Student Physiotherapists’ Narratives and the Construction of Professional Identities

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Abstract

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Drawing upon the biographical narratives of eight student physiotherapists and situated within an interpretive paradigm this thesis has explored the construction of professional identities within physiotherapy education. It has been predicated upon notions of identity as constructed through social interactions, therefore a relational concept requiring interaction, enactment and reciprocity. It took place within a contemporary professional context epitomised by increasing interprofessionalism challenging notions of what being a physiotherapist means.

The main findings of this study suggest that student physiotherapists enter physiotherapy education (or very soon after, develop) with a well formed idea of what being a physiotherapist means, constructing an idealised professional self. This idealised professional self becomes the lens through which they subsequently experience and evaluate their professional education experiences.

The process of constructing professional identities involves student physiotherapists in a continuous cycle of performance, mediation and impression management, through which they seek opportunities to confirm their idealised professional self. The findings of this thesis suggest that student physiotherapists exercise individual agency to construct socially and spatially situated professional identities in everyday professional interaction and supports contemporary notions of professional socialisation as interactive.

This thesis contributes to the contemporary understanding of the process of identity construction. Theoretically, it emphasises the concept of role models and highlights the importance of anti-role models or disidentification. Practically, it offers physiotherapy educators the opportunity to reconsider the complexities of professional identity and its place within the learning context. Finally, for the students who took part in this study telling their stories has rendered their experiences with meaning and their stories have the capacity to become important cultural tools for future students.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
Chapter 1: Introduction and context

Professional identity is important; it provides professional life with purpose, meaning and unity, bringing these things together in the person (Jenkins, 2004). Exploring professional identity with student physiotherapists has the potential to enable them to seek a greater personal understanding about their emerging professional selves and provide important cultural tools for future generations of students.

Introducing the thesis

This chapter will introduce the focus of this thesis, the research study itself and the contextual frame(s) within which it was undertaken. It will establish the focus of study by describing how my personal research interest in professional identity came about and through this establish the concerns which precipitated this particular study. Through a critique of contemporary health care practice and UK physiotherapy education, it will contextualise the study and allow the reader to situate it within a broader professional context. The chapter will describe the structure of this thesis and outline what will follow. The final section will provide a brief synopsis of my own professional journey into and through physiotherapy and how my story has, consciously and unconsciously, influenced this research project from its inception through to its presentation in this thesis.

Structure of the thesis

This section will outline the overall structure of the thesis for ease of reading. This thesis is divided into five chapters. As this is a narrative based study, chapter two is concerned with an in-depth discussion of a number of key theoretical perspectives associated with narrative. I will draw upon Bruner’s (1986, 1990, 1991) conceptualisation of narrative knowing as a legitimate way of constructing knowledge as well as using Ricoeur’s (1984) concept of time and narrative. This chapter will explore narrative as a methodology as a precursor to chapter three which will describe in detail the narrative methods of data
collection, analysis and presentational considerations. As well as providing a
critique of the methodological claims of narrative research it will also explore
professional identity from a social constructivist perspective alongside Foucault’s
(1977, 1989) notions of power, recognising identity as multiple, evolving, never
fixed and something always in the making. Lastly it will provide an overview and
critique of the professional identity literature generally and more specifically as it
relates to physiotherapy. Chapter three describes my methods of data collection,
analysis and presentation. The study’s ethical considerations will be discussed
and finally I will address the issues of authenticity and legitimacy in relation to
narrative research and this study in particular. The fourth chapter will present my
key findings. This chapter will commence with the presentation of participant
vignettes. The key findings will be presented through three narratives, each
illustrated through the stories of my participants and as far as possible told
through participants own words. In this way I hope to have privileged the voices
of my participants, by presenting collective narratives through individual stories.
The three narratives presented in chapter four are shared across and between
individual participants; in this way I have presented individual stories and used
them as a vehicle through which I have also attempted to present collective
accounts. The final chapter is concerned with a reflexive discussion and
conclusion of key findings. Rather than separate out the literature into a distinct
chapter, I have embedded the literature into relevant chapters in an attempt to
make this thesis flow and avoid repetition.

**Establishing the focus**

The field of study of this thesis can be described in broad terms as professional
identity. More specifically it is concerned with understanding more fully the ways
in which and how student physiotherapists construct a particular professional
identity within a learning and practice context that places increasing emphasis on
interprofessionalism and collaborative working (DH 2000; 2001; 2002; 2009; Barr

1 I use the nomenclature authenticity and legitimacy as alternatives to validity and reliability in light of the
thesis’ interpretive perspective
2 Collective narrative refers to the way in which these narratives were shared across individual accounts
As later chapters will outline I have focused upon the social aspects of professional identity through the exploration of how students’ interactions within sites of construction influence the ways in which they construct their identity as physiotherapists. Emphasising the social aspects of identity and thus the comparative aspects of identity construction, my findings will emphasise the importance of difference to my participants in the construction of professional identity. The importance of difference is presented in chapter four and discussed in chapter 5 as an important issue.

This study was primarily concerned with understanding how the macro-policies of interprofessionalism in health care practice and education impacts upon the micro-experiences of individuals who are learning to be a particular type of professional. It is an exploration of the construction of a uniprofessional identity in physiotherapy in an increasingly interprofessional world. The increasing drive for interprofessionalism has, I would argue, complicated the process of uniprofessional socialisation of professional students. For professional students, developing an understanding of their future professional role and understanding how their chosen profession is positioned within the broader health care team is important to identity construction.

For student physiotherapists, the whole process of constructing a professional identity is complex. In order to be recognised by the profession itself and the public as a physiotherapist, students need to be able to demonstrate competency in physiotherapy-specific knowledge and skills and so be deemed to be fit for practice, legitimising their subsequent professional label. It can be argued that this profession-specific learning usually takes place in a uniprofessional learning environment, alongside this, the need for physiotherapists to be capable of collaborative working occurs through interprofessional learning, creating an inherent tension between the two (Vanderstraeten 2000, Wackerhausen 2008). This tension is probably most acutely felt during the pre-registration stage where there is a requirement to acquire professional knowledge, demonstrate

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3 Social perspectives of professional identity consider the relationship between the individual, the profession and society and through this offer explanations of ways in which social forces impact upon identity.

4 Professional student in this context is used to define students who are studying a pre-qualifying health care programme.
profession-specific skills as well as display profession-specific behaviours. In practice, blurred professional boundaries, contestable roles and shifts in professional positioning make for a complex process of constructing a uniprofessional identity. Where students experience the wide variations in practice and a wide variety of physiotherapists each with different (sometimes conflicting) professional identities it is hard for students to easily navigate their way through the differences (Fitzpaterick, White and Roberts, 1996; Howkins and Ewen, 1999; Apker and Eggle, 2004; Ferraro Coates and Crist, 2004; Adams, Hean, Sturgis and Mcleod-Clarke, 2006; Kell and Owen, 2006; Baxter and Brumfit 2008).

There is an assumption in physiotherapy education that on completion of their undergraduate programme students will have a fully formed professional identity, formed through an unproblematic and uncomplicated process of professional socialisation. I argue that this is not the case; instead I am proposing that constructing a professional identity is hard and exerts a considerable amount of pressure on students who have to learn to deal with differences, a process made more complex because it is taken for granted and therefore largely unacknowledged by physiotherapy educators. Contemporary health care is a complex business; this complexity has put increasing demands upon students during their undergraduate education. Advances in technological and knowledge advances, advances in diagnostic and treatment interventions, alongside service development and delivery changes creates a very complex context for professional learners. Physiotherapy educators are charged with reflecting these advances within the curriculum which is increasingly squeezed, leaving little room for a more overt consideration of the process of professional socialisation. This has, in my view, led to a situation whereby educators are forced into a position where professional socialisation goes largely unacknowledged and therefore unproblematised. This thesis raises a number of questions for physiotherapy educators and challenges them to think about and consider alternative models of delivery.

5 The Chartered Society of Physiotherapy (CSP) Curriculum Framework outcomes sites the development of a professional identity as an intended curriculum outcome (CSP 2005)
Constructing the thesis

As the previous section has outlined the focus of this thesis, this next section will outline how I have attempted to construct this thesis in line with other narrative studies. Narrative studies allow for the study of human lives conceived out of the desire to honour lived experiences as an important source of knowledge and understanding (Clandinin and Connelly, 2000). I consider this thesis to be a collaborative piece of work, jointly constructed by myself and my participants. I do not claim that the stories of chapter four accurately reflect reality rather that they privilege lived experiences as a legitimate way of accessing the subjective reality of these participants. It was primarily concerned with exploring the lived experiences of eight student physiotherapists. I set out to explore the phenomenon of learning to be a physiotherapist in one university from the perspective of eight individuals and used their stories and experiences as a way of exploring how they construct their professional identities. In this way, this thesis offers an interpretation of a collective experience from the perspective of individuals. This study has attempted to privilege the voice of students as a way of entering their lived world and as a way of better understanding it from the viewpoint of those whose lives it describes.

In summary, this thesis argues that the process of identity construction, far from being something that occurs almost by chance, occupies a central place in the learning experiences of student physiotherapists and as such deserves renewed attention from physiotherapy educators.

Research questions and aims

Concerned with understanding more about the process through which student physiotherapists construct their professional identity and taking a narrative approach thus placing the lived experiences of students as the central focus my research question was:

How do student physiotherapists’ construct their professional identities?

The aims of the study are;
To understand more fully the process of constructing a professional identity in a professional context which promotes interprofessionalism

To explore the interaction between students and significant others and understand how these interactions impact upon students' professional identity

To explore sites of identity construction described as significant and important by students

To elicit students' narratives as a way of understanding their lived experiences

Setting the scene

All research is situated within a particular context. The context(s) in which research takes place shape all aspects of research from the original research idea, research focus, and methodological choices to presentation of findings. This next section will set the scene for this thesis by providing an overview of physiotherapy professional education, physiotherapy practice and contemporary health care. In order to frame the reading of this thesis, in this section I will propose a number of arguments which suggest ways in which political and professional contexts have the potential to impact upon how identity is constructed.

I will look at this complex changing context through a series of lenses: first looking through a historical lens at physiotherapy itself, then through the discourse of interprofessional education, and the major shifts in contemporary health care practice. Finally I will focus on the contemporary perspective of shifts in accountability, the discourse of empowering patients, and on workforce modernisation.

Physiotherapy

This section will introduce the reader to the world of physiotherapy from an education and practice perspective. In this way I intend to explain how I view the contemporary professional context and how I see this as impacting upon the
lived experiences of students in their everyday learning experiences. It offers an historical perspective to set current practice in context of the past 100 years and includes a brief review of the issues associated with contemporary health care professionalism.

The Chartered Society of Physiotherapy (CSP) (2002, p5) defines physiotherapy as,

‘A health care profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. It is science based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgement and informed interpretation is at its core’

The physiotherapy profession has a long history which can be traced back to the early 1900s. In 1920 it was granted a Royal Charter to improve the status and perception of physiotherapy to the public and was finally granted autonomy in 1977. Under The Health Professions Order (2001) the title ‘Physiotherapy’ was given legal protection. This legal protection of title means that it can only be used by those who have successfully completed an approved course and who have registered with the UK statutory regulator the Health Professions Council (HPC) in recognition of the need to protect the public. As with other health care professions, physiotherapy is highly controlled, in respect of the eligibility of new registrants and the continuation of existing registrants to remain on the register and to retain the professional title of Physiotherapist.

Throughout its history, physiotherapy has been dominated by its alignment with medicine (Dixon 2005) and this alignment to the medical professions has provided a level of status the profession has used to its advantage (Higgs and Titchen 1995a, Robertson, 1995; Higgs, Hunt, Higgs and Neubauer 1999). Prior to 1994 when physiotherapy became an all-degree profession and the autonomy of practice this inferred, medical referral was a requirement to access prescribed physiotherapy treatment. The pursuit of a scientific basis to underpin
physiotherapy knowledge and move to all graduate status in 1994 all reflect a desire to emulate the medical model and the professional entitlement that brought. One could argue that the founders of physiotherapy used the association with one of the oldest professions to further its own journey in the development of physiotherapy as a bona fide health care profession. (Kell and Owen 2006).

The 2002 CSP definition of physiotherapy reflects its origins and connection with medicine, its technical-rational basis alongside a new emphasis on a patient-centred approach to health care delivery (CSP 2002, Richardson 1997, 1999a, 1999b, 2004, Cross 1997, Clouder, 2000, 2004; Turner 2001). The emphasis on a more patient-centred approach reflects the professional and political discourses of patient empowerment which signal a shifting the power relationship between health professionals and their patients-nomenclature such as client, service-user are increasingly used to counter the discourse of passive patients (Barr, 1998; Allen, 2000; Bligh 2005; Cooper, Spencer, Dawes and McLean 2005; Baxter and Brumfitt 2008). Kell and Owen (2006), suggest that there is a growing disquiet amongst members of the physiotherapy profession. They suggest that differences of opinion exists between members of the profession reflecting an epistemological difference between positivist and interpretive stances. For example, this may be displayed through differing approaches to clinical practice. Individual physiotherapists aligned more closely to positivist stances may limit their therapeutic interventions to empirically evidence based techniques, focusing on outcomes and dismissing intuitive practitioner-based techniques where the empirical evidence base is absent or less compelling. Individuals who align themselves and value practitioner based evidence as valid may be more inclined to take a more exploratory and intuitive approach to their practice as well as being more comfortable with the uncertainty of clinical practice and patient responsiveness.

As Wigmore and Welsh (2007) suggest, the growth in professional networks as a way of developing new knowledge belies a privileging of the artistic, intuitive aspect of professional knowledge and practice and the increased emphasis on the intuitive, tacit nature of professional knowledge (Schon 1983; Eraut 1994, 1995 2000; Lave and Wenger 1991; Wenger 1998). Reflective practice, put simply, is the term used to infer learning from practice and is now an integral
component of professional education. Reflection supports the use of practitioner based intuitive knowledge as a basis for practice development and is the means through which it is believed that contemporary practitioners are equipped to deal with the complexity of clinical practice (Schon 1983; Health Professions Council 2007). The differences in the epistemological positioning of physiotherapists has the potential to create a situation where there is a lack of professional unity. These differences have the potential to impact on the learning experiences of student in terms of course philosophy and the practice placements they encounter. This lack of professional unity, I would argue, potentially creates a confusing learning context for students where they encounter competing professional positioning.

Differences in the epistemological stance of individual therapists have the potential to impact on their enactment of their professional role and their professional identity. The research which forms the basis of this thesis suggests therefore that notions of a split in the epistemological positioning of physiotherapists and physiotherapy as suggested by Kell and Owen (2006) has the potential to complicate the process by which the student physiotherapist develop their professional identities. Rather than professional socialisation being a taken for granted, unproblematic outcome of professional education I propose that it occupies a significant (unacknowledged) space in the learning experiences of students and as such warrants greater attention and research.

In summary, this section has provided an overview of the world of physiotherapy education and practice in acknowledgement of the increasing emphasis on interprofessionalism in health care (Barr, 1998; Cooper et al, 2005; Baxter and Brumfit, 2008 Cote, Luazon and Kyd-Strickland 2008). The next section will introduce interprofessional education, a necessary prerequisite of physiotherapy education and practice.

**Interprofessional education**

As this thesis is concerned with exploring the construction of a uniprofessional identity within an increasingly interprofessional world, this section will provide an overview of interprofessional education as an introduction to the complexities
and tensions inherent in combining uniprofessional and interprofessional learning. Interprofessional education (IPE) is simply defined as “occasions when two or more professionals learn with, from and about each other to improve collaboration and the quality of care” (CAIPE 1997). Over the last 30 years, IPE has become established and shared learning between health and social care professionals is now embedded in most undergraduate curricula and extends through to post-graduate professional development programmes. Successive governments continue to issue clear policy to encourage collaborative practice (Judd and Jones 2003; McNair, 2005; Hall, 2005; McKay 2007) and partnership working. From a professional perspective; physiotherapy educators have a responsibility to develop students who are able to undertake their professional role through effective interprofessional working (Finch, 2000; Barr 2007; Barrett, Sellman and Thomas, 2005; Carlisle, Donovan and Mercer, 2005; Reeves, Lewin, Espin, Zwarenstein, 2010).

Although professionals may have informally shared learning experiences and expertise specifically planned and structured opportunities for IPE were not established in the United Kingdom (UK) until the 1960s (Barr, 2007). In the UK, the evolution of IPE has been integrally linked with political change and social growth.

The factors contributing to poor working relations between health and social care professionals are extremely complex; many professions had their professional roots entwined with status, class and gender (Barr, 1997), promoting prejudice or professional mistrust (Carpenter, 1995). Professional isolation was perpetuated through the use of specialist language or jargon (Pietroni, 1992), or keeping individual patient records. Indeed, as McMichael & Gilloran,(1984) found health and social care students were not only entering their professional training with established prejudice regarding other professions, but qualifying and leaving with their prejudices reinforced. This raised the possibility of using education to improve interprofessional understanding and successful collaborative working and is now well documented in the IPE literature for example; Hornby and Atkins, 2000; Howkins and Bray, 2007; Miller, Freeman and Ross, 2001; Colyer, Helme and Jones, 2005; Freeth, Reeves, Koppel, Hammick and Barr, 2005a;
Meads, Ashcroft, Barr, Scott and Wild, 2005; McKeown, Malihi-Shoja and Downe, 2010.

In 1987, the Centre for the Advancement of Interprofessional Education (CAIPE) was established in the UK. The 2001, government white paper Working together, learning together: a framework for lifelong learning for the NHS (DOH 2001), provided a strategic framework and co-ordinated approach to continued professional development. It stated “core skills, undertaken on a shared basis with other professions, should be included from the earliest stages in professional preparation in both theory and practice settings”.

Shared learning between health and social care professionals is now embedded in most undergraduate curricula and continually extends through professional development. Successive UK governments continue to issue clear policy to encourage collaborative practice and partnership working, to develop students able to undertake and contribute to effective NHS interprofessional working (Finch, 2000). The next section will discuss how interprofessionalism is contextualised within contemporary health care practice.

**Contemporary health care practice**

Greater consumerism in the healthcare sector has shifted the focus away from the professions themselves to the communities they serve (Heyman and Culling 1996; Ginsburg, Regeher and Hatala 2000, DH 2001, 2001c; Goldman, Reeves, Lauscher, Jarvis-Seluga and Silver 2008). For health professionals this means viewing patients and the public as partners in care rather than as passive recipients of care. A number of authors have suggested that this shift poses a number of challenges for health professionals, not least associated with what being a health professional means and looks like in contemporary health care to professionals themselves and to wider society.(General Medical Council 1993; Howe 2002; Inni 2003; Ellis 2004; DH 2009; Hilton and Slotnick 2005). Stronach et al (2002)suggest that in contemporary professional life, professionals are in effect being rewritten through what they term an ‘economy of performance’. They assert that professionals such as teachers and nurses are located in a complicated nexus between policy and practice. Their critique of contemporary
professionalism and the nature of contemporary professional identity lead them to assert that as professional practice is local, situated and indeterminable; they conclude that professional identity is much more nuanced than has been previously suggested.

In terms of this thesis I propose that this has the potential to impact upon students’ learning through student/professional interactions. If, as Stronach et al (ibid) suggest, professionals themselves are located in a complex and shifting nexus between policy and practice and are engaged in reconstructing their professional selves, then I would assert that this has the potential to impact upon students’ professional identities. Besides this, a number of other factors are at play which collectively create a context where the professionalism of health care professionals is being challenged (Niemi 1997; Middlehurst and Kennie 1997; Klein 1998; Wear and Castellini 2000, Jotkowski, Glick and Porath 2004; Bligh, 2005). One of these factors is increased accountability; high profile failures in traditional care delivery contributed to the call for greater collaboration of health care professionals. Examples such as the Bristol Royal Infirmary Inquiry (DH 2001b), the Victoria Climbie Inquiry (DH 2003), clinicians who had gone bad, such as Harold Shipman and Beverley Allitt, Daily Mail, 2001; The Independent, 2001; Walshe and Higgins, 2002). It was these types of failure that led to an increased scrutiny of health and social care professional practice and the creation of clinical governance frameworks,

‘Clinical governance is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’.

(DH 1998, p33)

Up to this point health professionals had enjoyed a high level of autonomy, self-regulation and little requirement for accountability. Outside of the professions themselves there has been increasing scrutiny of health professionals and some would argue this has eroded their professional autonomy and status (Cruess, Cruess and Johnston 1999; Foster and Wilding 2000). The following section will outline the chronology of these changes as a way of contextualising the ways in
which today’s health care professionals are experiencing real challenges to their professionalism from both within and out with the professions.

**Increased accountability**

This section will discuss how increased scrutiny and accountability has affected the way in which professionals view themselves and, in turn, the implications this has for how they are viewed by broader society (Arnold 2002). The concept of a profession is a highly contested construct; the prominent approach to defining professions has evolved from 1960’s where a trait approach dominated, to the 1970’s where sociologists took the stance of exposing the ideology of professions as a mechanism of control and power (Cahill 1998; Stronach et al 2002; Callero 2003). By the 1980’s sociologists were describing professions through their role and knowledge base. Wilensky (1964) described professions as occupations whose work was founded upon knowledge and a technical base which was protected by law as being specific to that professional group, organised around a coherent professional group who trained, controlled and maintained the competence of those belonging to the profession. Wilensky’s work was based on a study of law, medicine and divinity defining professions as having ‘a successful claim to autonomous practice, exclusive technical competence and adherence to the service ideal’ (1964, p156).

Contemporary health care’s priority to promote greater interprofessional practice and the implications inherent in this of professionals being able to *stand in for* each other to shift roles and responsibilities amongst themselves in the best interests of the patient, has the potential to imply that health professions do not have a distinctive knowledge or exclusive technical skill base (Nancross and Borthwick 2005). The priority imperatives of generic competence and the theoretical ability for different health care professionals to be able to take on the roles and responsibilities historically undertaken by other health professions challenges the traditional notions of professionalism (Arnold 2000, Ginsburgh 2000; Elcin et al 2006; Ellis 2004).

The drive for interchangeable health professions capable of extending/shifting role boundaries to include roles historically undertaken by others is suggestive of
a new definition of professional in health care, the impact of which is seen across all health care professions (Needham 1996; Rolfe et al 1999; Nancarrow and Borthwick 2005). Today’s health care professionals are arguably experiencing their greatest challenge to their professionalism since the NHS was created in 1948. As students learn in clinical contexts I believe that the impact of these changes and challenges impacts upon their learning experiences in ways which are not overtly obvious, and should be of interest to physiotherapy educators.

When the New Labour government came to power in 1997, they published the white paper *The New NHS: Modern Dependable* (DH 1997). This fundamentally shifted the way in which the NHS was to develop. Increases in accountability and the introduction of clinical governance and audit became the mechanisms through which quality of care provided by health professions was to be measured and assured,

‘What counts is what works... to shift the focus onto quality of care... doing the right things, at the right time, for the right people, and doing them right.... Nationally there will be evidence-based national service frameworks bringing together the best evidence of clinical and cost effectiveness’

(DH 1997 pp10, 11, 17, 18)

Following this, in 2000, the NHS Plan was published. This reinforced the message of doing the right thing at the right time, and that doing the right thing would include health care being delivered by the right professional. This concept of care being delivered by the right professional challenged the way in which professionals had worked, via the introduction of national service frameworks predicated on care and not profession-focused pathways. Care-pathways, in a sense, helped to erode the positional power professionals had enjoyed for so long (Heyman and Culling 1996; Harrison 1998; Irvine 1999; Stronach 2002; Hilton and Slotnick 2005; Nancarrow and Borthwick 2005). Care-pathway driven health care demanded professionals work more collaboratively; health professions were reorganised into clinical rather than professional teams.

Foster and Wilding (2000) suggest that since the 1980’s and 1990’s professionals such as teachers, doctors and social workers have been subjected to increased
political and managerial controls. Contextualised by the repeated failings of other health professionals, such as those already mentioned, it is very difficult to argue against increased scrutiny, professional self-regulation had clearly failed to adequately protect patients from harm. National audits were published annually and patients for the first time could view the performance rating of individual hospitals and doctors, in effect producing hospital league tables.

In 1999, the National Institute of Clinical Excellence (NICE) was formed. Its two main functions were to undertake evidenced based evaluations of clinical interventions and recommend treatments to be available (or not) on the NHS and secondly to give approval to evidence-based clinical guidelines for the management of medical conditions (NICE Guidelines 2006).

Around the same time the regulation of professions allied to medicine was transferred to the then newly formed Health Professions Council (HPC) from the then Council of the Professions Supplementary to Medicine and the Allied Health Professions professional bodies (HPC 2002). As Harrison, (2002) observes the introduction of clinical governance as a mechanism to hold clinicians to account was probably the most systematic strategy for controlling doctors and as a consequence other health professionals Clinical governance fundamentally changed the way in which health professionals were held to account for their everyday professional practice and the rights and choices of patients and the public became much more centre stage. Some authors suggested that this created an NHS where the power of health professions was gradually being diminished and replaced by greater patient and public empowerment (Harrison 2000; Stronach et al 2002; Jotkowitz et al 2004).

Along with this the marketisation of professional practice, where professional services were priced and commissioned at market rates, set a new agenda for the health professions, for the first time they needed to be able to justify their worth, prove value for money and demonstrate outcome (Middlehurst and Kennie 1997). This need to quantify and demonstrate worth undoubtedly places emphasis and importance on the technical elements of professional work and no or little acknowledgement of the more qualitative aspect of professional practice, which defies numerical measurement.
During the 1990’s evidence-based practice (EBP) dominated physiotherapy discourses (and, I would suggest, continues to do so) and as a profession physiotherapy wholeheartedly embraced the EBP agenda further aligning the profession to the medical model and the pursuit of a positivist approach to knowledge generation. (Higgs and Titchen 1995a; Rosenberg and Donald 1995; Harrison 1998; Turner 2001; O’Brien 2001; Bateman and Cantab 2005). The resultant protocols of practice based upon the best evidence dictated physiotherapy interventions in a way which had not been apparent before this time. These protocols dominated professional practice to the extent that intuitive and practitioner based knowledge became sidelined. Protocols of intervention in some ways reduced practice to a number of routinised steps, thus it can be argued reducing professional claims, or at least reinforcing the technical rational aspect of professionalism (Robertson 1995). Professional discourses which privileged evidenced based practice reinforced the positivist ontological basis of the physiotherapy profession. However a number of counter claims were also being made (Eraut 1994, 1995; Cross, 1997; Richardson 1999; Clouder 2000; Clouder and Sellers 2004) emphasising reflective practice and the artistic intuitive side of professional practice by recognising interpretive dimensions of professional epistemology and placing value on practice based upon knowledge emerging from practitioners networks (Wenger 1998; Eraut 1994).

The renewed emphasis on thinking skills such a critical appraisal and reflection has in some ways created a dissonance between the need to quantify worth in a technical-rational way whilst at the same time, embracing a more patient-centred approach to physiotherapy practice. This ability to prove worth through technical-rational efficacy and at the same time respond to empowered patients through a partnership approach to practice has, I would argue, complicated the professional landscape of physiotherapy, proving a context for students that offer a number of competing and at times conflicting professional paradigms. A technical-rational approach medical model is in many ways diametrically opposed to a more social model of care; together with a focus on interprofessionalism this creates a complex dynamic for those learning to be a particular type of professional in a professional context of radical NHS reform.

