *mothered* male residents. Seeing female residents working hard to prove themselves and being treated poorly, they empathised with them.

### **Looking ahead.**

Reconstructing identity.

Discovering that ideals were unrealistic.

The thing that I've found most trying coming from nursing school to nursing is just you have a lot of ideals and they slowly get broken away I'm already finding that slowly I'm kind of just pulling back more on things that I know that in the past I would have been more passionate.... So I know it's something a patient would benefit from and something they need but I won't phone the doctor at 3 o'clock in the morning for a Ventolin nebulizer when by law I should. I'd just give it to them. But [now] I'm less willing to do that and just wait it out until I can get a physician.

*Kathy, Canada*

Reflecting about myself.

I'm caring. I know that I'm a caring person. And I know that I'm a smart person. I know that I think a lot. I watch people and I watch situations and I take that all in. I have a strong personality. And I strive for balance ... *Ann, Canada*

I am my own person ... I think I'm very open-minded, I would definitely listen to any other person's opinion, I wouldn't think that theirs was wrong [laughs] ... I have come across nurses that are completely different to me. [They] have different beliefs and understandings and they have a different way of working. *Kim, UK*

Finding my passion and my role.

My current priorities and aspirations are that patients who don't want to receive a certain kind of surgery don't get talked into getting it.... I think I value the ability for patients to have a peaceful death a lot more than I ever thought. At first I was like, "Wow! Technology! Look what we can do! Oh, everything's available to patients of any age, isn't that fabulous!" And after a couple ... of years experience I'm thinking, maybe it's just nicer to have a peaceful death. And maybe that 92 year old doesn't need a pacemaker to live an extra six months. *Ann, Canada*

This sounds morbid ... we had this particular gentleman that I was talking about, they wouldn't stop treating him. His dying wish was that he wanted to see his dogs and we managed to get ... the dogs to come in and like literally as he was taking his last breath. And I was like crying, it was horrible but you know, we did that for him and that's important I think. *Karen, UK*

Being my own person.

It's my job but it's not my life.... Like I could never be a matron because I just have to spend too much time you know at work ... I love my job but ... if I didn't have to work [laughs] I wouldn't you know.... I think for me my life is about like my friends really and my family. But I like my job... And I like helping but it's not my life ...  
*Karen, UK*

But I'm almost 30, I'm going to be 30 this year so my life didn't start with four years of nursing and it didn't end with four years of nursing so ... I became a nurse. Ann became a

nurse, but you know, I'm not *Nursing* [*emphasis added*].  
*Ann, Canada*

Junior nurses were aware of their situation in relation to their work environment and keenly attuned to their own feelings and reactions to this milieu. They exhibited an astute ability for reflection and self-awareness which was congruent with such emphasis in nursing school. Their reflections were expressed in terms of the dynamic juxtaposition of self versus the constraints and contingencies of the workplace.

Their frustrations with the workplace were largely related to its constraints in terms of the authority structure which disempowered them and prevented them from responding to patients' needs in a timely manner. At times this structure led to junior nurses having to acquiesce to medical decisions which ran contrary to their own ethical convictions, causing moral distress. These disappointments led to a sense of disillusionment with the healthcare delivery system in hospitals.

This sense of disillusionment forced them to realign their priorities and goals; which they did with varying degrees of cynicism and rebellion. As Sabina, a nurse from Canada recalled, "[They] are so stressed out by it that they sometimes can't come to work because instead of ... approaching a physician, they'll start yelling and they'll start screaming ... because they're very anal about patient care." However, those interviewed were still a part of the system and despite their disappointment had reconciled and realigned their roles. In doing so they had not become subservient, but merely shifted their focus.

Within the constraints and conventions, they decided to focus on those areas which were congruent with their personal values and which they found fulfilling. Invariably their triumphs and fulfillment were located in advocating successfully for the patient or in

some way providing comfort to the patient. Such triumphs were most empowering when their execution involved skill and knowledge, thus validating their capability. Despite the constraints and circumscription, they had all found a niche or a role that was fulfilling.

While they invested themselves in their work, negotiated a fulfilling role and professed pride in their profession, they did not want to be defined by it. They saw themselves as larger than what the role would have them be, as well as apart from it. Could this be a result of being disappointed, disempowered and unsupported by the profession or a trait of their generation which will not be pinned down by labels?

### **Mega theme.**

Reconciling professional fulfilment.

The narratives of junior nurses' transition from nursing school into the workplace are held together with expressions of reconciliation and compromise. The seeds of discontent are sown in nursing schools as unrealistic and ill-formed expectations, divorced from the realities of the workplace.

Transiting into the workplace, the need to reconcile expectations becomes evident in many spheres. Novices quickly realize that the support anticipated from senior nursing colleagues is not consistently forthcoming; in fact these fellow professionals may watch and judge while they *sink or swim*. Furthermore, senior colleagues are a product of a different time and culture and do not share their values, particularly their sense of independence and will therefore not always support their cause; while at the middle level, nurses who could have bridged the gap are largely absent.

In the sphere of nursing knowledge much of what they have learned is inapplicable because work is mostly procedural; moreover their assessment and diagnosis is seldom taken into consideration for medical decision making, as nursing notes remain hidden

from the medical eye. Finally they lack the authority to implement many simple changes and have to wait for medical approval. Reconciling to this state of affairs, they begin to adopt the role of an advocate instead of that of an executive.

These roles are enacted within systems which are frequently overburdened and understaffed. Here competing priorities are played out and the nurses find themselves in the role of the defender of the status quo, instead of a member of a collaborative hospital team which is yet another readjustment.

Highly aware of themselves and their self-worth; having been taught about their equal contribution to patient care, they find themselves working in a place where intimidation and even abuse by senior physicians is still tolerated and unpunished and have to negotiate a position they can come to terms with.

Finally, while they may have entertained career ambitions, they realize that rising to higher echelons in nursing will take them away from intimate patient contact, which is the source of job fulfillment for most of them and therefore reconcile to limit further ambitions, so that they can continue to advocate for the patient.

## Chapter 6

### Comprehensive Understanding: Arriving and Returning

#### Introduction.

In this chapter, I will develop a comprehensive understanding of the interview texts, through iterative interpretations, in keeping with the hermeneutic process. To begin with the naïve and thematic interpretations explicated in the preceding chapter will be shown to be congruent with each other. Following this, these interpretations will be examined with reference to the research questions and existing scholarship, in particular the social identity theory. Other theoretical lenses will be invoked as the data compel, such that the comprehensive understanding can be situated and elaborated within relevant theoretical frameworks and scholarship.

#### Congruence of naïve and thematic interpretations.

The naïve interpretations of the interview texts, represent the non-methodic interpretation of individual narratives. In these each person's story has been told in their own voice through *enplotting* salient events within the structure of a narrative. It has taken the reader through the subject's experiences, challenges and decisions leading on to *resolution* reflected in the life they have envisaged and the roles they have prefaced. Though a limited number of events were employed to create the plot, the naïve interpretations have demonstrated the progression of interrelated events that impacted construction of each person's professional identity. Despite stories being personal and unique, similarities in the plots and outcomes were evident in the nurses' and residents' groups respectively, for example resolution for nurses was usually achieved by identifying a fulfilling role such as that of a patient advocate, and for residents resolution

was envisaged as a time in future when they would be in control of their work environment. While naïve interpretations focused on the overarching meanings of individual texts and fleshed out the linear dimension, thematic understandings employed meaning units as the unit of analysis and scanned the breadth of the collective text. In this way the emerging themes, and subthemes were expanded, decontextualized and interpreted. The naïve and thematic interpretations thus explore complementary dimensions of the whole text and together can be subjected to the research questions to develop a comprehensive understanding. The above explanation is encapsulated in Polkinghorne`s (1995) description “... paradigmatic [thematic] knowledge is focused on what is common among actions, narrative knowledge focuses on the particular and special characteristics of each action” (p. 11).

**The data and the research question.**

The interlinked questions that I will ask of the data are based on the objectives of the research laid out in chapter 3, that together illuminate the over arching research question: how do the processes that lead to socialization, professional identification and identity formation in nursing and medical schools influence talk about collaborative team work upon graduation? It needs to be reiterated here that junior residents and junior registered nurses were deliberately chosen as subjects of this study and the interviews focused on the narratives of workplace experiences, so that the influences of professional education are recalled through the lens of current experience.

The first two objectives of this research explore the construction of professional identity in students attending medical and nursing schools and the impact of their uniprofessional education on the perception of self versus the other. Assuming that

professional identification and identity influence students' perception of the other profession, the two objectives are closely linked and share the temporal space of professional schools. As such they will be taken together.

**Professional school: self and the other.**

We see Harquail's (1998) emotional, cognitive, and behavioural dimensions of identification that are discussed in chapter four, expressed in the stories of residents and nurses even as they enter professional school. Before joining medical school, students identify with the image of the physician as a respected leader, living an exciting and challenging life, as portrayed by the media; this had a powerful emotional component. For the children of doctors who had vicariously experienced the rewards of status and respect and lived the medical discourses, emotional identification was exceptionally strong and real. Such strong positive emotional identification overwhelmed any negative associations of the profession or its challenges for now. This was evident by the absence of stories of challenges or controversy in the lives of their parents or the fictional medical characters they remembered. For those who had interacted with the profession as volunteers or workers in healthcare delivery, such as the medical student who had worked with disabled children, identification had a cognitive dimension based on value concurrence with those elements of the profession to which they had been exposed. In preidentification with medicine as a profession, behavioral identification was largely absent. Clearly behaving as a doctor required expertise that students did not possess at this stage; however some understood the need for being responsible and spoke of it as a character trait they recognised in themselves.

For nurses, on the other hand identification with the nursing profession was spread across the three identification domains. For most, the discourses that they had grown up with epitomised nursing as *caring* and they identified with this value cognitively and emotionally. Others had acted out the *caring role* in either a family or social setting, thus they had taken it a step further and expressed it in their behaviour. Interestingly, nurses who saw themselves as bright and capable identified emotionally with nursing as a respected profession.

Returning to medical students at entry to school; we see that they bring with them values and aspirations formed through their personal and social affiliations and a sense of identification with the profession as described above. They encounter the life of a professional student that does not confer them with elements of the profession that had attracted them. For most, emotional identification with the profession although not yet validated, continues to buoy them for some time as family and friends, particularly medical school hopefuls admire and respect them. As they become immersed and often overwhelmed by studying, work becomes the focus of their life, while the future recedes. In contrast to the intense socialization termed divestiture (Ashforth & Mael, 1989) described in chapter two where medical students are stripped of their previous identities and indoctrinated into a medical culture through rituals, myths and symbols, we found narratives of such acculturation were largely absent in our interviews. In place of collective socialization, we encountered stories of individual reflection and a struggle to eke out self-meanings, particularly in relation to work-life balance and principles to guide priorities and boundaries. Several questions arise: Were socializing practices really absent or diluted and why? Were they unimpressive or were they disregarded? Is the

current generation of students more individualistic and less susceptible to socialising cultures? Bleakley, Bligh and Browne (2011) explains:

Medical communities of practice are notorious for their initiation rites and codes of conduct, histories and idiosyncrasies (Becker et al., 1980). However current practices are eroding some of the traditional identity producing or identification processes of socialization as medical firms and stable teams give way to new flexible and ad hoc working arrangements. (p. 74)

We see medical students accept the mantle of hard work and responsible behaviour.

These values soon formed the core of the medical student's identity and the substance of their bonds with each other and separation from others. Although hard work was largely accepted and embraced, the loss of work-life balance conflicted with preexisting values for most medical students. While they worked hard they strove to maintain balance and look forward to a future lifestyle congruent with their expectations. In this area they struggled with the demands of the profession, unable to change their current circumstances, they resolved this conflict by choosing a specialty in the future that was compatible with their lifestyle choices. Recent studies including a cross sectional mixed model study at a Swedish medical school (Diderichsen et al., 2011), concurs with our interpretations and concludes that:

“Today's medical students expect more of life than work, especially those standing on the doorstep of working life. They intend to balance work not only with a family but also with leisure activities” and goes on to assert that today's medical students “seemed unwilling to sacrifice private life for work” (p. 140).

The need to be responsible is seen as nonnegotiable in the medical culture and students learn to concur with this value (Stern, 2000). They understand that responsibility will be expressed in terms of patient care and is critical, but as junior students they also described

social settings where they were expected to behave responsibly and remain sober and sensible while others students could let their hair down. They struggle and feel like imposters but come to terms with these demands from within and without the profession and begin to express it in their behavior. While tacit this responsibility is a lead up to the role and mantle of leader.

In addition to working hard and behaving responsibly, the struggle to find one's place in the profession and construct self-meaning is remembered as a negotiation between the contradictions of the formal and the hidden curriculum. Guafberg, Batalden, Sands and Bell (2010) describe the hidden curriculum as "learning that occurs by means of informal interactions among students, faculty and others and/or learning that occurs through organizational, structural and cultural influences intrinsic to training institutions" ( p. 1709). When the formal and hidden curriculum contradict each other students experience tension and dissonance and struggle to forge a professional identity. In our narratives we see this repeatedly as students react to negative models who contradict the lessons of the formal curriculum. Narratives about the lack of compassion and disregard for collaborative practice, dominated these stories as seen in chapter five.

Consequent upon the loss of socializing myths and rituals, diversification of the student body, conflict between the formal and hidden curriculum and loss of validation of the emotional identification with the profession that students arrived with, medical students appeared to have a diffuse and tentative sense of professional identity. At the close of medical school one recognizes a senior medical student as someone who has been prepared to lead and be responsible, who is acutely aware of the contradictions and diversity of the profession and relies on him or herself to navigate training and then

recapture a balanced life. Such a student identifies with peers in terms of shared hardships and with the student's chosen area of specialization in terms of its compatibility with their lifestyle choices and particular abilities and aptitude. Beyond this the student shares with their generation a need for work-life balance, expresses a plurality of identities, such as those forged through personally held values, associations and interests and portrays him or herself as an individual defined by all of these and none of these at the same time and refuses to be constrained by group or category.

Returning to the entrant nursing student, we see that the centrally held value of caring is carried forward through nursing school but there is very little feel of other shared values. The contradictions and conflicts in nursing education are more overt than in medicine. While the medical student struggles to make sense of the discrepancies in what is taught and what is practiced, the nursing student is exposed to explicit contradictions. These contradictions frequently reflect the generation gap between different instructors as described by Cohen in 1981. This is exemplified in the accounts of our interviewees who recall senior instructors who teach about hierarchical nurse-physician interaction and instill a fear of physicians while younger instructors insist that the table has now been levelled. Nursing students usually align themselves with the opinion more proximal to their own generation that speaks of their education being equal but different from medicine. As they enter nursing practice such contradictions and confusion are responsible for fear and timidity felt by most interviewees when first approaching physicians.

Some nursing and medical students intersected in structured IPL. These experiences were neither ubiquitous nor uniform. In this study, only three out of 11 nurses and eight

out of 11 physicians had any experience of IPL. Outside structured IPL, there were other influences that impacted their perception of each other. Medical students were taught through the formal curriculum that team work was a *good thing*. The ethos of team work was reinforced in lectures and case studies; they were expected to mention it and penalised for not doing so. The hidden curriculum however conveyed indifference through failing to flesh it out or model it in real life contexts. Medical students, therefore, did not have a good grasp of the nurses' role, educational background or the way in which they were expected to collaborate with them. Worse, negative role models who mocked collaborative practices as in the narrative of a physician who dubbed multidisciplinary meetings as *fluff rounds* delivered an alternate message and tacitly gave students permission to do likewise. Nonetheless medical students saw themselves as people who appreciated the contribution of team members and wished to collaborate, although there was considerable ambiguity about what this meant, as they had no experience in *doing* collaboration. In terms of identification, collaboration was a value they emotionally and cognitively identified with, but acting it out had to be deferred and at this point they did not know how it would impact them. It was unclear if this was a value acquired in medical school or whether this proceeded from their personal sense of balance and appreciation of alternative life trajectories.

In nursing school, as already noted messages about nurses' position vis-à-vis physicians were full of contradictions and as in medical school usually lacked situated experience. Here too there was no clear understanding of collaboration but all students were taught how to approach and what to say to doctors in routine transactions. They knew that the consequences of an unprepared approach may be unpleasant. Most implicit

and explicit messages, other than from young instructors pointed to an uneven table in which the nurse had to defer to the physician and even be fearful. This was not congruent with self-awareness and self-esteem being cultivated in the curriculum and students and nurse entrants found it difficult to reconcile with this contradiction. However, they saw medical students as fellow learners and those who attended IPL came to these experiences with curiosity and enthusiasm.

For the most part all IPL was organized out of the work context where two or more sets of professional students came together to learn from and with each other. The numbers of students, professions and stages of students represented varied from course to course. Learning was usually centred on problem solving related to patient scenarios. Medical students found these contrived and frequently recoiled feeling insulted. The few nurses who attended IPL felt lost amongst the others. Apart from occasional improvement in understanding of each other's role, nurses and residents did not see the benefit of these sessions from the vantage point of work. Additionally within this contrived atmosphere some recognised the propensity for misconceptions and misplaced judgements of other professions, causing them to disregard the whole experience. For the few who experienced IPL by working alongside other professionals, the sense of being part of the team versus getting in the way made the difference between meaningful learning and waiting to get out of the situation.

How can one explain these dismal and lack lustre recollections? As we saw earlier both nursing and medical students wished for collaborative team work. Their reactions cannot be explained by professional bias or resulting from professional identification. What then is the explanation? Returning to the texts one sees that there was a lack of meaning for

students in these IPL activities and we come across the refrain of not being able to understand how this was supposed to work out. The disjuncture between real work and out of context learning was evident to students and led them to question this exercise. This invokes Lave and Wenger's (1991) sociocultural theory of *communities of practice* (COP) or *situated learning* as well as exhortations by experts in the field to locate IPL in experiential learning (Ho et al., 2008). In situated learning the learner is actively involved in meaningful acts of participation or doing as opposed to passively receiving knowledge. Bleakley et al.,(2011) explains "Meaning is central to Wenger's view of how learning and identity relate. There is no learning and consequently no identity construction without personal meaning" (p. 70). This concept elegantly explains the forgettable experiences of IPL in terms of their lack of personal meaning and resonates with their complaint of not knowing how such IPL was expected to help. Egan and Jaye (2009) apply Wenger's model to the health care setting and describe the impact of peripheral participation in a *community of clinical practice* (COCP) upon the learner. We see that when students arrive at the periphery of a COCP, the student can be legitimized through preparation, inclusion and support. In this situation the student practices and constructs his identity by doing, whereas when participation is marginalised and the student is made to feel redundant, these opportunities are lost. Although a couple of residents described experiences of legitimized participation as they spent time with physiotherapists and occupational therapists, others had experiences that resonated with marginalized participation, such as the resident who spent time in a nurse run ward and felt that they were not interested in him and that he was slowing them down. The few residents who had actually worked in the capacity of nursing aids or volunteers expressed empathy

towards the other profession and carried it over into the workplace. Yet, they too encountered the conflicting priorities between nurses and residents later on but were able to comprehend the other's perspective better.

Finally, with respect to IPL the participation and involvement of the medical teachers and role models was notable by its absence and once again students confronted the hidden curriculum that clearly did not value collaborative practice enough to be invested in it. The IPL courses were often seen as tokenisms and a part of vested agendas. Based on the social identity theory and intergroup interactions, in which a high status group is purported to distance itself from activities that narrow the status gap, it is not difficult to understand medical reluctance to be involved, interested or invested (Whitehead, 2007).

Thus medical and nursing students arrive at the threshold of work, aware that they will encounter the other, but little more. Both have been too invested in their respective uniprofessional training to pay attention to the other. A few nurses have been allowed legitimate peripheral participation during practicums and have occasionally spoken with physicians but most have not. Most residents have not had the opportunity of legitimate peripheral participation and do not know all that will be expected from them nor how they will act out their role. They believe that they will be supported and helped by all staff and systems; they want to be collaborative as noted but this is an attitude devoid of experience. We did not find that medical students entered residency with a stereotypical image of the nurse or a hierarchical framework of work. Although they saw themselves as leaders; how this leadership was to be enacted also lacked depth and dimension. Their understanding of leadership was framed in terms of being ultimately responsible for the patient, not necessarily in terms of an authoritative figure. These assumptions and ideas

about who they would be as a physician were loosely held in a yet diffuse and liquid identity waiting to be constructed through *doing*, *being* and *becoming*. Some narratives of students about becoming residents still described their expectations through images propagated by popular media. This seems surprising as they had been trained within hospital settings during clinical clerkship. Either their training was removed from the actual workings of the hospital or the images of the media were very compelling.

Nursing students, at the completion of their course are more aware of the physician's role and have been taught how to interact but only in transactional terms. Contradictions within the curriculum and disparate images painted by instructors about nurse-physician relationships juxtaposed against their high self-esteem and awareness are reflected in a sense of uncertainty and fear. Their view of collaboration is ambiguous but at the heart of it lies the hope that their contribution and knowledge will be valued. They too are preoccupied with meeting expectations as a novice but anticipate support from senior nurses.

Through professional schools, both nursing and medical students have struggled to negotiate an identity that reconciles their previously held values acquired through life experiences and other social affiliations with contradictions and disconnects between the formal and hidden curricula. They share their generation's emphasis about life-work balance and a healthy regard for other life trajectories. These values have not been trumped by that of commitment to the profession. Though afraid, both have a positive self-image and recognise each other through a generational lens.

**The workplace: self and the other.**

With nursing and medical students transiting to the workplace, I will address the next two objectives of this research, which consider the impact of nursing and medical identity on the ability to work as a team and the shift in interpersonal perceptions with this transition from school to work. We have demonstrated the tentative nature of student identities constructed through socialization in professional schools. To grasp how they are further constructed in the milieu of COCPs, through meaningful participation we go to the experiences of *doing* work. The environment and demands of work have been amply described through the texts and interpretations in chapter five. Here I shall recapture their essences and consider their implications.

At the point of transition all nurses and residents speak of its precipitous and frightening nature. A few nurses spoke about an initial period when they were a supernumerary or were mentored and gradually moved from peripheral participation in the COCP to its centre with increasing responsibility commensurate with ability. For most participants of this research, both residents and nurses, the experience was one of being thrown in the deep end, of isolation, fear and unpreparedness. Here their incompetence and unpreparedness was humiliatingly visible and their sense of self frequently violated. In such a threatening and unstable environment actions were largely reactive to the work situation rather than directed by any sense of socialized professional self, which we have demonstrated as tentative and nebulous apart from a few core values. We see this repeatedly in accounts of residents trying to ingratiate themselves with senior nurses to get the help they need, while resenting being humiliated in this way. Junior nurses describe an equally humiliating dynamic in their interactions with senior

physicians. This emerging understanding is in keeping with situated learning in COCPs and was astutely observed by Eliot Friedson in 1970. He claimed that:

Now there is no question at all that the education in attitude and skill that the physician obtains in medical school and in the hospital where he is an intern and resident is an absolute source of much of his performance as a practitioner ... Nonetheless, I argue that education is a less important variable than work environment. There is some very persuasive evidence that 'socialization' does not explain some important elements of professional performance half so well as does the organization of the immediate work environment (pp.88–89).

The trajectory of nurses in the first two years is different from that of residents.

Residents rotate through several departments over the course of two years, are repeatedly new to the location, culture and expectations in each place. The Canadian resident has shorter rotations than the UK counterpart and expresses *change fatigue* more conspicuously. What is expected of them varies with each rotation and possibly even within each rotation; it is contingent upon the team they are on call with and the location to which they were called and problem they need to address. As such they cannot be said to be consistently in a COCP, which by definition is a stable authentic community of practice. In this unstable environment the realisation of the professional self is deferred while the resident meets immediate needs through whatever means are within their grasp. Bleakley et al., (2011) recent exposition concurs with this: "Junior doctors (interns and early residents) are now experiencing a de-territorialising of medicine through which they must learn to be travelers rather than members of a stable 'house'"(p. 66). Accounts of residents on call are powerfully reminiscent of Bleakley's description of *negotiated knotworking*:

... we are entering an era of “negotiated knotworking” of rapidly pulsating work where groups of people come together for coordinated, cooperative, connected or collaborative tasks with an engagement that requires letting go as much as forming where there is no stable ‘center’ (such as a fixed leader), or the center does not hold. Thus there is no development of identity as a team member.... In other words; you work with what you have, not with a planned team where identities are fixed by hierarchy and role. (p. 66)

Newness and instability marks all of the first two years of residency and residents have difficulty developing a stable identity that can inform them who they are in relation to other members of the team and what they do. Repeatedly, the narratives of residents under extreme stress have questioned their decision to enter medicine and postpone the realisation of their professional identity to the future. However when challenges are manageable their sense of self as competent doctor is reinforced and enriched. Pratt et al (2006) who examined how identity is constructed by physicians during residency training in a six year longitudinal study report a very similar dynamic. They describe the effects of identity infractions and violations and their consequences as the texts of this study reveal. They report:

As we further analyzed the data, it became clearer that changes in identity were intertwined with changes in work. Specifically, we found that professional identity changes occurred when the residents’ ideas about ‘who they were’ as professionals (i.e., their professional identity) did not match the work they did. (p. 241)

Despite these difficulties in developing a stable identity, as they move through residency they begin to define boundaries and in turn are defined by their decisions. We see this in narratives of how far they will compromise themselves to get by or get the job done. Based on their sense of responsibility for the patient, they reach similar conclusions

and decide that they will stop short of compromising the patient and in so doing develop one of their defining ethical principles. An interesting corollary of this principle is that as they begin to focus on doing right by the patient, this becomes a central and nonnegotiable tenet. When their sense of what is right for the patient collides with the nurse's, this principle becomes the cause for contention.

For many nurses, the initiation into work was also treacherous and a point at which they discovered that they are not consistently supported by their seniors. Instead they were expected to prove themselves and either *sink or swim*. (McKenna, Smith, Poole & Coverdale, 2003). This led to significant disenchantment and loss of identification with nursing as a profession. The nurses' sense of newness is however short lived. They are usually located within a circumscribed physical environment, as a member of a stable team which approximates a typical COCP and are expected to accomplish a level of competency at the routine accomplishment of tasks which they master within a few months. At this point their sense of self is validated by their competence and by their peers. Even while they are disenchanted by the healthcare delivery systems within the hospital and by some senior nurses, they find fulfillment in areas of work where they find personal meaning. These are the areas where they can make a difference, in particular in protecting the patient's interests and in so doing internalize and adopt the role of the patient's advocate.

It is clear that the nascent identities of both the nurse and the resident are intimately connected to the patient's well-being and when perceived congruently this leads to synergistic functioning but when viewed differently, such differences can lead to resentment, confrontation and even conflict. Synergistic functioning is seen in the

narratives of how nurses and physicians worked together to resuscitate a patient. Both in the stories of nurses and of residents one sees a spirit of team work described as *standing shoulder to shoulder and doing what it takes* in these situations. Here the perceptions of patients' interests are undisputed and urgent and an interprofessional team emerges spontaneously. The sense of common purpose and teamwork infuse these stories and one sees an alternative identity, the interprofessional identity being expressed here. As argued at this stage there is plurality of identities and clearly one of these is an interprofessional one. Bleakley et al. (2011) explain:

Just as the 'identity' of medicine itself, of doctors and surgeons and of educators, can no longer be thought of as stable, but is now liquid, so we must think of the emergence and management of plural identities, including that of the professional 'doctor' merging with the interprofessional 'doctor as team player'. (p. 65)

The process through which such interprofessional teams assemble and then quickly dissolve is best explained by another social learning theory. Through the cultural-historical activity theory, Engestrom (2001) describes that within activity systems people and artifacts work together on objects to achieve goals. Within these activity systems the division of labour determines how the object may be shared or become fragmented. In the case where the patient's needs are immediate, the patient as the object of activity is shared and the focus of the entire team is to resuscitate him. Similar but a less cohesive sense of team and expression of interprofessional identity is seen in the texts where groups of nurses, physicians and others get together to focus on the patient's problem, when this problem is prioritised by all members.

The texts also speak of teams disbanding and players retreating behind professional lines immediately upon resolution of the problem. We see this exemplified in the many

stories of nurses and physicians working in the emergency ward. From both nurses and residents we hear of the change in team dynamics as soon as the emergency is dealt with. The same nurses and residents who stood shoulder to shoulder disband and are reluctant to help each other with simple tasks such as a nurse helping the resident apply an arm sling. This can be understood in terms of how the shared object is now fragmented. Although the activities of all members are focused on patients or even a single patient, the patient as the object is fragmented because the division of labour and different accountabilities preface different priorities. Many narratives of confrontation and conflict can be explained when viewed in terms of fragmentation of the shared object of work. Such situations develop when the wards are busy and no one patient requires immediate attention of the team. Although patients may remain at the centre of the activity, the nurses' priorities are different from the physicians, for example, the nurse needs to have a discharge sheet ready while the resident feels the need to review a patient who is ill before preparing the discharge. As tasks are often interdependent, priorities collide and under stress players retreat behind professional lines, where interactions are enacted out of uniprofessional identities. Repeated enactment of these professional confrontations become internalised and formative for nascent identities, which then determine the tone of future interactions. Unfortunately the largest component of time spent at work is in these situations.

The occasions when work pressures are not overwhelming another aspect of the identity of junior nurses and residents is prefaced. In these times we encounter narratives of bonding and of getting to know each other or of mutual empathy as they find the space to act out of their personal identities in getting to know about each other's lives or just

sharing a box of chocolates. Clearly then we see a plurality of identities which find their expression contingent upon the work environment and at this stage are not fixed or necessarily oppositional. As professional identification is not very strong, actions proceed more from the contingencies of work than from intergroup biases as originally anticipated. These inferences are congruent with Freidson's (1970) view quoted above, which becomes even more compelling in contemporary times where diffuse and inconsistent socialization in professional schools and *unsituated* learning intersects with students who are not disposed to being defined by a dominant professional identity.

Hafferty and Hafler (2011) recent explanation corroborate our argument:

...the highly siloed and truncated nature of medical training and transitory nature of healthcare relationships (including peer relationships) teach students—in a highly invisible and tacit way—to value temporary adaptation over internalized identity formation. Conversely, the more consistent and integrated the learning environments, the less distance there is between the formal and the hidden curriculum, and the greater the internalization of a consistent professional identity. (pp. 20–21)

From the above discussion, working together in the hospital implies that workers get professionally determined transactional jobs done, to collectively serve the interest of the patient. Each profession is patient centred but does not necessarily perceive the patient's interests identically. This is in part determined by the responsibility and accountability and physical structures of the workplace but also by how patients' interests are perceived by the nursing and medical professions. The interviews have spoken of conflicts and confrontation when, for example, the nurse wants restraints for a violent patient and the resident does not. Interestingly the areas which provoke confrontation or conflict are limited and often relate to pain relief, sedation, restraint and prolongation of life. It is at

these junctures that glaring transactional nature of communication between the professions becomes evident. Communication is seldom face-to-face and explanations for views held or requests made are largely absent. This transactional nature of communication is accepted on all sides and serves to promote resentment and conflict that after iterative cycles leads to derogatory and negative stereotyping, especially in terms of the motives of each profession. Residents and nurses learn by *doing* now that they are different and wedges in team work become evident. The culture that promotes and accepts such transactional communication and clearly noncollaborative practices is passed on by senior nurses and physicians who are an integral part of the culture.

I will now proceed to examine the complexities and nuances in cross professional and cross-generational interaction. Within this complex matrix, I shall consider those aspects that have surfaced as salient to the construction of identity or to the way teamwork is practiced or understood. To begin with in both research locations there was a relative vacuum at the middle grade nurses that reflects a wider trend in hospital nursing. This led to overburdened senior nursing staff many of whom were perceived as *burnt out* or *near retirement* and often seen as unhelpful or downright abusive by new nurses. Additionally the long term relationships of senior staff with senior physicians or their tacit acceptance of hierarchical relationship was seen to fuel their reluctance to change the status quo and stand up for junior nurses when they were intimidated by senior physicians. This resulted in junior nurses feeling unsupported at several levels. Junior nurses however are trained to see themselves as bright and capable and once they become proficient are assertive in their interactions both with senior nurses and physicians, thus increasing the intra professional tension. The collision of generations and their implicit values in nursing

practice has been well explicated by Santos and Cox (2000) and mirrors the findings in this study. While hospital regulations everywhere vouch to protect employees' rights, senior physicians go unpunished even when they intimidate nursing staff. These contradictions and hypocrisy is not lost upon junior nurses and even if infrequent, the horror tales feed the discourse of continuing medical dominance and hegemony that devalue the nurses' sense of self, causing emotional distress.

The interactions of residents with nurses have been amply related and the causes for conflict and confrontation have been explicated. These are accentuated in residents interactions with senior nurses and particularly so in the case of women residents. A facet of these relationships that is seldom commented on is the absence of cross professional responsibility for training of new entrants in the other. This was aptly illustrated in the author's encounter with a senior nurse in the emergency room during a half day nonparticipant observation described in chapter five. The senior nurse expressed frustration in having to accommodate residents in the department while being unaware of the resident's discomfiture and distress as she did not feel she needed to play a role in mitigating it. No doubt there are narratives of residents being taken under the wing of a senior nurse or a senior physician teaching a nurse, but these are not the norm.

Residents, especially in the beginning eschew whatever is meted out, but slowly learn to dig their heels in and draw boundaries for themselves. More than a few recounted experiences with bitterness and anger. It is unclear how such scars will shape their interprofessional stances as they emerge from residency. Will they retain their enthusiasm for collaborative practice?

Based upon the journey of the novice nurse and resident through professional school and their complex trajectory and interactions in the workplace, the answers to the questions posed in this section can be encapsulated in the profiles of nurses and residents developed. Nurses who have worked for a year are competent and confident in what they are expected to do. They achieve a sense of stability and identity based on their role in the nursing team and in relation to the patient. Their fulfillment comes from enacting roles congruent to their values and skills. At this point their focus is to fulfill these roles and protect the patient's interests, as they see them. Although they started with an attitude of collaboration, this has become secondary to being the patient's advocate.

Residents meanwhile have navigated their way through multiple rotations in a fluid and dynamic environment. Their sense of self has been constantly violated but they are increasingly drawing boundaries and defining priorities. They have learned what it means to be responsible and act in the patient's best interest. This is their guiding principle and they too are willing to suffer infractions and dig their heels in to uphold it. Having entered with an attitude of collaboration they have suffered at the hands of senior nurses and the structures in which they work; while they still espouse the virtue of collaboration, they expect to collaborate from the position of leadership as they become more senior. Neither residents nor nurses wish to be defined by their profession, but while nurses have found an identity to work through, residents have postponed realising their professional identity and recapturing their life-work balance to a time in future.

I return again to the over-arching research question: How do the processes that lead to socialization, professional identification and identity formation in nursing and medical schools influence talk about collaborative team work upon graduation? Through the texts,

interpretations and comprehensive understanding, it has become progressively clear that although the processes of socialization in nursing and medical schools both in UK and in Canada contribute to preparing students for work, these processes alone do not determine how they will collaborate. The knowledge and skills in professional schools, especially in medical schools are largely acquisitional and the contradictions and ambiguities encountered therein lead to a diffuse sense of professional identity. Additionally the current generation of students' value life-work balance and chafe against circumscribed definitions of self or intimate identification with their professions.

Therefore while socialization and identity formation at school imbues them with some core values, it is through meaningful participation at work that they construct their identities and in enacting their values in this place, they iteratively define and constitute themselves. At the cusp between school and work both groups express attitudes of collaboration. However as they acquire divergent understandings of patient's interests and encounter intimidation from the other profession, this positive attitude is eroded but not lost. Although this research sought to explore the research question through the lens of professional identities and social identity theory, enlisting sociocultural learning theories, in particular the COP and the cultural historical activity theory has helped explain the phenomenon more holistically. This approach has also explicated the salience of *doing* in the situated context versus learning out of context.

## **Conclusion**

The impact of contemporary undergraduate nursing and medical education on the ability to practice collaboratively is obfuscated by internal contradictions and overshadowed by the contingencies and demands of the workplace during residency and

early nursing practice. In medical schools the intense socialization of yesteryear appears weakened and replaced by individual reflection and a struggle to maintain work-life balance. Values internalised during school years are of a sense of responsibility, very long hours, and hard work. Team work and a collaborative attitude are seen as desirable but students lack training in enabling competencies and in practical application to achieve this in the workplace. Both the exposure to IPL and its impact are variable and inconsistent, with a more positive impact reported from experiential learning in the workplace. Disjuncture between the assertions of collaboration in the formal curriculum and its disregard by some faculty caused dissonance and distress. In nursing schools, the value of caring is carried forward and self-awareness and assertiveness promoted. Training for future collaboration with physicians is largely transactional and students' understanding of the status of the nurse vis-à-vis the physician is ambiguous and mired in contradictions.

Although they value collaboration, neither residents, nor junior nurses can rely meaningfully on their experience of professional school, when faced with the workplace. The contingencies of the workplace determine how they act and initiation into the workplace is mostly precipitous. For residents the community of clinical practice is also fluid and repeatedly new. Novice residents and nurses are overwhelmed by unpreparedness, workload, and responsibility and acts to get by and get the job done. In learning to get by, residents develop an ethic of doing the *best for the patient* and not doing anything that will *compromise patient care*. At the same time, nurses become proficient at tasks routinely demanded of them and find fulfilment in being the *patient*

*advocate*. In time these roles and values concretize and their collision has a propensity for conflict.

Additionally in the environment of a busy ward each group has interdependent but competing priorities that lead to adversarial expressions of uniprofessional identity and consequent derogatory out-group stereotyping. In contrast situations demanding urgent focused attention such as a cardiac arrest lead to the spontaneous formation of a collaborative team that expressed an interprofessional identity and a clear focus on the patient, but disbands immediately after.

The attitude of collaboration is favored by both junior nurses and residents but not necessarily modeled by senior nurses and physicians. Adversarial cross-generational and gender-based interactions are not uncommon and lead to resentment and anger. While junior nurses derive fulfilment from their role as the patient's advocate, residents look forward to collaborating with other health professionals on their own terms in the future, when they are independent practitioners. Together, both medical and nursing education and the work environment into which novices are precipitously propelled do not facilitate sustained and consistent collaborative practice.