In summary, I propose that the shift away from professional self-regulation to an increasing emphasis upon professional external regulation challenges the status
of professions and professionals and fundamentally shifts the notion of professionalism in health care in ways which have not been previously experienced. This challenge to professional autonomy, I would argue, impacts upon how physiotherapists construct their professional identity which in turn has implications for the professional socialisation of student physiotherapists. An integral and important element of the socialisation process is the construction of a professional identity. Within this thesis I propose that changes and challenges to the notions of professionalism, professional role and status within health care have the potential to complicate how students experience socialisation and how the process of constructing a professional identity (Middlehurst and Kennie 1997; Exworth and Halford1999).

**Empowered patients and public: shifting the power**

The previous section has described the increased accountability of health professionals and suggested ways in which this increased scrutiny affects professional identity. This next section will continue this by exploring how the discourses of increased patient and public empowerment potentially challenges professionals’ identity.

Since the early 1980’s the NHS has been on a trajectory of increased patient and public involvement in the commissioning, planning and delivery of health services in the UK (Patterson 1992). The traditional medical model of care, predicated upon the passive patient acquiescing to the ministrations of the expert professional has slowly been challenged by the introduction of social models of care where patients are constructed as active participants/equal partners in their health care (Allen 2000). As technology and medical advances were made, the NHS has had to shift from an acute illness service to one which provides a service designed to manage and prevent long term or chronic disease/conditions (DH2001, 2001c, 2006). The shift in the population’s health needs led to a significant increase in the cost of providing ever increasing health services to meet demand. Recognising the rising cost of the NHS the then Labour government embarked upon a radical NHS modernisation agenda. The Labour government’s sweeping reform programme (DH 2000a, 2000b, 2001a, 2006) was led initially by the Modernisation Agency between 2000 and 2004 and from 2004...
by the National Institute for Innovation and Improvement (NHSi) (DH 2006). A central tenet of this was that for modernisation to occur and for the NHS to be truly patient-led health professionals had to work more collaboratively and that for modernisation and improvement to occur in health and social care services, interprofessional working was key to its success (Barr 1998; Horder 2004). The political imperative to ensure continual service improvement was felt to be unachievable without professionals working together (Batalden and Davidoff 2007). NICE supported the notion of creating a more flexible workforce that could operate across boundaries and promote partnerships (www.nice.org.uk).

In summary, from as early as the 1980’s, the public were increasingly portrayed as knowledgeable consumers of health care rather than passive recipients; consumerism was introduced into health care (Patterson 1998; Harrison 2000). The wholesale redesign of health services designed to improve the health outcomes of the population led to a complete reconfiguration of health services. These redesigned services led to a requirement to redesign the health care workforce (DH 2002; MA 2004; NHSi 2006, 2007).

Never before have health professionals needed to convince the public and the dominant political party of their worth in quite the way they have been asked to do so in recent years. Professions have a relationship with the state or society which is unique to each professional group. This relationship in effect controls the degree to which professions are valued by society, for health professionals this is a particularly challenging time. The status each profession has in society is directly related to the amount of bargaining power they have for occupational autonomy, monopoly and reward. For health professionals high profile failings have seriously dented society’s trust and as a consequence notions of what it meant to be a professional in the twenty first century was debated in professional and political literature (Irvin 1999; Cruess et al 1999; Arnold 2002; Ginsberg et al 2000; Foster and Wilding 2000; Ellis 2004; Elcin et al 2006).

This section has highlighted a number of connected reforms which created a context where health professionals have had to revise their notions of what being a professional means as a consequence of NHS modernisation, increased consumerism in health care and increased public scrutiny and accountability. If as Stronach et al (2002) infer professionals’ identities are in flux then I argue
that this has a knock on effect upon the learning experiences of professional students. Not surprisingly, the shift in professional role/function boundaries has challenged traditional professional identities, creating uncertainty for individual who have had to rethink their professional role and function in reconfigured health services (McKay 2007). I believe this uncertainty translates into student learning contexts.

**Workforce modernisation; shifting the boundaries of professional practice**

As the previous section suggests, increasingly patient-centred health care reforms led to the necessity to modernise the workforce creating further challenges for health professionals in respect of professional boundaries. As I have already discussed, this thesis is focused exploring the process of constructing a professional identity. From a social perspective the link between professional role and identity is acknowledged (Cahill 1998; Callero 2003; Stryker and Burke 2000) the following section will explore the impact of work force modernisation on professional roles.

From the early 2000’s onwards a number of new roles were being introduced to the NHS. These new roles, rather than being situated within a particular professional group, tended to be designed and promoted as roles which transcending traditional professional boundaries and were lauded as providing much coveted flexibility (Ketefian et al 2001). The job titles of these new roles tended to be of a generic nature, for example assistant practitioner, extended scope practitioner, advanced practitioner, non-medical consultant (DH 2006, NHSi 2006). These new roles were seen as a solution to breaking down barriers created by professional silos, supporting the constraints the European working time directive placed upon doctors working hours and as a consequence supporting the transfer of tasks and roles from one profession to another (DH 2004; DH 2006; NHSi 2005,2006, 2007).

Advanced practitioner and non-medical consultant roles were created support to the transfer of tasks normally undertaken by doctors to these new roles. Assistant practitioner roles were created to take on some aspects of the role and
activities normally undertaken by graduate professionals (CSP 2006; COT 2005; NHSNW 2005). The professional workforce was, in effect, being forced into relinquishing some aspects of their role to other professionals and to the non-professional workforce. All of which created a situation where professional boundaries in and between professionals and the non-professional workforce were less certain than they had been. Individuals’ understanding of their professional role is demonstrated through the way in which they practice physiotherapy in everyday situations (Lee 2002; Taylor 2001). In this way professional identity is played out in everyday practice. For example physiotherapists who believe that effective practice is best achieved through a patient /clinician partnership, where patients are valued as equals will enact their everyday practice differently to physiotherapists, who assume a dominant role, exerting their professional power through expert practice and who see patients as recipients of care. Therefore I propose that as professional roles become less clear and distinct, issues of professional identity emerge.

The introduction of the Knowledge and Skills Framework (KSF) (DH 2006), supported the ideas of a competency based workforce rather than a profession based workforce. The implications of this generic knowledge and skills framework were profound. No longer was the specific profession of primary importance, the introduction of the KSF and its use inferred that professional title and background were, to all intents and purposes, superfluous to the delivery of quality health care, professional allegiance was of secondary importance; what mattered was the competence of the individual professional. The notion of ‘what counts... is what works...doing the right things at the right time... the right care being provided by the right professional at the right time’ (DH 1997, 2000, 2001) fundamentally and irrevocably shifted the focus away from individual professions, creating a system where professionals were no longer holding all the cards.

The idea that competencies were shared across professional boundaries and professionals, supports the idea that professionals were interchangeable with each other, challenging individuals’ professional identity (Foster and Wilding2000). Whilst health policy promoted the ethos of patient-centred health care, the challenges to their professional selves experienced by professionals resulted in entrenchment. Old notions of professionalism were challenged in an
unprecedented way, suggestive of a view which inferred a greater degree of
genericism and less specialism amongst and across different health professional
groups.

At the same time, three key policy documents were published; Modernising
Medical Careers (1999), Modernising Nursing Careers (2000) and Meeting the
Challenge: a Strategy for Allied Health Professions (2000). These documents set
out the strategy for modernising the workforce to meet the challenges posed by
the modernisation of health care. For the physiotherapy profession the
publication of Modernising Allied Health Professions in 2000 signalled a significant
shift in the way in which the individual professions who collectively made up the
Allied Health Professions were subsequently referred to in government strategy
documents, signalling a collective labelling of individual allied health professionals
under the nomenclature of Allied Health Professions\(^6\) (AHP). This, in effect, I
believe resulted in the silencing of individual professional naming. Uniprofessional
discourses were superseded by discourses privileging allied health profession and
interprofessional discourses. Referring to individual professions such as
physiotherapy became taboo almost overnight. Within the Allied Health
Professions the publication in 2000 of the Meeting the Challenge: A Strategy for
Allied Health Professions document further emphasised the importance of
collaboration and cross boundary working outside of traditional uniprofessional
silos. This silencing of uniprofessional labels was, I would suggest, a challenge to
traditional professional identities. Although primarily concerned with describing
the changes in the roles of AHP within contemporary health care one of the
strategy’s main tenets effectively called for a renaming of all individual AHP
professional groups away from their uniprofessional label to the collective AHP
label; uniprofessional identity had become a political issue at macro and micro
levels.

In summary, over the past 10 years the modernisation of the NHS has seen a
significant cultural shift in the way that health care is delivered, requiring health

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\(^6\) Allied Health Profession is the generic term used to define and refer to 13 distinct professional groups, namely
physiotherapists, occupational therapists, dieticians, orthoptists, prosthetists and orthotists, paramedics,
operating department practitioners, speech and language therapists, diagnostic and therapeutic radiographers
and podiatrists
care professionals to work in very different ways. As Harrison (2002) proposes the self-conscious use of labels has been a prominent tool in the re-making of the Labour government since its election in 1997; modernisation was one such term which captured the idea of ‘throwing off historical ideas and providing a new sense of direction’ (Taylor 1997 p104). Modernisation in the NHS was promoted as the way in which health care in the UK would be refocused and patient rather than profession led. Service modernisation has resulted in service delivery models predicated upon care-pathways and not profession-focused pathways, practitioners increasingly work in multi-professional teams associated with a specific care-pathway (e.g. long term conditions, stroke, cancer, end of life, musculoskeletal) as described in the National Service Frameworks (DH 2006). This, I argue, has fundamentally changed the way in which health professional work is organised, how health professionals undertake that work and, as a consequence, has the potential to change notions of professional identity particularly for students who have yet to develop their professional self.

The increasing promotion and use of Allied Health Professionals as opposed to individual professional naming has, I would argue, actively silenced the uniprofessional voice. This silencing has implications for the process of uniprofessional socialisation and identity construction.

To conclude, this chapter has provided the reader with a comprehensive critique of the contexts and issues within which this thesis was written and justified its focus. I hope to have explicated for the reader a suitable justification for this study’s focus. I propose that the collective effect of radical health care reform such as; the shift away from profession focused to patient-centred health care, the repositioning of patients as experts and partners, workforce modernisation and redesign, the creation and growth in generic roles, increasing focus on collaboration, interprofessionalism and the subsequent blurring of professional boundaries, increased accountability and regulation all line up to challenge notions of professionalism and professional identity for individual professionals.

**My story**

As this thesis is presenting the findings of a narrative study and acknowledging the interpretive and subjectivity of the research process, this next and final
section will provide the reader with a reflexive account of how I am located in relation to this study. It will provide a way of seeing the influence I have had on each aspect of this thesis from inception, through execution and finally through the presentation of this thesis. Providing an auto-biographical perspective I hope to provide the reader with a glimpse into my own world view of physiotherapy and thus explicate the frame from which I have undertaken the work of this thesis.

I entered the world of physiotherapy as a student in 1982 and since then have enjoyed a number of roles within the profession. I started my clinical career in 1985 and during this time progressed with relative speed to a senior clinical role within the area of elderly rehabilitation. In 1995 I changed course and started work as a lecturer in physiotherapy, progressing to a senior management role within five years. In 2002, I stepped out of physiotherapy into the wider health field of Allied Health Professionals. On reflection, my own journey into and through the world of physiotherapy has been a successful one. Enjoying a professional context of plenty in terms of jobs and opportunities, it has been an enjoyable experience. During this time I have consciously and unconsciously made sense of my career through the telling and listening to stories of physiotherapy. As Geertz (1995) states, having stories to tell, views to unfold and images to impart is an important aspect of the researcher’s journey. This telling of my own story has in some ways made it easier to listen to the stories of others and in other ways much harder. As Conle (2000) suggests, my own story has, over the lifetime of my career, provided a number of subconscious question marks which have ultimately led me to undertake this particular study. These questions marks have occurred in relation to my professional identity, professional self, role, value and purpose.

Alongside my own experiences, a number of critical conversations with other physiotherapists, patients and students have led me to have an enduring interest in the interconnections between, professional role and identity and how these are played out in everyday professional practice. My move into higher education shifted this focus from professionals to students. As a student physiotherapist I
can recall expending great amounts of time and energy of attempting to mirror the behaviours of clinical supervisors\(^7\). In Goffman’s (1959) terms I recall spending a great deal of time spent on ‘impression management’ in an attempt to positively manage my clinical supervisor’s expectations of me as a student physiotherapist. I was, in this sense, outwardly shaped and moulded; this outward performance did not always reflect my emerging professional identity. However, in many ways I did this successfully although in many incidences my fellow students were less successful in this. My own professional journey was not problem free. As Melia (1987) and Clouder (2003) observe I often found myself playing different roles in order to fit into the clinical context.

I have written this thesis from a number of standpoints, but primarily from my professional standpoint as physiotherapist and educational manager. During the course of this doctoral journey I have read widely and examined in some detail my own world views; a reflexive account of this will be included in chapter two.

Over twenty years of clinical and educational experience have shaped me. I am able to recall with clarity some of my most painful and most rewarding learning experiences with patients as a student and as a clinician. Whether or not my recollections are a true reflection of what I experienced is questionable. Essentially my recollections recall a clinical environment which was in many ways less complex than the clinical environment experienced by today’s students. During my student days, physiotherapy was not a graduate profession and for the majority of my professional working life, clinical audit and the evidence-based practice movement were yet to become centralised. Physiotherapy practice was largely routinised, prescribed by doctors, straightforward and my professional relationship with patients was characterised by myself as the expert professional and my patients as passive recipients, in these ways it was less threatening, less challenging and more stable.

From my perspective, I understand professional identity as being inextricably linked to the job itself, in so much as how individual professionals view

\(^7\) During the 1980’s the nomenclature Clinical Supervisor was used to describe those physiotherapists responsible for the supervision and assessment of students in practice. This term has been replaced in contemporary nomenclature with Clinical Educator
themselves is reflected in how they are able to enact their professional role, hence the focus of this thesis.

**Conclusion**

This chapter has provided the reader with an overview of the various contexts in which this study is situated. By providing the focus it has explicated the justification of undertaking this study at this time. It has described the purpose and focus alongside a brief insight into my own personal socialisation process in an attempt to provide a frame from which the reader can view the chapters that follow. The next chapter will continue by providing a critique of the theoretical perspectives of social constructivism, Foucault's notion of power, narrative and identity which I have used to frame this thesis.
Chapter 2: Theoretical perspectives

Introduction

This thesis is located within a theoretical framework where notions of professional identity are considered to be complicated, contestable and subject to relations of power. Emphasising the social aspects of identity I do not mean to suggest that individuals are not capable of individual agency nor do I intend to completely ignore the personal dimensions of professional identity; however by stating my intentions of exploring professional identity from a social perspective I am hopeful that my readers are able to assess this thesis from the same perspective from which it was produced. Social perspectives of professional identity consider the relationship between the individual, the profession and society and through this offers explanations of ways in which social forces impact upon professional behaviour and identity (Cahill 1998; Callero 2003).

Building on chapter one which described the political, professional and social contexts of this thesis, this second chapter will provide the reader with a considered account of the theoretical perspectives I believe have provided me with a useful set of ideas and themes through which I have explored professional identity within my own professional field of physiotherapy.

In this chapter I will consider how ideas taken from social constructivism, Foucauldian notions of power and narrative have enabled me to develop a coherent theoretical framework to explore how students’ professional identities are constructed. Social constructivism supports the idea that realities are constructed through human interactions and allows for multiplicity of meanings. It enables us to consider how objects are constructed within particular social and historical discourses. By considering Foucault’s notion of power it is possible to problematise the taken for granted and explore how power is exercised through discourses Foucault allows us to problematise the taken for granted as he observes,
‘to step back from a way of acting or reacting to present it to oneself as an object of thought and question it as to its meaning, its conditions and its goals’

(1986 p388)

Taking a critical stance towards things we take for granted enables us to question the status quo. His notions of power provides us with the tools to explore how power exerts its influence,

‘The ability of power to shape and form population collectivity and individual subjectivity through surveillance, exclusion, classification and regulation.’

(p235).

Together ideas taken from social constructivism and Foucault support a view of reality as a construction, constructed through interaction between human beings and whose interactions are governed by discourses. These ideas will be explored further alongside a sociological perspective of identity, specifically through the work of Stryker(1968, 2002), whose identity theory was created out of notions of symbolic interactionism espoused by Cooley (1902) and Mead (1934). I will also draw upon contemporary notions of identity through the work of Burke and Stet (1980, 2009), Lawler (2008) and Cote and Levine (2002). The relevant literature associated with professional socialisation will be included where appropriate. However as this thesis is only concerned with the construction of professional identities and in the interest of space this will be limited. To prevent duplication the relevant literature associated with professional identity is embedded in the appropriate sections rather than presented as a standalone section. There is a wealth of interdisciplinary identity literature and in recognition of this the literature presented in this chapter has been drawn from sociological and psychological texts. In respect of professional identity I have drawn upon the related fields of teaching, nursing, occupational therapy, social work and medicine and the limited literature relating directly to physiotherapy.

In chapter one I presented a picture of contemporary health care characterised by a significant change programme wide sweeping in impact, affecting all parts of the health care system from clinical care re-design, the creation of new clinical
care pathway delivery models, redrawn professional role boundaries, an increased emphasis on collaborative working practices and interprofessionalism to greater patient and public empowerment (DoH 1990, 1996, 2001, 2002, 2004, 2005). I have explained how it is precisely this challenging and changing professional context that provided me with the impetus to undertake this research study and in particular the impact this may have on the ability of student physiotherapists to construct a salient professional identity. My interest and focus on everyday interactions between individuals in professional learning contexts leads me to taking a sociological stance. A sociological stance enables me to focus on how professional contexts and professional roles combine to provide individuals with a sense of professional selfhood and professional identity. I am particularly interested in understanding more about the connection between professional identity and professional role. I understand identity theory to have the potential to offer perspectives on the ‘dynamic mediation of the socially constructed self’ (Hogg et al, 2003 p255) and that this is a useful way of exploring professional identity construction within the field of physiotherapy. As Burke and Stet claim,

‘identity theory seeks to explain the specific meanings that individuals have for the multiple identities they claim: how these identities relate to one another for any one person, how their identities influence their behaviour, thoughts and feelings and emotion and how their identities tie them into society at large’

(2009 p3)

In terms of my narrative approach, I recognise that the range of approaches (Polkinghorne 1995; Mishler 1990, 1995; Cortazzi 2001; Roberts 2002; Reissman 2001, 2005, 2008; Andrew et al 2008) within the field of narrative research has led me to develop my own approach to undertaking narrative research, underpinned by an appropriate theoretical frame. I understand a paradigm to be a basic belief system which helps us to understand and make sense of the world. The individual nature of paradigm building for me relates to the way in which we each have a personal belief system or paradigm which influences all that we do. Whilst we draw upon paradigms as described by others there is still an element of the personal to how we interpret and use them. In recognition of this, this
chapter will describe how I have used a number of theories to shape my research study and which have influenced the production of this thesis.

The final sections of this chapter will include a consideration of how I have interpreted a range of narrative approaches to develop an appropriate theoretical frame bringing together ideas from social constructivism, Foucault and narrative in order to explore professional identity. As Housten observes, ‘social constructivism links our narratives about ourselves and the worlds to our actions through meaning making’ (2001 p847).

As previously discussed in chapter one of this thesis I have a personally held belief that the process of constructing a professional identity is a taken for granted aspect of physiotherapy education, and that in my personal experience, it remains part of the hidden curriculum. As a consequence I believe that physiotherapy education discourses do not routinely allow for an open exploration of the complicated nature of professional identity. I would propose that this absence prevents physiotherapy educators from considering the complexity of constructing a professional identity. This, in effect then leads to the process of constructing a professional identity becoming taken for granted and unproblematised component of physiotherapy education. This is suggestive of the view that constructing a professional identity is straightforward and deterministic in nature. Within this thesis I make tentative suggestions that students' experiences of constructing a professional identity is neither straightforward, nor simplistic and in some parts and for many students it remains a difficult process to negotiate and navigate. As Olesen and Whittaker (1968) suggest, the constructing of a professional identity remains contained within the ‘silent dialogue’ of education programmes.

**Social constructivism**

In developing my theoretical frame I now turn to social constructivism. I understand social constructivism to mean a theoretical framework which supports the idea that the world is constructed through people’s interactions with their world and through interaction with other people in that world. It supports the idea of the world and human beings being constructs of each other and that
realities and knowledge are not fixed *a priori* but constructed through discourses (Housten 2001). In terms of this thesis, this allows me to consider physiotherapy and physiotherapists as constructs that can be understood as socially determined and negotiated between social actors. In other words, there is an emphasis on the social aspect of meaning (Guba 1990). From a personal perspective, during my own journey of becoming a physiotherapist I was often acutely aware of how different professional contexts forced me to ‘act out’ being a physiotherapist in different and sometimes conflicting ways. This acting out did not always reflect my emerging professional self/identity rather it reflected others’ expectations of me as a physiotherapist.

As Melia’s (1987) research into the professional socialisation of nurses shows, fitting in and getting on was a big part of how student nurses experienced being socialised into nursing. This is reflected in a number of other studies (Campbell, Lavireeet al 1994; Du Toit 1995; Bogler and Kremer-Hayon 1999; Clouder 2001; Assuncao-Flores 2001; Ferraro-Coates and Crist 2004; Bathmaker and Avis 2005; Dymoke and Harrison 2006). Acting out being a physiotherapist involved working out others’ expectations of me and acting in ways which reflected these expectations. I was conscious of the need to act in certain ways for certain people and that I was forced to hide my developing professional self and act out an alternative professional identity.

Social constructivism enables me to acknowledge the importance of context in shaping and influencing how I and other participants view the world of physiotherapy and live in it and therefore how they have made sense of their professional world. By focusing upon the lived experiences of participants I will emphasise the importance of ‘research in context’ and attempt to privilege the subjective nature of reality and knowledge through my methods of data collection and analysis as described in chapter three. For me, social constructivism has enabled me to problematise in a systematic way my own professional beliefs and question how I have come to think in certain ways; I see it as an appropriate theoretical stance for exploring professional identity.

In privileging individual experiences and individual voices of my participants as a legitimate source of knowledge and reality I focus on the role of social
participation, particular values and the subjectivity of human endeavour. I have tried to concern myself with the quality and richness of data focusing upon the attitudes, perceptions, beliefs, feelings and values of student physiotherapists. As I have already described in chapter one, an important influencing factor on the production of this thesis has been my own journey of becoming a physiotherapist, and social constructivism allows for the recognition of the human inquirer as a form of instrumentation. This leads to an emphasis upon the importance of acknowledging the influence of the researcher on the research process. I see myself as an integral part of my research and the knowledge it produces. Incapable of stepping outside of my own experiences I view this thesis as a co-production between myself as researcher and my student participants.

**Ontological and epistemological assumptions**

In this section I will discuss the ontological and epistemological assumptions associated with social constructivism and explain how I understand these to relate to my work. Social constructivism has, as its central tenet relativist ontology and a subjectivist epistemology (Guba 1990). In the words of Lincoln, social constructivism allows for ‘the presentation of multiple, holistic, competing and often conflicting realities of multiple stakeholders and research participants’ (1990, p73). As Parker explains social constructivism ‘radically questioned the idea of objective fact’ (1998, p14). From an ontological perspective, social constructivism supports the idea of a potentially unlimited number of alternatives in the constitution of reality. If individuals construct their world through their interaction with it, then it is possible for a number of different meanings to co-exist. This allows me to acknowledge the individual experience as a legitimate way of constructing reality. I view the participant’s stories presented in chapter four as a potentially important source of knowledge which may help me to understand more fully the process of identity construction.

For example, using individual stories as a way of presenting the key findings in chapter four, acknowledges the range of alternative viewpoints. I recognise that the findings presented in this thesis will not necessarily be transferable to other contexts nor resonate with other students. The knowledge contained and presented in this thesis is recognised as being historically and culturally specific.
In terms of my own work, physiotherapy does not exist independently of the political and lay constructions of it, as a physiotherapist myself it has not been possible for me to step outside of my professional self in order to complete this thesis, I am an integral part of it, an objective viewpoint is impossible. As Temple, asserts 'this is not a denial of reality, rather it is an acceptance that researchers are human beings who cannot see an issue from all sides at once' (2001 p2). Since understanding is negotiated between researchers and research participants then there are many possible constructions of social life. As Temple (2001) states the way concepts are defined matters for the kind of action that follows. Taking Burr’s (2003) stance, we can only know our social world from our particular position in it. I believe that social constructivism has been a useful lens through which I have been able to explore professional identity.

As social constructivism places emphasis on the social aspect of meaning making and the importance of group relations as influencing the process of sense and meaning making (Berger and Luckman 1966; Guba and Lincoln 1996; Potter 1996; Parker 1998; Young 2004; Bujold 2004), it has provided me with a set of ideas from which I have been able to think about professional identity in a critical and constructive way. As this thesis is concerned with providing a voice for students (whose voice is often silent) social constructivism with its emphasis on individual constructions of meaning, knowledge and experience (Guba 1996; Cox and Lydon 1997; Burningham and Cooper 1999; Denzin and Lincoln 2000; Schwandt 2000; Houston 2001; Cohen et al 2004) and upon the social, personal and individual notions of reality as a relative construction (Bujold 2004; Guba 1996; Denzin and Lincoln 2000) has provided a useful starting point.

In summary, from a social constructivist perspective, truth(s) and meaning(s) are constructed in and through engagement with the world (Berger and Luckman 1966; Parker 1998; Burningham and Cooper 1999; Houston 2001; Cohen et al 2004). Human beings, through their lived experiences and contact with their social world, construct their own realities out of experience (Polkinghorne 1990; Crotty 1998). The next section will consider how Foucauldian notions of power in relation to this thesis.
Foucault: power and forms of professional control

Foucault’s (1977, 1978, 1980) notions of power and his ideas of how social and political processes provide forms of social control have been helpful in understanding the dynamics of ‘student and other’ interactions and the potential for these sites of interaction to exercise professional control. For Foucault, the self is located in discourses, suggestive of the idea that the self is articulated through language games. Relating this to the professional world of physiotherapy, students construct themselves in and through professional discourses between themselves and others. It is through these social interactions of everyday professional life that we display our professional identities (Gubruim and Holstein 2000).

These professional interactions constrained by particular professional discourses means that individuals are able to act out some professional identities and not others. Goffman’s (1959) presentation of self in everyday life is helpful in understanding the way performance works in everyday interactions. For Goffman we are all actors and as such he considers the self as dramaturgic,’ while in the presence of others the individual infuses his activity with signs which dramatically highlight and portray’ (ibid p40) in other words the self presents itself to others in light of whatever social discourse (or in relation to this thesis professional discourse) is dominant. Just as a theatrical performance has roles, a stage and a play to perform, so does everyday professional life. It is this stage where individuals as actors develop their roles. As Cortazzi observes ‘ in narrative performance teachers are enacting their professional selves and in doing so are coming to know their own and others’ selves framed in the sociocultural contexts of classroom events’ (2001 p42). Cortazzi (ibid) suggests that teachers’ narratives are a form of impression management.

In respect of this thesis, I propose that students are required to act out their professional identity on a number of different stages to different audiences, all with differing expectations of their performance. In this sense students rehearse and perform ‘being a physiotherapist’, to a number of different audiences often at the same time. To all intent and purpose it is a theatrical performance constrained and controlled by whatever professional discourses dominate at any
one time. These every day rehearsals and performances provide the vehicle through which students actively construct their professional selves.

Foucault’s (1977,1978, 1980) work tends to focus on the extent to which there are multiple and conflicting world views, where some world views have more power than others and provides ways of examining why this is the case. In talk between students and others through which identities are constructed language is never objective it creates positions of relative power and dominance, aligned with accepted practice. For Foucault, language is never objective, it creates meaning and understanding and the self is assumed to be socially constructed through social interaction. In this way Foucault’s work has provided me with a potentially useful interpretive framework from which I have been able to examine sites of interaction and identity construction as potential sites of power. I have been concerned with trying to understand how the interaction between students and significant others, shapes and constrains the extent to which students are able to act out their emerging identity in ways that are personally helpful and meaningful, enabling them to construct a salient professional identity.