## Chapter 7

### **Original Contributions, Limitations and Recommendations: Looking Back and Looking Ahead**

#### **Introduction**

Looking back, I respectfully submit my interpretation of the original contributions of this research, through its conception to its execution and analysis, as well as its limitations. Looking ahead, I go on to present recommendations for change and future research in medical and nursing professional education and workplace structures and organization in healthcare delivery, based on the findings and conclusions drawn from this research.

#### **Original contributions.**

This study has made original contribution to scholarly literature in several spheres, namely, in the design of the study; methodologically, in the creative expression of data analysis congruent with hermeneutic phenomenology; in the advancement of substantive knowledge and in the exploration of theoretical perspectives that illuminate the impact of educational processes and work experiences on nurse-physician interaction. The conduct of this research has also led to unanticipated benefits outside the academic arena.

Several aspects of this study's design are unique and contribute to its rigour and transferability. First the inclusion of both residents and junior nurses who shared common work environments in training hospitals serves to triangulate the other's perspectives and experiences. Second the proximity of all participants to their respective professional school ensured attention to a highly focused stage of physicians' and nurses' career development. Interpretations were not contaminated by highly variable experiences, seniority and cross-generational attitudes, as has been the case with much research

exploring nurse-physician interaction. Third this study is unique in that it spans national boundaries to include locations in Canada and the UK. Consequently, findings common to both locations, such as the impact of IPL, influence of role models, trauma of transition from student to practitioner role, the impact of the structure of work, and generational and gender conflicts are clearly not culture or location specific and findings are transferable to other contexts that mirror the ones described.

Methodologically, the congruence of hermeneutic phenomenology with the research question and the theoretical lens of social identity was arduously researched and firmly grounded in existing scholarship. While remaining true to the methodology, data analysis was ultimately expressed through a juxtaposition of narrative analysis and analysis of narratives to achieve a holistic and expanded understanding of the participant's accounts. Such an arrangement led to comprehension in both the individual and the collective dimensions. This original and creative use of narrative tools paves the way for further exploration in data analysis and its expression.

The substantive contributions of this study are directly related to its design and methodology which have allowed a telescoped view of professional education through the context of work. Alongside recent literature (Bleakley et al., 2011; Diderichsen et al., 2011) but independent of it, this study demonstrates the contemporary weakening of the influence of socialization practices and consequent professional students' identity in medical school. It highlights the importance work-life balance over career ambitions and a disposition toward collaborative practice among all recent graduates studied. This study has contributed rich descriptions of the meaning and impact of precipitous transition from being a student to becoming a practitioner and furthered understandings of relationships

between the immediacy of tasks, the expression of team work and interprofessional identity. Uniquely, through the binocular perspectives of residents and nurses it has demonstrated the complex multigenerational and gender intersections in hospital practice and their influence on collaboration.

Finally, based on empirical data this study has demonstrated the preeminence work has over education as the arbiter of collaborative behaviour. To explicate this interpretation, the author invoked social learning theories, namely the COP and the cultural historic activity theory as a theory of social identity alone could not explain the phenomenon of transition from student to practitioner and the interprofessional interactions, at this cusp. Arguments that support the invocation of social learning theories in this situation have been contemporaneously put forward by Bleakley et al. (2011) and Hafferty and Hafler (2011). The author arrived at this understanding independently and based on the empirical data. This lends further credibility to the arguments advanced in this dissertation and in turn lends credence to their professional opinions through empirical research.

Outside the area of scholarship, several benefits accrued from this study. For many interviewees the process of reflection brought new and deeper insights into their situation as expressed in the interview texts in the “Interpretation of the Texts: The Lives of the Inhabitants” chapter. Furthermore, interprofessional links and relationships were formed through the researcher’s activities at the local, provincial and international levels. Future researchers had the opportunity to meet with local ethical board members in Victoria in a meeting organized by the researcher and this has helped to facilitate the process of applications for ethical approval for some of them.

**Limitations.**

In both Canada and the UK this study was located in training hospitals and thus reflects the working environment in the acute and subacute settings of healthcare delivery. This environment and its interprofessional dynamics are distinct from community settings and from settings such as palliative care where evidence of *successful* interprofessional practice is often sought out by researchers (Way, Jones & Busing, 2000). It must however be emphasized that all residents spend a large proportion of their first two years of training in the hospital setting and the vast majority of junior nurses work in hospitals. As such their formative experiences of work are located within traditional hospital settings and thus justify the choice of location.

**Recommendations.**

Consequent upon the coherence of findings within this study that straddles two countries and professions and the congruence of conclusions within theoretical frameworks and contemporary literature cited, the following recommendations are submitted for consideration. As we have seen, multiple stakeholders together determine how and if physicians and nurses collaborate. Influencing change at the micro level are individuals, at the meso level are the institutions entrenched in their structures and at the macro level is the policy and philosophy of provincial and national health care. It follows that shared vision, common goals, and mutually agreed upon strategies at these levels and between stakeholders is critical. Without alignment and coherence of vision, isolated changes mooted by champions or institutions are likely to run aground or fail to be fully realized. Thus before proceeding to make recommendations directed at individual stakeholders, the author would like to emphasize the need for ongoing dialogue across these levels and caution that while champions of collaborative practice are responsible for

its initiation, they alone cannot sustain it or be responsible for its implementation in the workplace. As such the involvement and influence of other members within stakeholder professions and administration should not be overlooked or discounted. The impact of detractors has been amply demonstrated in this study. At the meso and micro levels the recommendations address aspects of medical and nursing education and structures which determine the nature of teamwork in practice.

#### Medical education.

Evidence that the impact of socialization, and the professional identity of the medical student are becoming weaker and more diffuse is mounting and is corroborated by this study. Additionally generational values which emphasize work-life balance over *career first* and consequently the emphasis on status and hierarchy are giving way to more collaborative values. Through continuing professional development the medical faculty needs to become aware of these trends and develop a strategy to respond to them. It is an opportune time to promote the physician's collaborator role but we see that behaviors that do not model collaboration or valuing of other team members are still common. They conflict with the formal teaching, create disjuncture and dissonance, and tacitly give permission to students to do likewise. Thus, although champions of collaboration are the movers, others among the faculty can devalue and derail the collaboration agenda and strategies, therefore, to educate and enlist them is an imperative.

The data point towards an agreement with the principle of collaborative practice amongst medical faculty, yet students lack instruction in the enabling competencies of the role of effective collaborator even at the fundamental level of understanding another

professional's role. The medical faculty require training in both modeling and teaching the collaborator role throughout the curriculum.

#### Nursing education.

The data from this study echo the independence and assertiveness imparted by nursing education but is strident in its condemnation of programs that are removed from the reality of nursing practice and replete with internal contradictions, especially in terms of the nurse's role vis-à-vis the physician. While exposure to teachers with varied backgrounds and different generations may have value, the lack of a cohesive voice among nursing faculty is confusing for students and weakens identification with the profession. These issues need to be addressed so that nurses receive an education that fosters a positive but realistic nursing identity congruent with nursing practice.

#### Interprofessional learning.

This research has highlighted that outside of the context of practice, IPL is interpreted by participants to have variable, marginal or even deleterious impact on participants while contextual learning alongside practitioners of another profession, where the student is welcomed to participate legitimately at the periphery of a community of clinical practice is much more highly valued. Based on this data, the social learning theory of COP and exhortation by workers in the field (Ho et al., 2008), it is strongly recommended that IPL be jointly developed by the two professions with shared goals and clear objectives; that it be carefully planned and where possible be implemented as learning strategies in the workplace, run by those who are enthusiastic and committed.

Participation by key clinical faculty, including active support of such programs is vital.

While IPL delivered in professional school contexts makes intuitive sense, evidence for successful implementation of prelicensure IPL is lacking. This study also demonstrates the primacy of the work environment over school-based IPL. Based on this, it is recommended that prelicensure IPL be developed with these caveats in mind and be evaluated rigorously.

#### Transition from student to practitioner: Integration of undergraduate and postgraduate medical education.

This study has demonstrated that transition from being a student to becoming a resident is precipitous and traumatic and is repeatedly so through multiple rotations. To a lesser extent the same holds true for junior nurses who are precipitously pushed to bear responsibility prematurely. The ensuing newness and unpreparedness colors many interprofessional interactions. Medical training is apparently inadequate in supporting its trainees at the cusp between student and residency. While the structure of residency and rotations are arduously organized, the process by which a new resident in any rotation is initiated and moves towards bearing full responsibility needs review. Furthermore integration of undergraduate and postgraduate medical education, leading to review of preparation for practice at the end of studentship and beginning of residency is the way forward. The length of individual rotations during the early years of residency also requires reappraisal.

#### Continuous professional development of physicians and nurses.

As with faculty in medical and nursing schools, physicians and nurses in clinical settings also require ongoing education about generational trends, enabling competencies for collaboration and the impact of role modeling. Additionally, healthcare organizations that are sincerely invested in promoting collaborative care need to ensure that incidents of

interprofessional abuse or intimidation are justly dealt with and perpetrators are brought to book.

#### Loss of communication.

Paradoxically at a time when collaboration is being exhorted, face-to-face interaction between nurses and physicians is diminishing, with fewer or no common *rounds*, especially in large wards catering to multiple specialties. While structural constraints and distinct uniprofessional workloads are cited as reasons, the loss of community, collegiality and possible collaboration needs to be weighed against this emerging trend.

#### Common guidelines for difficult clinical decisions.

The clinical situations that result in conflict and dissatisfaction are limited, although they present themselves in different guises and situations repeatedly. Examples of these are aggressive treatment at the end of life, prescription of medicines for sedation and pain, and restraint of a potentially violent patient. Guidelines or protocols which are mutually agreed upon by nursing and medicine may be a move towards averting conflict and derogatory attribution.

#### Interprofessional interventions in the workplace.

The data suggest that interprofessional responsibility for trainees between medicine and nursing is lacking and collegiality is left to chance. Both medicine and nursing could consider utilizing the other to integrate each other's trainees into the collaborative healthcare team. Anecdotal accounts of employing senior nurses to orient residents in a dysfunctional obstetrics unit attest to this strategy in promoting collegial interaction (O. Casiro, personal communication, January 25, 2012). This strategy may serve to build bridges across the professions and enhance mutual understanding at multiple levels.

**Future research.**

The findings of this study open the field to several areas of exploration. First amongst these is the replication of this study in part or entirety to verify its findings. Second, longitudinal studies that examine the impact of time and seniority among residents and nurses on attitudes and practices of collaboration in relation to previous IPL and work environments will help guide and refine recommendations suggested here. Third, studies comparing the impact traditional work environments with those expressing a COCP will guide future workplace structures to facilitate collaborative patient centred practices.

**Post script.**

Finally, while collaboration with its implication of equal and synergistic contribution has been accepted as the standard to aim for, this study reveals that collegial cooperation is a satisfactory goal in many nurse-physician interactions. We are left with some questions such as: Is cooperation sufficient in some circumstances? Is the expectation of widespread collaboration realistic?

## References

- Albert, S., Ashforth, B. E., & Dutton, J. E. (2000). Organizational identity and identification: Charting new waters and building new bridges. *Academy of Management Review*, 25(1), 13–17.
- Albert, S., & Whetten, D. A. (1985). Organizational identity. In L.L. Cummings, & B. M. Staw (Eds.), *Research in organizational behavior* (Vol. 7, pp. 263–295). Greenwich, CT: JAI Press.
- Allen, D., & Hughes, D. (2002). *In Nursing and the division of labour in healthcare*. London, England: Palgrave MacMillan.
- Anells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23, 705–713.
- Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *Academy of Management Review*, 14(1), 20–39.
- Baggs, J. G., Schmitt, M. H., Mushlin, A. I., Eldredge, D. H., Oakes, D., & Hutson, A. D. (1997). Nurse-physician collaboration and satisfaction with the decision-making process in three critical care units. *American Journal of Critical Care*, 6(5), 393–399.
- Bailey, P., Jones, L., & Way, D. (2006). Family physician/nurse practitioner: Stories of collaboration. *Journal of Advanced Nursing*, 53(4), 381–391.
- Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., ... Tamblyn, R. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *CMAJ*, 170(11) Retrieved from <http://www.cmaj.ca/cgi/content/full/170/11/1678>
- Barr, H. (2002). *Interprofessional education today, yesterday and tomorrow* (Occasional Paper No 1). London, England: LTSN for Health Sciences and Practice
- Barr, H., Freeth, D., Hammick, M., Koppel, I., & Revves, S. (2006). The evidence base and recommendations for interprofessional education in health and social care. *Journal of Interprofessional Care*, 20(10), 75–78.
- Becker, H. S., Geer, B., Hughes, E. C., & Strauss, A. (1961). *In Boys in white: Student culture in medical school*. IL: University of Chicago Press.

- Bettencourt, B. A., & Bartholow, B. D. (1998). The importance of status legitimacy for intergroup attitudes among numerical minorities. *Journal of Social Issues, 54*(4), 759–775.
- Bleakley, A., Bligh, J., & Browne, J. (2011). Producing Doctors. In S. J. Hamstra (Series Ed.), *Medical education for the future: Identity, power and location* (pp. 63–79). Dordrecht, Netherlands: Springer. DOI 10.1007/978-90-481-9692-0
- Blue, I., & Fitzgerald, M. (2002). Interprofessional relations: Case studies of working relationships between registered nurses and general practitioners in rural Australia. *Journal of Clinical Nursing, 11*(3), 314–321.
- Bouchikhi, H., Fiol, C. M., Gioia, D. A., Golden-Biddle, K., Hatch, M. J., Rao, H., ... Schultz, M. (1998). The identity of organizations. In P. Godfrey (Ed.), *Identity in organizations: Building theory through conversations* (pp. 33–80). Thousand Oaks, CA: Sage.
- Boyd, C. (2001). Philosophical foundations of qualitative research. In P. Munhall (Ed.), *Nursing Research: A qualitative perspective* (3rd ed., pp. 65–90). Sudbury, MA: Jones & Bartlett.
- Bucknall, T., & Thomas, S. (1997). Nurses' reflections on problems associated with decision-making in critical care settings. *Journal of Advanced Nursing, 25*(2), 229–237.
- Busby, A., & Gilchrist, B. (1992). The role of the nurse in the medical ward round. *Journal of Advanced Nursing, 17*(3), 339–346.
- Caldwell, K., & Atwal, A. (2003). The problems of interprofessional healthcare practice in hospitals. *British Journal of Nursing, 12*(20), 1212–1218.
- Canadian Health Services Research Foundation. (2007). *CHSRF Synthesis: Interprofessional collaboration and quality primary healthcare*. Retrieved from [http://www.chsrf.ca/Migrated/PDF/SynthesisReport\\_E\\_rev4\\_FINAL.pdf](http://www.chsrf.ca/Migrated/PDF/SynthesisReport_E_rev4_FINAL.pdf)
- Canadian Institute of Information. (2007). *Health care in Canada*. Retrieved from [http://secure.cihi.ca/cihiweb/products/hcic2007\\_e.pdf](http://secure.cihi.ca/cihiweb/products/hcic2007_e.pdf)
- Carpenter, J. (1995). Doctors and nurses: Stereotypes and stereotype change in interprofessional education. *Journal of Interprofessional Care, 9*(2), 151–161.
- Carpenter, M. (1993). The subordination of nurses in health care: Towards a social division of approach. In E. Riska & K. Wengar (Eds.), *Gender, work, and medicine: Women and the medical division of labour* (pp. 95–130). London, England: Sage.
- Chou, S., Cole, G., McLaughlin, K., Lockyer, J. (2008). CanMEDS evaluation in Canadian postgraduate training programmes: Tools used and programme director satisfaction. *Medical Education, (42)*, 879–886.

- Cohen, H. A. (1981). *In The nurse's quest for a professional identity*. Menlo Park, CA: Addison-Wesley.
- Commission on the Future of Health Care in Canada. Romanow, R. J. (2002). *Building on values: The future of health care in Canada*. Retrieved from [http://www.cbc.ca/healthcare/final\\_report.pdf](http://www.cbc.ca/healthcare/final_report.pdf)
- Conrad, P. (1988). Learning to doctor: Reflections on recent accounts of the medical school years. *Journal of Health and Social Behavior*, 29(4), 323–332.
- Coombs, M. (2003). Power and conflict in intensive care clinical decision making. *Intensive & Critical Care Nursing*, 19(3), 125–135.
- Coombs, M., & Ersser, S. J. (2004). Medical hegemony in decision-making—a barrier to interdisciplinary working in intensive care? *Journal of Advanced Nursing*, 46(3), 245–252.
- Cruess, R., & Cruess, S. (2006). Teaching professionalism: General principles. *Medical Teacher*, 28(3), 205–208.
- Curran, V. (2004). *Interprofessional education for collaborative patient-centred practice research synthesis paper*. Retrieved from <http://www.med.mun.ca/getattachment/3a9bf92b-c99e-4b5b-9648-4a755604a124/Curran--Resarch-Synthesis-Paper.pdf.aspx>
- Department of Health. (2000). *The NHS plan: A plan for investment, a plan for reform*. Retrieved from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4002960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960)
- Devine, B. A. (1978). Nurse-physician interaction: Status and social structure within two hospital wards. *Journal of Advanced Nursing*, 3(3), 287–295.
- Diderichsen, S., Andersson, J., Johansson, E., Verdonk, P., Lagro-Janssen, A., Hamberg, K. (2011). Swedish medical students' expectations of their future life. *International Journal of Medical Education*, 2, 140–146. doi:10.5116/ijme.4ec5.92b8
- Doane, G. (2003). Reflexivity as presence: A journey of self inquiry. In L. Finlay, & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 93–102). Oxford, England: Blackwell Publishing.
- Egan, T., & Jaye, C. (2009). Communities of clinical practice: The social organization of clinical learning. *Health (London)*, 13(1), 107–125. doi:10.1177/1363459308097363
- Ekman, I., Skott, C., & Norberg, A. (2001). A place of ones' own. The meaning of lived experience as narrated by an elderly woman with severe chronic heart failure. A case-study. *Scandinavian Journal of Caring Sciences*, 15, 60–65. doi: 10.1046/j.1471-6712.2001.1510060.x

- Ellemers, N., Wilke, H., & Van Knippenberg, A. (1993). Effects of the legitimacy of low group or individual status on individual and collective status-enhancement strategies. *Journal of Personality and Social Psychology*, *64*(5), 766–778.
- Engestrom, Y. (2001). Expansive learning at work: Toward an activity theoretical reconceptualization. *Journal of Education and Work*, *14*(1), 133–156.
- Fagermoen, M. S. (1997). Professional identity: Values embedded in meaningful nursing practice. *Journal of Advanced Nursing*, *25*(3), 434–441.
- Finch, J. (2000). Interprofessional education and teamworking: A view from the education providers. *British Medical Journal*, *321*, 1138–1140.
- Freeman, M., Miller, C., & Ross, N. (2000). The impact of individual philosophies of teamwork on multi-professional practice and the implications for education. *Journal of Interprofessional Care*, *14*(3), 237–247.
- Freidson, E. (1970). *In Profession of medicine: A study of sociology of applied knowledge*. New York, NY: Harper & Row.
- Freidson, E. (2001). *In Professionalism: The third logic*. IL: University of Chicago Press.
- Gadamer, H.-G. (1998). *In Truth and method* (2nd ed.). New York, NY: Continuum. (Original work published 1960)
- Gaufberg, E. H., Batalden, M., Sands, R., & Bell, S. K. (2010). The hidden curriculum: What can we learn from third-year medical student narrative reflections?. *Academic Medicine: Journal of the Association of American Medical Colleges*, *85*(11), 1709–1716. doi:10.1097/ACM.0b013e3181f57899
- Genn, J.M. (2001a). AMEE Medical Education Guide No. 23 (Part 1): Curriculum, environment, climate, quality and change in medical education—a unifying perspective. *Medical Teacher*, *23*(4), 337–344.
- Genn, J.M. (2001b). AMEE Medical Education Guide No. 23 (Part 2): Curriculum, environment, climate, quality and change in medical education—a unifying perspective. *Medical Teacher*, *23*(5), 445–454.
- Gioia, D. A. (1998). From individual to organizational identity. In P. Godfrey (Ed.), *Identity in organizations: Building theory through conversations* (pp. 17–31). Thousand Oaks, CA: Sage.
- Glaser, B.G., Strauss, A.L. (1967). *In The discovery of grounded theory: Strategies for qualitative research*. New York, NY: Aldine Publishing.
- Guba, E. G., & Lincoln, Y. S. (2008). Paradigmatic controversies, contradictions, and confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed., pp. 255–286). Thousand Oaks, CA: Sage.

- Haas, J., & Shaffir, W. (1987). *In Becoming doctors: Adoption of a cloak of competence*. London, England: JAI Press.
- Hafferty, F.W. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine*, 73(4), 403–407.
- Hafferty, F. W., & Hafler, J. P. (2011). The hidden curriculum, structural disconnects, and the socialization of new professionals. In J. P. Hafler (Ed.), *Extraordinary learning in the workplace* (pp. 17–35). Dordrecht, Netherlands: Springer. DOI 10.1007/978-94-007-0271-4
- Hall P. (2005). Interprofessional teamwork: Professional cultures as barriers. *J Interprof Care*, 19(Suppl. 1), 188–196.
- Hall P. (2005). Interprofessional teamwork: Professional cultures as barriers. *J Interprof Care*, 19(Suppl. 1), 188–196.
- Harquail, C. V. (1998). Organizational identification and the “whole person”: Integrating affect, behavior, and cognition. In P. Godfrey (Ed.), *Identity in organizations: Building theory through conversations* (pp. 223–231). Thousand Oaks, CA: Sage.
- Health Canada. (2004). *Executive summary interprofessional education for collaborative patient-centred practice: An evolving framework*. Retrieved November 30, 2008 from <http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/summ-somm-eng.php>
- Health Canada. (2008). *Interprofessional education for collaborative patient-centred practice: An evolving framework*. Retrieved November 30, 2008 from [http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html)
- Henderson, J., & Atkinson, D. (2003). *In Managing care in context*. New York, NY: Routledge.
- Henneman, E. A. (1995). Nurse-physician collaboration: A poststructuralist view. *Journal of Advanced Nursing*, 22(2), 359–363.
- Herbert, C. (2005). Changing the culture: Interprofessional education for collaborative patient-centred practice in Canada. *Journal of Interprofessional Care*, (Suppl. 1), 1–4.
- Hewstone, M., Rubin, M., & Willis, H. (2002). Intergroup bias. *Annual Review of Psychology*, 53(1), 575–604.
- Hiles, D. (2002). *Narrative and heuristic approaches to transpersonal research and practice*. Retrieved from <http://www.psy.dmu.ac.uk/drhiles/N&Hpaper.htm>
- Ho, K., Jarvis-Selinger, S., Borduas, F., Frank, B., Hall, P., Handfield-Jones, R., ... Rouleau, M. (2008). Making interprofessional education work: The strategic roles of the academy. *Academic Medicine*, 83(10), 934–940.

- Hojat, M., Gonnella, J. S., Nasca, T. J., Fields, S. K., Cicchetti, A., Scalzo, A. L., ... Torres-Ruiz, A. (2003). Comparisons of American, Israeli, Italian, and Mexican physicians and nurses on the total and factor scores of the Jefferson scale of attitudes toward physician-nurse collaborative relationships. *International Journal of Nursing Studies*, 40(4), 427–435.
- Jacox, A. (1978). Professional socialization of nurses. In N. Chaska (Ed.), *The Nursing Profession: Views Through the Mist* (pp. 10–20). New York, NY: McGraw-Hill
- Joudrey, R., & Gough, J. (1999). Caring and curing revisited: Student nurses' perceptions of nurses' and physicians' ethical stances. *Journal of Advanced Nursing*, 29(5), 1154–1162.
- Keddy, J., Gillis, M. J., Jacobs, P., Burton, H., & Rogers, M. (1986). The doctor-nurse relationship: An historical perspective. *Journal of Advanced Nursing*, 11(6), 745–753.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21, 827–836.
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigor and representation. *Journal of Advanced Nursing*, 24, 174–184.
- Kohn, L. T., Corrigan, J., & Donaldson, M. S. (2000). *In To err is human*. Washington, DC: National Academies Press.
- Kvale, S. (1996). Interviewing as research. In S. Kvale (Ed.), *Interviews: An introduction to qualitative research interviewing* (pp. 3–16). Thousand Oaks, CA: Sage.
- Kvarnstrom, S. (2008). Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care*, 22(2), 191–203.
- Lahey, W., & Currie, R. (2005). Regulatory and medico-legal barriers to interprofessional practice. *Journal of Interprofessional Care*, 19(Suppl. 1), 197–223.
- Lave, J., & Wenger, E. (1991). *In Situated learning: Peripheral Participation*. England: Cambridge University Press
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3). Article 3. Retrieved August 4, 2011 from [http://www.ualberta.ca/~iiqm/backissues/2\\_3final/html/laverty.html](http://www.ualberta.ca/~iiqm/backissues/2_3final/html/laverty.html)
- Leathard, A. (Ed.). (2003). Introduction. *Interprofessional collaboration* (pp. 1–10). Hove, England: Brunner-Routledge.

- Lindseth, A., Marhaug, V., Norberg, A., & Uden, G. (1994). Registered nurses' and physicians' reflections on their narratives about ethically difficult care episodes. *Journal of Advanced Nursing*, 20(2), 245–250.
- Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences*, 18, 145–153. doi: 10.1111/j.1471-6712.2004.00258.x
- Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *Lancet*, 358(9280), 483–488
- Mannheim, K. (2002). *In Ideology and Utopia. Collected works of Karl Mannheim*. London, England: Kegan Paul.
- Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews [63 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 11(3), Art. 8. Retrieved from <http://nbn-resolving.de/urn:nbn:de:0114-fqs100387>
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *BMJ* 1995;311: 109–12.
- McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experience of registered nurses in their first year of practice. *Journal of Advanced Nursing*, 42(1), 90–96.
- Munhall, P. (1989). Philosophical ponderings on qualitative research methods in nursing. *Nursing Science Quarterly*, 2(1), 20-28.
- O'Brien-Pallas, L., Hiroz, J., Cook, A. & Mildon, B. (2005). *Nurse-physician relationships. Solutions & recommendations for change*. Retrieved from <http://www.scribd.com/doc/23634605/Nurse-Physician-Relationships-Solutions-and-Recommendations-for-Change>
- Pitkala, K. H., & Mantyranta, T. (2003). Professional socialization revised: Medical students' own conceptions related to adoption of the future physician's role—a qualitative study. *Medical Teacher*, 25(2), 155–160.
- Polkinghorne, D. (1983). *In Methodology for the human sciences: Systems of inquiry*. Albany: State University of New York Press.
- Polkinghorne, D. E. (1988). *In Narrative knowing and the human sciences*. Albany: State University of New York Press.
- Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education*, 8, 8–25.
- Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52, 137–145.

- Pratt, M. G. (1998). To be or not to be? Central questions in organizational identification. In P. Godfrey (Ed.), *Identity in organizations: Building theory through conversations* (pp. 171, 207). Thousand Oaks, CA: Sage.
- Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. (2006). Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal*, 49(2), 235–262.
- Purkis, M. E. (2007). Aftermath of the curriculum revolution: What did we overthrow? In L.E. Young & B.L. Paterson (Eds.), *Teaching nursing. Developing a student-centred learning environment* (pp. 364–382). Philadelphia, PA: Lippincott Williams & Wilkins.
- Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Hammick, M., & Koppel, I. (2009). Interprofessional education: Effects on professional practice and health care outcomes. *The Cochrane Library*, (1). Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002213.pub2/pdf/standard>
- Reynolds, J. (2007). Discourses of inter-professionalism. *British Journal of Social Work*, 37(3), 441–457.
- Santos, S., & Cox, K. (2000). Workplace adjustment and intergenerational differences between matures, boomers, and Xers. *Nursing Economic\$, 18(1)*, 7–13.
- Shirley, J. M., & Padgett, S. M. (2006). An analysis of the discourse of professionalism. In D. Wear & J. M. Altman (Eds.), *Professionalism in medicine: Critical perspectives* (pp. 25–41). New York, NY: Springer.
- Stein, L. (1968). The doctor- nurse game. *The American Journal of Nursing*, 68(1), 101–105.
- Stern, D. T. (2000). The development of professional character in medical students. *The Hastings Center Report*, 30(4) S26–S29.
- Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, 63(3), 224–237.
- Storli, S. L., Lindseth, A., & Asplund, K. (2008). A journey in quest of meaning: A hermeneutic-phenomenological study on living with memories from intensive care. *Nursing in Critical Care*, 13, 86–96. doi: 10.1111/j.1478-5153.2007.00235.x
- Suchman, A.L., Williamson, P.R., Litzelman, D.K., Frankel, R.M., Mossbarger, D.L., & Inui, T.S. (2004). Toward an informal curriculum that teaches professionalism: Transforming the social environment of a medical school. *Journal of General Internal Medicine*, 19(5), 501–504. doi: 10.1111/j.1525-1497.2004.30157.x
- Szasz, G. (1969). Interprofessional education in the health sciences: A project conducted at the University of British Columbia. *Milbank Quarterly*, 67, 449–475.

- Tajfel, H. (Ed.). (1978). *In Differentiation between social groups: Studies in the social psychology of intergroup relations*. London, England: Academic Press.
- Tajfel, H. (1982). *In Social identity and intergroup relations*. England: Cambridge University Press.
- Teasdale, G. M. (2002). Learning from Bristol: Report of the public inquiry into children's heart surgery at Bristol royal infirmary 1984-1995. *British Journal of Neurosurgery*, *16*(3), 211–216.
- Thomas, E. J., Sexton, J. B., & Helmreich, R. L. (2003). Discrepant attitudes about teamwork among critical care nurses and physicians. *Critical Care Medicine*, *31*(3), 956–959.
- Thomas, K. W. (1992). Conflict and negotiation processes in organizations. In M.D. Dunnette, & L. M. Hough (Eds.), *Handbook of Industrial and Organizational Psychology* (Vol. 3, pp. 651–717). Palo Alto, CA: Consulting Psychologists Press.
- Thomson, S. (2007). Nurse-physician collaboration: A comparison of the attitudes of nurses and physicians in the medical-surgical patient care setting. *MedSurg Nursing*, *16*(2), 87–91, 104.
- Uden, G., Norberg, A., Lindseth, A., & Marhaug, V. (1992). Ethical reasoning in nurses' and physicians' stories about care episodes. *Journal of Advanced Nursing*, *17*(9), 1028–1034.
- Van Maanen, J. (1979). The self, the situation, and the rules of interpersonal relations. In W. Bennis, J. Van Maanen, E. H. Schein, & F. I. Steele (Eds.), *Essays in interpersonal dynamics* (pp. 43–101). Homewood, IL: Dorsey Press.
- Van Maanen, J., & Schein, E. H. (1979). Toward a theory of organizational socialization. (B. M. Staw, Ed.). *Research In Organizational Behavior*, *1*(1), 209–264. JAI Press. Retrieved from <http://www.mendeley.com/research/toward-a-theory-of-organizational-socialization/>
- Way, D., & Jones, L. (1994). The family physician-nurse practitioner dyad: Indications and guidelines. *Canadian Medical Association Journal*, *151*(1), 29–34.
- Way, D., Jones, L., & Busing, N. (2000). Implementation strategies: “Collaboration in primary care—family doctors & nurse practitioners delivering shared care”. *Ontario College of Family Physicians*. Retrieved from <http://www.eicp.ca/en/toolkit/hhr/ocfp-paper-handout.pdf>
- Wear, D. (1998). On white coats and professional development: The formal and the hidden curricula. *Annals of Internal Medicine*, *129*(9), 734–736.
- Wear, D., & Kuczewski, M. G. (2004). The professionalism movement: Can we pause?. *The American Journal of Bioethics*, *4*(2), 1–10.

- Weinholtz, D. (1991). The socialization of physicians during attending rounds: A study of team learning among medical students. *Qualitative Health Research, 1*(2), 152–177.
- Whitehead, C. (2007). The doctor dilemma in interprofessional education and care: How and why will physicians collaborate?. *Medical Education, 41* 1010–1016.
- World Health Organization. (2006). *Working together for health*. Retrieved from [http://www.who.int/whr/2006/whr06\\_en.pdf](http://www.who.int/whr/2006/whr06_en.pdf)
- Zwarenstein, M., Reeves, S., Barr, H., Hammick, M., Koppel, I., & Atkin, J. (2000). *In Interprofessional education: Effects on professional practice and health*. Oxford, England: The Cochrane Library.
- Zwarenstein, M., Reeves, S., & Perrier, L. (2005). Effectiveness of pre-licensure interprofessional education and post-licensure collaborative interventions. *Journal of Interprofessional Care, 19*(Suppl. 1), 148–165.

## Appendices

### Appendix A Sample Interview Questions

#### Sample questions for semi-structured in depth interviews

“The Impact of Uniprofessional Medical and Nursing Education on the Ability to Practice Collaboratively”

How does team work look like in your current posting?

What supports successful team work?

What are the barriers to team work?

How do you view your role as a health care team member in your current rotation/posting?

How is this role different from what you consider your ‘ideal’ role to be?

How did you come to understand your ideal role?

What are priorities and values that guide your work?

What do you feel should be the role of a nurse/physician within a team?

How would you describe your relationship with nurses/physicians in your unit?

Have you encountered any difficulties in your interaction with nurses/ physicians?

How is your understanding of teamwork and your priorities different from when you were a student?

## **Appendix B Consent Form Canada**

### **Participant Consent Form**

#### **THE IMPACT OF UNIPROFESSIONAL MEDICAL AND NURSING EDUCATION ON THE ABILITY TO WORK COLLABORATIVELY**

You are invited to participate in a study entitled “The Impact of uniprofessional medical and nursing education on the ability to work collaboratively” that is being conducted by Dr Kiran Veerapen, FRCP (Edin), MMed (Dundee).

Dr. Veerapen is a Interdisciplinary PhD student of the Faculty of Graduate Studies at the University of Victoria, BC, Canada and you may contact her if you have further questions by email at [REDACTED] or by phone [REDACTED].

As a graduate student, Dr. Veerapen is required to conduct research as part of the requirements for an Inter-disciplinary Ph.D. degree. It is being conducted under the supervision of Dr. Mary Ellen Purkis [Human and Social Development].

You may contact her supervisor at [REDACTED]

You may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice- President Research at (250) 472-4545 or ethics@uvic.ca and Vancouver Island Health Authority Research Ethics Office at 250-370 8620.

This study is funded through the Banting and Best Canada Graduate Scholarship offered by Canadian Institute of Health Research (CIHR).

#### **The purpose of this research is to explore:**

1. The construction of professional identity in medical and nursing schools
2. The impact of uniprofessional education on the perception of self versus the ‘other’ (physicians/ nurses).
3. The impact of professional medical and nursing identity on the ability to work as a team
4. The shift in interprofessional perceptions after transiting from professional school to professional work

#### **Importance and Implications of Research for Education and Healthcare Policy**

This research hopes to inform both medical and nursing education about how the socialization processes, the formal, informal and hidden curriculum impact the construction of the students' interprofessional identities and values, which have a bearing on collaborative nurse-physician practice. These findings will inform the changes within each system and highlight the areas of possible dialogue across nursing and medical faculties to arrive at mutually congruent expectations for collaborative practice. The need for congruence between educational objectives and workplace realities will also implicate health care policy makers. Ultimately changes can be expected have a positive impact on patient outcome, practitioner satisfaction, retention of health care personnel and cost of effective delivery of health care.

### **Participant Selection**

You are being asked to participate in this study based upon your expression of willingness (e-mail/ telephone contact with me) to do so upon receiving an invitation to participate [REDACTED], and/or after attending an information session about this research.

You are invited to participate if you are a medical resident in the post graduate training program [REDACTED] in the critical care, medical or surgical services between 1<sup>st</sup> March 2010 and 30<sup>th</sup> June 2010 or if you are a registered nurse who has graduated within the last three years and [REDACTED] in the above areas between the dates stated.

You are being asked to participate because of your experience as trainees in professional schools and as health care practitioners. As recent graduates of medical and nursing schools, your evolving or changing understanding of working as a health care team member and your experiences in this area will be invaluable in helping me understand the congruence of professional education with professional practice.

You should have received a copy of this contact form by e-mail, after you contacted me with an offer to participate.

If you contact me with an offer to volunteer after sufficient number of participants has already been recruited in your area of practice, I will not be able to include you as a participant in this study

### **What is involved?**

You will be asked to participate in three interviews. It is estimated that the interview process will take approximately 3 hours and 15 minutes in all, over three sessions. In this first meeting, (which will be held at least 48 hours after a copy of the consent form has been sent to you by e- mail), I will explain the objectives of the research and processes involved. I will answer any questions or concerns that you may have. After obtaining your informed consent, I will provide you with a framework of the research questions for

the second meeting. I will also ask you to fill in a short pre-interview questionnaire. This first meeting will take approximately 45 minutes.

The second meeting will be arranged within the next two weeks during which I will ask you to respond to questions based on the framework provided. Your responses to a scenario involving nurse physician interaction will also be invited during this meeting. Additional questions may arise during our conversation which will allow exploration of your unique experiences in relation to the research questions. This meeting will take approximately 1 hour and 30 minutes and will be audio taped.

In the final meeting, approximately two weeks later I will present to you a written analysis of our in-depth interview for verification and invite your comments and any new information or insights you may wish to add. This meeting will take approximately 1 hour and will be audio-taped.

At any time you will be free to introduce and discuss areas not covered in my questions which you think are important to address. If at any time you wish to terminate the interview for any reason, you will be free to do so. If you withdraw from the research, the data that you have provided will be removed from the analysis unless you give your permission for it to be included.

Venue and time of interviews: [REDACTED] which allows for privacy and confidentiality to be maintained, outside your working hours and at your convenience

### **Inconvenience**

Participation in this study may cause some inconvenience to you, in terms of the dedication of time but it very unlikely that it will cause you any emotional or physical discomfort.

You will be free at all times to steer the conversation to the next or other topic in the event that you are uncomfortable with any aspect of the interview.

### **Risks**

There are no known or anticipated risks to you by participating in this research

### **Benefits**

This information has important applications to professional education and health care policy and will contribute to more congruent and realistic expectations of collaborative practice and training in the health care professions.

It is possible that this interview will help you reflect and understand your own collaborative practice better.

### **Compensation**

No form of compensation will be provided for your participation in this study.

### **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be deleted and not used unless you give your explicit permission for it to be included.