For Foucault the notion of a fixed and unified professional identity would be flawed. He asserts that identity is neither predetermined nor consistent but is constructed within and by relationships between human beings; ‘Do not ask who I am and do not ask me to remain the same’ (Foucault 1989 p19). Taking a Foucauldian stance, I understand professional identities to be shaped and changed by their enactment and performance in clinical practice. Professional identities therefore are constructed at the dynamic intersection of experience through symbols, language and practice within specific professional settings. Professional identity is shaped by involvement in particular professional discourses. For Foucault, discourses are defined as ‘practices which form the objects of which they speak’ (Foucault 1972 p49); discourses are powerful in constituting realities and in positioning people within those realities.

Burr further explains that discourse ‘refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events’ (1995, p64). Discourses are
displayed through symbols, language and practices which reflect the dominant cultural scripts\textsuperscript{8} at play. Dominant cultural or professional scripts go unspoken, are recognised by members of organisations as reflecting ‘the way things work around here’ in organisations. From a Foucauldian perspective, discourses reflect not necessarily beliefs and opinions but are reflective of the culture that individuals inhabit (Burr 1995). Therefore the discourses used to communicate dominant cultural scripts do so in ways which govern the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others (Hall 2001). Foucault’s work is helpful in understanding how these function in organisations as forms of control and this is a useful way to understand how power functions in students’ interactions in learning contexts.

Foucault argues that discourses reflect commonly held assumptions and provide the basis of knowledge and that nothing exists outside of these discourses. In this way professional discourses get status and power as a consequence of power relations; pre-given cultural scripts displayed in discourses between professionals gain power by their status, knowledge embedded within professional discourses enables them to dominate. For Foucault it is not within the individual that power resides nor even does it reside in one place, but rather it resides in a multitude of power relationships which exist at the same time which are exercised through a productive network (Burr 1995).

For Foucault discourses differ from site to site and from institution to institution. Institutional discourses limit storytelling, the local and the particular continually insinuate themselves over time to construct diversity and difference in the stories that emerge (Foucault 1988, 1997). I note here and will discuss further in the next chapter the way I see the interview itself as a site of identity construction. Participating in this study has provided the students with the opportunity to construct their stories of becoming a physiotherapist and through these reach personally meaningful conclusions about to their professional journey via

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\textsuperscript{8} Dominant cultural scripts are defined as the unwritten, unspoken rules which govern the way in which individuals are able to act in any given context. In essence they control ‘how things are done’ and through this exert control over how individuals are able to act.
personal stories of where they have been, where they are and where they hope to be.

Foucault’s notion of the institutional gaze, suggests that within institutions and organisations, local culture is always in the making, localised configurations of meaning are mediated by organisational conditions where self-construction is embedded (Burr 1995, 2003; Gubrium and Holstein 2000; Clandinin 2007; McKay 2007) This is not to suggest that individuals simply adopt the dominant professional cultural scripts as expressed through discourses, but that in everyday professional life they are engaged in interpretive acts between competing and conflicting organisational affiliations. As Foucault observes,

‘If power were anything but repressive, if it never did anything but say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted is simply the fact that it doesn’t weigh on us as a force that says no, but it traverses and produces discourses. It needs to be considered as a productive network which runs through the whole social body’.

(1986 p120).

However, this version of Foucault’s lens is in danger of fixing students in a position of powerlessness overlooking the degree of agency they maintain. Within occupational therapy Bjorklund (2000) suggests that the same may be true in occupational therapy. The individual occupation therapy paradigm of students has a significant impact upon how they construct their identity. They suggest that the process of socialisation and the construction of a professional identity is affected by the mismatch between student paradigms of occupational therapy and those of occupational therapists. They, like Clouder, (2003) suggest that occupational therapy students are able to exert a degree of agency to the process of constructing a professional identity, where they use their professional paradigms as personal benchmark, which enables them to resist alternative professional paradigms. Clouder (2003) proposes that occupational therapy students are able to exercise personal agency into their professional socialisation rather than be simply moulded. For Pratt, Rackman and Kaufman (2010) medical students constructed their professional identity through work identity violations.
They describe these work identity violations as incidences where medical students experienced a mismatch between what qualified doctors did and what they said. Medical students used these mismatches as a way of customising their own professional identity. Burman’s (2003) study in teaching found similar problems, the interface between the implicit expectations of individual teachers and the realities of the classroom when implicit expectations are transgressed was an important part of the process of teacher socialisation. The ability of individuals to successful navigate the transgression was important for the development of a salient professional identity. For Stott (2004) the isolation experienced by male nursing students had a negative impact upon their ability to construct salient professional identities. The notion of identity as a negotiated construct mediated through human interaction leads to a consideration of the issues relating to structure and agency and the extent to which individuals are able to exercise personal agency or the extent to which they are constrained by structure.

The concept of praxis shock as identified by Melia as early as 1987 remains a recurring theme in contemporary professional socialisation literature. Praxis shock refers to the feelings experienced by students and novices where their expectations of practice were mismatched with the realities of practice. Melia’s study of the sociology of work for nurses identified fitting in and getting on as important aspects of successful socialisation. Nursing students, who were able to develop a better understanding of their professional role and who adopted less polarised views in the work place fared better. Clouder (2003) states that a large part of occupational therapy students’ professional socialisation process was characterised by learning to play the game, or fitting in and getting on. Jones’ (2003) work into teacher identities suggests that for students to construct a salient professional identity novice teachers need help to reconcile their personal values and beliefs about teaching with the realities of teaching and the classroom; suggestive of teacher praxis shock. The importance of the motivations for pursuing a particular career choice is well documented, and suggests an important link between, individuals’ preconceived ideas of their chosen profession, their perceptions of the job role and personally held believes. I propose that the way in which these preconceived ideas ultimately get played out or not, have a significant impact upon the process of professional
socialisation of students and novice professionals (Holland 1999; Kelchermans and Ballet 2002; Hawkins and Ewan 2000).

Kelchermans and Ballet’s (2002) study into teacher induction and teacher socialisation identify praxis shock. They confirmed the importance of continued support and the quality of teacher induction to achieve successful teacher socialisation. They suggest that the struggles and conflicts associated with the teacher socialisation are alleviated by student teachers building coalitions and collaborations and that these coalitions and collaborations helped students to cope with vulnerability and visibility of socialisation to support them through the process of socialisation. Murray and Male (2004), suggest that socialisation of experienced teachers moving into higher education was equally challenging despite a previously successful teaching career and that the construction of a salient professional identity was a lengthy process occurring over many years. The association between students’ previously held believes about their chosen career is recognised as impacting upon the socialisation process and is often associated with the need to radically rethink previously held beliefs about professional roles. (Bullough 1997; Hawkins and Ewans 2000). For Rognstad, Aasland and Granum (2004) reconciling the difference between expectations and reality was fundamental to professional identity. For Radcliffe and Lester (2003) the process of professional identity construction was characterised by increased levels of stress, relating to periods of transition; reporting that the characteristic state of medical students was one of anxiety. Johansson and Hamberg (2007) conclude that medical students enter medical school with a very specific idea of the ideal doctor. They found that for medical students, the culture of learning and teaching in universities impacts upon student’s sense of professional self. Mismatches between the medical students ideas of being a doctor and their experiences in medical practice creates a significant difficulty for medical students, resulting in the normal state of medical students being one of anxiety. They found that where students perceived themselves to marginalised and isolated, rather than valued as members of the medical/ health team, medical students struggle to develop a salient professional identity.

Another important consideration is the effect of students’ temporary immersion into a number of different clinical learning contexts. The ways in which clinical
placements are organisation may have a negative impact. Typically student physiotherapists are placed in clinical placements sites for short periods of time. Students are in effect temporary members of a professional team for the short period of time they inhabit the clinical setting as students. Students enter clinical placements ignorant of the dominant professional discourses which govern how they need to act and with little time to work them out. As a consequence it is necessary for them to engage in interpretive acts as a way of making sense of competing and conflicting discourses they encounter in different clinical learning contexts. This I propose problematises their effective integration into some clinical contexts. In this sense, discourses of the self-emerge as continuing adaptations of discourse-in-practice (Gubrium and Holstein 2001).

Students encountering a number of clinical organisations will encounter a number of professional discourses in action which may or may resonate with previously experienced professional discourses or their idealised ideas of what being a physiotherapist means. They may well be just beginning to engage in a particular discourse and starting to make sense of their position within it when they exit and move onto another setting. As a consequence the temporary immersion into different clinical settings potentially creates a situation where students are unable to fully immerse themselves before they are moving onto another setting starting the whole process again.

It is my intention to focus upon the micro level and focus upon students as individuals. In particular I am interested in the ways in which they act to protect and verify their professional self-conceptions of who they are. From a sociological perspective, social structures are created out of forms and patterns of behaviour of an individual which in turn develop and transform social structures and individuals within them. The social structures of physiotherapy education (emerging out of the actions and interactions of individual physiotherapists who are in positions of power) help control and maintain boundaries and the status quo. As Burke and Stet observe ‘social structures are not something individuals experience directly, social structures emerge from individual actions over time...are patterned over time and across individuals’ (2009, p5). Relating this to physiotherapy, the social/professional structures of physiotherapy are not something students are aware of, yet they are controlled and constrained by
them. These professional structures control and constrain how students ability to act out their professional identity in the clinical placement.

Acknowledging professional socialisation as relational, interactional, reciprocal and negotiated emphasises the importance of relationships between individuals. In respect of the relationship between students and clinical educators and academic tutors, the concept of role models is well established. The vast majority of literature exploring the concept of role models does so from a positive perspective (Jung 1986; Lockwood and Kinda 1997; Colwell 1998; Gibson 2004; Shakespeare and Webb 2008). Role models are acknowledged as being vital as self-comparators in the process of continuing professional socialisation (Gibson 2004). Role models are generally defined in the literature as those individuals who occupy positions of status and power and who because of their status and power are able to exert a positive impact upon the students/newcomers/novices with whom they interact. The literature suggests that role modelling involves a process where students attempt to replicate and mirror the attitudes and behaviours of role models. Despite the interest in roles models and their central importance in the professional socialisation process the term remains largely ill-defined and vague (Elsy et al 2000; Eischbach and Bhattacharaya 2001; Shanahan 2002; Kenny et al 2004; Gibson 2004).

The concept of the role model promotes the importance of the interrelationships between individuals in the socialisation process and infers that professional identity is constructed through social processes of comparison. This relational element is important and infers that students and novices develop a professional sense of self through their interactions with others. This interaction serves to establish their sense of professional self in relation to others with whom they associate and against whom they compare themselves. Therefore, whilst the literature associated with the concept of role models is helpful in establishing the importance this inter relational nature of professional socialisation there remains a limited exploration of how individuals chose their role models. I suggest that within physiotherapy education, there is an assumption that students automatically accept the role models given to them.
The literature associated with role models infers that a common understanding of who is and who is not a role model exists between the role model themselves and the newcomer/student. Within the field of physiotherapy there seems to be an acceptance that clinical educators and others occupying positions of seniority and who enjoy professional status are recognised and accepted as positive role models by students. By going unacknowledged, this is problematic, in that it is impossible for physiotherapy educators to understand the how and the who of students’ choice of role models. Just as the individual student is actively constructing themselves, they are reciprocally engaged in constructing the others with whom they are interacting; a process which goes undetected and therefore uncontrolled. Therefore, individuals who occupy a particular role such as a clinical educator, academic or other high status professional role may or may not be seen as role models by students. There is scant evidence in the literature which explains or explores how individuals chose their role models.

Gibson’s (2004) work associated with role models is particularly important. He states that the concept of role models is limited and stresses the importance of the individual agency of students to either identify with or reject role models in practice. He supports the ideas of the social self, where the self is constructed through social comparisons. Gibson proposes a theory of role models consisting of two dimensions; cognitive and structural. He sub-divides cognitive dimensions into global and specific and structural dimensions into close and distant, up, across and down. He proposes that although the concept of role model remains vaguely defined role models are critical for growth and have putative importance. As I have already stated, the traditional concept of the role model is one defined as a person in an influential position Gibson proposes an alternative view which may be helpful in exploring how student physiotherapists construct their professional identity.

Gibson defines role models as active cognitive constructions that individuals devise in an attempt to construct their ideal self; ‘a cognitive construction based on the attributes of people in social roles that the individual perceives to be similar and desire to increase perceived similarity by emulating their attributes’ (2004, p136). Importantly he raises the point that the concept of a role model is dependent upon acts of identification based upon the perceptions of individuals.
and that it is the act of identification which makes another person a role model rather than someone being declared a role model simply because of the position they occupy. The concept of role modelling in physiotherapy is currently under researched and raises issues relating to the individual agency of students to accept or reject physiotherapy role models. If, as Gibson infers, role models are constructed by students, the potential for individual student to exercise agency is supported.

The literature relating to role models tends in the main to have positive connotations, there is limited consideration of negative role modelling and counter identification (Elsy-McManus, Simons and Russell 2000). Positive role models are important in helping others to define and develop their self-concept. Gibson’s (2004) work suggests that medical students create an ideal vision of themselves and seek medical role models to confirm this. He does not explain how medical students create their ideal self.

In this thesis I explore the possibility that competing and conflicting professional discourses experienced by students (in multiple clinical sites across multiple uniprofessional and interprofessional teams) may have the potential to create problems for students constructing their professional identity. Thinking back to my own journey I experienced a range of professional discourses throughout my education which I perceived as functioning as a monitoring, controlling, regulating discourses. It is through these professional discourses that educators then pass judgement on the legitimacy of students’ professional identities. In many ways, the professional gaze of the physiotherapists controlling the education experiences of students act as a kind of surveillance tool, designed to assure conformity and constraint and preserve the status quo.

**Identity Theory - a sociological perspective**

This section will provide a reasoned account of how I have begun to think about professional identity from theoretical and practical perspectives. Building upon the previous sections which have explored ideas which view reality as constructed in and through human interactions alongside an exploration of how power manifests itself in human interactions through dominant discourses; I will
now focus upon the process of identity construction rather than the product— the identity itself. As Cote and Levine suggest ‘sociological work on identity reinforces a number of points; identity processes can be found at two irreducible but interrelated social levels: interaction and institution’ (2002 p44). I have attempted to privilege the social basis of the self-predicated upon Stryker’s (1968, 2002) identity theory.

Stryker, one of the originators of identity based his own work upon early work of Cooley, Mead and Goffman, considers the self to be comprised of multiple identities played out through circumscribed practises associated with the roles in society individuals inhabit such as professional roles. For Stryker ‘a person has an identity or an internalised positional designation’ for each different position or role they hold in society (2002, p60). Identity theory is focused upon explaining individual behaviour through role related behaviours and attempts to explain social behaviour in terms of the reciprocal relations between self and society. This offers a useful set of ideas through which to explore professional identity. Its central tenet proposes that the self is constructed through social interaction and enactment of roles (Stryker 1968; Cerulo 1997; Callero 2003). These internalised positional designations constitute a form of meanings, such as what it means to be a physiotherapist. As Burke and Stet (2009) observe ‘people possess multiple identities because they occupy multiple roles meanings of these identities are shared by members of society’ (p3). For example role identities, such as being a physiotherapist, can be viewed as a form of self-definition that individuals apply to themselves as a consequence of role position, labelling and group membership. The self in this way is thought to reflect wider social structures and is in effect a self-constructed through a collection of identities derived from social positions. For Callero (2003), satisfactory enactment of roles confirms and validates a person’s status as a role member and is required for positive self-evaluation and the construction of a salient professional identity. For Stryker (ibid) social networks have an important impact upon an individual’s identity. He proposes that social networks link ideas of selfhood to the wider social structure, emphasising the notion of socially situated selves and the behaviour of individuals is mediated through role identities. Positions in society carry with certain roles and roles themselves carry with them shared sets of meanings thus ‘people become part of the social structure, occupying and
identifying with structural positions’ (Burke and Stet 2009). Labels associated with positions in society such as physiotherapist and student define individuals in terms of their position, 'they are relational in the sense that they tie individuals together ‘(ibid).

Stryker’s theory contains the following tenets;
1. Human behaviour is premised on a named world and these names have meaning in shared behavioural expectations which in turn grow out of social interaction. Social interactions then teach individuals how to behave
2. Positions in society carry with them shared behavioural expectations which are known as roles. According to Burke and Stet roles such as physiotherapists therefore,

   ‘are not just constructed and created a new in each situation. They exist [and have existed in historical time]. People perceive, react to them within society. They are shared by members of the culture and only slowly change or evolve as their use may change’

   (2009 p26)

3. People in society are essentially actors who name and label each other in terms of the position they occupy which in turn evokes shared meanings and expectations of behaviour
4. Individuals also name themselves in terms of their positional designation such as physiotherapists, 'it is these labels and the expectations and meanings attached to them that become internalised as the parts of the self we call identities’ (Burke and Stet 2009 p26)

The following definition is helpful in contextualising the remainder of this thesis,

   ‘An identity is the set of meanings that define who one is when one is an occupant of a particular role in society, a member of a particular group or claims particular characteristics that identify him or her as a unique person’

   (Burke and Stet 2009 p3)

Identity theory is a theoretical construct which supports ideas which privilege and place value upon the nature of interaction between individual human beings and
the societies they constitute. It supports the notion of multiple identities linked to roles in society which emerge out of social interactions. Rooted in the work of Cooley and Mead and symbolic interactionism, identity theory proposes that identity is interactional, multiple and closely tied to societal roles. (Cote and Levine 2002; Lawler 2008; Burke and Stet 2009). Over the past six decades identity theorists have been concerned with understanding and describing the nature of human beings in relation to society. As Burke and Stet assert, 'identities are important because they provide us with ties to others and to what is social in a situation. Part of their content consists of symbols and meanings pertaining to the self' (2009 p10). Drawn from the collective work of Cooley, Mead, Blumer, Kuhn, McCall, Rosenberg, Stryker, Turner and Weinstein identity has comprises of three main tenets; self, language and interaction (Burke and Stet 2009).

**Constructing the self**

According to Burr (1995) the self is a rather vague concept difficult to define and contested. As Jenkins states, when we talk about the self we tend to refer to the individuality or the essence of a person or thing, 'simultaneously evoking consistency or internal similarity over time and difference from external others (2004, p27) and thus meanings of the self tend to parallel definitions of identity. Jenkins proposes a definition of the self as ‘an individual’s reflexive sense of her or his own particular identity, constituted vis-a-vis others in terms of similarities and difference, without which she or he wouldn't know who they are’ (ibid. p27). As McCall and Simmons observe, ‘the individual achieves selfhood at that point at which he first begins to act towards himself in more or less the same fashion in which he acts towards other people’ (1978, p52 cited in Burke and Stet 2009). The self therefore is described as the essential aspect of a person and comprise a multitude of identities emerging out of social interaction. Burke and Stet, suggest that the self ‘is that which characterises an individual’s consciousness of his or her own being or identity’ (ibid p9). The concepts of the self and identity are complex and at times both separate and interrelated. It is not possible to include here a full discussion and therefore for clarification purposes, as this thesis is focused upon professional identity, I will use the terms professional self and professional identity interchangeably to refer to an individual’s sense of who they are.
The concept of the social self is not new, as early as the 1930s James and Cooley were writing about the concept (Gubruim and Holstein 2001). The concept of the self as essentially a social entity suggests that selves are constructed through interaction with others; a sense of who we are is developed out of how others respond to us, individuals are unable to see themselves outside of their social setting and conceive themselves indirectly from the standpoint of others (Callero 2003). This thesis will explore how professional selves, expressed through the enactment of professional identities are conceived through a reciprocal relationship between students and significant others involving the simultaneous co construction of each other. This reciprocal construction I suggest creates a dynamic characterised by the potential for misunderstandings to occur between individuals. As Cooley suggests, ‘as society members interacted, they took others into account. In the process they developed a sense of who they were from how others responded to them, individual selves arose out of the social’ (Cooley in Gubruim and Holstein 2000 p4). For Cooley, individuals and society are two sides of the same coin. For Goffman ‘information about the individual helps define the situation, enabling others to know in advance what he will expect from them and what they may expect of him’ (1959 p13). This infers reciprocal expectations each of the other on the part of the performer and the audience at the same time.

During the process of physiotherapy education, students are required to interact with a number of other professionals in a number of different professional contexts and in each of these different encounters are required to act out their professional identities which are in turn judged as being appropriate or otherwise. In terms of my own experiences as a student I interacted with others in a number of professional contexts and consciously and subconsciously took these others into account. Through this process I developed a sense of my professional self from how others responded to my performance of being a physiotherapist. I became very aware of learning to play the game by adjusting my performances as Melia (1987) observes to get in, fit in and get through. From this point of view, the concept of the social construction of the professional self appears to be appropriate.
As early as 1934, Mead was suggesting 'the individual experiences himself as (an object) not directly but only indirectly, from the particular standpoints of other members of the same social group... the individual becomes an object to himself just as other individuals are objects to him... it is impossible to conceive a self outside of social experience' (Mead pp138-140 in Gubruim and Holstein 2004, p4). The concept of the social self therefore suggests that an aspect of the self is socially grounded and dynamic, in the words of Holstein and Gubruim (2000), the self is not something we are but an object we actively construct and live by.

Thinking about my own experiences, I recall engaging on how I presented myself on clinical placement. As a student I was conscious of acting in different ways in order to work out how to satisfy my clinical supervisors. For me this was a very conscious performance and one that was not always successful. Stryker’s identity theory progresses these early ideas and states,

‘the human organism as an object takes on meaning through the behaviour of those who respond to that organism. We come to know what we are through others' responses to us...The manner in which they act towards us defines our self. We come to categorise ourselves as they categorise us and act in ways appropriate to their expectations’.

(1980, p116)

The concept of a social self translates into exploring the professional self. From a sociological perspective, society is created out of the interactions of individuals and that these individuals’ actions are produced in context. (Stryker 1980, 2002) As Burke and Stet point out the self emerges out of, ‘elaborate systems of mutual influences between characteristics of the individual and characteristics of society’ (2009 p4). Relating this to the world of physiotherapy, individual physiotherapists make up the world of physiotherapy, thus creating a society of physiotherapy that is different at a micro level where individual physiotherapists interact with each other. Clouder (2003) proposed that the professional socialisation of occupational therapy students could be considered as an interaction rather than moulding. Clouder’s work raises questions about the professional socialisation of occupational therapy students which may resonate across other health professionals and as such has been useful in contextualising my own work within physiotherapy.
This thesis is concerned with exploring the sites of identity construction through students’ narratives of experience. The sites of students’ and others’ interactions become sites of identity construction. This thesis is focused upon the sites of interaction between students and others (as social actors), and the patterns of behaviour which emerge between these social actors.

From an identity theory perspective, the social self wants to live up to the expectations of others’ sense of who and what they are (Cahill 1998; Stryker and Burke, 2000; Callero 2003; Hogg 2005). If the professional self is conceptualised as essentially a social self then it may be helpful to explore the sites of interaction as a way of offering new insights into how students construct themselves as physiotherapists. In my own case, I wanted to live up to the expectations others (patients, physiotherapists and the wider multiprofessional team) had of me as a physiotherapist. As Holstein and Gubrium (2000) suggest, in today’s world of proliferating sites and scenes of identity work, the self is an increasingly institutional project.

I believe that student physiotherapists wish to live up to the expectations of those such as clinical educators, patients and members of the multiprofessional team. I believe they enter the clinical placement environment with high expectations of themselves and of others.

This idea is particularly pertinent to this thesis; I propose that student physiotherapists enter the clinical environment ready to rehearse their emerging professional identity through their performance of their imagined clinical role in ways which will make their professional identity clear to themselves and others. Through their conscious and unconscious actions and every day learning interactions student physiotherapist attempt to convey a particular professional image of themselves which in turn belies their emerging professional identity. The images they are able to successfully project are affected by the unspoken expectations of powerful others. For example, interactions with their clinical educator control the extent to which students are able to act out their idealised professional self. The extent to which the students’ identity mirrors that of their clinical educators will dictate what is and is not possible. In turn clinical
educators’ own professional identity will in effect reflect dominant professional discourses in action in particular professional contexts. I propose that is not unreasonable to infer that dominant professional discourses differ from context to context. In essence, the dominant professional discourses in professional settings control how things are done and understood; ‘a social institution with particular ways of doing and framing matters of relevance to participants, they offer distinct senses of whom and what we are, were and can be’ (Holstein and Gubrium 2001 p13).

Drawing on Foucault’s (1986) notion of power allows us to question how power is organised in organisations such as the clinical placement. For Foucault, power is exercised through language in the form of dominant discourses. He sees language as being central to power and he proposes that the language human beings use shapes and directs the ways in which human beings think about things and name things. This thinking and naming then becomes a sort of convention. In terms of this thesis, the dominant professional discourses exercise a decisive influence on professional behaviours and practices and that these then become regimes of truth. These discourses then exercise power over our thought by controlling what we see as truth and how we understand the world and hence our acting and our doing (Gergen 1998). As Moss et al (2000) explain, power in professional fields controls professional practices, it controls how problems are constituted, how people are classified and what constitutes appropriate behaviour. The self can be viewed as a product of interpretive practice, under construction at every turn of social interaction.

The previous sections have provided an overview of identity theory which emphasises the connection between role and identity. This is particularly important in respect of professional identity. As McCall and Simmons work on role identities suggests, for role identities to work individuals need to identify with, internalise and become the role, ‘ones imaginative view of himself as he likes to think of himself being and acting as an occupant of a particular social position’ (McCall and Simmons 1978, p65, cited in Burke and Stet 2009 p39). Identity theory emphasises interaction. Interaction in turn involves exchange between individuals, which in turn involves, negotiating, bargaining and rewarding. In our everyday interactions, we all learn to respond to the cues in
our environment through a collective understanding and shared meaning of signs (objects) and symbols (words). These signs and symbols derive their meaning from social consensus predicated upon the culture of the environment. In other words the ways in which signs and symbols derive meaning is through a process of social interaction, which produces a social definition and shared meanings amongst social group members.

For example the world of physiotherapy education comprises physiotherapy symbols which derive their meaning through the interactions of groups of physiotherapists involved in the education of students. Physiotherapy language therefore is the vehicle through which individual student physiotherapists come to interpret physiotherapy signs in similar ways. Language therefore is symbolic communication which shapes and controls interactions between individuals in any social situation. Physiotherapy education involves interaction through language between students and physiotherapists which in turn is the way in which identities are communicated. Language therefore is the vehicle through which identities are communicated between individuals in organisational positions and roles. Identity theory allows for the consideration of identity as ‘improvised and negotiated’ rather than ‘normative and conventional’ (Burke and Stet 2009, p39). Thus, the traditional conceptualisation of identity as a fixed singular and individualistic entity has been replaced by ideas which consider identity to be a dynamic construct made up of a multiplicity of selves (Bruner 1986; Clandinin 1998; Clandinin and Connelly 1987; Shotter and Gergen 1994; Gergen 1998; McAdams 2002; Housten 2001; Callero 2003) situated in social relationships and emphasising identity as relational, social and interactional (McLure 1996).