### **Anonymity**

In terms of protecting your anonymity any identifying information regarding you personally will not appear in the results of the research.

### **Confidentiality**

Your confidentiality and the confidentiality of the data will be protected by storage in computers and other recording equipment under the direct control at all times of the researcher, Dr. Veerapen.

### **Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways:

- Dr. Veerapen's Ph.D. dissertation
- Publication in peer-reviewed journals.
- Paper presented at scholarly meeting.
- Letter of thanks to study participants with study update

### **Storage and Disposal of Data**

Data from this study will remain in electronic form, under the control of Dr. Veerapen in her personal computer and will not be stored in an institutional or electronic storage system with public access.

Data may be used for further analysis, only by Dr Kiran Veerapen. All data will be destroyed 10 years after completion of the study (expected date of destruction 2021)

### **Contacts**

Individuals that may be contacted regarding this study are as detailed on the first page of this form.

**Conflict of Interest** – None.

**Funded by** Canadian Institutes of Health Research (CIHR)

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

---

*Name of Participant*

---

*Signature*

---

*Date*

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

## **Appendix C Consent Form UK**

### **Participant Consent Form**

#### **THE IMPACT OF UNIPROFESSIONAL MEDICAL AND NURSING EDUCATION ON THE ABILITY TO WORK COLLABORATIVELY**

You are invited to participate in a study entitled “The Impact of uniprofessional medical and nursing education on the ability to work collaboratively” that is being conducted by Dr Kiran Veerapen, FRCP (Edin), MMed (Dundee).

Dr. Veerapen is an Interdisciplinary PhD student of the Faculty of Graduate Studies at the University of Victoria, BC, Canada and you may contact her if you have further questions by email at [REDACTED] or by phone---- (to be inserted)

As a graduate student, Dr. Veerapen is required to conduct research as part of the requirements for an Inter-disciplinary Ph.D. degree. In the UK this research is being conducted under the supervision of Professor Alan Bleakley, Professor of Medical Education/Deputy Director Institute of Clinical Education, Peninsula College of Medicine and Dentistry.

You may contact her supervisor, Dr A. Bleakley at [REDACTED]

This study is funded through the Banting and Best Canada Graduate Scholarship offered by Canadian Institute of Health Research (CIHR).

#### **The purpose of this research is to explore:**

5. The construction of professional identity in medical and nursing schools
6. The impact of uniprofessional education on the perception of self versus the ‘other’ (physicians/ nurses).
7. The impact of professional medical and nursing identity on the ability to work as a team
8. The shift in interprofessional perceptions after transiting from professional school to professional work

#### **Importance and Implications of Research for Education and Healthcare Policy**

This research hopes to inform both medical and nursing education about how the socialization processes, the formal, informal and hidden curriculum impact the construction of the students' interprofessional identities and values, which have a bearing on collaborative nurse-physician practice. These findings will inform the changes within each system and highlight the areas of possible dialogue across nursing and medical faculties to arrive at mutually congruent expectations for collaborative practice. The need for congruence between educational objectives and workplace realities will also implicate health care policy makers. Ultimately changes can be expected have a positive impact on patient outcome, practitioner satisfaction, retention of health care personnel and cost of effective delivery of health care.

### **Participant Selection**

You are being asked to participate in this study based upon your expression of willingness (e-mail/ telephone contact with me) to do so upon receiving an invitation to participate and/or after attending an information session about this research.

You are invited to participate if you are a medical doctor in the Foundation Programme of the [REDACTED] who has graduated within the last three years and working at the [REDACTED] [REDACTED] between 1<sup>st</sup> June 2010 and 30<sup>th</sup> December 2010 or if you are a registered nurse who has graduated within the last three years and practicing in [REDACTED] [REDACTED] in the between the dates stated. You will be above the age of 18 years.

You are being asked to participate because of your experience as trainees in professional schools and as health care practitioners. As recent graduates of medical and nursing schools, your evolving or changing understanding of working as a health care team member and your experiences in this area will be invaluable in helping me understand the congruence of professional education with professional practice.

If you contact me with an offer to volunteer after sufficient number of participants has already been recruited in your area of practice, I will not be able to include you as a participant in this study

### **What is involved?**

You will receive an e-mail containing an invitation to participate in this research and an invitation to attend an information session about the same.

You may attend an Information Session (optional) for approximately 20 minutes

You can inform the researcher of your interest/ intention to participate at the information session or by e-mail and clarify concerns or/and asks questions through the same means of communication.

If you express an interest in participating, you will receive a consent form, researcher's curriculum vitae and a list of guiding questions for the semi-structured interview by e-mail or at the information session. A meeting with the researcher will be arranged not less than 48 hours after receiving the consent form.

You will be requested to meet with the researcher at a time outside working hours which is convenient to you, at a location which affords privacy and confidentiality for one and a half hours. You can clarify any further issues pertaining to the consent or the study and if satisfied you will sign the consent form in duplicate. You will be asked to fill a pre-interview questionnaire and proceeds to engage in a semi-structured, audio recorded interview with the researcher.

Within the next 15-30 days, you will receive a transcript of the interview via secure e-mail and will be invited to comment or add to it by e-mail or audio recorded telephone conversation.

June 2011 (approximately): You will be sent a summary of the study results upon completion along with a letter of thanks.

### **Inconvenience**

Participation in this study may cause some inconvenience to you, in terms of the dedication of time but it very unlikely that it will cause you any emotional or physical discomfort.

You will be free at all times to steer the conversation to the next or other topic in the event that you are uncomfortable with any aspect of the interview.

### **Risks**

There are no known or anticipated risks to you by participating in this research

### **Benefits**

This information has important applications to professional education and health care policy and will contribute to more congruent and realistic expectations of collaborative practice and training in the health care professions.

It is possible that this interview will help you reflect and understand your own collaborative practice better.

### **Compensation**

No form of compensation will be provided for your participation in this study.

### **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be deleted and not used unless you give your explicit permission for it to be included.

### **Anonymity**

In terms of protecting your anonymity any identifying information regarding you personally will not appear in the results of the research.

### **Confidentiality**

Your confidentiality and the confidentiality of the data will be protected by storage in computers and other recording equipment under the direct control at all times of the researcher, Dr. Veerapen.

### **Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways:

- Dr. Veerapen's Ph.D. dissertation (upon completion this PhD dissertation will be archived in the electronic 'dspace' of the library of The University of Victoria, BC, Canada. <http://dspace.library.uvic.ca:8080/>)
- Publication in peer-reviewed journals.
- Papers presented at scholarly meeting.
- Letter of thanks to study participants with study update

### **Storage and Disposal of Data**

Data from this study will remain in electronic form, under the control of Dr. Veerapen in her personal computer and will not be stored in an institutional or electronic storage system with public access.

Data may be used for further analysis, only by Dr Kiran Veerapen. All data will be destroyed 10 years after completion of the study (expected date of destruction 2021)

### **Contacts**

Individuals that may be contacted regarding this study are as detailed on the first page of this form.

**Conflict of Interest** – None.

**Funded by** Canadian Institutes of Health Research (CIHR)

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

---

*Name of Participant*

---

*Signature*

---

*Date*

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

## **Appendix D Invitation to Participate Canada**

### **Invitation to Participate in a Doctoral Research Project**

**Title of Research:** The impact of uniprofessional medical and nursing education on the ability to work collaboratively.

I would be most grateful if you would consider being a participant in my research project; the detailed information about this research is laid out below.

If you are willing to participate in this research, please e-mail me at [REDACTED] or call me at [REDACTED].

I will also be holding an information session about this research at the venue and time indicated in the e-mail accompanying this invitation. You are invited to attend this meeting if you would like further information.

#### **The purpose of this research is to explore:**

- The construction of professional identity in medical and nursing schools
- The impact of uniprofessional education on the perception of self versus the 'other' (physicians/ nurses).
- The impact of professional medical and nursing identity on the ability to work as a team
- The shift in interprofessional perceptions after transiting from professional school to professional work

#### **Importance of this Research for Education and Healthcare Policy**

This research hopes to inform both medical and nursing education about how the socialization processes, the formal, informal and hidden curriculum impact the construction of the students' interprofessional identities and values, which have a bearing on collaborative nurse-physician practice. These findings will inform the changes within each system and highlight the areas of possible dialogue across nursing and medical faculties to arrive at mutually congruent expectations for collaborative practice. The need for congruence between educational objectives and workplace realities will also implicate health care policy makers. Ultimately changes can be expected have a positive impact on patient outcome, practitioner satisfaction, retention of health care personnel and cost of effective delivery of health care.

#### **Selection of Participants for this Research**

You are invited to participate if you are a medical resident in the post graduate training program [REDACTED] rotating within [REDACTED] in the critical care, medical or surgical services between 1<sup>st</sup> March 2010 and 30<sup>th</sup> June 2010 or if you are a registered nurse who has graduated within the last three years and are (or will be) practicing in [REDACTED] in the above areas between the dates stated.

You are being asked to participate because of your experience as a trainee in professional school and as a health care practitioner. As a recent graduate of medical and nursing schools, your evolving or changing understanding of working in a health care team and your experience in this area will be invaluable in helping me understand the congruence of professional education with professional practice.

If your offer to volunteer is received after sufficient number of participants have already been recruited in your area of practice, I will not be able to include you as a participant in this study.

You will receive a copy of the consent form by e-mail, after you contact me with an offer to participate.

### **What is involved?**

You will be asked to participate in three interviews. It is estimated that the interview process will take approximately 3 hours and 15 minutes in all, over three sessions. In the first meeting (which will be held at least 48 hours after a copy of the consent form has been sent to you by e-mail), I will explain the objectives of the research and processes involved and provide you with a copy of my curriculum vitae. I will answer any questions or concerns that you may have. If you agree to participate I will obtain your written consent and provide you with a framework of the research questions for the second meeting. I will also ask you to fill in a short pre-interview questionnaire after you have signed a written informed consent. This first meeting will take approximately 45 minutes.

The second meeting will be arranged within the next two weeks during which I will ask you to respond to questions based on the framework provided. Your responses to a scenario/s involving nurse physician interaction will also be invited during this meeting. Additional questions may arise during our conversation which will allow exploration of your unique experiences in relation to the research questions. This meeting will take approximately 1 hour and 30 minutes and will be audio taped.

In the final meeting, approximately two weeks later I will present to you a written analysis of our in-depth interview for verification and invite your comments and any new information or insights you may wish to add. This meeting will also be recorded and will take approximately 1 hour and will be audio-taped.

At any time you will be free to introduce and discuss areas not covered in my questions which you think are important to address. If at any time you wish to terminate the interview for any reason, you will be free to do so.

Venue and time of interviews: A location in the [REDACTED] which allows for privacy and confidentiality to be maintained, outside your working hours and at your convenience

Measures will be taken to protect your identity and confidentiality as outlined in the section on confidentiality below.

### **Inconvenience to you**

Participation in this study may cause some inconvenience to you, in terms of the dedication of time but it very unlikely that it will cause you any emotional or physical discomfort.

You will be free at all times to steer the conversation to the next or other topic in the event that you are uncomfortable with any aspect of the interview.

### **Risks**

There are no known or anticipated risks to you by participating in this research

### **Benefits**

This information has important applications in professional education and health care policy and may contribute to more congruent and realistic expectations of collaborative practice and training in the health care professions.

It is possible that this interview will help you reflect and understand your own collaborative practice better.

### **Compensation**

No form of compensation will be provided for your participation in this study.

### **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be deleted and not used unless you give your explicit permission for it to be included.

### **Anonymity**

In terms of protecting your anonymity any identifying information regarding you personally will not appear in the results of the research.

**Confidentiality**

Your confidentiality and the confidentiality of the data will be protected by storage in computers and other recording equipment under the direct control at all times of the researcher Dr. Veerapen.

**Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways:

- Dr. Veerapen's Ph.D. dissertation
- Publication in peer-reviewed journals.
- Paper presented at scholarly meeting.

**Storage and Disposal of Data**

Data from this study will remain in electronic form, under the control of Dr. Veerapen and will not be stored in an institutional or electronic storage system with public access.

Data may be used for further analysis, only by Dr Kiran Veerapen

I have no conflict of interest in relation to this study. This study is funded by a CIHR doctoral award.

Thank you for taking the time to read through this invitation. If you are interested in participating, please contact me, by e-mail at [REDACTED] or call me at [REDACTED].

I will also be holding an information session about this research at the venue and time indicated in the e-mail accompanying this invitation. You are invited to attend this meeting if you would like further information before deciding to participate or not.

Thank you,

Dr Kiran Veerapen FRCP (Edin) MMed (Dundee)  
PhD Candidate, Graduate Studies, University of Victoria,

Adjunct Clinical Instructor, Island Medical Program,  
University of Victoria

## **Appendix E Invitation to Participate UK**

### **Invitation to Participate in a Doctoral Research Project (Information sheet)**

**Title of Research:** The impact of uniprofessional medical and nursing education on the ability to work collaboratively.

I would be most grateful if you would consider being a participant in my research project; the detailed information about this research is laid out below.

If you are willing to participate in this research, please e-mail me at [REDACTED] or call me at (to be inserted).

I will also be holding an information session about this research at the venue and time indicated in the e-mail accompanying this invitation. You are invited to attend this meeting if you would like further information.

#### **The purpose of this research is to explore:**

- The construction of professional identity in medical and nursing schools
- The impact of uniprofessional education on the perception of self versus the 'other' (physicians/ nurses).
- The impact of professional medical and nursing identity on the ability to work as a team
- The shift in interprofessional perceptions after transiting from professional school to professional work

#### **Importance of this Research for Education and Healthcare Policy**

This research hopes to inform both medical and nursing education about how the socialization processes, the formal, informal and hidden curriculum impact the construction of the students' interprofessional identities and values, which have a bearing on collaborative nurse-physician practice. These findings will inform the changes within each system and highlight the areas of possible dialogue across nursing and medical faculties to arrive at mutually congruent expectations for collaborative practice. The need for congruence between educational objectives and workplace realities will also implicate health care policy makers. Ultimately changes can be expected have a positive impact on patient outcome, practitioner satisfaction, retention of health care personnel and cost of effective delivery of health care.

#### **Selection of Participants for this Research**

You are being asked to participate in this study based upon your expression of willingness (e-mail/ telephone contact with me) to do so upon receiving an invitation to participate and/or after attending an information session about this research.

You are invited to participate if you are a medical doctor in the Foundation Programme of the [REDACTED] who has graduated within the last three years and working at the [REDACTED] [REDACTED] between 1<sup>st</sup> June 2010 and 30<sup>th</sup> December 2010 or if you are a registered nurse who has graduated within the last three years and practicing in [REDACTED] [REDACTED] in the between the dates stated. You will be above the age of 18 years.

You are being asked to participate because of your experience as trainees in professional schools and as health care practitioners. As recent graduates of medical and nursing schools, your evolving or changing understanding of working as a health care team member and your experiences in this area will be invaluable in helping me understand the congruence of professional education with professional practice.

If you contact me with an offer to volunteer after sufficient number of participants has already been recruited in your area of practice, I will not be able to include you as a participant in this study

### **What is involved?**

You will receive an e-mail containing an invitation to participate in this research and an invitation to attend an information session about the same.

You may attend an Information Session (optional) for approximately 20 minutes

You can inform the researcher of your interest/ intention to participate at the information session or by e-mail and clarify concerns or/and asks questions through the same means of communication.

If you express an interest in participating, you will receive a consent form, researcher's curriculum vitae and a list of guiding questions for the semi-structured interview by e-mail or at the information session. A meeting with the researcher will be arranged not less than 48 hours after receiving the consent form.

You will be requested to meet with the researcher at a time outside working hours which is convenient to you, at a location which affords privacy and confidentiality for one and a half hours. You can clarify any further issues pertaining to the consent or the study and if satisfied you will sign the consent form in duplicate. You will be asked to fill a pre-interview questionnaire and proceeds to engage in a semi-structured, audio recorded interview with the researcher.

At any time you will be free to introduce and discuss areas not covered in my questions which you think are important to address. If at any time you wish to terminate the interview for any reason, you will be free to do so.

Venue and time of interviews: A location in the [REDACTED] which allows for privacy and confidentiality to be maintained, outside your working hours and at your convenience

Measures will be taken to protect your identity and confidentiality as outlined in the section on confidentiality below.

Within 15-30 days of the interview you will receive a transcript of the interview via secure e-mail and will be invited to comment or add to it by e-mail or audio recorded telephone conversation.

June 2011 (approximately): You will be sent a summary of the study results upon completion along with a letter of thanks.

### **Inconvenience to you**

Participation in this study may cause some inconvenience to you, in terms of the dedication of time but it very unlikely that it will cause you any emotional or physical discomfort.

You will be free at all times to steer the conversation to the next or other topic in the event that you are uncomfortable with any aspect of the interview.

### **Risks**

There are no known or anticipated risks to you by participating in this research

### **Benefits**

This information has important applications in professional education and health care policy and may contribute to more congruent and realistic expectations of collaborative practice and training in the health care professions.

It is possible that this interview will help you reflect and understand your own collaborative practice better.

### **Compensation**

No form of compensation will be provided for your participation in this study.

### **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation.

If you do withdraw from the study your data will be deleted and not used unless you give your explicit permission for it to be included.

### **Anonymity**

In terms of protecting your anonymity any identifying information regarding you personally will not appear in the results of the research.

### **Confidentiality**

Your confidentiality and the confidentiality of the data will be protected by storage in computers and other recording equipment under the direct control at all times of the researcher Dr. Veerapen.

### **Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways:

- Dr. Veerapen's Ph.D. dissertation (upon completion this Ph.D dissertation will be archived in the electronic 'dspace' of the library of The University of Victoria, BC, Canada. <http://dspace.library.uvic.ca:8080/>)
- Publication in peer-reviewed journals.
- Paper presented at scholarly meeting.
- Letter of thanks to study participants with study update

### **Storage and Disposal of Data**

Data from this study will remain in electronic form, under the control of Dr. Veerapen and will not be stored in an institutional or electronic storage system with public access.

Data may be used for further analysis, only by Dr Kiran Veerapen

I have no conflict of interest in relation to this study. This study is funded by a CIHR doctoral award.

Thank you for taking the time to read through this invitation. If you are interested in participating, please contact me, by e-mail at [REDACTED] or call me (to be inserted).

I will also be holding an information session about this research at the venue and time indicated in the e-mail accompanying this invitation. You are invited to attend this meeting if you would like further information before deciding to participate or not.

Thank you,

Dr Kiran Veerapen FRCP (Edin) MMed (Dundee)  
PhD Candidate, Graduate Studies, University of Victoria,

Adjunct Clinical Instructor, Island Medical Program,  
University of Victoria

## Appendix F UBC Certificate of Approval Minimal Risk

Page 1



The University of British Columbia  
Office of Research Services  
Behavioural Research Ethics Board  
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

### CERTIFICATE OF APPROVAL - MINIMAL RISK

<b>PRINCIPAL INVESTIGATOR:</b> Oscar Casiro	<b>INSTITUTION / DEPARTMENT:</b> UBC/Medicine, Faculty of Paediatrics	<b>UBC BREB NUMBER:</b> H09-03408
<b>INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:</b>		
Institution	N/A	Site
N/A Other locations where the research will be conducted: Location at the University of Victoria Campus which allows confidentiality and privacy (outside the hospital)		
<b>CO-INVESTIGATOR(S):</b> Kiran Veerapen		
<b>SPONSORING AGENCIES:</b> Canadian Institutes of Health Research (CIHR)		
<b>PROJECT TITLE:</b> The impact of uniprofessional medical and nursing education on the ability to work collaboratively		
<b>CERTIFICATE EXPIRY DATE:</b> January 4, 2011		
<b>DOCUMENTS INCLUDED IN THIS APPROVAL:</b>		<b>DATE APPROVED:</b> January 4, 2010
<b>Document Name</b>	<b>Version</b>	<b>Date</b>
<b>Protocol:</b>		
Final Proposal Uniprofessional Medical and Nursing Education and Collaborative Practice	Version Date 17th December 2009	December 17, 2009
<b>Consent Forms:</b>		
Confidentiality agreement transcriptionist	Version 17th December 2009	December 17, 2009
Consent Form	Version 18th December	December 18, 2009
Withdrawal form	Version 17th December 2009	December 17, 2009
Confidentiality agreement research assistant	Version 17th December 2009	December 17, 2009
<b>Questionnaire, Questionnaire Cover Letter, Tests:</b>		
Sample Scenario	Version 17th December 2009	December 17, 2009
Pre-Interview Questionnaire	Version Date 17th December 2009	December 17, 2009
Framework for in-depth semi-structured interview	Version Date 17th December 2009	December 17, 2009
<b>Letter of Initial Contact:</b>		
Contact letter to neutral third party and nurses	Date 17th December 2009	December 17, 2009
Contact letter to neutral third party and residents	Date 17th December 2009	December 17, 2009
Information and Invitation letter	Version 18th December	December 18, 2009
<b>Other Documents:</b>		
Letter of approval by supervisory committee	N/A	December 16, 2009
Letter of support from host supervisor UK	N/A	September 8, 2009
Researcher's brief curriculum vitae	Date 17th December 2009	December 17, 2009
The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.		
Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:		

Dr. M. Judith Lynam, Chair  
Dr. Ken Craig, Chair  
Dr. Jim Rupert, Associate Chair  
Dr. Laurie Ford, Associate Chair  
Dr. Anita Ho, Associate Chair

## Appendix G UVic/VIHA Joint Research Ethics Sub-Committee Certificate of Approval



UVic/VIHA Joint Research Ethics Sub-Committee  
Human Research Ethics, University of Victoria  
PO Box 1700, Stn CSC, Victoria BC, V8W 2Y2  
Tel (250) 472-4545 Fax (250) 721-8960 Web www.research.uvic.ca




Vancouver Island Health Authority, Memorial Pavilion, Kenning Wing  
1952 Bay Street, Victoria BC, V8R 1J8  
Tel (250) 370-8261 Fax (250) 370-8108 Web www.viha.ca

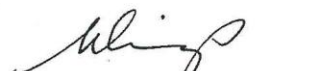
### UVic/VIHA Joint Research Ethics Sub-Committee Certificate of Approval

<u>Principal Investigator</u> Kiran Veerapen	<u>Department/School</u> GRAD	<u>Supervisor</u> Mary Ellen Purkis	
<u>Co-Investigator(s):</u> Mary Ellen Purkis, Supervisor, UVic Oscar Casiro, Co-Supervisor, UVic Lynn Cummings, Nursing Research Facilitator, VIHA Susanne Phillips, Program Manager, UBC			
<u>Project Title:</u> The Impact of Uniprofessional Medical and Nursing Education on the Ability to Work Collaboratively			
<u>Protocol No.</u> J2010-001	<u>Approval Date</u> 02-Feb-10	<u>Start Date</u> 02-Feb-10	<u>End Date</u> 01-Feb-11

#### Certification

This certifies that the UVic/VIHA Joint Research Ethics Sub-Committee has examined this research protocol and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects and the Vancouver Island Health Authority Research and Evaluation administration.

  
Dr. Afzal Suleman  
Associate Vice-President, Research, UVic

  
Ms. Lynn Cummings  
Acting Co-Chair, Joint UVic/VIHA Sub-committee

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions or minor amendments may be granted upon receipt of a Request for Annual Renewal or Modification form.

J2010-001 Veerapen, Kiran

**Appendix H  
National Research Ethics  
Service**

Royal Devon and Exeter   
NHS Foundation Trust

Professor Alan Bleakley  
Professor of Medical Education/Deputy Director  
Institute of Clinical Education  
The Knowledge Spa  
Royal Cornwall Hospital  
Truro  
Cornwall  
TR1 3HD

Royal Devon and Exeter  
Hospital (Wonford)  
Barrack Road  
Exeter  
EX2 5DW

Tel: 01392 411611

**GENERAL MANAGEMENT**

Direct dial: 01392 403919

Direct Fax: 01392 403911

Email: [Medical.Director@rdehc-tr.swest.nhs.uk](mailto:Medical.Director@rdehc-tr.swest.nhs.uk)

20 August 2010

Ref: VP/MC/R&D/DM

Dear Dr Bleakley

**Study Title:** The impact of uniprofessional medical and nursing education on the ability to work collaboratively  
**R&D Ref:** 1115499      **MREC Ref:** 10/H0203/41

I have reviewed the Trust R&D file for your study and I note that this study received ethical approval from the Southwest 1 Research Ethics Committee dated 12/08/10. I am happy to give approval on behalf of the Trust.

The documentation approved for use with this study is listed on the separate sheet:

**Research Governance**

The Director of Research and Development has asked me to remind you of your responsibilities as an NHS researcher, which are:

1. Work must be carried out in line with the new Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research.

More information about all these responsibilities can be found on the Department of Health Research and Development web pages at:

<http://www.dh.gov.uk/en/Policyandguidance/Researchanddevelopment/A-Z/Researchgovernance/index.htm>

With best wishes for a successful study

Yours sincerely

  
Dr Vaughan Pearce/Mr Martin Cooper  
**JOINT MEDICAL DIRECTORS**

Cc R&D Study File  
Dr Kiran Veerapen – Student / External Investigator

## Appendix I UBC Certificate of Approval Minimal Risk Amendment

<https://rise.ubc.ca/rise/Doc/0/UV4NRPBHBSKKL6BPM459118C27/f...>



The University of British Columbia  
Office of Research Services  
**Behavioural Research Ethics Board**  
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

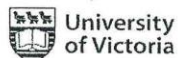
### CERTIFICATE OF APPROVAL - MINIMAL RISK AMENDMENT

<b>PRINCIPAL INVESTIGATOR:</b> Oscar Casiro	<b>DEPARTMENT:</b> UBC/Medicine, Faculty of/Paediatrics	<b>UBC BREB NUMBER:</b> H09-03408
<b>INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:</b>		
<b>Institution</b>		<b>Site</b>
N/A		N/A
<b>CO-INVESTIGATOR(S):</b> Kiran Veerapen		
<b>SPONSORING AGENCIES:</b> Canadian Institutes of Health Research (CIHR) - "The impact of uniprofessional medical and nursing education on the ability to work collaboratively"		
<b>PROJECT TITLE:</b> The impact of uniprofessional medical and nursing education on the ability to work collaboratively		

Expiry Date - Approval of an amendment does not change the expiry date on the current UBC BREB approval of this study. An application for renewal is required on or before: January 4, 2011

<b>AMENDMENT(S):</b>	<b>AMENDMENT APPROVAL DATE:</b> December 7, 2010	
<b>Document Name</b>	<b>Version</b>	<b>Date</b>
<b>Letter of Initial Contact:</b>		
Information for non participant half day observation	30th July 2010	July 30, 2010
<b>Other Documents:</b>		
Approval VIHA/UVic Ethics for non participant observation	N/A	November 24, 2010
The amendment(s) and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.		
<i>This study has been approved either by the full Behavioural REB or by an authorized delegated reviewer</i>		

## Appendix J Modification of Approved Protocol



UVic/VIHA Joint Research Ethics Sub-Committee  
Human Research Ethics, University of Victoria  
PO Box 1700, Stn CSC, Victoria BC, V8W 2Y2  
Tel 250-472-4545 Fax 250-721-8960 Web www.research.uvic.ca



Vancouver Island Health Authority, Memorial Pavilion, Kenning Wing  
1952 Bay Street, Victoria BC, V8R 1J8  
Tel 250-370-8261 Fax 250-370-8106 Web www.viha.ca

### Modification of an Approved Protocol

PRINCIPAL INVESTIGATOR:	Kiran Veerapen	ETHICS PROTOCOL NUMBER	J2010-01
POSITION:	Ph.D. Student	ORIGINAL APPROVAL DATE:	02-Feb-10
DEPARTMENT:	GRAD	MODIFIED ON:	09-Nov-10
SUPERVISOR:	Mary Ellen Purkis	APPROVAL EXPIRY DATE:	01-Feb-11
PROJECT TITLE: <b>The Impact of Uniprofessional Medical and Nursing Education on the Ability to Work Collaboratively</b>			
RESEARCH TEAM MEMBERS: Mary Ellen Purkis, Supervisor, UVic Oscar Casiro, Co-Supervisor, UVic Lynn Cummings, Nursing Research Facilitator, VIHA Susanne Phillips, Program Manager, UBC			
DECLARED PROJECT FUNDING: CIHR Banting and Best Canada Graduate Scholarship			

#### CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol. Extensions or minor amendments may be granted upon receipt of a Request for Annual Renewal or Modification form.

##### Amendments

To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

##### Extensions

Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Annual Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol before your expiry date.

##### Project Closures

When you have completed all data collection activities and will have no further contact with participants, please notify the UVic/VIHA Joint Research Ethics Sub-Committee by submitting a "Notice of Project Completion" form.

### Certification

This certifies that the UVic/VIHA Joint Research Ethics Sub-Committee has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants and the Vancouver Island Health Authority Research Ethics office.

Dr. Rachael Scarth  
Acting Associate Vice-President, Research

Ms. Lynn Cummings  
Acting Co-Chair, Joint UVic/VIHA Sub-committee

Certificate Issued On: 10-Nov-10

J2010-01  
Veerapen, Kiran

## **Appendix K**

### **Residents Naïve Interpretations: Remaining Stories**

Jenny's Story: Canada.

Jenny is nine months into the first year of residency and is currently rotating through pediatrics.

Speaking of life as a resident.

It's really tricky ... basically every month you're on a new service and it's really tricky I find for the first half if it's something you never done before because you're trying to figure out, how, every ward does things differently. The charts all look a little different, they all keep vital signs in different places, the nurses are always different, just the set up and logistically it's always tricky for the first half and then you finally start getting the swing of it in the second half and you move onto something else.

The stressful thing probably for me is just this sudden change in responsibility that you don't really have as a medical student but all of a sudden you do as a resident and yet you don't really know that much more. Especially in this first year when your rotating through everything and being sort of an off service resident the whole time. For me I find that stressful because I, the reason I chose the residency that I did is that I'm not a generalist, I think a bit more in terms of specifics and I can get a bit maybe sort of bogged down in details which is a useful thing for my specialty but not necessarily for everything. Especially when you're rotating through something new every month you don't have time to get bogged down in details.... So for me that's been stressful.

I certainly get nervous when I'm on call and I want to make sure I'm doing the right things and I have been known to go back and double check my orders because I'm just "did I write that correctly, I think I did, but I need to go check just to make sure". I just think that's the sort of [a] personality thing for me.... You have good on call days and bad on call days. The good ones are when it isn't too, too stressful and too, too busy on the ward and so you can be in the residents room and usually there's a resident or two who also are there and you can bond or talk.... That's just this feeling that I have that you should know what's going on because

you're the doctor and why don't you know what's going on and how come you can't tell.

For me just having a supportive colleagues [*sic*] and in especially tricky situations to know that you've bounced ideas off people, you have feedback so you're not making decisions on your own so you've got that support I think is huge ... yeah. I've had a couple scenarios where it's, there've been cases where they could be, in theory, a medical/legal issue and they make me extra nervous because especially then you [do] not want to do something wrong and faux pas and yeah, so that's been tricky.

It's great to work with the more senior nurses because they can have a lot of really good, helpful tips and insights just because their knowledge base is so much more vast than mine just because they're so specialized to that particular floor and they've been doing it for so long. And they kind of have the sixth sense about who is sick and what not.... But I think in general.... [I]t's been easier to form a bit more sort of rapport and relationships with nurses who are closer to their training like I am.... [I]t's probably is just a combination of just being able to be relatable in terms of age but also in terms of what our knowledge base is and whatnot.

I mean I think I was a pretty responsible person even before, but there's certainly an extra weight of responsibility that you carry around. Just in general with having those couple letters after your name and in terms of even how people outside the medical profession and just your peers and society views you as being slightly different and rightly or wrongly.... Even when you're just trying to live a normal life and maybe go out with some friends and relax there's still this feeling of "she's the doctor if anyone got hurt she would know what to do" even if you're out with your friends and you're having a glass of wine or something everyone's just all relaxed but there's still this extra.... We just feel like we're, it's almost like we're imposters if you don't feel that way. You know, society expects us to feel that way but we just feel the same.

When I get introduced to other people and it's always "this is the doctor" and "this is the resident" or it's one of the first things people would say about me and be "she's the resident". They wouldn't say "she's my friend who likes to travel" and other things. The first thing they say is the she's

the physician and it's, if I ever, not that I would but if I ever decided medicine's not for me I'm going to not do it anymore I think people would be very confused because that's what they know me as. I have other things that define me.... Yeah, sometimes it's hard to keep that in the forefront because sometimes you feel like it is this all consuming everyday. (personal communication, March 12, 2010)

### Kevin's Story: UK.

Kevin has just commenced the third year of residency and is now based in orthopedics. He is training to become an orthopaedic surgeon.

Before I started medicine I did a degree in physiotherapy. It was when I was doing my physiotherapy training that I decided that medicine was for me when I saw the surgery, the different types of surgery ... and then looked into it more and thought yeah, well actually I think that's probably what I want to do. I think basically I'm just a logical person. I like things to ... kind of be nice and neat and I like lists and I like to be able to work through them and get things ticked off. And so I think that's why I like the procedural element to surgery where you can just kind of do something, go onto the next step.

Speaking of belonging to the medical fraternity.

[It] used to be a really big deal before I started studying, then I almost felt a bit disempowered when I started medical school.... And then when I qualified it wasn't a big deal any longer ... I never kind of introduced myself as a doctor, I, you know it was always Kevin.

Recalling early residency.

I remember turning up on my first day as a first year resident after a holiday, so two weeks after people who'd already arrived and got settled. Not quite knowing how things worked I followed my colleague updating the list and the consultant coming on the ward and saying, "Why are you updating the list? Why aren't you seeing the patients?" And me saying, "Well I don't know how things work on the ward."

Especially on my first day having just come from ... orthopedics and not really knowing any of the ... nursing staff, not knowing where anything is. Just simple practical things. That you don't know where things are, it slows you down. And it can, you know, act as a stressor and you don't get your work done as efficiently and that can have a knock on and effect to how you treat patients. But, you know, over a period of time obviously I managed to settle in and got some good working relationships with the nurses and the physios and you can't get your work done without kind of without other people.... But then there are certain things when you're assessing a patient who's unwell that it's

really down to you and you can't turn around and say, "Do you think I should do this?"

On learning to get by.

I'm quite shy anyway and so when I meet new people and especially in a kind of medical/nursing area, and especially in a specialty that I'm not familiar with I sometimes find it quite difficult to say, "I'd like you to do this, this and this." And I might not delegate tasks. I might just take it on myself to do everything because I'm too introverted or shy to actually say, "Can you do this for me." ... Maybe that's because I don't quite know what the nurses' role might be or what they might be prepared to do. I don't want to offend them and so sometimes I think it'd just be easier if I do it, because I'm able to do it. I just get on with it. I think, again, being quite a shy person my take on that is that if I come out and ask somebody who I don't know to do something, they might see it as me trying to off load work onto them, pass the buck. And I don't want to come across like that. ... But again, the last thing you want to do when you're starting a new rotation. ... [Y]ou might be asking them to do things that their not comfortable with and they might not take to that too kindly and then it makes your job difficult.

On moving ahead.

At the level of training I'm at [now as a third year resident and trainee in orthopedics] we all seem to work together and people will just ask each other to do things because they need to be done. ... [Y]et I won't turn around and say, "No, no, no. We're not going to do that. We're going to do this. We're going to stick with this." Because perhaps I don't have the confidence just to completely override someone without hearing their point of view. And obviously as I've become more senior and a bit more confident.

I think at this stage, I kind of feel like I'm in a bit of a transition. So I don't see myself as a surgeon yet. I see myself as somebody who is on the way to becoming a surgeon. ... More so now than ever I enjoy it when, you know, there's a kind of list. ... I feel that I've got a good handle and I can relate to medics and surgeons in terms of what their priorities are. Obviously with my physiotherapy background there's some influence there.

When I'm at work I'm obviously a bit of a different person to how I am when I'm not at work because you need to uphold a certain kind of professional standard.... And there's a way of doing things so that you can get on in your career.... Working with other surgeons who fit a certain personality trait rubs off on you and I think that does change you as a person. So it's influence from those around you.

Reflecting upon his identity.

But I don't think my work defines who I am.... It was an achievement and I was pleased obviously but it wasn't something that I thought, you know, I've really arrived and yes, I'm a doctor and, you know, I never kind of introduced myself as a doctor, I, you know, it was always Kevin, you know, that was it. There's no airs and graces about it.... I mean most of my friends, I say unfortunately [because] most of my friends are medics but then when you do meet other people you realize that there's so many other things that different people do.... I don't feel precious about being a doctor. (personal communication, August 24, 2010)

Nat's Story: UK.

Nat has just entered the second year of residency and is currently posted in the orthopedics unit.

Thinking back, he recalls.

I think I always probably wanted to be a doctor but never really considered it before the summer before applying.... Well I grew up watching quite a bit of American sort of doctor programs, *ER* and that kind of thing. And I think they create like a very good positive role model sort of thing of a doctor in sort of a young professional exciting life, sort of respected generally and I think that's just their role in society I guess.

Speaking of medical school.

We all stayed together.... You sort of socialized with medics, obviously you worked with them ... your whole life just becomes consumed by medicine.... When you see other people in their lives and you just feel very different, almost alienated from their life of just sort of going to lectures, going out and that kind of thing and you're going to the hospital every day, working every night.

Starting as a new resident in the accident and emergency unit.

I didn't know anyone at all when I started ... you're just sort of thrown in there. It was quite stressful.... Totally in the deep end.... Accident and emergencies are especially busy.... We got showed around by [the] consultant, explained the role, given a piece of paper that our role is on. But it was very hard to put the paper and that into actually doing it. And the first month and a half I suppose, it was just a feeling you're not really getting on top of things. And everything was just sort of passing you by.... I've never, since I started work, when I was in medical school as well, I never been in a position where I thought I knew enough about anything. So I think everything, all the practical skills, all the knowledge, talking to patients, you had obviously done it at medical school but when you're the actual person responsible for doing it, it's very different. And everything is scary. It just feels different when you're introducing yourself as a doctor and doing it on your own and taking responsibility for what they tell you [and] what you tell other people.