As is often noted in identity literature structure versus agency, reaction versus pro-action and compliance versus resistance are often cited as being of central importance (DuToit 1995; Niemi 1997; McLure 1996; Abbas and McLean 2001; Flores 2001; Jones 2003; Clouder 2003; Kenny et al 2004; Karaoz 2004; Apkar and Eggly 2009; Hurst, 2010). Any exploration of identity usually includes some consideration of the agency/structure binary. Agency is the capacity of individuals to act independently and make behavioural choices and decisions based upon negotiation, compromise, conflict and contention; to act wilfully in order to active negotiate with others in order to create certain roles. Structure debates focus
upon external factors and explore the way in which societal norms exert influence and control how individuals are able to act and behave in roles that are assigned to them. Sociologically, identities are embedded in roles and individuals occupying roles play out the parts associated with these roles that are expected of them. For example, students do what they are supposed to do and behave in ways which are expected of them. The concept of identity as interaction is where agency and structure meet and influence how individuals construct their identity (Burke and Stet 2009). It is therefore appropriate to consider how individuals and society interact. In any given situation individuals use the resources available to them to perform an identity and enact a particular role. As this performance and enactment is done in the company of others, as Blumer suggests

‘in order to interact with others we first must establish both who we are and who they are....... we must learn the identity of the others with whom we interact, they must be labelled symbolically and thus given an identity....... the categories and classifications that are used for this purpose are provided by language and culture in which we are enmeshed’

(1962 cited by Burke and Stet 2009 p13)

**Professional Identity**

This next section will introduce the main themes highlighted in the literature associated with professional identity. In the interests of space and to prevent repetition I have not included the professional identity literature already cited in the earlier sections of this chapter/thesis. Nor have I attempted to include the full breadth of professional socialisation literature, rather I have focused this section on the literature most pertinent to my research focus. In recognition of the paucity of literature within my own professional field of physiotherapy, I have drawn upon literature from the related health care fields of medicine, social work, occupational therapy and nursing as well as drawing upon the extensive literature in the field of teaching. The main themes arising from the literature can be divided in the following broad areas; role models, peers, expectations of job role, professional function, status and self-esteem, career choice and professional
socialisation (Bjorklund 2000; Cook 2003; Clouder 2003; Jones 2003; Bathmaker and Avis 2005; Kaufman 2006; Adam et al 2006; Johansson and Hamberg 2007).

Within physiotherapy the focus in the literature tends to be on the outcomes rather than the process of professional socialisation (Richardson et al 2002; Lindquist et al 2004, Ohman et al 2001; Ohman, Solomon, Finch 2002). Despite the increasing interest and promotion of reflective practice (Schon 1983, Eraut 2000), in my view this signifies a dominant professional discourse and professional interest in the technical-rational basis of the profession and as the effect of diminishing the importance of intuitive aspects of physiotherapy professional practice. Strongly aligned with the medical literature this infers a priority value on the acquisition of professional competence through the acquisition of profession specific knowledge and skills. Apker and Eggly’s (2009) study into the professional socialisation of medical students suggests that they construct their professional identity through discursive practices and that these practices privilege and legitimise a medical professional identity which privileges technical medicine and diminishes the bio psychosocial aspects of medical practice. This is supported by Harker and Krone (2001) who emphasise how communicative practices tell students to do things in certain ways.

Richardson et al (2002) explored the expectations of first year physiotherapy students of being a physiotherapist with the intention of informing curriculum design. They found that early expectations of physiotherapy students were centred upon functional and behavioural aspects of being a physiotherapist such as acting professionally, instructing, caring and communicating. They conclude that students entering physiotherapy education do so with a wide range of views about physiotherapy and that educators need to guide students views to fit in with modern practice; ‘there is a need for educators to consider how to monitor the students’ developing concepts of their professional role’ (2002 p625). Within the context of professional socialisation in physiotherapy Ohman (2001, 2002) explored the impact of gender on career choice and professional preferences in Sweden and Canada the professional socialisation of within physiotherapy. Sparkes (2002) explored the role and professional identity of physiotherapy educators and its impact on individuals. She proposes that the creation of a profession of physiotherapy educators is required to support physiotherapist who
move into physiotherapy academic roles. Predominantly, these studies consider socialisation in terms of qualified and practising physiotherapists rather than considering it from the prospective of students. In respect of this study, the work of Richardson and Lindquist is of pertinence and highlights the importance of understanding more about how students experience the process of professional socialisation. However Lindquist et al’s work has largely been focused upon the outcomes of professional socialisation rather than the process and in many ways appears to supports ideas which see professional identity as fixed and deterministic (Lindquist et al 2006, 2009). Education outcomes such as the acquisition of professional competence, skilled and evidenced based technical application of physiotherapeutic skills and competencies (Higgs 1993; Richardson 1996; 1997; Williams 1998; Higgs et al 1999; Higgs and Titchen 1995; Bligh 2005; Mercer et al, 2002; Snelling 2004 Richardson 1999a, 1999b, Gard and Sunden 2003). For example Richardson’s extensive work (1999a, 1999b, 2006) linked the acquisition of professional knowledge, the culture of learning and the notions of continuing professional development as evidence of the successful professional socialisation of student physiotherapists. Clouder (2003) proposed that the professional socialisation of occupational therapy students could be considered as an interaction rather than moulding. Clouder’s work raises questioned about the nature and process of professional socialisation within the field of Occupational Therapy. As already indicated I will now consider two authors in more depth as I see their work has being particularly relevant and influential in respect of my own work. I will first of all consider how Clouder’s (2003) work within occupational therapy followed by a consideration of the work of Lindquist et el (2006, 2009).

Although there are significant differences between the educational philosophy of occupational therapy and physiotherapy education there is also considerable parallels to be drawn. Clouder was one author within the health care field to challenge the traditional notions of professional socialisation as a deterministic process. Her work exploring the complexities of professional socialisation in occupational therapy argued for an alternative to the traditional notions of socialisation as passive moulding of newcomers into the professional norms to one which suggested professional socialisation as interaction. She looked at the ways in which occupational therapy students identified with professional norms.
and suggested that despite the power of the occupational therapy profession to regulate practice there was still scope or individual students to exercise personal agency. The major themes she identified as being important to the professional socialisation of occupational therapy students were; learning to care in a professional context, dealing with virtue, stability and change and the dynamics of support mechanisms. This work has been personally influential in a numbers of ways. At the time it signalled a shift in the way in which health professionals could think about and problematises professional socialisation, whilst much of the nursing literature still promoted professional socialisation as a moulding process, through which nurses internalise the knowledge, skills and behaviours established as the norm in nursing. Her findings echo those of Melia (1987) in that occupational therapy students learnt how to adapt to the clinical situations they found themselves in. She found that occupational therapy students engaged in tactics such as learning to play the game, putting up with things, not rocking the boat and using silence as a conscious strategy to get through.

Within physiotherapy, Lindquist et al’s (2006) longitudinal study aimed to define the professional identity of student physiotherapists on the edge of working life. These authors conclude that at the end of their undergraduate education physiotherapy students have developed one of three professional identities and these are described as; empower, educator and treater. The results of this study suggest that professional identity is well formed at the point of graduation and that it can be defined and described via a typology approach. Lindquist et al’s work although not overtly stated appears to favour ideas which suggest that professional identities at the point of graduation are fixed.

**Professional identity construction**

This next section will present as number of relevant studies within the professional identity literature focused upon the process of socialisation and identity construction. The link between professional role clarity, job function and professional competence is well documented as being important for the construction of a salient professional identity (Taylor 2001; Masson and Lester 2003). Adkin’s (1995) describes the socialisation process of qualified nurses as a
process through which nurses develop a sense of professional task competence, clarity of professional role, the resolution of issues relating to role ambiguity, role conflict, revisions of their idealised expectations of nursing (and thus alleviating praxis shock), and the development of successful interpersonal relationships. Adkin’s study infers that organisational differences made the process of professionalisation more complicated.

For Pullon (2008) the salience of a professional identity in nursing is related to being professionally competent, understanding the nursing role and being able to form meaningful relationships’ with patients, clients and colleagues. Pullon’s work highlights a number of important points which impact upon the professional identity these are; organisational and funding structures, organisational and employment issues and training and education issues. She concludes that although professional identity is essentially individual, thus emphasising difference and distinction, the development of shared values and goals and mutual interprofessional respect as a result of being professionally competent were equally important to professional identity. Adams and Hean’s (2006) work exploring the interface between professional identities and interprofessional education for health students suggests that students enter professional education with a well-developed sense of professional identity, and that physiotherapy students displayed and sustained a stronger professional identity than other health students.

For Murray and Male (2004) qualified teachers on average took three years to develop a salient professional identity after graduation. Teachers described a lack of role clarity and insecurities relating to job competence as having a significant impact upon their professional identity and that this lack of clarity led to novice teachers experiencing high levels of confusion, anxiety and uncertainty about being a teacher during their teacher training. Lee (2002), Jenson (2003) and Hodson (2002) all found that clarification of role, job and the ability to cope with job stresses alongside satisfactory supervisory experiences were influential in the development of professional identity in nursing. For Nixon (2001), the most important aspect of professional socialisation was issues relating to role clarity and role status. For individuals; identity work involves evaluation of the self and others (Jenkins 2004; Burr 2002; Clouder 2003). For new and emerging identities
to be salient individuals have to receive positive evaluations of their emerging identity from others who occupy the same role; ‘the number and importance of social relationships premised on a particular role identity may influence the salience of that identity’ (Hogg et al 1995, p258). This is of particular importance in terms of student physiotherapists and their interactions with clinical educators.

Niemi (1997) suggests that little is known about the process of professional identity construction or how students identify professional values they find personally important as a way of constructing their professional selves and that more work is needed to understand more about how students identify the choice and opportunities offered to them and how they then finally commit to those they find personally important. They suggest that at the end of undergraduate education medical students do not have a fully developed professional identity and they continue to engage in testing out hypothetical career opportunities and professional identities beyond graduation. In contrast, Cook et al’s (2003) work in nursing suggests that nursing students enter nurse education with a well-developed sense of what being a nurse means and that early clinical education experiences (year one) are instrumental in continuing to shape their nurse identity.

Payne’s (2006) work within the field of social work focused upon the politics of identity within the multiprofessional team suggests that the multiprofessional team acts as an important site of identity construction for social workers. Payne found that social workers view the multiprofessional team as a place where they can achieve acceptance and recognition of their professional role. For Payne professional identities are no longer as tightly controlled and ascribed as they previously were and shaped by a whole set of relationships in which individual professionals participate; ‘social work identity relies less on official responsibilities prescribed by government and more on roles that they can gain acceptance for in a myriad of agencies and professional groups, each seeking to negotiate their own position in relation to others’ (2006, p141). McMichael’s (2000) work looking at social workers identities supports the connections between the salience of professional identities with the perception of professional status. Perotta’s (2006) main findings identified three main elements which appear to be important in identity construction these are professional boundaries, perceived
disempowerment of individual professionals and the perceived value and worth of professional members of the multiprofessional team. Perotta suggests that within the multiprofessional team the construction of a common identity rather than a professional identity creates a number of issues for some individuals in respect of their emerging professional identity. His work is helpful in understanding professional identity in and across communities of practice; he suggests that how identities are constructed in learning environments allows for a reconsideration of role of cultural contexts in the production of identities. His work describes the process of professional identity construction as problematic, messy and culturally specific. His main findings suggest that construction of a professional identity is rarely neat nor merely an individual process but always informed by texts and discourse which belie the cultural context in which they are constructed. He uses the work of Wenger (1998) as a theoretical basis for his work, ‘we define who we are by negotiating local ways of belonging to broader constellations’ (Wenger 1998, p149 cited in Perotta 2006).

The previous sections have described my proposed theoretical framework predicated upon ideas associated with social constructivism, a Foucauldian notion of power, the theoretical considerations associated with identity theory thus privileging the link between social interaction and identity. This next section will continue to outline my theoretical frame in relation to narrative and identity and as such will serve as an introduction to chapter three.

**Linking Narrative and Identity Narrative as resources of self-construction**

In chapter one I outlined in detail my narrative approach to this study. This next section will explore the ideas of the narrated self and narrative ways of knowing as they relate to this thesis and the knowledge produced within it. As McAdams suggests,

‘we are all tellers of tales, we each seek to provide our scattered and often confusing experiences with a sense of coherence by arranging the episodes of our lives into stories. This is not the stuff of delusion or self-deception. We are not telling ourselves lies, rather through our
personal myths each of us discovers what is true and what is meaningful’.

(1993, p30)

Narratives of becoming a professional are powerful ways of sense making for individuals. This thesis has privileged the voice of the individual students and proposes that through personal narratives this thesis provides a unique perspective of how student physiotherapists navigate their learning experiences to construct their professional identity. As Lawler (2008) observes, stories are important as a mechanism through which identities can be understood and constructed. Lawler sees identities as ‘made up through making a story of a life... identities can be seen as creatively produced’ through characters, actions and plots (p11). In McAdam’s terms a personal myth delineates an identity. I propose that this study has been instrumental in helping participants construct their own personal and professional myth, ‘the process of focusing on the life and translating it into words helps the author to identify or construct a coherent view of the self’ (1993, p254). Through the stories they tell, students construct themselves and others. For me, professional identity is too complicated and too socially inflected and context specific to adhere to a typology approach.

There is an increasing interest in the narrative quality of lives, and the personal story has been resurrected as an important source of data (Polkinghorne 1995: Mishler 1987; Sparkes 1996; Temple 2002; Reissman 1996; 2004, 2008; Cortazzi 2001; Roberts 2000; Andrews et al 2008). We are constantly being reminded that selves are constructed through storytelling. The process of self-construction stands at the intersection of discursive practice and discourses-in-practice. (Gubrium and Holstein 2000, p103). Narrative practice lies at the heart of self-construction therefore I believe that seeking stories of experience is an appropriate way of exploring professional identity from an identity theory perspective and by combining ideas taken from social constructivism, Foucault and narrative.
The value of narrative ways of knowing: a justification

The following section will consider how narrative ways of knowing have shaped this thesis. Building upon the idea of knowledge as constructed through interaction, context-specific and locally determined, this section draws upon the work of Bruner (1990) and Ricoeur (1984) to suggest ways in which I see narrative as a way of producing knowledge which is meaningful to both individuals and society. As previously stated I have been concerned with exploring identity from a social perspective, privileging the notion of the professional self as a social self, borne out of interaction and professional identity as a product of interpretive practices. In this final section I will explore how I understand the work of the Bruner (1990) and Ricoeur (1984, 1986) and how I have used their ideas to shape this thesis. For Ricoeur (1986), stories are particularly suited as a linguistic form in which human experience as lived can be expressed, ‘to answer the question who?...is to tell the story of a life. The story told tells about the action of the who’ (1986, p246). The identity of this ‘who’ therefore itself must be narrative identities. Identity for Ricoeur means oneself as self-same, capable and inclusive of change over a lifetime but providing a sense of personal cohesion and constancy over a lifetime, ‘as the literary analysis of autobiography confirms, the story of a life continues to be refigured by all the truthful and fictive stories a subject tells himself or herself. The refiguration makes it a cloth of woven stories told’ (ibid, p246). As Polkinghorne (1995) suggests narrative provides discourses concerned with the everyday and view these as a legitimate way of accessing experiences.

Bruner (ibid) argued that human beings understand the world in two distinct ways; paradigmatic modes of knowing and narrative modes of knowing. Paradigmatic modes are associated with tightly reasoned predicted reality and empirical truth suggestive of cause and effect relationships, suggestive of an unambiguous truth which can be tested and proven or otherwise. For Bruner this type of knowing is unable to predict or make sense of human desires and goals, stories are particularly helpful in that they often mean more than they say and narrative modes of knowing are concerned with human wants and goals, the strength of this way of knowing stems from the belief that human events are often ambiguous and resistant to paradigmatic attempts to understand them. As
Bruner asserts, ‘people do not deal with the world event by event or with text sentence by sentence. They frame events and sentences in a larger structure’ (1990, p64). Ricoeur considers identities to be creatively produced through what he call emplotment of experience, ‘emplotment configures a self which appears as the inevitable outcome and actualisation of the episodes which constitute a life’ (cited in Lawler 2009 p16). In this way Ricoeur sees identities as something profoundly social, continually interpreted and reinterpreted.

For me the strength of a narrative approach is that emplotment provides a way to talk about the process of weaving separate events into a meaningful whole, and is consistent with my approach to this research. For Polkinghorne, plots can be defined as a ‘type of conceptual scheme by which a contextual meaning of individual events can be displayed’ and therefore reveal the relational significance of events (1995, p7). Narrative knowing seeks to explain events in terms of human actors striving to do things over time. For McAdams (1993) Human experience is storied because of the way most of us comprehend our worlds through our actions that are organised over time.

Ricoeur (1985) suggests that time becomes human time to the extent it is organised after the manner of narrative, narrative in turn is meaningful it portrays the features of temporal existence, suggesting that human beings tend to comprehend time in terms of stories. As time passes events happen and stories are created as events are connected by the individual into a coherent sense making whole. In respect of this thesis, the stories of becoming a physiotherapist (constructing a professional identity) as told by my participants are stories which have connected a number of distinct experiences (which have occurred over time) and put together so as to create unique stories. Through these stories I have been able to offer a perspective on how students’ experiences influence the construction of their professional identity. Participating in this study has provided the space in which participants were able to connect significant experiences and events into a meaningful whole; building up highly individual personal stories of becoming a physiotherapist. Whilst these individual stories may have provided personal meaning I suggest they have also provide a collective meaning which may resonate with other physiotherapists and thus be helpful in the future. In this sense I hope to have privileged the way in which
individual’s reason with themselves through the telling of stories to themselves and others who have the capacity and interest to listen.

As McAdams explains,

‘When we comprehend our actions over time we see what we do in terms of story. We see obstacles confronted and intentions realised and frustrated over time. As we move forward from yesterday to today to tomorrow we move through tension building to climaxes, climaxes give way to denouements and tensions building again as we continue to move and change. Human time is a storied affair’.

(1993, p30)

Bruner argued that narrative knowledge was more than just an emotive expression, but rather that it is a legitimate form of reasoned knowing. Narrative cognition is particularly directed to understanding human action as Polkinghorne suggests;

‘Human action is the outcome of the interaction of a person’s previous learning and experiences, present situation. Unlike objects, in which knowledge of one can be substituted for another, human actions are unique and not fully replicable. Whereas paradigmatic knowledge is focused on what is common among actions, narrative knowledge focuses upon the particular and special characteristics of each action’

(1999, p11)

Narrative reasoning operates by noticing the differences and diversity of people’s behaviours and narrative knowledge is maintained in emplotted stories, ‘storied memories retain the complexity of the situation in which an action was undertaken and the emotional and motivational meaning connected with it’ (Polkinghorne 1995 p11). The emotional and motivational meaning in stories provides a unique insight into how things are experienced. This feels potentially valuable to the teller but I believe has the potential to be valuable in a wider context as more stories are told and talked about. Narrative cognition gives us explanatory knowledge of why a person acted as he or she did, it makes another’s actions understandable. Narrative reality results from a telling and a retelling of events and as Bruner (1990) states, ‘the self is a narratable entity.’ Narratability is not about intelligibility but about familiarity with the spontaneous narrating structure of memory (Caverero 2000). Narrative knowledge and reality
occur through thematically organised plots, structuring stories in particular ways
to tell a particular version of events. These narrative structures also perform a
function for the tellers, by providing a ‘practical coherence in personal stories ... 
and focuses attention on the how’s and the what of narration’ (Gubrium and
Holstein 2004, p164). This thesis is built on the idea that professional identities
are strategic social constructions made valuable and meaningful to individuals
through narratives of experience.

**Conclusion**

Within this chapter I have explained how the challenging and changing
professional context of contemporary health care has provided me with the
impetus to undertake this research study and sustained my professional interest
in how the learning experiences of student physiotherapists are influenced by the
complexities of contemporary professional contexts and roles and in particular
the impact this complexity may have on their ability to construct a salient
professional identity. My interest and focus on the sites of interaction as sites of
identity construction leads me to taking a sociological stance.

My interest in the process of professional identity construction is in part related
to my own experiences of being in clinical placement settings, of coping with the
differences between clinical educators across contexts and how these differences
influenced my professional self. My own experiences reflect a situation where I
did not always feel free to act in ways that reflected my professional identity. I
have remained interested in how locally determined professional discourses such
as those experienced by students across different learning sites have the
potential to act as mechanisms of control, creating contexts where students may
not be free to act as individual agents.

Building on chapter one, this chapter has provided a reasoned account of the
theoretical basis of this thesis. I have attempted provide my readers with an
account of how I have used social constructivism and Foucault’s notion of power
as the basis for a critical exploration of how student physiotherapists construct
their professional identity. Supporting the idea that notions of professional
identity are neither benign, neutral or stand outside relations of power
As Foucault (1977), suggests concepts are derived from economic, social, philosophical, political and historical contexts. The knowledge contained within this thesis is acknowledged as being bound in ways which Foucault describes and is a product of its time. I have attempted to value the importance of individual stories of experience as a vehicle through which the process of constructing professional identities can be explored. A narrative approach privileges notions of multiplicity in terms of meaning making, reality and knowledge construction. I propose that by combining ideas from social constructivism, Foucault and narrative provide me with a sound theoretical basis from which to problematise the taken for granted process of professional identity construction. As Housten (2000) observes, ‘social constructivism links our narratives about ourselves and the world to our actions through meaning making’ (p847). In chapter three I now turn to a consideration of my methodological approach.
Chapter 3: Methodology

Introduction

In this chapter I will present and discuss the methods I used to undertake this study. This chapter is primarily concerned with providing a detailed description of my data collection methods and data analysis approach. In recognition of the wide divergence of approach and execution of narrative studies, this chapter will provide the necessary details for my readers of how I have come to develop my own approach to doing narrative research. My approach will be justified through a consideration of the theoretical underpinnings of narrative inquiry. For clarity and ease of reading this chapter will also reaffirm the overall research question and research aims as described in chapter one. In the final section I will describe in detail my practical approach to narrative analysis and my own analytical model based on my reading of Polkinghorne (1995) and his distinction between narrative analysis and analysis of narrative, alongside the model described by Lieblich et al(1998) and McCormack’s storying of stories (2004). An example interview transcript and a worked example of analysis is presented in appendix 5 and 6 respectively. In recognition of the role of the interviewer in constructing biographical information from interviewees (Holloway and Jefferson 2000; Holstein and Gubrium 2000), I will also include an account of how I dealt with issues relating to insiderness, authorship, voice and representation. Narrative cannot be understood without reference to the role of the audience for whom it was produced. In this way I hope to convince my examiners and readers of the claims I make in this thesis. In keeping with the tradition of interpretive research, I will also consider issues relating to authorship, voice and presentation. Reference will be made to the theoretical perspectives associated with narrative as a methodology and professional identity, both of which are presented in more detail in chapter two. In order to locate the reading of this chapter with the overall research questions I have restated them here.

The research question was:

How do student physiotherapists’ construct their professional identities?
The aims of the study are:

- To understand more fully the process of constructing a professional identity in a professional context which promotes interprofessionalism
- To explore the interaction between students and significant others and understand how these interactions impact upon students’ professional identity
- To explore sites of identity construction described as significant and important by students
- To elicit students’ narratives as a way of understanding their lived experiences

**Methodological Overview**

As described in chapter one, this thesis has been primarily focussed on exploring the process through which student physiotherapists construct a physiotherapy identity through and as a consequence of their undergraduate learning experiences. As with other narrative studies I have attempted to privilege the viewpoint of the individual participant, providing a vehicle through which participant voices can be heard, issues relating to authorship and voice will be examined in a later section of this chapter.

My primary interest has been to better understand the meaning of behaviour and experiences from the perspective of individuals involved. I believe narrative to be a useful device through which individuals can communicate their feelings and which elements of their experiences are important and why. I understand narratives to be ‘discourses with a clear sequential order that connects events in a meaningful way for a definite audience’ (Hinchman and Hinchman 1997, p3). Narrative offers insight about the world and/or peoples experiences of it. The three key features are chronology, meaningfulness and an emphasis on the social aspects of human interaction. As Labov and Waletzky (1997) assert, the defining

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9 As these participants had completed their undergraduate studies and the fact that the interviews took place only after completion I have defined these participants as physiotherapists and as such refer to them as either participants or physiotherapists throughout this thesis. Also, during the interviews it was apparent that each participant did identify themselves as physiotherapists.
feature of narrative is the placing of events in a sequence as a way of making sense of them. My intention was to adopt a narrative approach and as such study human experiences through the stories people tell. In recognition of the diversity of opinion around narrative research and the use of stories as a way of making sense it is important for me to clarify my own perspective which this next section attempts to do. I define narrative research as a research approach that allows for the study of experience as forms of storytelling (Andrews 2008; Clandinin and Connelly 2006). Narrative approaches enable the collecting and analysing of accounts people tell to describe their experiences. As human beings we all tell stories, not only to recall events but also as a way of understanding those events and their importance to us. In many ways stories can be both personal and social (Webster and Mertova 2007). For me, the strength of narrative is derived from the idea that they allow me as a researcher to frame everyday human experiences in a story form and in the interconnectedness they allow between incidences and events in a coherent sense making way.

In essence the purpose of this study was to capture and analyse individual stories as a way of documenting the critical life events of learning to be a physiotherapist in a way which promoted a greater understanding of what these everyday events meant to those experiencing them and to what extent the part they played in shaping the future of these participants. As Clandinin and Connelly (2000) assert, narrative approaches put human beings at the centre of the research process and promote the legitimacy of the subjective experiences of individuals as a way of understanding the lived world (Clandinin and Connelly 2000; Reissman 2004).

Prior to commencement of the study, I engaged in a series of critical conversations with other physiotherapy colleagues about professional identity and had the opportunity to discuss issues of identity with past students. As this took place in my professional context, I felt it important to be open about it. I wished to engage colleagues in conversations about professional identity openly, for them to be aware of the project; my existing relationship with them helped with access to participants as well as helping me to reach conclusion about the focus of this study.
The study took place in the summer of 2008 in a university in England which provided physiotherapy education. It utilised unstructured interviews to elicit new insights into the process of professional identity construction. I did consider alternative and additional ways of exploring how student physiotherapists constructed their professional identity through and as a consequence of their learning experiences including looking at the reflective diary extracts from participant’s professional portfolio. As these are designed to help students reflect upon their professional development throughout their undergraduate programme, I imagined that they would be sources of rich data pertinent to my research interests. However on reading a number of them, it became clear that in the main they were at best richly descriptive but largely lacking in terms of a reflective element. Descriptions of events and happenings without the *so what* element did not allow me access to the meaning making these students had undertaken which did not fit with the main purpose of this study which was to get to the meaning making point of constructing a professional identity. With this at the forefront of my mind, I rejected the idea of using these written experiences as a way into exploring professional identity. My interest in the individual experience led me to pursue a method of data collection that would enable me to explore what meanings and significance students placed upon particular learning experiences they themselves identified as being influential on them. This led me to the desire to elicit individual stories through interview.

I believe stories elicited through narrative research offer a legitimate way into generating new knowledge out of lived experiences. The doctoral programme is specifically designed to enable practitioners to undertake research which has the capacity to influence local contexts. This has provided me with the opportunity to undertake research in my own professional context and I hope to use the findings presented in chapter four to inform future physiotherapy educational practice within my local context and hopefully beyond. Using a one-off unstructured interview approach designed to elicit stories of becoming I believe I have been able to enter the world of these participants and generate new knowledge and insight about how students interact with their learning experiences in order to develop themselves professionally. From my perspective, an unstructured approach to the interview itself was the best way of eliciting the stories these participants chose to tell, what to include how to tell it and I hope
the space to be able to understand themselves more easily what impact their learning experiences had.