So we have the accident and emergency version of a ward clerk, whose job it is to get people out on time basically and if they came up and sort of said, "What's the plan?" they wouldn't care so much. So then after that then a nurse would come up tell you the plan and then another nurse and then a more senior nurse will come back to you and it'd just [that] I found it very stressful. Suppose if you were a more laid back person you'd just sort of, you don't care as much but I found the constant, constant interruption.... I'm happy that they're coming to me and making me aware that something needs to be done. That's not the problem but there are maybe two occasions, one especially when I think a manager came into the department and started very publicly sort of taking me to the books ... it's just somebody nonclinical and it's just completely ridiculous. It was just because they basically said that I should be working more as a team and doing things to get the patient out quicker. So I had diagnosed the problem, sorted all the follow-up for them that kind of thing and they were waiting for, what I'd say were the nursing jobs to be done before they could go. And their manager came and told me that I should be helping the nurses when in reality I had done a lot of their stuff for them.

Why I got so angry was there'd been times when you ask the nurse to do something it doesn't happen, it's just quicker to do it yourself. So I'd give patient's medicines, I'd sort of take urine samples, ECGs, observations, all that kind of stuff because they're busy and sometimes it's quicker to do it themselves ... I think on the whole, my experience on management in the year and a bit I've been here they've just been interfering on some level.

Speaking of conflicting priorities.

I don't particularly care either way whether they [patients] are there for four hours or five hours, as long as they're treated and sent to the right place. I really despise the situations where I've been pressured into making decisions and they've gone to the wrong place.... I think, the patient is first and if they're there for ten minutes later I don't care at all. And I think that came across very much when I was there.... Well if I see somebody that I perceive as sick and they need things doing for them I sort of want them done.... Yeah and I want the patient to get the best treatment.

Of exhaustion and fear.

I work quite hard and there are periods, sort of days last year when I didn't stop at all, all day, you'd stay late, you'd go in early and you'd still get hassled.... And I think it was my impression that they [nurses] didn't really appreciate how hard you are working and that kind of thing, I mean, all I do in those situations is sort explain my situation, I mean sometimes they just don't understand that you're looking after a couple of really sick people. All you can do really is just point that out. But most of the time they'll say they don't care and they want it done anyway. And then if you sort of say, well, like last night I stayed until eight o'clock and all this kind of stuff. And they just don't care.

There were times last year when I just felt absolutely terrified. But then in front of other people you have to, you can't really appear to, like you can't have someone whose relative is sick and then the doctor's sort of looking a bit like a crumbling mess. So there are times when you have to sort of pull it together but generally not.... When I go to a new job I think for the first bit everyone says I just look terrified all the time; don't really say an awful lot, very quiet and then towards the end I'm pretty much a different person.... And you just get on with everyone ... and you have more fun as well.

The more you do the easier it gets to change. Still the first day in any job is still horrible and then when you get to the end of a job and you realize that you're going to become new again you have to learn a whole new sort of job, a whole new role, a whole new set of nurses, everything changes.

Looking for meaning outside.

Outside hospital, I still live with doctors, still socialize with doctors.... Apart from nurses and doctors I have no other friends. So I still ... live in their life they live in my life but when I'm meeting new people, I'm quite reluctant to use that as a sort of a label. I don't really want to be a doctor outside of work. I just want to be a, like a person. (personal communication, August 31, 2010)

Nina's Story: Canada.

Nina is nine months into the first year of residency and is currently rotating through psychiatry.

Speaking of medical school.

Definitely in the first year you're very elated that you got in and ... everybody's very proud of you and you feel you're part of this big picture.... And I think in third year when you get actually in the hospitals, when you're interacting with other doctors ... with other residents, when you actually see patients, when you have patients that die that are sick and don't get better, when you have really frustrating patients, when you work and you're very tired because you're on call all the time those initial ideas come a bit jaded. The thoughts of helping people or using your knowledge. It becomes very kind of in the background because you are just trying to get through the day and you work with some difficult physicians who ask a lot of questions and you just always feel inadequate. And so you start wondering why you've done this, right? And I think it was after you go through third year and you realize this is why it's really hard to get into medical school because it requires so much of your time and so much of your effort and it really pushes you. It pushes you to really rethink what you value. And I think when I came out of third year those values were just even stronger because they were pushed ... to so many limits that I really, really had to hold on to them.... [O]kay it was very, very difficult and I am proud of myself, I'm not going to deny that but at the same time it's very, very humbling. It's a very, very humbling experience.... Whenever you see suffering or sickness you become very, you're just almost in awe of it because of its complexity and how much it can affect people and their families, right.

Moving on to residency.

Currently I'm on psychiatry and I'm working on call in the emergency room.... I've done neurology, emergency, internal medicine, cardiology, pediatrics [and] that's it for this year.

On call you do feel very, very lonely. Very isolated.... You can always call your staff doctor, but you want to make sure you've kind of done everything.... When you're by yourself and having really sick patients and being really afraid that you don't know what you're doing and not having somebody right there to kind of bounce ideas off of. That's again where nursing working with nurses is really important because when nurses are really worried about

patients I get really worried because they know if patients are really sick or not.

You get a call overnight and then I go and assess the patient and because I'm new I don't want to miss anything so maybe I do a bit more than what an older physician would do and I've heard comments, the nurse was, "Oh, all we wanted was a Tylenol order, we didn't need all this lab work." Or, "The patient's sleeping and now we're just waking him up and trying to do all these investigations on him." Kind of just passive comments, not so much directed at me but because I have done this, this is the consequence of that, yeah. So a bit more passive aggressive sort of feelings that I've had.... I had to realize very quickly that the patient comes first. Absolutely. So not [*sic*] matter if my ego's hurt or if people think I'm stupid, there's nothing much I can do much about how other people perceive.... We do have a lot of responsibility I'm not going to deny that, that definitely come[s] with the territory. Yeah, that's real. And we take that very, very seriously.

I think they don't really understand how much training we go through to get to the point where we are and how much we've actually really given up or I can just speak for me personally how much I've neglected my family or neglected other parts of my life because of medicine.... So I think if people understood that.... I'm not saying you know, we need to be showered with respect or anything but have maybe more sympathy or more empathy ... when we get calls about changing diet orders at three o'clock in the morning ... they could understand why there would be more frustration with those sort of things because we're overworked and overtired.

Reflecting and looking ahead.

I don't think that I can just have the lifestyle that I ideally want, where I work maybe one day a week or something and not work the rest. I don't think that's adequate and that's my personal opinion. There is a responsibility to give back to the community the knowledge that you've acquired.... Other people may disagree and think that, you know, but it's up to you. It wasn't easy to get into medical school and it wasn't like there was nobody else applying if you know what I mean. There are thousands of applicants and somehow luckily I got one.

But I don't really identify myself as that, I still think of myself as Nina, that's how I still view myself ... there was a time where medicine wasn't a part of my life ... medicine has shaped who I am but at the same time if I lost it I would still be myself.

Looking back for meaning.

I would say the time, my family, my family life, my parents are very, very good people, my siblings who are my best friends, the time that I spent playing music, doing dance, just even, just thinking of the times spent with my friends, happy sort of moments, really sad moments, those things are things that shape you. Medicine has shaped me definitely, I'm not going to deny that. (personal communication, April 19, 2010)

### Sam's Story: Canada.

Sam is eight months into the first year of residency and is currently rotating through psychiatry.

#### Speaking of fraternity amongst residents.

I feel no sort of fraternal connection to other residents any more than I do, for example some of the hospital pharmacists or some others.... Even from the beginning I didn't like the idea that we were going to be some elite part of the society or that we were going to have special privileges that other people didn't have. I didn't like that idea and I didn't like being part of that idea ... I think when you compare to some classmates, if they came from a family of doctors and their mother and their father and their brother and their sister were all physicians then I think they had a bit of a different feel. I didn't come from a professional family and I didn't really want that feeling.

The day that I started medicine my wife started nursing school. And so we knew each other before and we've been able to complement each other, even not only through school even after school.

#### Speaking of learning from others.

You know I really do think that everybody you meet has something to teach and if that something to teach is just an example of what not to do that's still a lesson.... He [a physician] has the office set up such that he doesn't require any assistance. He does all of his own scheduling, when the patient is there he makes the bed, he enters all the data ... I don't understand that because I think everybody, whether it's a receptionist or whether it's a nurse that you see or whether it's an assistant doing a technical job or whether it's the person ... who you're interacting with for follow up, they each add to the patient experience in a way. And if you don't have all those people and you just have basically interaction with the doctor and nobody else I think they're probably losing a lot.... And so I think by doing it all yourself and not having any help like that is not really a, it's probably not a very efficient ... I think that's something ... I've picked up being around hospitals and clinics for a few years.

So I think starting the year with the opinion that it's a collaborative thing, I need to have the involvement and need to recognize that many of these nurses have been nursing longer than I've been alive. And they know a heck of a lot more than I do about how the system works.... I think as a student ... we're told that it exists, that you will be working as part of a team. But we don't get any formal exposure to working in a team. We don't get any training on how to work within a team, or at least I didn't. Like within a team that we're actually going to be working with.

Recalling a difficult encounter.

Usually the situations that are most likely to butt heads, it's usually on call situations because usually you're tired and it's late and you may or may not have eaten ... [an example] this patient was delirious and uncooperative and whatnot and I had seen the patient and I left at least four different prn [as needed] medication things that they could choose to help with behavioral management.... And then it hadn't been I'm sure 15 minutes and I got a call saying, from the nurse for the patient, wanting an order for physical restraints. And I said, "Well, I've seen the patient and I've basically made, I think it was four different prn medication orders and I think I've given you some options to choose from and what we can do is try some of those and see how things go and if things don't seem to be manageable with these combinations, if and then we'll think about physical restraints. But having been taught that there's no place on hospital for physical restraints then I'd like not to do that." And the nurse wasn't happy at all. They wanted an order for physical restraints and I said, "Well, you're not getting it from me try those other things and we'll see what happens." And so then about, I think it was about 20 minutes, it wasn't very long and I got another page, this time from the charge nurse in emergency wanting to know why they haven't gotten an order for physical restraints. And so I had worked with this woman before, good interactions, and I said, "Look, this is basically the way that I've been trained to do it is to give these options and see how things go and if and only, if and when, those things don't work then we can talk about restraints." And she wasn't happy either. And I said, "Has the patient received anything?" No, they haven't tried any of the four medications and I said, "I'd really like to just try something and we can readdress and see how it goes." And then she wasn't very happy and I explained, "I'm a resident, this is

my way of doing things and if that's not good enough then feel free to call a staff directly and ask them what they want to do." I don't know if that was a good idea or not. Because they did.

The point of my story being that I guess this is an example of I'm quite calm and I think I'm quite logical and I think I did all the right things and in retrospect I guess didn't speak face-to-face with the person, with the nurse of that patient but at the same time with one other patient seizing and the other one having a myocardial infarction I thought giving them four options [was] alright.

Anyway the staff ended up basically ordering physical restraints over the phone. Over the telephone, just like that.... Ultimately if they want something it doesn't matter what you say or how you negotiate with them if they're not going to listen right?

When I think about ... if I picture being in their shoes and having to deal with an agitated patient and maybe having a few years of experience of agitated patients maybe assaulting staff or there being some physical altercation because the fact that they weren't in restraints maybe I'd be a bit more likely to go directly to physical force. (personal communication, March 4, 2010)

Temara's Story: UK.

Temara was an academic professor at a prestigious university before joining medical school. She has completed one month of the first year of residency and is currently posted in the respiratory unit.

Speaking of her decision to study medicine.

[I] didn't just do it suddenly.... I wanted the more variety, more varied, something more varied and something more orientated to the world around us ... I was very intellectually interested in the academic disciplines involved in medicine for quite a long time, yeah.... It was a bit strange to go back as an undergraduate when you've been a lecturer that was the most difficult side of it. I don't think you appreciate how much you're treated as a child as a student. [laughs] I funded my way through med school by teaching part-time for the open university.

Of her experience of medical school.

I can't say that I particularly felt that I belonged to a general club of medicine, no. I've found it quite a conservative culture, socially conservative culture, whereas academia's a quite liberal culture.... I suppose not many people were interested in things like environmental issues which I remember us all being interested in that sort of thing, you know, not really that connected with the wide world around them. A lot of the charity and wider world things that a lot of the medical students were doing struck me as very focused towards their own CVs. [They were] not necessarily academically elitist ... but sort of socially quite elitist. And that's speaking as, you know, I'd been lecturing at X ... which has a reputation of being rather elitist and I felt this is certainly at least as elitist if not more so.

Troubled by IPL at medical school, she recalls.

So very few people knew much about their own professions, it was potentially harmful because ... there was a danger and some people did kind of identify the behavior of individuals which might not be very professional with the profession they were supposed to be representing.... So people came back saying, "All the nurses behaved in this ridiculous way." Which is complete nonsense, you know, they were just 18 year olds, three weeks, four weeks into their first degree at university,

they're having a week skiving off. I picked that at random, you know. So some slightly immature behavior by people who are a few weeks into their first degree, having a laugh away from home was then seen as representative of that profession.

Of working as a resident.

It's been busy a bit frenetic. I don't know exactly what I expected really but it's not been particularly surprising... The most difficult thing is managing the workload; prioritizing, getting the important things done and realizing what can be left for tomorrow and in particular managing [with] a lot of interruptions. Constantly having to reevaluate my workload in the light of something changing ... well, I mean I find it quite stressful ... you know, quite stressful. I feel like I'm very slow with everything I do at the moment. I think, you know, okay that's sort of to be expected but it's very difficult to have a good, clear picture of exactly what is expected at my level and, you know, am I falling short of it or beating it, it's a bit unclear. The person I'm working with most is an experienced SHO four years from graduating so there's quite a big difference between us so I don't have a very close match to compare myself with. So that's quite difficult on the medical side

The scariest thing is if I feel like I have to cope with somebody getting worse on my own ... I've done three nights on call... That was quite scary but it was good as well. It was a really nice F2 ... we just went around the hospital together.... One night the patient did deteriorate very rapidly and got really quite sick and ... the registrar came and did all these things and yeah, that would have been really scary if [he had not].

Speaking of her encounters with the matron.

I mean I'm not very delicate natured but she swears a lot and shouts a lot and, you know, and once or twice if I've had to ask her something ... I can get shouted at but to be honest I'm quite thick skinned it just rolls, I know it's, in that particular case it's [a] her more than me thing and how she is.

Looking ahead.

I'm much better at getting in depth into a narrower field ... so a more intellectual approach than I have at having a large, broad brush approach.... So I would definitely want to do something which is a sort of well-defined specialty ... I would be interested in having a research side or a teaching side.

Reflecting on her identity.

I'm definitely not defined by the profession. I haven't lived in residences, I ... carry on with the things I was interested in before. (personal communication, August 31, 2010)

## Appendix L Nurses Naïve Interpretations: Remaining Stories

Heidi's Story: UK.

Deciding to study nursing.

When I was at school I did some work experience in a care home and I really enjoyed that ... I really liked the medical side of things. So that's why I wanted to go into it really ... I like trying to make a difference ... just that you can help people.

Starting work as a new graduate.

It was quite nerve wracking starting because it was ... a new skill that you didn't even get training in it at nursing school for like dialysis and things like that. Yeah, I started on the dialysis unit ... and there was a lot of training and yeah, you're made to feel like you could ask questions and things like that which is quite nice.... I had a mentor ... she's called a practice facilitator. She basically takes you for the first, I can't remember how many weeks it was, you're a supernumerary.

Encountering problems.

... because the doctors are obviously looking at the patient from a medical point of view whereas the nurses see the patient every day and that sort of thing. So they might think a different thing for the patient.... Well you just have to put your view across and just hope that they take it into account when they make their decision. I don't know whether it's because sometimes we don't get across everything that we need to, to them. So they don't know the full picture.... Not enough time, bad communication, I guess ... we don't actually write in the medical notes either which is something that I've brought up because I think we should be. So that they can see what we've been doing. We can see what they've been doing ... I think that's how things get missed otherwise.

Working with residents.

I think that the F1s and F2s will take into account what we say more because they don't have as much knowledge ... the ones that we get are on rotation; they've never done

renal before. So obviously they look to us as well as the consultants to help them.

When things go well.

I think the doctors normally take charge in an acute situation. And the nurses will have some input but they all, the doctors will be the ones that make the sort of snap decisions, yeah.... In an acute situation I think the teams work really well together.

Building teams.

Well not long ago we did a renal away day. And that was a lot of team building, we were put in teams and did like assault courses and things like that, which helped a lot as well ... it was really good, it was and because we mixed everybody up so we had doctors in our groups and things like that as well ... it made a difference it was different to see people outside of their professional side of it.... It was slightly friendlier.... Yeah. And it just felt like better teamwork. (personal communication, August 19, 2010)

Laura's Story: Canada.

Laura graduated almost two years ago and has been working in an oncology unit since.

Speaking of nursing as a career.

I was working as a bank teller, working the whole day shift thing and I worked with a couple girls who were in the nursing program.... And I wanted a job that I would enjoy, that I would come out of after four years of schooling and actually have a job that paid well that didn't require further education to get somewhere. I know it's an ongoing learning thing, which I really like. So that's kind of why I got into it.... Yeah, I really enjoy it. I really like it. I became more aware of myself, of what I want, of what I'm capable of. It also kind of makes you become aware of also what's going on around you. You're more aware of how the healthcare system works, of how you can be with people, of how you're capable of interacting.

Of working with doctors.

Practice-wise we're, the interdisciplinary team we definitely interact with everybody on a daily basis when dealing with patients. But for bonding and socialization and stuff it's more like a nurse, nurse and nurse thing ... our clinical nurse leader is quite approachable.... You can just chat with her ... she can actually get stuff done. When bad things have happened on the unit she's got debriefings happening and other things.

I find it's easy for me to be more direct in questioning with the residents and the newer doctors.... [S]ometimes it's frustrating because it's obvious that they're having to report back to somebody else so things don't quite happen as quickly as you want them to happen. Especially for simpler things because they have to go to someone higher up or a lot of little things ... whereas with other [senior] doctors it's sometimes easier. You're, "My patient's nauseated, I need something." and they give you what you want like that rather than researching further and getting back to you in 20 minutes.... They're [residents] very thorough and they want to know all your assessments and everything like that. I guess ... I am comfortable phoning a ... resident in the middle of the night for things I need but I think long and hard before I phone for someone, one of the oncologists because it's the oncologist on call that's

covering those patients. Unless it's something that needs to happen right now I'll put it off. I'll be a little more inclined to phone for things from the residents. It's little less scary, they don't yell at you.

I'm not much of a challenger. I don't really want to be, "Why did you do that? I think you should be doing this." Because that's not what I do at all.... I think it's me. Because I know other nurses that are definitely more assertive ... I don't want to really rock the boat too much.

You recognize that something's not right with your patient, you have these wonky vitals are not looking right. And they phone the physician and the physician doesn't give you any direction. You see the patient, you know something's not right with them but you can't get really any direction from the doctor at all, they kind of brush it off.... You can describe your assessments to them until the cows come home but nothing's happening.... We are working for the patient to get things happening. We want them to not be nauseated; don't want them to be in pain. But we're the ones that [are] carrying it out, we're the one that's interacting with the doctor to get things happening.

I find when patients are really acute then there's a closer collaboration ... when patients are really acute then we're working very closely with them.... Things definitely happen a lot more, because they're giving us an order, we're carrying it out, and we're telling them what's happening we're back and forth, back and forth, back and forth, a lot closer with that sort of situation.