**The interview**

The data collection method took the form of individual unstructured interviews. As is common to other narrative studies, the interviews of this study can be loosely described as conversational in style and were conducted in a way as to facilitate stories to unfold uninterrupted (Elliot 2005). As a useful starting point and in an attempt to get my participants started, I asked them to consider why they had made a career choice of physiotherapy in the first place. I saw this has a useful starting point. Specifically, participants were encouraged to tell their story of becoming a physiotherapist and in doing so consider their experiences in light of the following;

- Significant people
- Significant places
- Significant events

To me these questions are helpful in inviting participants to reflect on significant people, places and events. This in turn is an appropriate way of evoking the instances and events that individuals weave together into a narrative. In this way I can facilitate the construction of a rich and relevant narrative.

**Managing the interview**

The intention in the interviews was also to provide the space for participants to tell their particular story10 in a way they chose to tell it and indeed to determine which stories they told. Taking part in the study gave them the space to reflect on their experiences and the opportunity to make sense of what those

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10 Whilst the debate continues in the literature (Reissman 2008, Andrews 2008) regarding the use of the word story or narrative to define and describe the product of narrative studies I have chosen to refer to these physiotherapist’s narratives as stories, this more accurately reflects their purpose and the way in which they have been presented here.
experiences meant to them. In many ways participation in this study allowed participants the confidential space to explore their professional development; I see the interview as a site of data production (Chase 1995; Cox 2003). As Mishler (1999) suggests the discourse of the interview is jointly constructed by the interviewer and interviewee and the role of the interviewer needs to be taken seriously. Narrative approaches to interviewing allow for a free flow of talk, where participants are invited to tell their story with little or minimal interruption from the interviewer (Reissman 2001). Each interview took place in a private room, on the university campus and was tape recorded. Where participants indicated an end to their story, I then drew them back to points in their story which related to my research question. I used interview notes to record points of the interview I wished to revisit as and when the interview allowed. This allowed me to avoid interruptions and at the same time prompt me to seek further information at the points where natural breaks occurred.

In the interests of eliciting free flowing stories I made no attempt to restrict what my participants could talk about. I allowed participants to decide for themselves which people, which places and which events were important enough for them to talk about. Whilst the limitations of this study will be explored in the final chapter, it is important for me to justify my data collection methods. The decision to undertake a one off interview with final year students’ right at the point of graduation was felt to be appropriate; the nature of the Ed.D process and the associated timescales necessitated a pragmatic approach to the research component in terms of its timing and duration.

**Research Procedure**

**Participants**

A total of eight student physiotherapists (self-selecting volunteers) from a final year cohort of twenty four physiotherapy students from a University in England were recruited to take part in this study. All final year physiotherapy students were eligible to take part in the study. Potential participants were initially approached to take part during an informal meeting between myself and the final year group. During this session I explained the purposes of the study and
distributed information sheet (appendix 2) and copies of consent forms (appendix 4) for students to read at their leisure. Students were invited to contact myself directly to indicate their willingness to learn more about the study and to agree to take part if happy to do so.

**Participant sampling strategies**

Whilst I make no claims of statistical representation this section will describe the approach I took to participant sampling. The premise upon which I made sampling decisions was purposive in nature. As Rice and Ezzy (1999) suggest often qualitative researchers “aim to select information rich cases for in depth study to examine meanings, interpretations, processes and theory” (p43). Sampling in qualitative research is always purposive in nature; my participants were drawn from a cohort of 24 full time final year Physiotherapy students all of whom were eligible to participate. Pragmatically, I needed to recruit a sufficiently representative group of participants to address issues of legitimacy in relation to my findings as presented in chapter four. At the same time I wished to preserve the potential for producing findings which emphasised depth over breadth in line with my narrative approach.

My primary purpose was to seek participants who were interested in exploring for themesleves their lived experiences and who were willing to share these experiences with me; this approach is often referred to as volunteer sampling. As Mason (2002), suggests qualitative work sampling usually involves practical and resource based issues as well as the important question of focus. These practical issues and the practitioner emphasis of the Ed.D programme led me to focus my attention upon potential participants from within my own institution and the advantages and disadvantages of this were explored through the ethical approval process as described below. A primary focus was the capacity of my research to influence and improve the learning experiences of students within my own institution first and foremost.

The issue of focus was instrumental to my sampling strategies and my research question and aims became the primary consideration when selecting participants. I was not concerned with trying to conduct a piece of research which looked at
all aspects of professional socialisation nor professional identities per se. As with all qualitative research and in particular narrative based work my focus has been on depth, nuance and complexity in relation to my research questions. The eight self-selecting volunteers in my view were representative of a cohort of final year students, and were largely representative of the full cohort in respect of gender, ethnicity and age profile and as such enabled me to explore my research question in depth. Additionally my participant group were broadly representative of the wider physiotherapy student population. As Mason (2002) suggests ‘the combined theoretical and empirical considerations that come into play in sampling decisions hinge upon the question of what you see as the nature and significance of the wider universe or population from which your sample is drawn’ (p 121). The diagram below provides a step by step representation of the research process.

### Steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ethical approval for study sought and gained</td>
</tr>
<tr>
<td>2</td>
<td>Entire final year cohort of 24 students approached to take part. Information sheets and explanation of the study undertaken</td>
</tr>
<tr>
<td>3</td>
<td>8 self selecting volunteers from final year cohort consented to participate (broadly representative of the full final year cohort, represented approximately 25% of the total and included a range across age and gender - 4 men and 4 women)</td>
</tr>
<tr>
<td>4</td>
<td>Narratives elected for inclusion and presented in chapter 4 were reflective of a different stance than that postulated in the existing literature. Emphasising difference as a key element of identity construction</td>
</tr>
</tbody>
</table>

### Ethical issues

Prior to the commencement of the study ethical approval was sought and granted from the Faculty Ethics Committee of my employing university. The ethics proposal submission was supported by copies of the study’s participant information sheet and consent form. Following initial scrutiny a number of observations were made and a number of issues/requests for information arose which needed to be addressed, I was required to;
Provide a list of prompt questions to be used in the interview

Clarify how I intended to ensure the confidentiality and anonymity of participants as described in the participant information sheet

Clarify what measures I would employ to mitigate concerns regarding the potential to pressurise and coerce students into taking part\(^{11}\)

A detailed response was made and re-submitted and addressed the above concerns in the following ways;

I did not provide an interview script as I did not have one since the interview was to be conducted more as a guided conversation (Reissman 2005). I was unable to provide a detailed list of questions to be used within the interview itself. Instead I was able to clarify for the ethics committee my approach to the interview process and refer them back to my research aims/questions. In place of an interview script I was able to provide the theme/topic list I intended to use as a way of promoting story telling (appendix 2).

In respect of anonymity, each participant was allocated a pseudonym.

In an attempt to address the concerns associated with my position in the department in which I worked, and the potential this had for pressure and coercion, I made the decision to engage the help of the Faculty’s Student Liaison Officer \(^{12}\) to undertake the formal consent process with each participant. On reflection this seemed to work well in so much as participants were able to consent to taking part without me being present. I believe this to have been an appropriate compromise in so much as it distanced myself from the early stages of consent, a neutral space was provided where participants were able to freely decide to take part, rather than in any way feeling pressured by myself into doing so.

\(^{11}\) This was particularly acute in respect of my position within the department and the potential for students to feel obliged or directed to take part rather than freely volunteering to do so.

\(^{12}\) The Student Liaison officer is a person employed by the faculty to act as a point of contact for all students and is primarily there to ensure that students concerns are raised at the appropriate level and that students have named point of contact for any matter they wish to discuss outside of academic support. They are essentially there to offer a single point of contact for students and as such are viewed as being a strong advocate for students.
Whilst no major obstacles or ethical concerns beyond those described above were raised by the ethics committee it is important to acknowledge the potential problems relating to insiderness (Labaree 2002). It is impossible to eradicate the issues of power researchers have over the researched, for this study it is particularly acute where I, the researcher, was also the Head of Department and a physiotherapist. Insiderness was a particular concern for me and I therefore made a conscious effort to discuss with and inform a range of individuals of my intended study prior to it taking place. This helped me locate myself within this study and through this to declare my subjectivity. I define these individuals as gatekeepers\textsuperscript{13} and see them as having had influence on the margins of this study.

**Data Analysis**

This section will outline my practical approach to analysis. Within the literature there are many varied approaches to narrative analysis, which for the novice researcher is confusing. In an attempt to provide a framework for analysis I created my own analytical map, based upon the work of Lieblich, Tuval-Mashiach and Zilber (1998), Polkinghorne’s (1998) and McCormack’s (2001) approach. This next section will describe in detail my own practical approach to narrative analysis. The focus of the analysis has been related to my research question; how do physiotherapy students construct a professional identity?

Whilst I am mindful of the dangers in asserting too strongly my findings given that as many report there is always an infinite number of interpretations possible (Temple 2001), I believe that this thesis offers a reasoned and trustworthy account of my research findings. I have not suggested that this thesis provides the only way in which this data could have been analysed, I have endeavoured to provide a detailed outline of the process of analysis by illustrating the analytical framework, the focus of my analysis (in acknowledgement that

\textsuperscript{13} I define gatekeepers here as those others who may have had a vested interest in this study, both in terms of carry it out but also the results and conclusion. For me these include, the physiotherapy course team, in particular the course leader, clinical physiotherapists supporting students in the workplace, patients receiving care from these participants and other students not included in this study.}
interviews always elicit data which falls outside of the research focus) as well as a detailed description of how I undertook each stage of the analytical process.

In consideration of the messy business of interpretation of interview data and the need to satisfy myself and ultimately readers of this thesis I approached data analysis by asking myself the following questions based upon the work of Holloway and Jefferson’s (2000);

1. What do I notice?
2. Why do I notice what I notice?
3. How can I interpret what I notice?
4. How can I know that my interpretation is justifiable?

As with other narrative studies, I was interested in three interconnected, yet distinct points of analysis, these were, content (what was said), structure (how events and happenings were linked together through the process of emplotment) and language (how it was said). I understand that the function of narrative analysis is to answer questions about why particular stories are told, analysing how they are told offers opportunities to better understand why a particular outcome came about. Stories are told for particular purpose and audiences and narrative analysis allow for attention on the three points above in a holistic way. As Gubrium and Holstein state ‘narrative practice helps to characterise simultaneously the activities of storytelling, the resources used to tell stories and the auspices under which stories are told...centring attention on the relation between the how’s and the what’s of narration’(2007, p164). Also, as Polkinghorne states ‘the resulting storied analysis is an attempt to understand individual persons, including their spontaneity and responsibility, as they have acted in a concrete world’ (1995, p19).

On embarking upon a narrative research study I underestimated the plethora of approaches to narrative inquiry. The literature is drenched with a variety of approaches, creating a level of complexity I had initially under estimated. However, throughout the process of this doctoral programme I have explored a range of approaches and, as stated earlier in this chapter, I have used three narrative experts as a basis from which I have created my own analytical framework. My analytical priority has been to retain data wholeness. As
Reissman (2008) asserts irrespective of the approach taken by researchers what links narrative researchers in their endeavour to keep whole rather than reduce down to segments and it is the sequences and consequences of keeping whole that differentiates narrative research from other types of qualitative approaches.

My working analytical model is focused on events and happenings as plots or plotlines, structure as emplotment, that is the way in which individual events and happenings are linked together and also language participants use to tell their story. Emplotment is a key feature of narrative and enables us to understand the point of stories from the perspective of the teller. The plot provides the systemic unity to the story; it is the glue that connects the parts together (Polkinghorne 1995).

The diagram below attempts to depict my approach to analysis, and I hope demonstrates my commitment to undertaking research and producing a thesis which is judged as satisfactory. By focusing upon the wholeness of stories I was able to read/re read the interview transcripts in ways which did not lead to fragmentation and a reduction to isolated themes.

Practical guide to analysis

- **content**
  - plots, plotlines
  - events and happenings configured and composed in a series of characters

- **Structure/Form**
  - Emplotment: shape and substance
  - Beginnings, middles and endings
  - How talk was organised

- **Language**
  - Discourses: cultural and context specific
  - metaphors
  - explanations of actions and responses
In practical terms I approached analysis by following a number of steps\footnote{although presented here in linear form, in reality I retraced my own steps on several occasions as a way of self-regulation and critique}, and these are;

1. Transcription
2. Reading and rereading
3. Condensing data into bounded stories
4. Authentication/validity of interpretation – returning stories to participants, professional scrutiny and critical conversations
5. Making decisions about presentation/representation

The following section will describe each stage in more detail.

**Process of transcription and reduction of raw data into condensed stories**

Each interview was transcribed verbatim, the resulting interview transcripts ranged from 8,000 to 13,000 words, providing a total of over 90,000 words of transcribed talk. As I intended to undertake narrative analysis, my approach to transcription was to transcribe verbatim, I included pauses and periods of silence. These transcriptions were accompanied by notes I made during the interview itself, largely consisting of points which I wished to bring participants back to.

**Reading and re-reading**

I read and reread several times each interview transcript in an attempt to get an overall feel for the stories being told. I made notes of where a series of events and happenings seemed to create a number of plots associated with my research focus. I noted where characters were introduced and paid particular attention to how these characters/actors was developed and how they were interrelated in
the plot. This early reading stage also enabled me to identify the scripts at play. The scripts contained in the earlier part of the interview were often illustrative of pre given/learnt professional scripts, later scripts were less habitual and I would argue more reflective of the participants own emerging professional script rather than reflective of others.

When reading and rereading the interview transcripts I consciously concerned myself with the following;

- What plots emerge from the interview data?
- How are the scripts articulated by the participants to tell their story in a particular way?
- How is language used to emphasise some aspects and not others?
- How are scripts spoken to construct a particular story about physiotherapy?
- How do the participants structure their story to reinforce a particular story about physiotherapy they are trying to tell?
- How do participants give authority to the story they tell to persuade of its authenticity

My major concern was to read the data in ways which enable me to identify where participants had linked together events, actions and happenings in interview data into storied accounts which hang together through the process of emplotment. Identifying the plots was a central part of my analysis.

**Condensing data into bounded stories - concerns with structure and storied form**

A major consideration for me was to maintain the cohesion and wholeness of the stories my participants shared with me. In order to condense data into bounded stories I had to identify narratives within the interview transcripts using the structural norms of stories, beginnings middles and ends. Mindful of Polkinghorne’s (1995) distinction of narrative analysis I sought to differentiate narratives from other segments of data. I did this by a systematic reading of data seeking storied boundaries or the beginnings middles and endings. Beginnings offer us the who, what, where and when, in Labov’s (1974) words they orientate the reader to the story about to be told, the endings offer us an evaluation of
why things happened as they did, in this way the endings are the sense making aspect, in a sense it is the ending that makes the story worth telling in the first place. Or as Reissman (2008) puts it the endings tell us how the teller wants us to understand them, it is the way in which teller try to theorise their experiences in order to understand them. This process of emplotment central essentially linking events, happening and actions together and through that produced personal experience storied accounts within the broader cultural social and political contexts in which they are told (Clandinin and Connelly 2000; Mishler 1999; Andrews et al 2008).

In this way I attempted to follow McCormack’s (2004) approach to identify nested stories focused upon my research question and aims. I see my interpretations as meaning possibilities rather than truths, future meanings are always possible, in this way these stories provide insight into a life in process.

In respect of my analytical model the third and final element I considered when reading the transcripts was the way in which participant discourses create particular scripts of experience and professional identity. As Fairclough (1995) asserts, human beings use language to construct identity. Thus participants create scripts through discourse is an important aspect for analysis. By examining how the features of language, such as imagery, metaphor and repetition are used by my participants to tell particular stories, I have attempted to include how events and happenings are signalled as important to these participants. All good stories include metaphors for dramatic effect, they help to emphasise struggles, traumas, difficulties and triumphs. As Reissman, states ‘language is the major cultural resource that participants draw on to jointly create reality, narrative retelling in interviews is a vivid instance of this’ (2008 p195). Storied accounts of experience are therefore a naturalistic way in which we can tell others about ourselves. In this way we create our own realities and hence forth ourselves, our identities through the strategic choices we make through and as a consequence of social interaction. Undertaking narrative analysis is appropriate to studying the presentation of selves in everyday professional life, and storying experience is a very naturalistic way of telling others about ourselves.
Authorship, voice and representation

This section will deal with issues of authorship, voice and representation. As with most types of narrative research, issues of whose voice is heard and whose is not, whose voice is privileged and which voices are silenced requires careful attention on behalf of the researcher (Cortazzi 2001; Mason 2004; Reissman 2008; Wengraf 2007). My positioning as first and foremost a physiotherapist and author/researcher and hence the social and professional categories to which I belong, has impacted upon what I have come to know, how I have come to know it and how I have chosen to write about it in respect of this thesis. As Sparkes (1994) asserts the researcher can never rid themselves of their past and their experiences, but can only try to be open about how past experiences have influenced the here and now.

As Mishler (1984) suggests, narrative research demands audiences to be a conversational partner, in the first instance being interested enough to listen and secondly to provide agreement with the teller of the evaluative aspect. Endings are critical for narratives because it is the endings which provide meaning of actions and events and the meaning provides the reason for telling the story in the first place.

In chapter one, my own story of becoming a physiotherapist provided an insight into how I came to be interested in professional identity and how subjective question marks made me question the impact of learning experiences on professional socialisation from the standpoint of the learner. In this next section I will explicate for my reader my position in this study, paying particular attention to the relationship between myself and these participants and how, as the researcher and a physiotherapist and head of department, these positions have influenced how this study has been conducted and presented in this thesis. Whilst I have made every attempt to privilege the position and voice of these participants I acknowledge that my positioning has brought to bear a significant influence on this study. As with any qualitative research project the location of the researcher as an integral part of the research process is acknowledged (Lieblich 1998; Cortazzi 2001; Andrews 2008; Reissman 2004; Mishler 1998). The particular lens through which I have conducted this study from start to finish has
been influenced by my own particular standpoint as described in chapter one through my reflexive commentary on the place I occupy within this study.

**Issues of insiderness**

There were a number of ethical dilemmas which I had to address prior to conducting this study. The department where the study took place was small, meaning that all staff and students enjoyed a close working relationship and as such were familiar with each other and regularly engaged in conversations about the student experience. Whilst I would say my pre-existing relationship with these participants was probably viewed as least important or significant it did exist. In this way I have been in a privileged position able to engage in conversations about their experiences in an informal way long before I conducted this study. Neither the participants nor I were coming to this study from an objective stance. Working within this context thus placed me in a privileged position of having easy access to physiotherapy students as well as enjoying a close working relationship with the physiotherapy course team. I experienced first-hand and shared some of their learning experiences, in Labaree’s (2002) terms I consider myself to be an ‘insider’. By insider I mean I was an integral part of the social and professional context in which this study took place. Whilst there are a number of challenges this poses, I considered this insiderness to be key in developing a deeper understanding of the lived experiences of these participants, to some extent we shared experiences and spoke about them in the course of day to day contact.

**Professional positioning: being a physiotherapist**

My positioning as a physiotherapist posed number of challenges. These included being conscious of my positional power as researcher and Head of Department and my professional power associated with being a physiotherapist. I consciously tried not to impose my own professional identity. By deciding to undertake unstructured interviews I tried to give the space and freedom for participants to talk and felt that taking a more structured approach may have placed too much emphasis on my professional positioning and thereby silencing theirs.
In many ways I see my professional positioning as being advantageous. Twenty years of collective experience as a clinician and an academic meant that I was well rehearsed in understanding the language/script of physiotherapy and I had a wealth of experience of health care; to some extent I could recognise some of my participant’s experiences as being very similar to my own. We talked the same language; we had a shared professional language which I believed helped and participants gave me the impression that this helped them talk about their experiences freely without them needing to explain any professional jargon or contexts.

**Issues of representation**

I make no claims of accurately presenting the lived experiences of these participants. It is only ever possible to offer an interpretation, and alternatives are infinitely possible (Andrews 2008; Tamboukou 2008). As Temple (2006) has asserted, narratives are always evolving, open to change and amendment and are always open to endless interpretations. In one way, there are several elements at play here. For instance, there were decisions I made during the interviews themselves. There were, for example, times in the interview where I drew the participants back to points in their story that I saw as related to my research questions. Rather than interrupt the flow of the participants talk, I made notes which enabled me to revisit these points once my participants had stopped talking. Therefore, the unstructured nature of the interviews allowed for a free flowing response from participants through which I was able to avoid unnecessary interruptions and allow participants to talk about what they chose to talk about yet pick up on points of interest at an appropriate point in time.

During the process of transcribing, reading and analysing the interview transcripts and bringing out the stories inherent within them, I had to make decisions about what to include and what to exclude; this inevitably resulted in large sections of talk being excluded from the findings presented in this thesis. As Cortazzi (1993) states, qualitative researchers have no choice but to decide what data to include in a thesis and what to discard.

As Sparkes (1996) suggests, the active voice of the subject should be heard in the account. The use of my participants’ words (exactly as they were said) in the
results section is a conscious attempt to avoid the introduction of second order constructs, whilst at the same time recognising that narrative work is always interventionist (Reissman 2008; Andrews et al 2008). After all, I made choices about which stories to represent here and how to represent them and I am aware of a number of conscious decisions I made in deciding which stories to include and which to exclude. I accept authorship and responsibility for what is presented here. As Andrews et al suggest ‘the meaning of words is never constant neither for speakers nor listeners’ (2008, p14). There is always on-going negotiation of meaning, ‘people answer the questions which they think we are asking them and we respond to the answers which we think they have provided us. Our understanding of their words, is always contingent upon our ability to imagine the worlds they are trying to convey’ (Andrews 2008, p14).

As with any type of qualitative research not all the data elicited has been included in this thesis, there is an inevitable collection of data which falls outside the particular focus of the research study (Reissman 2008). If participants are invited to talk as freely as possible about their experiences then it is always going to mean that they end up talking about things, events and experiences which fall outside the intended focus of particular research study. As Polkinghorne (1995) asserts, findings and analysis are always contestable, at best we can only hope to convince our readers of our integrity in interpretation by explicating in detail our approach knowing that it can always be contested and that there will always be other readings possible. Practical attempts at legitimising findings will be discussed in the next section. I see this thesis as being a co-production and I hope to have ensured that the voices represented here are those of my participants and not simply my own.

**Validity/authenticity**

In this final section I will describe how I hope to have assured my readers and satisfied examiners of the validity of the research presented in this thesis. The first section will explore the general issues found in the literature and conclude with the practical steps I took to assuring the legitimacy of the findings presented in chapter four. The notion of validity in interpretive research tends to be described as trustworthiness, legitimacy, credibility, authenticity and focussed
upon the degree to which findings and interpretations are representative of the data from which it arose (Silverman 1993; Guba 1996; Atkinson 1998; Denzin and Lincoln 2000; Wengraf 2001; Mason 2002; Pyett 2003; Overcash 2003; Moss 2004). It is less about seeking out a truth, and more about acknowledging that truth is whatever the participant tells you is true. Truth(s) are a subjective and context specific construct. Often, the focus for interpretive research is the identification of repetition, coherence and recurrence in data.

Hammersley (1990) suggests that for interpretive research, validity can be identified as having confidence in the knowledge we produce but not confidence in the certainty of its truth. Reality is independent of the researcher’s interpretation and the reality is always viewed through a particular perspective: research accounts should be viewed as representing reality rather than reproducing it. For Hammersley the validity of interpretive research can be viewed as ‘truth interpreted as the extent to which an account accurately represents the social phenomenon to which it refers’ (1990, p57). For Silverman (2001), validity is important irrespective of whether it relates to qualitative or quantitative research. All researchers will have an impact on the participants and the context of the research. I understand this to mean that my values as the researcher will influence and change my participant’s involvement simply by the very act of it taking place. This will impact upon the truth status of my participant’s accounts; because of this I see that issues of representation are important (Mason 1996; Moss 2004; Overcash 2003; Pyett 2003; Tobin and Bagley 2003).

**Validity in relation to narrative**

Certainly it seems that the prevailing concepts of verification and procedures for establishing validity are largely irrelevant to narrative studies (Atkinson 1998). Historical truth for narrative researchers is not the primary issue. Marked discrepancies can occur between the ordering of the telling and the ordering of the actual occurrences and it is always possible to interpret in different ways. Individuals will, and do, exclude experiences that undermine that which they are currently claiming. Plots within narratives are not innocent they are always laced with social discourse and power relations.
For Mishler (1990), knowledge is validated from within a community of scientists as they come to share non-problematic and useful ways of thinking about and solving problems. However, even this standpoint assumes that we all read the same way and interpret in the same way. In terms of the usefulness or otherwise of research findings, this is in itself a subjective notion, reliant upon the individual making the judgement. What is useful to one person is not always useful to another and so on. Plots within narratives are never innocent; they are laced with social discourse and power relations. There can often be marked discrepancies between the ordering of telling and the ordering of actual occurrences; it is always possible to interpret in different ways. Individuals will and do exclude experience that undermine that which they are currently claiming. Truth assumes an objective reality; the term trustworthiness is seen by narrative researchers as moving the process of validity into the social world and therefore a better way of describing the truth values of their research.

The strength of personal narratives is that they assume a particular point of view viewed as legitimate. Personal narratives are not meant to be read as an exact record of a life lived, nor are they intended to be a mirror of the world ‘out there’. Narrative researchers concern themselves with the following four tenets in an attempt to offer assurances about the validity of their findings (Reissman 1993; Cortazzi 2001; Guba 1990; Atkinson 1998; Roberts 2001). These are:

**Persuasion** – How persuasive are the narratives? They are deemed to be more persuasive when theoretical claims are supported by evidence from participant’s accounts.

**Correspondence** – the act of allowing participants to comment upon and validate the researcher’s interpretation. However a note of caution needs to be added. In Atkinson’s (1998), view, it is difficult to interpret narratives against established qualitative standards of analysis. For example, member checking (Denzin and Lincoln 2000) or correspondence (Riessman 1993) often cited in the literature as a legitimate way of assuring the validity of findings, is in itself problematic. Human stories are not static entities, meanings of experience shift as consciousness changes. However in the interests of assuring my readers of the legitimacy of this thesis and mindful of the possibility of creating new
meanings. I did return the stories presented in chapter four to each participant in order to provide the opportunity to input into the stories presented in this thesis.

**Coherence** - the extent to which, themes in narratives are threaded through the data in a consistent way. This is sometimes referred to as the narratives having internal and external consistency. Internal coherence relates to the degree to which parts of the narrative support other parts to give consistency of message rather than a message of contradiction. Having said this, this is not intended to suggest that contradictory narratives are any less important or interesting. Contradictions are in themselves worthy of analysis. External consistency applies to the extent to which the narrative has resonance with that which is already known.

**Pragmatic use** – the extent to which a particular study becomes the basis for others work. This again is a subjective notion, what individuals find interesting is dependent upon personal values. What one person thinks is useful might be viewed as unhelpful by another.

I hope that my research is considered to be sufficiently valid to be used by others as well as contributing to that which is already known. As such, the issue of validity is of significant importance to me as I have continued through my doctoral journey. In one sense, validity itself can be viewed as a construct made by the reader (Atkinson 1998). In my words, if readers can see how they themselves may have come to the same conclusions as the researcher or how the researcher has come to the conclusions that they have made, they would give the research validity. This is not to say that they themselves would have reached the same conclusions. As stated earlier it always possible to contest an interpretation. Guba’s (1996) concept of trustworthiness describes a number of ways in which interpretive research can be judged as valid. Narratives are not intended to be judged in respect of their predictability, but rather to what extent they are plausible or suggestive in showing how changes in people’s lives take place (Polkinghorne 1990). In light of the previous discussion, I have attempted to assure my readers of the validity of this research through the following;

- Detailed description of data collection method and analysis
Member checking in respect of providing the opportunity for participants to read, comment upon the stories I created out of their interview transcripts

Professional expert review of my interpretation and associated professional dialogue

Inclusion of a sample analysis and interview transcript

**Conclusion**

As I have already said, I understand narrative to offer both a personal and collective account of lived experiences. Accounts that individuals articulate are not just privatised accounts of private experience but are also able to provide public understandings, given voice through individuals. Scott (1992) suggests that experience is at once already an interpretation that in itself is in need of interpretation. In other words there is nothing new. What counts as experience is neither self-evident or straightforward, it is always possible to contest it. It is this very point that challenges me as I continue to develop as an interpretive researcher. The possibility of perpetual contestability bothers me in respect of how my work will be viewed and ultimately judged by others. However I would hope that this chapter provides sufficient assurance to my readers of the validity of this thesis.

Using a narrative approach, I am concerned with the subjective reality of my students rather than any historical truth. I hope to have acknowledged the subjective way in which I have both framed and enacted my research and I hope my considerations relating to insiderness and reflexivity has provided a way of making explicit my part in the research process. What I hope to have achieved through my research is a greater understanding of how the learning process impacts upon how individual students construct their professional identity in ways which will encourage physiotherapy educators to reflect upon alternative ways of organising the learning experiences of their students and to acknowledge more openly the complexity of professional socialisation in and through their interactions with students. I see the whole process of my research as being educative. My participants have had the space and opportunity to reflect on their experiences with a particular focus upon seeing themselves as physiotherapists and I hope they have benefited from taking the time to share their stories with
me, and that as a consequence of this study have more personal insight into their emerging professional identity and the impact this has on how they enact their future professional role.

In the final chapter of this thesis I will discuss and reflect upon the limitations of my work, and suggest future possibilities. I am not seeking validity in a quantitative sense, more trying to ensure the trustworthiness and credibility of my interpretation of data. My aim was to understand things better, rather than to know everything. In summary, as Clandinin and Connelly assert “the principal attraction of narrative as method is its capacity to render life experiences, both personal and social, in relevant and meaningful ways’ (1990, p10). Stories allow us to gain insight into what experiences can do to people as they live through those experiences (Webster and Mertora 2007). As Kuhn (1974) suggests, individuals wishing to participate in a culture need to experience that particular culture and this experience can be expressed through individual narratives. Therefore, I would argue, our sense of becoming a part of a particular community is established through telling stories about our experiences thus justifying my methodological approach.

I have attempted, in a serious way, to privilege the voice of these student physiotherapists and I believe that through a narrative approach I have been able to create a space for these participants to tell their story, in their way, that may have provided personal meaning and belonging in their own professional lives. As Atkinson (2008) states, we think in story form and speak in story form, stories matter and studies that utilise stories as a source of data matter.

As Moss suggests, the provisions of trustworthiness in narrative research are;

‘acts of integrity that researchers take to ensure they seek the truth by contextualising their studies and disclosing all relevant procedures used in the study. I further define provisions of trustworthiness in critical narrative research by the researcher’s commitment to include all points of view as contrasted to the common points of view that emerge, protecting participants wellbeing while putting their voices in the forefront as a model of authentic participation in educational research’.
Chapter 4: Key Findings

Introduction

Through the preceding chapters I have presented the professional context within which this study took place, this chapter will present the key findings, structured around of my original research question and aims. I have been concerned with understanding more the nature and operation of professional identities within physiotherapy education and how emerging professional identities are connected to playing/performing professional roles thus focusing upon the connections between identities and behaviours (Burke and Stet 2009).

I will be presenting my key findings in narrative form. Three narratives will be presented as individual participant stories both in the interests of space constraints and my desire to preserve the individual. Where it has been possible I will support these individual accounts by drawing upon the stories of other participants. Although it has not been my intention to present findings in the form of generalisations I believe it is important to highlight where participants shared elements of their stories with each other and which may in turn prove useful to other students in other contexts. As Lawler observes, ‘life stories must always incorporate the life stories of others: they will always be particular versions but nevertheless others’ stories must always be part of our own’ (2008 p 19).

This is not to say that there was complete consistency across participants’ stories, nor would consistency be anticipated. These findings I suggest reflect the elements of shared experiences of a group of student physiotherapists undertaking a common educational experience. Moreover it reflects my wish to present shared stories which may resonate in other contexts. Where commonalities exist, Holmes (2003) suggests that commonalities originate from broader cultural and historical discourses and I will discuss this in the analytical commentary which follows each narrative. The final sections of this chapter will consider how the research interview itself acted as a site of identity construction for my participants and created an opportunity for each participant to undertake their own historical journey of becoming a physiotherapist.
Structure of the chapter

I consider the findings presented in this chapter co-produced. By this mean that the production of these findings was a culmination of my interactions with my participants from the recruitment phase, through the interview and listening to their stories and finally reaching agreement via correspondence/member checking as to which stories to include in the thesis. As Reissman (2008) described, ‘all narratives are, in a fundamental sense, co-constructed. The audience, whether physically present or not, exerts a critical influence on what can and cannot be said, how things should be expressed’ (p31). She observes how narratives are produced as a result of collaborative conversational interaction. For example, appendix 1 shows Alistair’s full transcript, the reader can see here through my interruptions and questions the way in which I took Alistair back over certain aspects of his story. This taking back was focused on my research aims. My own knowledge and understanding have shaped the way in which I hear Alistair’s story; in effect they shaped my listening and questioning. As described in chapter three, I also engaged in a number of critical conversations with health professional colleagues (gatekeepers) sharing my analysis and seeking others’ confirmation of my interpretation. In light of this the stories presented here are ones which the participants and I consider to be a legitimate representation of their experiences and as such should be read as co-authored. The diagram below provides an illustrative example of how I define the findings as being co-produced.
Notions of identity as constructed through social interactions and therefore, a relational concept, requiring interaction, enactment and reciprocity I view professional identity as complex, contestable, always in the making and subject to the power of dominant professional discourses. As Jenkins (2004) observes, identity is our understanding of who we are and who other people are and reciprocally other peoples’ understandings of themselves and of others.

Consistent with my research approach and structured around three narratives I have privileged the voices of individual participants (which I have already established as being personally important and which I value as a strength of narrative) and illustrated how stories provide a powerful way of making our experiences meaningful (Conle 2001). In an attempt to privilege the words of my participants I will present each narrative using the actual words of each participant without any analytical intrusion, analytical commentary will follow each narrative.
Presentation of Key Findings

I will introduce my readers to each participant through a brief vignette. I acknowledge that due to the nature of narrative research, people who know my participants may be able to recognise them through their stories irrespective of my use of pseudonyms. Issues of research ethics and participant anonymity have been dealt with in chapter three and I do not intend to repeat those arguments here, however, by providing a brief vignette of each participant, I hope to introduce each participant to my readers in a way which will bring their stories to life and render them more meaningful.

Importantly, these findings will attempt to illustrate how student physiotherapists construct their professional identities in and through everyday professional practices. By focusing upon the sites of interaction as possible sites of identity construction I intend for this chapter to provide a narrative representation of how these participants communicate and mediate their emerging professional identities as they attempt to enact their professional role in three specific contexts which they identified as significant.

They will tell the story of how through their learning experiences students engage in rehearsing and performing their emerging professional identities through their enactment of their professional role, which in turn belies their professional values about what matters to different audiences. As discussed in chapter two, identity theory has provided me with a set of ideas through which I have been able to emphasise social aspects of identity. I remind my readers at this point that for identities to become salient, individuals need to receive positive affirmation/validation of the identities they are presenting. This positive affirmation in effect validates identity performances and in turn acts as a mechanism for self-affirmation.

The narratives presented in this chapter are illustrative of the significant sites of interaction (and hence professional identity enactment) these participants identified as being important. I signal here that not all interactions are successful or positive and in my final chapter I will discuss the practical implications of my findings.
Introducing the narratives

In this next section I will introduce the main plot of each narrative.
Using my theoretical and analytical frame I will outline how each narrative provides us with a unique valuable insight into how student physiotherapists construct their professional identities. I will show how distinct sites of interaction function to affirm distinct elements of professional identities identified as important by individuals in affirming their emerging professional selves.

Introducing the Participants

Brief vignettes are presented as a way of introducing the participants of this study. In the interests of anonymity, I have not been able to include as much biographical information as I would have liked and which would have enabled me to present each participant in full. My inclusion of brief biographical information alongside a quote taken from their interview allows me to introduce my participants in a way that manages to preserve their anonymity but still allows me to introduce them to my readers through both my words and their voices.

Jessica

Jessica is a 24 years old woman who has lived in the North West of England all her life. Jessica enjoys life actively seeking out new experiences, she displays a strong sense of justice. She is an accomplished sports woman a strong team player, active and outgoing keen to experience all that life offers her. She is looking forward to her career as a physiotherapist and is generally optimistic about her future and professional life and eager to secure her first job

'When I arrived at my outpatient placement, I had a full diary, that was my diary! My responsibility to keep it full, that was my independent case load’

'If I didn’t have anything to do on the physio side I’d go and volunteer to go and help them. I helped quite a lot with splinting, they said I was a little OT student as well’
Alistair

Alistair is a 21 years old man originally from Ireland. He is ambitious and keen to get on with the next stage of his life. Grown in confidence he actively seeks out new experiences and has aspirations to travel and hopes his career will enable him to do so. An active sportsman he is also community focused and engages in a range of charity work. Although relieved to have finished his degree, he remains unsure as to how he sees his future career progressing and is yet to decide what he will do in the immediate future.

‘You kinda get to know what you should and shouldn’t doing, what you should and shouldn’t be saying to your educators’

‘it’s kinda difficult when you go onto a clinical placement, you’re only there for six weeks and they’ve got established relationships you haven’t..... That’s years’ worth of friendship years’ worth of professional working!’

Mary

Mary is a 24 years old, single woman and living with friends. She continues to have a very active life, playing sport and is an accomplished pianist. Originally from Ireland, Mary isn’t sure if she will be going home to Ireland now she’s completed her degree or whether she will stay on in England. Although a little hesitant she is generally optimistic about the next stages of her career but plans to take some time out before she gets her first job.

‘over the whole six weeks I had three clinical educators, they all had a different way of doing things, so the main man expected me to do everything his way, even though the others had shown me their way! It all got very confusing’.

‘We mentored a second year student just before their first placement the mentoring let me see how far I’d come on since the first year, saw how much I’d grown, because until then I still felt like I didn’t know anything. I felt I didn’t know enough’

Jack

Jack is a 29 years old man who came into physiotherapy after a career in sport.
He remains enthusiastic and optimistic about the next stages of his career, he is anxious about his prospects of securing a job, he hopes to stay living locally amongst friends he has made during his three years at university.

‘I like to get to know the patient, having a rapport, If I sense they aren’t happy, it’s about taking a back seat, you’re not just there to assess and treat a person, you’re there to gain an understanding of how they’re feeling’

Natalie

Natalie is a 26 years old woman, a swim teacher in her spare time and an accomplished flute player. Natalie will be moving back closer to home to look for her first job. She is looking forward to her career as a physiotherapist and is focused upon getting her first job. She wants to secure a good job that will enable her to consolidate her skills. She feels relieved to have survived her course but remains anxious about what the future holds for her

‘She was so significant for me she had like a fresh pair of eyes, she wasn’t willing to just settle into what everybody else was doing, she looked at new things all the time’

I only got bad feedback, so If I did something wrong or something could be better

I remember spending the vast majority of the time in the toilets in tears I couldn’t cope it was really hard’

Julie

Julie is a 22 years old single woman, actively involved in volunteering, a keen sports woman and musician from the North West of England, is sure she made the right career choice and keen to get onto the next stage. Confident she has secured her first job and is keen and feels ready to take the next step

‘It’s kind of a test isn’t it? To carry on despite the negative experiences’

‘People don’t realise how much you have to go through to become a physiotherapist, it’s an achievement getting to the end of your three years’
Chris
Chris is a 22 years old man a keen and accomplished sportsman he is looking forward to getting a job. He is more than willing to move away from the area in order to secure that elusive job offer. Generally optimistic about his chances he is anxious about the competition for jobs. Ambitious Chris is already planning a post graduate course to enhance his career prospects.

‘Being with another student was important for me, we could bounce ideas off each other, we did struggle at time but if I was down, he’d pull me back and me him’

‘If I missed something, like a little thing, that would be the highlight of his feedback. I mean I can take critical feedback you can develop from that... but when it’s like negative critical feedback all the time’

Mark
Mark is a 24 years old man who has invested a lot of time into pursuing a career in physiotherapy. Mark gave up secure employment in order to follow a career path he had wanted since his teens. A keen sportsman and musician, he has maintained his passion for sport and managed to combine it with physiotherapy. He remains quite anxious about securing his first job and feels he won’t fare well against others because he doesn’t feel confident in his ability.

‘I’m feeling like I’m meant to be feeling like a physiotherapist, but in a way I don’t’

Presentation of Findings

Narrative One: The Me and the Not Me

Alistair’s story

Alistair’s story starts with his first clinical placement, ‘The first real stint at physio was my first placement and it was a real shock. I just found it quite difficult I was just sat there in the office answering phones and stuff like that all day….. I just thought this isn’t physio and my educator wasn’t great everyone else everyone else got on with their educator but personally I didn’t, I didn’t really
sort of get on with her that well. It didn't get me off to a very good start I just thought this was quite boring to be honest’.

Looking back Alistair recalls his first real clinical placement, ‘that first placement was very, very tough it was the educator and the environment it was it was quite intensive’. He describes his clinical educators, 'both educators well all three of the educators were very, very strict I found it a very intensive environment. Alistair remembers one day in particular, 'she’d put up an x-ray film of somebody’s chest this is my first proper placement and I’m not really confident in chest x-rays whatsoever, I find them really difficult actually and then not being able to just pick out all the anatomical points. His recollects confrontations with Kate, ' she’d be like 'what’s this?’ ‘say something’ 'no, it’s wrong’ and then there’d be a long pause and then I was thinking 'what is it, what is it, what is it? and start coming up with other stuff because I just didn’t want that silence and then she’d be like 'no, no, come on you know this, you know this, why aren’t you telling me about this?’ and those kinds of things and it wasn’t just the one off it was everyday and you’re getting absolutely hammered. I just didn’t really get on with my educators whatsoever’ he remembers how he felt, ' at the end of the 6 weeks I was so disappointed in my results that I just thought right, I’m going to chuck it’.

Looking back Alistair accepts his lack of preparedness, ‘it was my fault, it was my fault as well I mean I’m not blaming it all on her I mean I didn’t know my stuff before I went out but then I think, being the first placement you don’t know what to learn’. Reflecting on his experiences he recalls how he was affected by another student,’ I obviously didn’t do well and then erm I was a wee bit, I don’t want to blame it on the second student but this student was a bit of a flake, didn’t really turn up a lot of the time and that was quite difficult because she was angry at the fact that this student wasn’t around or didn’t turn up. So that obviously doesn’t do you well either having somebody not pulling their weight’. He remembers another encounter with Kate, 'I didn’t feel as if I could ask any questions because the response would be 'why don’t you know that, you should know that already’ and then when I should’ve been asking questions I didn’t because I didn’t really know and I going to be told that I should know it already in which case there’s no point in embarrassing myself further. The consequences of this for Alistair, transfer to patient encounters, ‘but then I had problems with patients, not detrimental problems with patients but just you know, they’d know,
you didn’t know, they’d see you speaking to somebody about them and that you didn’t know what you were talking about’. He recalls his feelings about Kate ‘bullying is a very strong word but it sort of felt as if that was what happening when I was on that placement. Alistair was soon able to ‘you kinda get to know what you should and shouldn’t be doing and what you should and shouldn’t be saying to your educators and you just get, kinda get a feel of what you should be doing during placements’.

Looking back Alistair ‘realised that not every physio is like that there’s some bad eggs in every society and every profession I thought if I just work hard I’d be alright, that placement even though it was a rough 6 weeks has probably sort of helped me to know what do I actually need to do’ She was really, really arrogant, she wasn’t there to help me. She criticised you a lot and that didn’t help myself confidence, after that I kind of realised that I don’t ever never want to be like that, I’m never gonna be like that’.

**Analysis and Interpretation**

This next section will use my analytical frame to provide an interpretation of Alistair’s story. To ease reading I remind my readers that I analysed interview transcripts and identified nested stories. I paid particular attention to story content, story structure (beginnings, middles and endings) and language. In line with my analytical approach of eliciting nested stories I will present this section under three main headings and these are; setting the scene, plotlines (themes) and the ‘dénouement’. I will illustrate how Alistair structures his story, describe the narrative devices he utilises and I will draw my reader’s attention to Alistair’s use of language providing emphasis and reinforcement to his story. Where Alistair’s story resonates with others I will include a brief excerpts from other participant accounts.
Setting the scene

The Routines and rituals of clinical placements

Professional discourses of physiotherapy practice and physiotherapy education control the routines and rituals of clinical placements. Students are assigned to an experienced physiotherapist otherwise referred to as a clinical educator (CE) for the duration of their clinical placement. These clinical educators, usually occupy a senior role within the organisation, are often a team leader and are recognised as an expert thus deemed suitable as positive role model. They are responsible for providing a good student experience. Prior to commencing a clinical placement students are expected to prepare for and arrive informed about what to expect. They are provided with a placement briefing pack; in essence this provides the official version of what students can expect during the clinical placement.

Alistair sets the scene of his story (which I read as resembling a battle) early by describing his first encounter with Kate as ‘very very tough’, ‘intensive’, ‘being hammered’. His depiction of the interaction between himself and Kate casts them immediately as adversaries, setting the scene for all that follows. In this way Alistair establishes the backdrop and creates the scene for the series of violations he then introduces in his story. Alistair casts Kate as his central character and his story is configured around his relationship with Kate his CE and himself as a student. When reading Alistair’s interview transcripts I was struck by the way in which his early encounters with clinical educators (prior to meeting Kate) were epitomised by battle images and struggles to be overcome.

Unlike the other participants Alistair is keen to point out that he had not arrived at physiotherapy school with a long held desire to be a physiotherapist he had not in his words had ‘that thing from being five’. I suggest here that student physiotherapists are well versed in the implicit requirement of physiotherapy discourses for them to demonstrate their caring and vocational drive prior to entering physiotherapy education and throughout their educational programme. Despite this, he enters the clinical setting with a fairly well established idea of what being a physiotherapist would look and feel like, he recalls being surprised by his first placement experience as ‘not being physio’. This notion of having a preconceived idealised professional self, although not easily articulated by Alistair
was clearly something that acted as a lens through which Alistair (and others) evaluated their subsequent learning experiences; setting the scene for what follows. I propose that the ideas of a preconceived idealised professional self are central to the subsequent construction of a professional identity. I signal here its importance and note my intention to return to this in chapter five. Throughout Alistair’s story he connects a number of interrelated themes (thereafter referred to as plots) which are centred around his relationship with Kate who he casts as his anti-role model in contrast to what he expects. The following section will consider them in turn.

**Plot One: Manifestation of Power and the learning context: The Alistair/Kate dynamic**

Before completing this study I had rather a naïve view about how power was embedded within the CE/student relationship. The influence of the clinical educator in respect of professional socialisation is well documented (Gibson, 2004; Clouder, 2002; Bjorklund; 2000). Clinical educators wield positional power through their organisational position in terms of role, title and status. For Alistair the difficulties he encounters arise from the mismatch between the expectations and realities of being in clinical practice with Kate. This is well documented in the literature for example, Jones (2003), Burman (2003), Melia (1987) Clouder (2003) and Rackman and Kaufman (2010). It resonates with Natalie’s and Chris’s story, ‘I only got bad feedback...... I remember spending vast amounts of time in the toilet in tears, (Natalie) ‘If I missed something, like a little thing it would be highlight of his feedback’ (Chris) Alistair’s story describes the shock he experiences and is reflective of ‘praxis shock’ identified by Melia (1987), Clouder, (2003), Radcliffe and Lester (2003) and Kelcherman and Ballet’s (2008). Alistair describes his arrival into Kate’s world and his immediate confrontation with her. In his words Kate is expecting him to arrive in her clinical area fully prepared, highly knowledgeable and ready to hit the ground running. This is likely to be in line with how Kate enacts her CE role. In effect she exercises her positional power (Foucault 1977) imposing her expectations through her routines of acting out her clinical educator role. She expects him to conform to the norms of what being a good student means in her clinical world, for example ‘she was like
what’s this, say something, no its wrong………… why aren’t you telling me this’.
Unfortunately this goes largely unspoken and it is difficult for Alistair to know how Kate expects him to behave. In its most simple sense identity is defined as ‘what it means to be who one is’ (Burke 2003, p1). Professional identity is often associated with labelling. Labels of any kind infer a number of expectations. In Goffman’s terms if we see the interactions between individuals as a performance then it is possible to interpret the encounters between Alistair and Kate as performances where they are performer and audience simultaneously for each other where they are each cast in roles by each other. By being cast in certain roles certain expectations are made with the understanding that the roles we play will be accepting by the other. Trouble arises in situations where roles and their associated expectations are not necessarily understood.

Alistair as a newcomer into Kate’s world is controlled and constrained by Kate’s expectations ‘I didn’t feel like I could ask any questions………. and then when I should have been asking questions I didn’t because I didn’t really know and I’m going to be told that I should know it already’. Alongside this Alistair has a reciprocal set of expectations of Kate as his CE which in turn go unspoken. In Blumer’s (1962) terms both Kate and Alistair fail in some part to establish who each one is to the other thus leaving room for misunderstanding to occur. Neither performs their roles in line with what is expected of them by the other. As Goffman (1959) observes for interactions between individuals to be successful each will enter interactions having first of all defined the situation based upon their past experiences, helping them know in advance what to expect of each other. Alistair’s narrative functions as a vehicle for impression management (Goffman, 1959; Cortazzi 2001; McCall and Simmons, 2003). His acceptance of the role Kate gives him reinforces his lack of power and Kate’s control. As Moss et al (2002) explain, Kate exercises positional power by controlling his professional behaviour within her clinical setting.

In Alistair’s story, Kate and Alistair get off to a bad start. Alistair has no choice but to attempt to perform in line with Kate’s expectations. Because Alistair is unable to do this successfully, his performance his not validated hence he begins to characterises himself as Kate’s victim. Unable to enact his emerging professional self he resorts to game playing and impression management, ‘you kinda get to know what you should and shouldn’t be doing and what you should
and shouldn’t be saying to your educators and you just get, kinda a feeling of what you should be doing’.

**Plot Two: Occupying multiple roles enacting multiple identities**

When labels are assigned to individuals, such as ‘good student’ this confers a whole set of meanings about what an individual is expecting the other to behave like and act like. For salience identities are dependent upon the acceptance by others of the role we enact as part of who we are (Stryker and Burke 2000). Difficulty arises because of the way in which ‘roles are externally defined by other’s expectations’ (Colbeck 2008 p10). In Alistair’s story both Kate and Alistair appear to fall short of each other’s expectations. He recalls ‘she was really really arrogant she wasn’t there to help me’. This further complicated by the multiple roles Kate and Alistair bring into their encounters. Alistair brings his student identity as well as his emerging professional identity. For Alistair it’s his first clinical placement ‘this is my first proper clinical placement and I’m not really confident’. Kate brings her clinical identity and her CE identity. Multiple identities can have contrasting meanings and expectations and different salience conferred upon them which could result in identity conflicts.

In terms of identity salience (Stryker and Burke 2000; Callero 2003; Cahill 2004) individuals favour the most salient identity and salience is affected by commitment, the greater the commitment to a role the more salient it becomes. I argue that the temporary membership of students in the clinical setting may lead to a lack of identity commitment (and hence salience) on both sides. For Kate her first impressions of Alistair are not favourable, ‘she’d be like what’s this? Say something, no it’s wrong and then there’d be a big pause and I was thinking what is it? What is it? And start coming up with other stuff I just didn’t want the silence’. This may then manifest itself in her subsequent commitment to Alistair and her role as his CE. For Alistair, his inability to connect with Kate from day one may have reduced his commitment impressing Kate. Salient identities require strong ‘ties’ and effective social relationships both of which are lacking in Kate and Alistair’s relationship (Burke et al 2009). Alistair seems to recognise this, ‘it’s kinda difficult when you go onto a clinical placement, you’re only there
for six weeks and they’ve got established relationships you haven’t....... that’s years’ worth of friendship years’ worth of professional working!'

Kate juggles a number of different roles, clinician, team leader and CE. These multiple roles may place conflicting demands upon Kate. Alistair arriving unprepared to his clinical placement may give Kate the impression of a lack of commitment on Alistair’s part. Alistair’s temporary membership in her team may mean she is less committed to her role as Alistair’s clinical educator than the other roles she occupies. In parallel, Alistair arrives in the clinical placement with a number of expectations of Kate as his CE (support, help, time to get up to speed etc etc), which as his story depicts he does not get.

As Goffman (1959, 2000) observes first impressions are vital for the success of future encounters and when we act in social situations we are forced into a situation where our performances will be judged by others, who because of their expectations of us expect us to perform in a certain way. For Alistair and Kate the problems begin on day one. Each, having unfulfilled reciprocal expectations of each other.

Foucault emphasises the importance of the past in shaping how people act in the present, he suggests that how people act and what they say is not necessarily conscious; ‘we have to walk in line because of extreme narrowness of the place where one can listen and make oneself heard’. If we apply this to Alistair’s story we can see how Kate’s positional power manifests itself in how Alistair is allowed to act, he has no choice but to act in line with Kate’s expectations of him. Because he fails to live up to Kate’s expectations he never reaches the point where he can rehearse and enact his idealised professional self. Instead he has to engage in managing Kate’s impression of him in order to get through the clinical placement intact.

Foucault penetrates the complexity of how power functions in his Archaeology of Knowledge (1972), he allows us to problematise the taken for granted such as the relationship between clinical educators and individual students, the dominant discourse of each clinical setting conceals what is not being said. As Foucault (1989) observed, events do not just happen, they are made to happen. Alistair is confined by the dominant professional discourse at play in Kate’s world.
Foucault’s work on prisons is also helpful in looking at how power is exercised within the relationship between Kate and Alistair. If clinical placements are seen as sites of identity construction then they become sites of identity performance producing statements about which identities can be performed and which cannot. The way in which Kate enacts her CE role Alistair controls how Alistair is able to enact his student physiotherapist role. This sets in motion what is possible and what is not. Foucault’s genealogy was an attempt to develop ways of explaining how power works. The themes of Alistair’s story illustrate the way in which Alistair’s choices and experiences are shaped by Kate’s enactment of her CE role. Kate controls the agenda. Casting himself in the role of victim, he describes how he is unable to deal with and confront the tension between him and Kate because of how power functions instead he avoids it and as such assists in maintaining the status quo. Alistair ‘didn’t feel he could ask any questions, stops asking questions’, something as a student he would most certainly felt he should have been able to.

As Burke and Stet (2009) imply, for identities to be salient individuals (students) must receive some form of positive affirmation from others (CE) of the identity (student physiotherapist) they enact, ‘salience hierarchy reflects situational self rather than ideal self..... it is the self that responds to the expectations of the situation rather than the desires of the self’ (ibid p41). Alistair’s strategy for coping with negative emotions when his identity goes unsupported is to resort to game playing as he says ‘you kinda get to know what you should and shouldn’t doing, what you should and shouldn’t be saying to your educators’. He in effect withdraws from his interactions with Kate.