I find that the longer I've been [here] the more I'm becoming familiar with the resources and the less I'm leaving to go to other people to get things done. I can put in my own home nursing care referral; I can do that sort of thing. I can talk to people and make little bits happen more. Which is nice ... kind of building on a body of knowledge and making it stronger.

Of being acknowledged.

The way things flow ... so much of our job is not nursing. I have confidence, I can get things done, I can make things happen. It's acknowledged.... Well, I think especially because we work with elderly population, we work with the oncology patients it's nice when you can make someone comfortable, when you can see them get better. Even if

they don't get better you can help them be comfortable to the end if you can be there with the families it's nice. And to be acknowledged, that acknowledgement shows, you know. (personal communication, March 18, 2010)

Lina's Story: UK.

Lina graduated from nursing school one year ago and has been on the renal unit since. She rotates between the renal ward and the dialysis ward.

Well I left school at 16 and didn't follow formal education because of family reasons and things.... After five years working, just sort of doing basic secretarial work I then went to work for a GP practice where I became assistant to the practice manager.... There had been an occasion when I'd been talking on the telephone to a patient who was threatening to kill himself ... he'd lost his mother and his brother who was known to us.... He was quite hysterical and I managed to calm him down. But after this scenario ... one of our senior nurses approached me and said that she thought I'd be a good nurse. It was literally almost like a snap, something went like that in my head.

I've been qualified a year now ... I came right to renal. I did six months on the ward and six months here [hemodialysis].... On the ward pretty much the team works very well. You basically come in, you have your handover, then you have your bay and you work pretty much alone with your healthcare assistant.... And you organize your own day, you know, you have to prioritize, manage your own time and things without very much ... interference ... I find that on the ward there's always somebody there who's willing to help to give a hand.... I then slightly reluctantly came down ... to hemodialysis because it was taking me away from my comfort zone I think.... It's a completely different kettle of fish down here. I feel there's a little bit more of *us and them* [emphasis added] scenario and you have some very, very experienced people ... a completely different culture, in a different country with different ways.... You try to turn to these more informed people, much more experienced and you feel they haven't got time for you. That they're busy doing what they're doing and well you've had your months training, you should know.... It's been a bit of a baptism of fire.... The minute you walk in the door they're telling you what to do, they'll take you away from what you're doing to do things for them and they're in charge, yeah. Which I have no problem with people. I'm quite a subservient in some ways. It's one of the things I have to learn that I need to be my own person. I need to find my niche. I need to be able to say, "Hang on I'm doing my work." So yeah the mentoring

side of it has gone slightly awry down here ... I think they've ended up having the more acute patients with some less qualified staff.... And we're having to step up to the plate a lot more quickly. Which can be quite stressful.... [W]ith one particular member of staff, the lady who's been here like 20 years ... the very experienced lady, delegates extremely well to the detriment of other people, you know, and their workload. And is very bossy and quite demanding.... She has driven me to tears but that has been pure and simply because some people have said and other new people down here have acknowledged that the only way to be with her is to actually be rude back.... But in the early couple of months I'd get so wound up because I kept stopping what I was doing to go and do things for her that I was getting angry inside, going off and having a good tear because I was so frustrated at my ... inability to deal with her.... But I am over that now but then I just feel sometimes that I'm being rude to her and I don't like that.

And I think it's just that I, you know, sometimes you can try and be all things to everyone, I've had to find that, I'm having to learn that I can't be, I have to be treated myself as much as my patients, you know, I don't only have to look after them I have to look after me otherwise I'm not going to be able to do the job properly.

I just find that I'm constantly looking out and observing how people are. You know, even the patients I'm not looking after, if I see somebody that's snuggled up in their blanket because they're cold I'll go and get them another one.... I mean ... that is me and I think that's why this business with this other lady doesn't sit well with me. It's spoiling my experience. I'm completely not alone, I mean I don't know if that's become evident that and I think people say it's cultural, blah de blah, that kind of thing. I don't care what it is I just, it's not fitting with me.

My biggest problem was actually learning to be assertive ... working as an advocate between the patient, a poorly patient and the doctor. Especially if the patient's requirements were, a patient was in pain and that pain wasn't being resolved. I found it quite difficult initially to keep bothering a doctor ... I had one particular patient who had had a renal biopsy. It was his second one ... it was intense pain.... And we had a wonderful, wonderful SHO who was approachable, a great guy. But that day the ward was really busy and I kept having to go out to him saying,

“He’s in pain.” And we started him on ... the pain relief ladder ... and I had to keep going out to the doctor saying, “His pain is worse.” ... but come the end even this really approachable doctor was sort of closing his eyes and taking a breath every time I went out to him because he was so busy himself. And I found that I was hesitant to keep bothering him again. When I came in the next morning ... he died during the night. It was horrible; I mean I found it extremely distressing because I knew he died in pain.... I just wish I’d stood at one time and said, “Right, hang on, look at me.”.... Could I have been more assertive with how I felt at an earlier point?

And it is something that I've learned through this last 12 months I am sort of starting to learn how to communicate more effectively. I'm less frightened of communicating. I think I was afraid of communicating with doctors when I first came in because I saw them as being up there.... Because I think the environment, when I first worked for GP surgery, the very first one where I worked, we called the doctors “Doctor”. You didn’t, it was an older established practice ... you didn’t question, you never questioned anybody in a healthcare profession.

I was afraid to approach them because they were at the top of the hierarchy, now I don’t look at it as being a hierarchy as such that we’re all the same, we’re all there for the same means and the same ends. And that this fear of approaching them and feeling stupid in front of them shouldn’t exist.

This definitely befits me and I know.... [I]f I’d been a nurse ten years ago, 15 years ago, I may well have followed a career pattern but it’s not what I'm after now.... Definitely it fulfills me completely.... It’s not mundane, you never stop learning.... I can do the mentorship course; I can do the renal course, eventually my learning, it’s never going to stop and I recognize that. (personal communication, August 19, 2010)

### Mary's Story: Canada.

Mary graduated almost two years ago. She is currently working in a Neurology unit. A few years before Mary joined nursing school she was diagnosed with breast cancer.

She recalls.

The oncology nurses were amazing. And I don't know if it's just Oncology, that's how come I went into nursing was from the nurses that I had received care from [from cancer] ... I had the most amazing oncologists. I had Dr. Z ... he was amazing ... and they worked really well together. The nurse would come in, do the initial assessment, meet with the physician then they would both come back in and ... they worked really well together.

I did the honors program in sociology and then ... did Masters of Psychiatry and then I started a PhD program in sociology. And then I got sick I had a better idea of what I wanted ... I thought of medicine but it's just a slightly different form of caring. I needed to be more closely working with patients.

Of being a new graduate.

The floor that I started out on I didn't feel very supported at all, it was lack of staff on the floor. You got put into situations sooner than you should have.... I was very anxious. I felt very overwhelmed. Because there were a lot of situations I wasn't sure how to handle and there weren't a lot of senior nurses on the floor because they were so short staffed. So it made it really hard trying to learn new skills and transition from being preceptored and having someone there all the time that you could talk to, to pretty much having [no one]. I think it was my fourth day of being on the floor, I had my own assignment with nine patients and I was, "Oh my God!" You know you come from nursing school where ... four is your maximum number and then you graduate and all of a sudden you've got nine patients and no supports there.... When I came here it was quite different. Yeah. Because here, I took a new grad position because I hadn't been nursing very long and it was completely different. It was really good. I felt, I didn't feel uncomfortable in any situation there was always someone there so ask. They even developed a new position on our floor just for new grads for someone to supervise and work through things with us, which was really good.

Sometimes I hesitate to ask questions because I'm not sure if they're the person to ask ... I don't want to insult them or just the personal feeling that [it] might be a stupid question to ask.... For a long time I didn't know what a speech pathologist did and we worked with them all the time but still I had no idea what they were learning or what their scope of practice was or anything like that.... It would be a good idea to have classes that are intermixed. You know with the different faculties. So that you can actually have more experience learning together. Which would be good, because those, you know, three sessions or whatever a year doesn't really do justice of how you're going to work together and what each person does. What their role is, what their scope of practice is, how it's going to overlap with yours.

I guess I have the picture sometimes how you see on TV the superior staff person. I just find it very intimidating because ... the neurologist there's male and female ones and I have no problem calling the female neurologists and then there's some of the older males and it's like we argue, "Okay, who's going to call him? I don't want to call him, you call him.".... Because usually the people that I'm thinking of you all know, okay don't call because you're going to get yelled at or, "Why are you calling me? Don't call me about that!" Just things, "I'm aware of that already!".... Other nurses that have been there longer would just argue with them. But, for me, being a new nurse, I think it's a little ... more scary to challenge. I think more of the younger surgeons ... are more interactive than some of the older ones. It's more like a hierarchical sort of system for some of the ones that are close to retirement.... [T]he residents are more involved. Yeah. I talk to them all the time.

Lots of times when we have patients that are on our floor they are very confused. Sometimes we need to have them restrained but you know you call and they say, "No, just try this first or that first." but they're not there with the person flailing around and you're trying to get security up there and things.... Most of ours is they've had cranies [craniotomies], you don't want them to fall. Lots of times they're crawling over the bed rails.

Speaking of her ideal role.

I think providing the best possible care for the patient.  
Yeah, in terms of not just the physical changing of

dressings or things like that but providing a more holistic type of care that takes a psychological, social and all that into consideration.... So being a patient within the system too has influenced my role as a nurse and the things that I value. I think you need someone there that's supportive, caring. That advocates for you. You know if you have concerns, someone's there that takes it and makes sure that all your issues are looked after. (personal communication, March 11, 2010)

### Sabina's Story: Canada.

Sabina graduated almost two years ago and initially worked in a clinical teaching unit. Currently she is based in a respiratory unit.

#### Speaking of the influence of nursing school.

I was very timid and I never, ever, ever stood up for myself. I never said anything to anybody, whether it be a family member or a sibling fighting who wanted something I would just give it to them. I never delegated. I was never in control. I was never decisive. And then after I was done [nursing] school I was totally different ... more confident of my decisions, of my knowledge, of me as a person. Of what I want I guess.

#### Speaking of being a new graduate.

Being a new grad you don't approach anybody, you don't talk to anybody because you hear the stories from other nurses, other staff members and you don't approach anybody.... I think one of the worst things was being a new grad and being told on a night shift, "Do not call unless there is an emergency, like a heart failure or a heart attack or someone coding otherwise you don't call." And it was the fear that the doctor would yell at you or they would hang up on you and you would be wasting their time.... Well, I remember when I was a new grad and I did call a physician because somebody had, they had hemoptysis [coughing blood], but I was I think a month into my [job] and I didn't want to say, "Yes, it's hemoptysis." or maybe it was vomit, blood in the [sic], I didn't know so I just called to say, "There is blood coming up, I'm not quite sure what it is." and I did get yelled at for not knowing exactly what it was and then I said, "Well, should I call somebody else to come assess?" And the physician said, "No." and that he would also not be coming up.... And then when he came up it was hemoptysis and I was yelled at in front of the entire staff and all the patients and family and told I was incompetent and that I wasted his time and he said many things and left and then came back and then charted about me.... But I did talk to my manager after.... She said that she liked him and that she didn't want to do anything about it but that she would speak to him and he said, "It was another nurse that I didn't like when I came onto the unit and I took it out on her but she's trainable." So its fine, he said it was fine and that was it.... I think the right thing to

maybe do was to at least put both of us in a room so that I would be able to verbalize that even if he was angry at the moment maybe he should have pulled me aside and said something to me in private. Even if it was the same words, but just in private.

In the morning report we have a daily discussion.... The discussion is, "This patient need[s] this, this and this but how are we going to get it? Who's going to talk to this person [physician]? How are we going to approach this person? Should we just leave a note? Should you go and talk to them? How do we butter it up to be approachable?" So we are always trying to find ways around.... [B]ecause you cannot tell that physician. If you say, "The patient wants this, this and this and this is what they told me." Well now you're telling the physician what to do. And he's not having that. That's not going to happen. It's not going to get dealt with ever.... The likely response is, "Who do you think you are?" And "I'm not doing that, that's the stupidest thing I ever heard of and they need to deal with it on their own." Or "They can go to their family physician and deal with it after they're gone, I'm not dealing with it." And it's like, okay.... I've never had that with the residents, no.... If it's doable with the resident or a resident also doesn't want to deal with it or they don't like being told what to do the response is definitely different.... The response is more, "That might be something that could be looked into and I'll see what I can do"

[Working on a the clinical teaching unit], I learned so much. I learned because I found that residents were asking nurses a lot of questions about patient care.... And so that made me learn as well because then if I didn't know I would research it and we would together or if something was ordered, sometimes it was ordered three or four times in a day and to know that shouldn't be or to be very careful about these things. It was good in that sense.... No, everyone was very, "Can you help me with this?" "Can we go and do an assessment of that?"... I feel that when you are comfortable with somebody, they are approachable, you can communicate. Communication is the biggest thing.

I think that sometimes we're quick to say doctors aren't part of the team but a lot of the times we don't look at well, what are we doing to make them kind of feel okay ... I feel we're clumped up and "Oh, we're the nurses, we're having fun, we're doing our 12 hour shift and ... this is us and then

there's you." So when we're doing that we're not including anybody else. And because we think that they don't want to be included.

At night shifts if we have to call a resident, I remember there's been a few that come up and if we'll have a jar of candy they'll just sit down and start eating with us and be, "How's it going?" It's very nice ... and everybody knows about this particular resident is so nice and so caring and so good with the patients and good with the staff, easy, approachable and word flies throughout and [it's] not a very big hospital.

I'm used to the culture now but ... we've had a couple nurses who are very much wanting and needing ... collaboration and are so stressed out by it that they sometimes can't come to work because instead of them approaching a physician, they'll start yelling and they'll start screaming and then it turns into this personal stress thing ... because they're very anal about patient care ... when they feel it's slipping through the cracks of the health care system.

Of her ideal role.

Not fighting so much I guess. I know that nurses are ... having to work so much harder to get things for your patient. When that doesn't happen, putting it on yourself. I feel like that it shouldn't be something that I should have to take home with me. My ideal role should be this is what I feel, this what it is, what do you think? Oh, you don't think so, why not? The *why not* [emphasis added] is what's never really answered.

The way that I deal with it unfortunately is that I just chart everything. So that way if something does happen it doesn't fall back on me.... It is because I don't want to be stuck in a lawsuit where it's like why was this not done? And then it will be like yeah, no I did my part and it is defensive.  
(personal communication, March 17, 2010)

Sarah's Story: UK.

Sarah graduated from nursing school two years ago and has been on the renal unit since. She rotates between the renal ward and the dialysis ward.

Before nursing school.

I did a gap year after I did school to go and do bank nursing ... just to make sure I definitely wanted to do nursing and it wasn't a big mistake that I was making. And did that for about a year, actually loved it. And then went off and did my training.

On working as a nurse.

It's very interesting. I think in all honesty I think working on the renal ward is like working on no other ward. Because we have quite a big team of doctors and a huge team of nurses and obviously we've got, down here we've got the dialysis nurses and then all the upper level branches that we have within renal and we are sort of like a little family unit because everyone knows everyone and the nurses up on ward rotate around dialysis and then back up.... It's quite a nice working relationship. Because on most wards it's kind of you work with a set amount of people, you don't really go out of that area, and you don't really meet anyone else. So it's quite, we're such a big unit and we're kind of encouraged really to get on with the doctors and they're kind of thrown into the deep end and they're already expected to know stuff about dialysis ... and things so they do turn up and they're a bit kind of like, "I don't know what I'm doing." So we kind of are quite nice to them in that way because we understand that you know they've turned up and ... they need a bit of support.

I know that the doctors are obviously more senior than us. But their knowledge is a lot greater than ours in some respect but most of the time I feel like we're kind of on a level. [In the ward] sometimes we have such a high level of acute patients; sometimes it can be almost too much. So if we've got eight or nine patients per nurse and you know that can cause a lot of pressure to be put on that one nurse ... then if the doctor keeps asking them, "Oh, I need you to do this, I need you to do this." And they're asking you questions and then you get pulled away by occupational therapists, physiotherapists, relatives, other patients calling out for things and any other problems. Like phone calls

about so-and-so's going for a scan or this kind of thing it means that the nurse get puts under a lot of pressure in that respect.

If we can't go on a ward round you know with the doctors they often don't tell us what they've said ... the doctor will always write everything down in the notes. They'll tell the patient what's going on and occasionally they will come back and tell us or, "Just to let you know, I've seen Mrs. X and that so-and-so and this is what we'd like to do."

Otherwise you have to go back to the notes and it's a bit annoying because you know you often don't have time to go back to the notes ... so that does tend to be one of the problems is the communication barrier sometimes that we can't get there and they are really busy and don't tell us what's going on with the patient so later on like a drug might be missed.

In the first year you have to build your knowledge so much in renal unit because you have to learn hemodialysis and peritoneal dialysis and you have to learn so much about the drugs and what you can and can't do and things like that I think you do get a huge amount of knowledge in your first year and I think after that's up you know you realize that actually there's still loads more to learn but your knowledge behind you already is so much that you feel that you can advise and support people.

#### Reflections.

I don't want to be matron though. I've never, I always used to think oh I don't know, I just think that's so much more paperwork and meetings and I've always, I've seen it in other, another hospital I used to work at when I was doing my bank nursing that the higher up you were the less patient contact you had and that really made me quite unhappy and I thought I really, I would be sad if I couldn't go and talk to my patients every day. When I became a registered nurse I actually started to miss that because as an auxiliary nurse, the untrained nurse, every day you know I'd go in and I washed the patients and I talked to them and I'd find out a lot about them and when I became registered ... I have found already that I have less patient contact.

And you know you do realize quite early on that okay, there's a lot of challenges you have to kind of you come up against and you have to try and sort them out but when you first qualify, the first six months is the scariest six months

of your life. Because you suddenly realize, okay, I've not got someone working with me anymore I have to have this knowledge, I have to know what I'm talking about and if someone comes to me and asks me a question I can't go, "Hang on a sec, I'm just going to ask my mentor".... [F]or the most part you are now responsible for your actions ... it's a very scary six months

On becoming assertive.

When you qualify at some point after you qualify it hits you, you think "Oh my God, I could actually, if I did something wrong here I could kill someone." I think when you first start you're very quiet, you're very timid and you don't really want to approach the doctors too much because you might think that you know that you're getting in their nerves and you're kind of bugging them for insignificant things. And I think as time progresses you get confident in your job role and you get confident with your knowledge and your knowledge of your patients and you feel more able to go up to the doctors and say, "Actually I need you to do this." Or, "Actually I think you need to come to see this person".... It's almost like enough confidence to be able to speak your mind, to deal with and to stand firm, yeah. So I think that gets more and more the more you know far down you are the line.

On what it means to be a nurse.

When I met my partner, you know one of the first questions he asked was, "And what do you do?" and I said, "Oh, I'm a nurse." And his eyes lit up. And people go, "Wow! You're a nurse! That's amazing! That's such a hard job to do and you must be like a really kind, caring person and wow, you must be so dedicated." It's like I don't think of myself like that. It's a job. You go and you do it and you're nice to your patients and you know you look after them and that's, I don't know, I sort of see it as a job. But obviously when you have, it's not like a regular job; it's a lot more. You have to put a lot more of yourself in. And it is definitely a vocation thing. (personal communication, August 20, 2010)