**Plot Three: Dis-identification - Anti-role models**

The central character in Alistair’s story is Kate who he casts as his anti-role model. Kate’s character serves a number of important functions. Firstly he uses his depiction of Kate as his antithesis. He positions others, including himself in opposition to Kate, she stand alone in her role as his anti-role model. Secondly, the centralisation of Kate as being ‘not like me’ and ‘being someone I don’t want to be like,’ ‘I kind of realised I don’t ever want to be like that, I’m never gonna be like that’ is central to how Alistair constructs his professional identity. He
learns an important lesson from his encounters with Kate, he learns how/what not to be and as a consequence what he should/wished be. On reading Alistair’s story I was struck by the debilitating effect his relationship with Kate had on his emerging professional self to the extent he describes himself as being ‘bullied’, ‘hammered everyday’. What strikes me in the way which Alistair tells his story is their sense of disappointment in each other leading to a situation where their misunderstandings become unrecoverable. For example Kate’s bombardment of questions ends in a situation where Alistair decides not to embarrass himself any further and he gives up trying to answer questions. In essence Alistair casts himself as Kate’s victim; contained and constrained. This forces him to engage in impression management to give the illusion of compliance. Engaging in the illusion of compliance. I propose he becomes unable to rehearse his idealised professional self instead he adopts strategies to get through. In terms of this thesis what it is to be a student physiotherapist is tied to what it means to be a clinical educator and what it means to be a clinical educator is tied to what it means to be a physiotherapists and so forth. The salience of our identities (including professional identities) is confirmed through positive interactions occurring through social networks and social relationships (Stryker and Burke 2000).

I wish my readers to note here that I do not intend to imply that Kate was in any way deficient, more I wish to illustrate how Alistair’s chooses to tell his story to position himself in opposition to Kate, he achieves a particular presentation of himself through his positioning against his main protagonist Kate. His story illustrates how misunderstandings can occur without either the student or the clinical educator being fully aware of the impact each is having on the other. I acknowledge that by privileging Alistair’s story I have in effect silenced Kate’s story, I recognise that Kate would probably tell a very different and potentially conflicting story. Dominant discourses surrounding the CE/student relationship played out on a daily basis control what is possible and what is not. Alistair’s story is a counter narrative (Andrews 2010) it that challenges the major narrative of the clinical educator as the positive role model seen as someone to whom students should emulate and for this reason it is important.
It has enabled me to illustrate how by problematising the taken for granted relationship between CE and students it has been possible to explore how power dynamics implicit within the CE/student relationship functions to constrain and influence professional identities. What it means to be a student physiotherapist is tied to what it means to be a clinical educator and so forth. I propose that power manifests itself to suppress students’ opportunities to rehearse their enactment of their emerging professional identities where these emerging identities cannot be accommodated within dominant professional discourses as enacted by their CE. This forces them instead to give the impression of compliance in order to survive the clinical placement intact. The dominant discourse of CE being synonymous with positive role model renders it as taken for granted by physiotherapy educators.

Alistair’s story illustrates that within this particular context of physiotherapy education positive mirroring and role modelling does not always occur. The importance of the CE/student relationship is well documented. Alistair’s story illustrates the impact of poor CE/student relationships and raises important questions about how student physiotherapists chose their role models. As Gibson’s (2004) work within medicine found further work is needed in order to fully understand how the concept of role modelling functions in practice. Alistair’ story supports this.

I have deliberately included this counter narrative as a mechanism for facilitating the possibility of taking an alternative position in respect of the CE/student dynamic. I would hope to have opened up the possibility for physiotherapy educators to problematise the CE/student interactions and consider how this impacts upon the overall learning experiences of students in order to improve it.

Without Alistair’s story I would have been unable to ‘see’ things from the student’s perspective and as a consequence probably fail to question my own professional stance.

**Plot Four: Lack of connectedness**

Alistair’s lack connectedness with Kate is a consistent thread which he uses to bind events together into an overall plot. He creates a sense of being fractured
from Kate, struggling to fit in get on and failing to build effective relationships. Established early in his story, he recalls his first day in the clinical placement setting the scene for all that follows. For example he describes getting off on the wrong foot. Later in his story he returns to this and deflects responsibility away from himself and projects it onto others such as Kate herself and another ‘flaky’ student who happens to be on placement with him. He recounts his experiences and depicts them as characterised by his sense of failure, feelings of unpreparedness, shocked and besieged by an overly critical Kate. He uses several language binaries (good v evil) to emphasis differences between himself, Kate and other characters. Kate in effect becomes his personal anti-identification tool against which he oppositionally authors himself and others throughout his story.

**Plot Five: Exercising personal choice**

As I have already alluded in chapter two, any exploration of identity involves a debate about structure versus agency and the extent to which identity is controlled by structural factors as in culture or the extent to which individuals are able to exercise personal agency. Traditional concepts of professional identity tend to consider identity as something which is largely controlled by cultural norms and as such involves students being moulded into the image of those already seen as being able to lay claims of being a physiotherapist. I read Alistair’s story as one where he consistently and coherently illustrates how he exercised individual agency. He is able to resist the professional discourses personified through Kate, he becomes highly cue conscious and learn how to behave’ you learn what you should and shouldn’t be saying what you should and shouldn’t be doing’. In part by depicting Kate as an anti-role model he is able to preserve his emerging professional identity. He is not moulded by Kate he is able to resist her as a role model. Playing the game and getting by shows how he outwardly gives the impression of compliance yet inwardly acts deviantly (Goffman 1959).

As the placement progresses he shifts from playing the victim role to a role where he is able to exercise individual agency by employing successful impression management strategies (Goffman 1959). He is able to give the
impression of complying with Kate’s expectations. He quickly resorts to not asking questions in order to not make a fool of himself, by learning what he should do and what he should say in order to get through the placement intact.

Dénouement

Ultimately Alistair’s story is a progressive. He concludes his story by reflecting upon the ways in which his traumatic experiences with Kate are fundamentally positive. By telling this particular story in a way which witnesses him developing and growing out of his confrontations with Kate, he makes good the negativity expressed in his story. His denouement suggests that he was implicit in not meeting Kate’s expectations of being unprepared. He concludes his story by emphasising how he used Kate as a useful anti-identification tool helping him to work out what he was not, ‘the not me’ in order to work out what he was thus reinforcing his emerging professional identity As Foucault observes,

‘the task of testing oneself, examining oneself, monitoring oneself in a series of clearly defined exercises makes the question of truth, the truth concerning what one is, what one does and what one is capable of doing central to the formation of the ethical subject’

(1984 p 68)

In summary, Alistair’s story of anti-role models resonates across every participant’s story to a greater or lesser extent hence my decision to include it in this thesis. For Natalie she recalls, ‘getting only bad feedback, spending vast amounts of time in tears’. Julie sees it is ‘a kind of test, carrying on despite the negative experiences’. Chris recalls, ‘if I missed something, like a little thing that would be the highlight, its negative critical feedback all the time’. I will include a justification for choosing to include this anti-role model narrative in chapter five. I propose that Alistair’s story has highlighted a number of important points which should be of interest to physiotherapy educators. It promotes and supports interactional notions of professional socialisation and ideas which are suggestive of professional identities as negotiated in contexts and finally raises important
issues relating to students preconceived idealised selves and how this influences their subsequent learning experiences.

**Narrative Two: The Multi-professional Team**

‘Consider yourself one of us’

Natalie’s story begins with recollections of a team leader on one of her clinical placements she recalls, when it came to him being the leader I didn’t really feel that he, he took the lead. She remembers, “There was a lot of communication problems erm and he was very skilled when you watched him working independently but trying to organise the team he really struggled with that and I think that as a team you need sometimes that lead and direction and that, it, it was very hard as a student erm because I could see all the problems going on because I was kind of on the outside and watching those issues arise when someone maybe doesn’t communicate very effectively. It, it affects the whole team and not just, just them themselves erm so that sticks out really as someone who doesn’t meet a standard.

In contrast Natalie looks back on her elective placement ,’my elective placement it was great, I didn’t spend time with other members of the team like I have done on other placements but I was allowed to just get on with it you know on my own independently and I really felt that I was valued as a member of that team rather than just being a student who was there but not always wanted. I felt I could be an active member and that my contribution was valid. Natalie recalls,’ The teams I’ve most liked working in are the ones where I feel like equal to the others in the team. I got a lot of cards when I left which I didn’t expect off members of staff and I’d only been there for 4 weeks, off the OTs and different members that I wasn’t really assigned to work with but I ended up working with them both my clinical educators were off sick in my final week so I got sent to the main hospital site and I was just helping out wherever they needed me. But the other staff from head injury rehab unit actually rang up the main hospital site and asked if I could go back to work with them, they said they’d loved to have me back to just work with them and shadow them so I went back to my placement site as a physio wasn’t actively practicing cos there was no-one there to supervise me but I was working with the OT and the nurses
and they’d asked me to go back so that was a big compliment really cos they
didn’t have to do that you know they could of just left me where I was and I felt
that yeah, they’d appreciated what I’d been doing and the help I’d given them.

Natalie emphasises the importance she places on her personal contributions, ‘I
think I’d really been able to contribute to the team making suggestions for
treatment etc etc. She recalls, ‘Quite often they’d discuss patients together and
I’d make suggestions for things regarding patients or even the way that we did
things like goal setting’. She was able to contribute to the team, ’I tried to make
suggestions about how they worked as a team. She describes how ,’if I didn’t
have any work to do on the physio side and for some reason my educators were
busy I’d volunteer to go help the OTs and Nurses , ask them did they want any
help, did they need another person to help with their transfers. I helped them
quite a lot with their splinting. The OTs did their own splinting and I went and
helped them position joints and things’, She remembers, ‘they said that I was a
little O.T student as well I took this as a real compliment. I just liked helping
other people and I don’t like sitting there with nothing to do and I would help the
physio assistant and I think just being there for everyone and not just the physio
side, understanding that sometimes you have to help and with other jobs as well
and helping the nurses out if they were short going and changing the beds and
things so just trying to be a real team member, so I like the teams that are quite
sociable and interacting and everyone comes together to work on things together
rather than feeling isolated and on your own.

Analysis and Interpretation

I will consider Natalie’s story within the context of contemporary health care
where the boundaries of professional work are less rigid than they once were. As
described in chapter one, the changes to traditional professional boundaries
means that the traditional constraints around what particular types of health
professional can and cannot do are no longer as well defined as they once were
chapter one that this may pose issues for students learning to be a particular
type of professional and in light of the recognised importance of role clarity and
job function to the salience of a professional identity as described in the
literature (see McCall and Simmons, 2003; Taylor, 2003; Masson and Lester, 2003 for example). I suggested student physiotherapists yet to develop a solid understanding of their professional role and function and without the confidence of professional status may struggle to deal with the complexity of multiprofessional team working and struggle to contribute effectively. As the following will illustrate my assumptions described in chapter one were not borne out by Natalie’s or others’ accounts.

**Setting the Scene: Uniprofessional and interprofessional identities**

Natalie’s story suggests that exposure to successful interprofessional working was emancipatory and supports the earlier work of Adam and Hean (2006) and Pullon (2008). These findings suggest that interprofessional discourses encourage and support the possibility for individual health professionals to negotiate and re-negotiate their own professional boundaries in context (Cooper et al 2005; Payne 2006; Sharland and Taylor 2007; Bray, 2008; Anderson et al 2009; Perrotta 2009; Freeman et al 2010). This suggests that interprofessionalism allows for more individualised notions of professional identity which signals a shift away from fixed uniform notions of professional identity. This supports ideas which see professional identity as more individualistic rather than collective. I propose that the interprofessional discourses support Natalie in finding her own physiotherapy identity. As she presents herself as the only physiotherapist in the team she appears unconstrained by other physiotherapists. Interestingly I note that physiotherapy and physiotherapists are largely absent from her story. Her construction of the MDT as a supportive, helpful, collaborative and a safe haven suggests that Natalie is empowered by the interprofessional team context rather than constrained by it, allowed to just get on with it, I really felt that I was valued as a member and my contribution was valid. Her depiction of the team context suggests that Natalie is largely unconcerned by her lack of role clarity, she seemed liberated from the constraints of rigid traditional role boundaries. ‘If I didn’t have any work to do on the physio side I’d volunteer to help the OTs and nurses’. I propose that the fluidity of professional boundaries in the MDT, rather than being problematic (as I suggested in chapter one) enabled Natalie to explore a different kind of
professional identity based upon new and different interprofessional perspectives which in the past would have been not available to them. From the lens of physiotherapy I suggest that the definitions of physiotherapy and physiotherapists were historically much more closely defined, bounded and rigidly defended in an attempt to assure the promotion of the physiotherapy profession and the value it held. Contemporary professional body discourses about what physiotherapy is and what role physiotherapists play are described in more flexible generic terms such as reflective, flexible, autonomous practitioner emphasising collaboration and professional agility, in turn these are reflected in the curriculum design and content of contemporary physiotherapy education (CSP 2008). For Jack his experiences of team working meant he was more attuned to the value of others, ‘well we’re not separate and I’m no better than anyone as a physio.......fitting in the team you’re kinda equal’. For Alistair other members of the MDT provide him with much needed support by working together, ‘I’ve seen the strongest link between OT and Physio...... I treated numerous amounts of patients with OTs we just said right lets go in together...... if I was struggling they’d be there to help you’.

I would propose that interprofessionalism and the associated flexible and fluid professional boundaries act to emancipate Natalie’s ideas about the possibilities of her emerging professional self in ways that differ from what may have been possible for past students learning in a context where professional boundaries were more clearly defined and more rigidly adhered to. This is evident in Natalie’s story in that I read it as a place where she could relax into her role as the physiotherapist in the team ‘rather than being the student who was there but not really wanted, she was asked to go back as the physio’ able to play out her professional identity and test it out on others in ways which helped her professional growth. This is not to deny the enormity of the changes and challenges facing health care professionals, but rather to suggest that maybe for students they are protected from some of the tensions and anxieties experienced by qualified members of staff (some participants were clearly aware of the tensions and did described situations where jobs were being cut and departments shut down and the pressure this caused for their clinical educators) Natalie’s story illustrates her openness to all the opportunities interprofessional team working afforded her. This suggests that Natalie was well prepared for MDT
working. Her story illustrates how she was able to explore her own scope of practice, value and worth within the wider context of the other professionals in the team, often by helping them out and often by contributing to team decision making, 'making suggestions for treatments..... even about the way we did things like goal setting'.

The MDT as a construct is expressed through discourses consisting of language and practices that enable interprofessionalism to be distinguished from uniprofessionalism. In order to be accepted as a member of the MDT individuals such as Natalie are expected to learn, understand and internalise MDT discourses. In everyday MDT interactions and practices, discourses consist of not singular but multiple discourses, often competing and creating different versions of the truth. As Foucault observes multiprofessional discourses through language, and practices lay down a set of common assumptions and through this regulate and discipline members of the team by privileging some versions of the truth over others. The following plots show how Natalie tells her story through language which emphasises team over uniprofessional discourses, her story forefronts team importance over physiotherapy

**Plot One: Collaboration**

My overall impression when reading Natalie’s story is her emphasis on a sense of belonging, 'I really felt that I was valued as a member of that team rather than just being a student who was there but not always wanted. 'Her use of language emphasises acceptance, trust, mutuality and reciprocity. She tells her story through language which is focused upon strong interpersonal relationships, which as identity theory suggests is vital for salient identities, for example, ‘valid contribution’, ‘equal to others’, ‘helping out’, ‘they said they’d love to have me back’, ‘they asked me to go back that was a big compliment’ ‘they said I was a little OT student as well’. Natalie describes being valued by other members of the team, she includes recollections of acts of kindness, ‘I got a lot of cards when I left which I didn’t expect off members of staff and I’d only been there for 4 weeks’, appreciation, being aware of making positive and valued contributions, of her own understanding of when other members of the team needed help ‘they’d asked me to go back so that was a big compliment really cos they didn’t
have to do that you know they could of just left me where I was and I felt that yeah, they’d appreciated what I’d been doing and the help I’d given them ‘.

It is in this setting that Natalie is able to assume the role of the physiotherapist with a degree of confidence, the positive feedback she receives from other members of the team in terms of her contributions is particularly important for Natalie’s emerging professional identity. During the early part of her interview, Natalie recalls in some detail a physiotherapist who has had a lasting influence upon her, she describes his friendliness, his similarity to herself and his apparent enjoyment of his job ‘I liked him as a person, the way he spoke about physio’.

This particular physiotherapist provides Natalie with an important role model. She returns to him on a number of occasions throughout her interview.

Natalie’s story is clearly situated within interprofessional discourse where patient centred and team orientated practice is promoted protected and privileged. The dominant discourse is collaboration. Power manifests itself through the emphasis upon patient centred care, team orientated routines and rituals where ‘the team’ exerts power over individual professional groups. Her story is devoid of events centred on particular professional group. The professionals Natalie encounters are presented as collaborators, sharing expertise, knowledge and skills in the interests of their patients who lie at the heart of how they enact their clinical roles and functions. For example, Natalie describes how the routines of the MDT encouraged shared treatment sessions, helping each other out and team goal setting and treatment planning was the order of the day. In Natalie’s story, we witness interprofessional working at its best.

Plot Two: An absence of physiotherapy

This plotline I read as being very significant and is an important feature in illustrating how Natalie through her telling of her MDT encounters is able to position herself with confidence as the physiotherapist in the team without overtly doing so. She achieves this through the absence of other physiotherapists in particular her CE. With no obvious mention of physiotherapy or any other physiotherapists the dominance of interprofessional discourses is evident. The
day to day functioning of the team are expressed through mutuality, interdependence and respect; Providing the right care, in the right place by the right professional is portrayed as the driving force. I propose that this provides Natalie with an alternative way of being a physiotherapist focusing upon her skill and competence as a team member rather than as a physiotherapist. Much of Natalie’s story is told through her recollections of doing other things and assuming other roles rather than her physiotherapy contributions. "I’d volunteer to go help the OTs and Nurses, ask them did they want any help, did they need another person to help with their transfers. I helped them quite a lot with their splinting." And, "helping the nurses out if they were short going and changing the beds and things so just trying to be a real team member". She is able to experience first-hand the value and benefits of team working and this provides her with a very powerful opportunity to rehearse her physiotherapy identity expressed through her attention to being helpful and putting the interests of the team above anything else. This supports Payne’s (2006) work within the field of social work who identifies the MDT as a place where social workers are able to establish and have recognised their professional contributions which in turn provides individual social workers with external affirmation of their professional value and worth. It is in opposition to Perotta (2006) who contends that the MDT creates difficulties around role boundaries and perceived disempowerment for individuals.

For Natalie, the MDT provided her with a very real opportunity to perform her professional role in a safe and supportive environment, being asked by other professionals for her ideas and contributions to goal setting for patients helped her to rehearse her professional role, she was able to contribute her uniprofessional knowledge and skills within the wider team. She describes her role as being independent of her clinical educator, it is almost as if her clinical educator within the MDT setting has given her the space to be independent and allowing her the stage to perform her emerging professional role. She emphasises her independence within the context of other professionals who validate her role as the physiotherapist on the team. Overarching this is Natalie’s demonstration of her team working ability, she talks about helping others in their tasks, seeing beyond her tasks as the physiotherapist, seeing beyond and being
there for others outside of physiotherapy helps her to self-confirm her professional identity within the MDT.

In lots of ways Physiotherapy and physiotherapists are absent from Natalie’s story. Her story is epitomised by her feelings of being valued by others, and valuing them in return. She recalls being trusted to do her job and enact her professional role within the team, she was allowed to just get on with it. This level of trust provides powerful self-affirmation for Natalie. Identity theory with its emphasis upon the relational, interactional, and reciprocal nature of identity construction foregrounds the importance of relationships between individuals in identity construction (McCall and Simmons 2003; Cove and Levine 2003; Lawler 2009). Natalie’s account is told consistently through her emphasis upon the importance she places on interpersonal relationships, ‘I like the teams that are quite sociable and interacting and everyone comes together to work on things together rather than feeling isolated and on your own.’ The absence of her clinical educator from her story emphasises the position she felt able to occupy as the physiotherapist in the MDT. She effectively casts herself as the physiotherapist in the MDT. For Natalie, the MDT is a context where she is empowered and able to grow in confidence. Her frequent descriptions of times when she gained positive feedback, thus providing her with ample opportunities for identity validation and acceptance (Cote and Levine 2003) from other professionals on the team emphasise the importance of the MDT as a site of identity construction.

As Burke and Stet (2009) imply, for identities to be salient individuals (students) must receive some form of positive affirmation from others (CE) of the identity (student physiotherapist) they enact, ‘salience hierarchy reflects situational self rather than ideal self..... it is the self that responds to the expectations of the situation rather than the desires of the self’ (ibid p41). She recalls being empowered to find her own feet, she describes how her suggestions for treatment ideas were welcomed, For Natalie this is an critical juncture, she is able to see herself as a physiotherapist as a consequence of others seeing her as such, ’I could be an active member and that my contribution was valid’.

Another important juncture is when she recollects being ‘invited’ back to work with the OT’s when her clinical educator is ill towards the end of her placement.
She describes how the OT’s referred to her as ‘a little OT student too’, not only does the MDT provide an important site of positive affirmation of her enactment of her emerging physiotherapy identity. I would also argue it also provides affirmation of the ‘common identity’ as Perotta (2006) also observes. An important affirmation point for Natalie is where she recalls about being seen as a physiotherapist and not the student. As McCall and Simmons (1978 cited in Burke and Stet et al 2009) her physiotherapy identity emerges out of her professional interactions. Discursive practices of the MDT affirm her professional performance. Natalie lives up to others expectations of who she is; she is able to satisfactory live up to the role others expect (Cahill 1998; Callero 2003; Hogg 2005).

Through this she is able to develop self-meaning self-worth and ultimately a strong professional self-definition. In line with interprofessional discourses her depiction of the MDT focuses upon describing the MDT’s reciprocity of value and respect amongst team members which are presented by Natalie as transcending professional boundaries. Natalie’s story illustrates how she is able to interpret and successfully internalise the signs (shared treatment sessions) and symbols (shared goal setting) of the MDT as any other member of the team MDT discourses of shared meaning and shared action are a major feature of Natalie’s story. The discursive practices epitomised by MDT discourses privilege shared meanings of the MDT over any one profession. Natalie tells her story in a way which suggests her ease with interprofessionalism; it does not appear to create difficulties for Natalie in contrast to the work of Jenson, (2003) Murray and Male, (2004), Hodson (2002) all of whom suggest that role clarity and role function are essential feature of constructing a salient professional identity and that interprofessional team working prevents this from occurring.

**Plot Three: Belonging**

Natalie’s story emphasises the importance of establishing strong interpersonal and professional relationships. Strong professional relationships are a central theme throughout Natalie’s story. She tells her story through language which reflects a sense of being joined and bound to others. She talks of doing things together, ‘Quite often they’d discuss patients together and I’d make suggestions for things regarding patients or even the way that we did things like goal setting’.
This emphasis upon goal setting and team working was also a highlight of the encounters she faced. Joint assessments and joint treatment plans were pivotal. She describes how different professionals came into treatment sessions and helped each other, bringing uniprofessional competence and skills to augment each other’s treatment for the betterment of the patient. There is no sense of professional rivalry and sensitivity. She talks of how each individual professional would offer help and advice; they worked with patients together, crossing over professional boundaries regularly. ‘Everyone knew each other, that really taught me the value of working with other people, I got a better understanding of their roles’. They did a lot of joint working, joint assessments, all the goals were set together as a team.

**Plot Four: Power and the MDT**

In the clinical placement setting as in other organisational settings, the power in organisations is formed by groups of people working together. Power for the group derives from their cohesiveness (Jenkins, 2004). ‘They’d sit down and plan all the joint sessions, they had a lot of goal setting meetings, where everyone would attend including patients’. Natalie’s description of the MDT illustrates cohesiveness. People in groups tend to be empowered by others and as a consequence act powerfully; members of the MDT are mutually empowered through shared focus upon the patients rather than their own profession. The MDT described by Natalie, is empowered within the organisation through its focus upon patient outcomes and goals and importantly the absence of professional sensitivities. The power of the MDT does not allow the presence of uniprofessional sensitivities; in effect they are organised out of the MDT professional discourses and collaboration is organised into the politics of the MDT.

The dominance of the interprofessional discourses, around team goals, team decision making, patient focussed outcomes, joint interprofessional treatment sessions create a situation where Natalie portrays herself as being able to relax into her professional role. The dominance of interprofessional discourses creates a context where uniprofessional discourses are discouraged leaving Natalie with a
freedom to rehearse her professional self without the spotlight being entirely on her performances.

I read Natalie’s account as one where the MDT is depicted as a liberating setting where she can get on with just being the physiotherapist in the team allowing her the space to make her professional contributions without being constrained by professional boundaries. The MDT provides a powerful alternative site of identity construction for Natalie. Her portrayal of the other professionals in the team shows them to be confident in themselves as a team and as a result unconcerned and unconstrained by their own or others’ professional boundaries’

‘they all just helped one another and worked a lot like even the consultant was in on some of the session, they all you know just crossed over quite a lot, would work together quite closely’.

I propose that Natalie is freed from concerns about her professional role boundaries Natalie is enabled to become a legitimate member of the team, she is unconcerned with who does what she reflects the prominence of MDT discourses through her account. In Natalie’s story, interprofessionalism is emancipating in so much as she is able to be a member of the team without being concerned about professional boundaries. As Wackerhausen (2008) observes team discourses dominate thus suppressing the possibility of uniprofessional dominance whilst at the same time as Payne (2006) observes allowing each individual professional to contribute. Within the MDT the surveillance by individuals in the team acts to promote team importance over the importance of individual professions/professionals. As Foucault states;

‘for although surveillance rests on individuals, its functioning is that of a network of relations from top to bottom, but also to a certain extent from bottom to top and laterally, this network holds the whole together and traverses it in its entirety with effects of power that derives from one another; supervisors perpetually supervised’

(1977 p176-177)

In this way I see Natalie as being influenced by ‘the’ team discourses expressed through her daily clinical encounters.
Thus, identity theory emphasises the importance of social relationships and ties, and implies that for a salient identity to be constructed individuals need to develop strong interpersonal relationships and social networks. For Natalie, strong interprofessional relationships and interprofessional networks are key to her professional identity and are as important to her emerging professional identity as uniprofessional ties, networks and interpersonal relationships. Patient orientated goals are the important glue that bind members of the MDT together and provide in group identification rather than the professional background being the important factor. The MDT provides an important site of identity construction for Natalie, she actively negotiates of her own role in direct relation to role of other members of the MDT. The way members of the MDT enact their everyday practice results in them supervising and being supervised simultaneously to emphasise collaboration; collaborative actions, activities, rituals and routines and through this exert ‘the power of the norm’ (Foucault 1977p184).

**Dénouement**

For Natalie her encounters within the MDT are very powerful site of identity authentication. She relies on the cohesiveness of the MDT as a way of validating her professional self, which in turn provides a vehicle of positive affirmation; vital for the salience of her emerging professional identity. The fluidity and interchangeability of her role within the team supersedes her focus upon uniprofessionalism and does not reflect the uncertainty observed by Foster and Wilding (2000); McKay (2007) and Wackerhausen (2008). Natalie does not portray her interactions within the MDT as any other than positive. She casts herself as someone very comfortable with uncertainty, being flexible and seeking out opportunities to work at the edges of her own professional boundaries; She tells this story in ways which celebrate and emphasise multiprofessional discourses and patient centred health care (see chapter 1). She portrays herself as being liberated by working in a MDT. Her MDT role models play a central role in her story.

In summary, Natalie’s story emphasises the social aspects of identity construction. Her story is progressive and demonstrates how, empowered by the other members of the MDT she undergoes professional growth. She is able to
capitalise on her perceived absence of traditional professional boundaries. They simply do not feature in her story. I propose that Natalie’s story opens up the possibility of professional identity as being more personalised and individualistic rather than a concept which is constrained by a fixed typology of what is possible. Natalie’s story provides a powerful and unique insight into how the MDT became a very liberating and empowering site of identity construction for Natalie and it is one which was shared across a number of other participants. For example Jack’s encounters within the MDT echo Natalie’s. Jack recalls how he was able to step back from his physiotherapy viewpoint and explore his clinical practice from an alternative viewpoint. 

*I think initially, I was biased towards physio and didn’t really think about any of the others..... but the intermediate placement made me think more about OT...... well we’re not separate and I’m no better than anyone as a physio*. For Jack his encounters with the MDT gave him the opportunity to put aside his professional viewpoint and consider patient interventions and outcomes from the perspective of other professionals, thus opening up new and alternative ways of enacting his clinical role. 

*I was thinking they’re just additional stuff....... but that’s changed now I’m aware we are the same level..... because I didn’t understand it.... I feel stupid for thinking that*. He was able to step away from seeing things only from a physiotherapy perspective. He recalls how his exposure to the wider MDT and other professionals helped him to recognise the value and contributions of others to patient outcomes. His encounters with the wider MDT allowed him to see that physiotherapists were not necessarily better than everybody else and how working with others changed in view of himself as a physiotherapist and how it shifted his interest from just being interested in physiotherapists and what they could offer to appreciating what other members of the MDT had to offer. For Chris, the MDT gave him a real opportunity to experiences the benefits of effective team working, *’in the acute stroke setting everyone respected each other’s roles you know right down to the cleaner and I think that was really nice to see even doctors and consultants, they were really helpful, they’d give their time straight away’.* Chris emphasises the impact this has on him through his inclusion of his encounters in teams were less cohesive, *’the pressure was on the physio, on your back all the time, the manager, the coaching staff, the players you were sort of on your own the respect wasn’t there’.*
I proposed in chapter one that fluidity and blurring around professional boundaries as evidenced in interprofessional discourses, would be problematic for students attempting to construct a uniprofessional identity. Natalie’s story suggests an alternative perspective which resonates across a number of other participant’s stories. The MDT is an important site of identity construction in that it has the capacity to support individuals to be less rigid about their professional identity. The MDT provides a context where they are instead able to explore a different kind of professional identity based upon new and different perspectives which in the past would have been not available to them. I would propose that interprofessionalism and more flexible and fluid professional boundaries act to emancipate students ideas about their professional self in ways that have differ from what went before.

As Foucault observes professional discourses through language, and practices lay down a set of assumptions common to that profession, in Natalie’s story interprofessional discourses lay down a set of assumptions privileging collaboration and collective endeavour over individual professional dominance thus regulating and privileging interprofessional versions of the truth over uniprofessional truths.

**Narrative Three - The Patient Consultation**

‘Their lives in my hands’

Jessica’s story starts on her first placement, ‘I remember my first placement it was in a school which looked after mild to severe neurological disorders in children. There was a physio team there from 9-3 everyday and you’d go around and see the patients. Generally the morning was going around getting everybody in a standing frame that needed to be in a standing frame or lying down if that’s how they needed to be and then in the afternoon it was more the physiotherapy that they had. There was a lot of sensory stuff so the children with that couldn’t see properly they had a light room with lots of balls/baubles/bubbles and they had a lot of really good equipment they got some good results from the children. She recalls,’ it made what you do in class real so you know you talk about what high tone feels like what low tone feels like what spasms or muscles...
feel like but in class and you were just like well I don’t know what any of this feels like. My classmates don’t have the conditions so I’ve still no idea what that feels like and I suppose the hands on aspect of it all for me was the most important. I remember being, quite not annoyed but more frustrated cos back in the classroom and you’ve only got normal people to practice on and everybody felt the same. We started to do respiratory stuff and you’re listening to these normal chests and you like well I can’t hear anything, my stethoscopes in the right way round and it was yeah it was frustrating you can’t feel what’s wrong. You go through the motions all these tests all these assessments and nothing’s clicking nothing’s crackling, so I don’t know if I’m doing it is right or wrong.

On her second placement Jessica recalls, ‘I did medicals and I remember the first time I auscultated somebody with a chest infection and I was like ‘think my stethoscopes broken, there’s some funny noises on the end of it’ it was because I’d never heard it before and that was kind of like a big ‘oh ! So that’s what it sounds like’. Every time I heard something new it was like oh well that’s what that sounds like and you know that’s what a chest infection sounds like, and that’s what pleurisy sounds like so and you kind of build on it and you kind of get to a point where you can listen and it’s like ‘oh I know what that is ooh and there’s a little bit of this as well practicing over a period of time you really kind of get the gist of what was going on’. That was a year ago now so I’m not entirely sure I’d be as good now as I was then I think I might need to practice a bit more. When, I’m with a patient seeing how I cope with it. I’m always thinking they’re going to uncover me as a fraud’.

Jessica recalls how she managed to cope with patients, ‘I found if I was if ever I had difficulty doing something I would write it down like a proforma for my assessments subjective, objective so I’d just have like a little piece of card and I’d be like subjective for respiratory patient and then just the order the questions that I would ask so then it was structured I knew what I was asking and there was little arrows going off to how to develop this question and on the flip side I’d just have like my objective assessments so you know look at this, this, this and this and then take it from there, it was important for me to get it right.

Reflecting back recalls Jessica I kind of realised you can never know everything at the same time and you’re always going to need to keep learning. Jessica
recalls her success with patients, 'I remember the first time I got somebody who had a shoulder impingement he hadn’t been able to abduct his shoulders beyond 90 degrees and he walked in his third week and he said ‘watch Jessica’ and he put his hands together above his head and I was like ‘no way, it worked’. I was so happy that it worked that was always nice feedback for me and I was like ‘whoa’ I am doing something right because this is working and someone’s got better. It’s always nice to see your patients come in and say you know ‘I can bend my knee this far now and I can do this many exercises’ and progressing so I must be doing something right. I think a lot of feedback from my patients rather than feedback from clinical educators really helped so if patients told me something was going well or that they were able to do something or I saw them being able to do something that they couldn’t the week before, that was my feedback to know I was doing something or that they just miraculously got better’.

She remembers, ‘I started doing a Sunday with the academy lads and it was basically just run on stuff, first aid, there’s not been an opportunity to do an awful lot of specific physio I’ve given out stretches to the lads and give them information on what’s wrong with them and it I suppose it’s helped me developed my communication skills more than anything I was so used to talking to adults now I’d got to explain something to a 9 year old and tell him that no he can’t go back on the pitch because he’s injured. You have to get use to ruining a little kids Sunday morning I think that, that’s helped an awful lot with my communication skills and having to explain things to parents and why I haven’t let their son go back on and why somebody’s kid’s got the opportunity to play the game and not theirs’.

Another time Jessica remembers, we had a young lad he was really spoilt we were trying to get him up onto crutches, he’d broke his, he broke his tibia so he was in cast from his foot up to the top of his thigh and he was quite a thick set, quite a heavy young lad so he was finding it difficult to sit up and get into his chair and it was oh so painful and he was, he, he was spoilt and he was big, he did seem to be being quite lazy, erm and just he didn’t want to do it and he was in oh so much pain and he wanted his mum to come and get him Hannah (Jessica’s clinical educator) went to see him with the Jake (another Physiotherapist), they were trying to get him up on the crutches and she came
out and said he doesn’t want me she said he wants you, erm she said he thinks I hate him and I was like but you do (laughter) she was like ‘I know’ she said but erm she said I just haven’t got time for him and it was, it, he started to wear on my nerves in the end, but, you know I seemed to get maybe a little bit more out of him because I was, I did have that little bit of patience, and I was like ok it’s like right we’ll take it in small steps do this first and see how we get on erm and in the end we got him up on crutches and got him home.’

Analysis and Interpretation

A number of themes resonate across Jessica’s story which she effectively brings together to present a powerful and cohesive account. The major overarching plotline is being competent or in Jessica’s words ‘getting it right’ which is values as being central to her emerging professional identity. The following sections will explore each interconnected plot in the same way I presented Alistair’s and Natalie’s accounts. I will draw upon her use of language and discuss how she weaves together a convincing account.

Setting the scene

The Routines and rituals of patient encounters

Real world experience as an integral element of undergraduate health professional education is well established and it is therefore not surprising that students’ encounters with their patients feature in their accounts as significant. Within the local physiotherapy education context of this thesis students are exposed to clinical practice in all three years of the programme. The form of this clinical education has been described in earlier sections (see chapter one) of this thesis and will not be repeated here. To avoid repetition I refer my readers back to Alistair’s story and the routines and rituals of clinical placements which should help my readers contextualise Jessica’s story in the way it did so for Alistair’s.

Student physiotherapists are closely supervised in the clinical environment by their clinical educators predominantly and by other professionals as they go about their day to day clinical practice. However, despite this close supervision
Jessica’s story highlights the importance student/patient encounters which occur outside the obvious presence of clinical educators. In particular it highlights the importance students like Jessica place on playing the role of ‘being the physiotherapist’ in the real world of clinical practice for the salience of their professional identity. She often resorts to quoting her conversations with patients as a way providing clarity, emphasis and persuasiveness. Her clarity of recollection helps her to tell a very convincing account. On reading Jessica’s story I was struck by her obvious pride in being able to recall numerous accounts of when she has been able to really demonstrate her professional competence in making her patients better. She contextualised this in comparison to her ‘annoyance’ and ‘frustration’ with her academic classes. Indeed she starts her story by recalling her difficulty in understanding abnormality in a classroom full of normal individuals, ‘it made what you do in class real........ my class mates don’t have these conditions so I’ve still no idea what that ( high tone) feels like, and I suppose the hands on for me was the most important’. The following sections will explore each plot line in turn to illustrate how she builds a credible account.

**Plot One: Getting it right**

On reading Jessica’s story I was immediately struck by her use of language. Her description and imagery is characterised by images which represents the value she places on getting it right for her patients and the importance she emphasises of getting feedback to reinforce her sense of competence, ‘I think a lot of feedback from my patients rather than just my clinical educators really helped so if patients told me something was going well that was my feedback’. She establishes early on in her interview the central place patients occupy in her story of becoming physiotherapist. She emphasises the importance of continuous feedback, her requirement for positive affirmation of her professional self. She underlines this by describing in detail the immense sense of pride and satisfaction she feels when able to recall incidents where she made a difference to her patients. The language she uses reinforces the overarching theme of getting it right.

Through her story it is possible to plot Jessica’s professional growth. In line with patient and public empowerment discourses her story stresses the importance
she places on feedback from her patients. For Jessica feedback from patients is presented as being incredibly important to her emerging professional self. In Jessica’s story there is no sense of playing a game, of getting through and of impression management (Goffman 1959) as we saw in Alistair’s story. She presents an account emphasising her need to be seen as a real physiotherapist by her patients.

Jessica’s story belies the importance of real world clinical practice on her emerging professional identity. Juxtapositioned against the sterile and plastic environment of the university classroom, ‘you’re listening to these normal chests and you like I can’t hear anything, you can’t feel what’s wrong, you go through the motions’ Jessica illustrates the centrality of patient feedback for her professional self-affirmation. For Jessica, when things go well for her patients and they experience a clinical improvement it becomes an important provides a unique and meaningful learning episode. She values this above any other type of feedback. She recalls in some detail conversations with particular patients and used their speech to reinforce her story ‘he walked in in his third week and he said watch Jessica and he put his hands above his head.... it worked’. She includes excerpts from recalled conversations, bring to life the remembered interaction. For Jessica her interactions with patients, are presented in her story in opposition to the classroom. She presents the classroom as frustrating and unhelpful. She portrays classroom learning as largely unhelpful when it came to the real thing in the clinic. Jessica describes how getting her hands dirty and ‘doing the hands’ on was what made it real for her. Many of her clinical encounters can be read as professional epiphanies. Jessica’s encounters with her patients provides an important site of identity construction for her, she actively negotiates of her professional role by displaying her professional competence through her therapy interventions and the thoroughness with which she prepares for patient encounters, (her ‘proforms’, ‘little pieces of card’, ‘order questions so it was structured’ etc) The way she sought approval and validation of her professional competence from patients in effect can be seen as the patient and public empowerment discourses at play in her everyday practice.
Plot Two: Being Competent

Being competent as opposed to giving the impression of competence in front of patients was an important theme in Jessica’s story. She derived a real sense of positive affirmation through the progress her patients made following her treatment interventions. She establishes this almost as soon the interview starts. She effectively sets the scene for her account through recollections of her first clinical placement. Here is establishes the value she places on physiotherapists who go the extra mile who do not settle for the same old routines day in day out. Her descriptions of Helen a young physiotherapist establish the importance of being creative and innovative in her approach to being a physiotherapist, ‘she was so significant to me because she wasn’t just willing to settle into what everybody else was doing with every child, she had a fresh pair of eyes... all the others were we do this we do that .. it was very much a set routine’. She portrays Helen in direct contrast to the other physiotherapists who settled for a very routinised approach to practice, whereas Helen constantly sought new ideas and looked to improve her physiotherapy interventions every day. Helen became Jessica’s clinical role model and standard for her own professional identity.

This early encounter sets the scene for the rest of Jessica’s story. The centrality of being clinical competent but not stuck into routines, willing to go the extra mile willing to try new things was a recurrent and strong theme Jessica describes another physiotherapist (Julie) ‘she was really influential to me to see that there are actually people out there who care enough to even make the effort.... it was one of my best placements I’d had purely because of her’. Being clinically competent in the eyes of her patients was central to Jessica’s self-legitimacy in respect of her professional role. This positive affirmation enabled Jessica to see for herself her professional development journey. Her use of rich description establishes the importance she places on her professional competence.

Portraying herself as committed to doing her best she describes how she made sure she was able to do the best by her patients. She recalls the little tricks of the trade that she developed in order to undertake thorough assessments of her patients. She portrays herself as methodical, improvising by developing proformas which helped her not to forget things when seeing patients. There is
no sense of pretending to be competent. For Jessica her encounters with
patients became a real testing ground for her ability to cope with the pressures
of clinical practice, provided her with the opportunity to authentically recognise
abnormality, rather than give the impression of recognising it when playing in the
university classroom. An important affirmation point for Jessica is where she is
seen as a physiotherapist and not a student. As McCall and Simmons (1978 cited
in Burke and Stet et al 2009) her physiotherapy identity emerges out of her
professional interactions. Discursive practices of patient encounters affirm her
professional performance. Jessica lives up to her own and others expectations of
who she is; she is able to satisfactory live up to being the physiotherapist her
patients expect her to be (Cahill 1998; Callero, 2003; Hogg, 2005). Through this
she is able to develop self-meaning self-worth and ultimately a strong
professional self-definition.

**Plot Three: Being Professional**

During the interview itself Jessica’s demonstrates her professional standing
through use of the ‘language of physiotherapy’ Despite her clear commitment to
patient centred care which comes through her descriptions of her patients
triumphs, she also demonstrates her professional competence through her use
of technical and anatomical terms (also reflective of our shared history of
physiotherapy) and her use of impairment terms to describe her patients. This
may on first reading appear to belie her epistemological professional stance as
described in detail in chapter one and as defined by the CSP,

‘A health care profession concerned with human function
and movement and maximising potential. It uses physical
approaches to promote, maintain and restore physical,
psychological and social well-being, taking account of
variations in health status. It is science based, committed
to extending, applying, evaluating and reviewing the
evidence that underpins and informs its practice and
delivery. The exercise of clinical judgement and informed
interpretation is at its core’

(Curriculum Framework for Physiotherapy, 2002 p5)
Her account centres around professional/technical skill and competence, consistent with biomedical and evidenced based medicine discourses. As described in chapter one, greater consumerism in the healthcare sector has shifted the focus away from the professions themselves to the communities they serve (Heyman and Cullingy 1996; Ginsburg, Regeher and Hatala, 2000; DH 2001, 2001c; Goldman, Reeves, Lauscher, Jarvis-Seluga and Silver, 2008). Jessica presents this through her account, she clearly views patients (and their carers) and the public as partners in care rather than as passive recipients of care. Throughout her story she has the tendency to reduce her patients to their anatomical problem; she talks of shoulder impingements and stiff knees, spasticity, Guillaine-Barre, SI joints, sensory definition, auscultating. This serves two purposes, she legitimises her use the label of physiotherapist and establishes very firmly in the minds of her audience of her professional competence, through her use of the signs and symbols of physiotherapy. Her recollections of patient encounters are epitomised by technical talk, demonstrating her professional distance and her maintenance of patient confidentiality as demanded by the profession and professional educators. By using the discourses of physiotherapy she establishes herself as a physiotherapist in her account.

For Jessica above anything else her patient encounters were important in confirming and affirming her emerging professional self. She describes how she developed her ability to plan, cope, assess and recognise abnormality. For Jessica her patient encounters provided positive affirmation, she was seen as competent as a physiotherapist by those that mattered most her patients. Positive affirmation from her patients helped her to recognise her growing professional competence and to illustrate her success in performance of her clinical role. Interestingly, Jessica emphasises feedback from her patients as more important than the feedback she received from her clinical educators; who remain quite peripheral to her story. For Jessica, other affirmation is central to shaping her emerging professional self. In her descriptions she emphasises the importance of professional accountability. The centrality of her patients to her story is firmly established and is not surprising considering the importance of patient empowerment to patient centred care and with it the transfer of power to service users to promote their position as partners in care. Professionals need
to constantly work on their professional selves in response to the imperative to empower patients. This requires professionals to become increasingly adept at demonstrating their professional value, worth and competence to patients with whom they interact. Empowered patients require a different kind of professional capable of adapting to different patient demands, Jessica’s story reflects this discourse.

**Dénouement**

Jessica describes how her daily patient encounters provide her with a very powerful site of identity authentication. She works hard to present herself as a competent physiotherapist in front of her patients and describes how she uses the tricks of her trade to ensure she gets things right. She is heavily reliant upon the genuine feedback she receives from her patients in terms of their physical improvements and through this achieves validation her emerging professional self. As identity theory shows us this is vital for the salience of her emerging professional identity. In contrast to Natalie’s story, Jessica’s account emphasises the importance of her understanding and demonstrating her professional role professional function effectiveness and patient outcomes. In this story Jessica is focused upon the development of professional competence as an integral element of her professional self. Jessica’s story alongside Alistair’s and Natalie’s is a progressive narrative. She casts herself as someone keen to develop a clear understanding of her professional boundaries, desperate to be sure she can make a positive contribution to the health outcomes of her patients. Her account reflects dominant professional discourses associated with depicting health professionals with a sense of vocation and as essentially caring professionals (Clouder 2003). She prioritises her patients’ judgement of her professional skill and abilities over her CE despite the power which resides with CE in terms of formal assessment of her professional competence. She actively seeks out feedback in order to improve. She tells this story in ways which celebrate and emphasise professional discourses of evidence based practice and patient centred health care (see chapter 1).

In summary, Jessica capitalises on her patients’ recovery as testament to her growing competence and which she presents as being central to her emerging
professional identity. As Foucault observes professional discourses through language, and practices lay down a set of assumptions common to that profession, in Jessica’s story being professionally competent and patient centred discourses lay down a set of assumptions for Jessica through which she tells her particular account and emphasising aspects of her experiences she privileges as important to her professional development and emerging professional identity.

The Interview as a Site of Identity Construction

The preceding sections have presented three narratives as a vehicle through which I have presented the key findings of this thesis. I have suggested that student physiotherapists enter physiotherapy education with a fairly well developed idea about what being a physiotherapist means and this preconceived idea is the lens through which they then negotiate their subsequent learning experiences and interactions with physiotherapists and others. The three narratives have illustrated how student physiotherapists negotiate their emerging professional identities in their everyday professional interactions and enactment of their professional role and this will be discussed in the fifth and final chapter. Consistent with my methodological approach this final section will explore how the research interview itself can be viewed as an important site of identity construction.

The Research Interview

I propose that for the student physiotherapists participating in my research, the research interview took place at a critical juncture in their journey of becoming. In the few days following their interview my participants took the trouble to share with me their reflections on taking part of my research study. I believe that the interview provided an important space in which they could meaningfully link past experiences to their imagined future; thus rendering their learning experiences personally meaningful at a time when they were experiencing a critical transition. Linking past experiences (some of which otherwise may have been lost over time) helped them to recognise the professional journey they had
encountered. It gave them as Jenkins (2004) suggests an opportunity to reflect upon their experiences of performing their professional role in relation to their emerging professional identity which on their admission they had not really considered before. The research interview can be considered to be a socially bound context where they actively constructed themselves to reflect their idealised professional self for me in my roles as researcher and physiotherapist. It allowed these participants to step back from their journey so far and reflect on their learning encounters and how these learning experiences shaped their professional identities. As McAdams (1995) says stories enable us to make sense of our scattered and often confusing experiences with a sense of coherence. Alistair’s anti-role model story becomes a powerful and positive encounter when retold during the course of the interview. The interview supported participants to reconcile negative experiences and render them personally evaluative. During the interview participants engaged in conscious and unconscious acts in order to present their idealised professional self and the stories they told can be seen as reflective of their professional identity. For example, we see in Jessica’s story being competent is central to her professional identity. Natalie highlights her skills as a flexible team player, Jack (see appendix 4) places great value on his abilities to mentor and support junior students and Alistair highlights the value of strong interpersonal relationships as important to his ability to enact his clinical role effectively.

As McAdams and others observe the process of focusing on a life and translating it into words helps the author to identify or construct a coherent view of the self (1993 p254). The interview and associated reflections enabled these participants to consider an imagined future, gave their learning encounters a sense of coherence. It enabled participant to bring (what may have been disparate events) into a coherent whole and as a such make them meaningful (Cotazzi 2003; Sparkes 2002; Reismann2008; Andrews 2008). This is not to say that these participants told their stories in a linear or chronological manner. In many cases they told their stories in a way which moved forwards and backwards returning on a number of occasions to significant people and events at several points in their interview thus reinforcing their accounts, providing a sense of coherence and persuasion.
I argue that, the interview gave these students the space to create their own narrative reality and was an important place for them to name and frame themselves acting to reinforce their idealised professional selves. As Williams (2011) observes I believe these stories also have the potential to become powerful cultural tools for future students. Bruner (2002) also asserts that narratives are the currency of cultures.

My own insider positioning as a physiotherapist gave me an advantage in terms of a shared access into the world of physiotherapy. This no doubt had the potential to constrain the stories my participants were able to tell. In Bourdieu’s terms these stories could be viewed as ‘normalised stories’ that they possibly envisaged as resonating with my own. However I believe that my participants felt able to tell stories which were personally meaningful rather than simply stories they anticipated I wished to hear. Bourdieu (ibid) defines normalised stories as stories which tell about things that ought to have happened rather what did. However if my participants felt only able to tell stories I expected then I doubt that the numerous anti-role model stories which occurred in Alistair’s account and others (a counter narrative in Andrews’ terms 2008) would have emerged across all my participants accounts. I read them as an indication of their willingness to share honestly and openly with me the stories they wanted to tell in the interview itself. Indeed, our shared history/ culture of physiotherapy I believe allowed them to share stories that they may not have been able to share with others. Stories told in the interview are subject to social sanctioning and negotiations as Burr (2003) observes, ‘in our attempts to represent ourselves in particular ways we are dependent upon the willingness of others to allow us to paint a picture of their part in the actions we are subject to the same limitations to allow them to paint a picture their part of the action that suits our stories’ (p145).

Our shared history and shared professional language meant that they were able to simply get on with telling their stories; their self-constructions were embedded in localised configurations of meaning made possible because of our shared history.
Putting on a performance: managing their impression

Their performances in the interview helped them to convey a particular professional self-acting out through their individual stories, allowing them to make sense of their lived experiences at a distance. The narratives they tell belie their individualised epistemological way of knowing (Yancy and Hadley 2005). As Ricouer (1984)suggests, narrative identities provide human beings with a subjective sense of self continuity. Narrative identities are formed in a complex interaction between events imagination, significant others, routines and habits. Bruner (2002)argues that narrative is the currency of cultures. Through narratives we create identities and the self. Narrative identity provides a storied resource and through stories human beings are able to perform social actions. People’s stories tell an account of events and experience. As a researcher I see these stories as cultural resources through which people construct themselves. As stories are always told in context they also provide insight into the kinds of interpersonal or organisations functions they fulfil (Bruner 2002). The repetitive patterns of narration allow human beings to rehearse and embody their professional identities.

In summary, I propose that the interview itself became an important site of identity construction by retrospectively facilitating an examination their professional behaviour and performance and arriving at a personal truth about what kind of physiotherapist they are. As Foucault ‘the task of testing oneself, examining oneself, monitoring oneself in a series of clearly defined exercises makes the question of truth, the truth concerning what one is, what one does and what one is capable of doing central to the formation of the ethical subject’ (1984 p68).

These participants I would argue used the interview as an exercise in self-editing at an important point of transition from students to graduate. As Foucault says, an individual’s sense of identity changes depending upon the circumstances they find themselves in, the interview in many ways can be seen as a way of supporting participants to self-edit their professional self which then becomes part of the on-going process of identity construction.

As Denzin and Lincoln (2000) observes research interviews are important. In some ways the interview talk typified established professional discourses and
enabled each participants to present a professional self which you would imagine fitted into dominant professional discourses. On reflection, I see the interviews as being emotionally charged, I consider them to be untidy social constructions. Irrespective of my opening question and subsequent steer during the course of the interview, I firmly believe that my participants told the stories they wished to tell. Our shared history and context of physiotherapy allowed us to negotiate our place in the interview. As Mattingley (1994) states social encounters involve all actors negotiating their place within the plot. She questions they way in which individuals are able to share experiences, 'how do actors, with their own individual perspectives, desires and commitments to a future manage to create a sense that they are in the same story together?'(p812). I believe taking part in the interview has allowed students to in McLure's (1996) terms 'continuity build', by looking back they have been able to construct their own continuity for their future. Here her work on transitions is helpful in explaining the importance of the interview itself in supporting students in the act of exiting their student world and entering their professional world. The interview allowed them to continuity build in order to support their exit from their present and enter their futures.

The findings of this thesis have illustrated how power is embedded, sustained and perpetuated in the everyday routines of student learning encounters. By focusing upon the social I have emphasised the importance of context. The three narratives presented in this chapter illustrate three different contexts within which these participants actively negotiated and constructed their professional identities. I have shown how power functions in clinical placement settings to control what it is possible for students to achieve in terms of developing their own professional world view and subsequent professional identities. As Foucault (1977) suggests power is everywhere, I have shown how the everyday interactions and actions of students are controlled by how power manifests itself in learning contexts and how these learning contexts become epitomised by it
Chapter 5: Discussion of findings

Introduction

At the outset of this doctoral programme I was concerned with understanding more about the nature and operation of students’ professional identities in the context of physiotherapy education. From a social identity perspective I was interested in how student’s emerging professional identities get expressed through enactment of professional roles in everyday interactions. I was particularly interested in exploring the potential impact of major shifts in contemporary health care policy and increasing interprofessionalism on students learning to be a particular type of professional; thus constructing a uniprofessional identity.

This final chapter will consist of a discussion of the key findings illustrated in chapter four. I will consider these findings in relation to the potential theoretical and practical implications, the authenticity of my findings, its limitations and the potential for future research. I will structure my discussion around my research question and aims which I include here as a reminder.

The research question was;

**How do student physiotherapists’ construct their professional identities?**

The aims of the study were;

- To understand more fully the process of constructing a professional identity in a professional context which promotes interprofessionalism *(evidenced through Natalie’s story)*

- To explore the interaction between students and significant others and understand how these interactions impact upon students’ professional identity *(evidenced through Alistair’s CE, Natalie’s members of the MDT, Jessica, patients and Jack mentoring relationships)*
To explore sites of identity construction described as significant and important by students (evidenced by the three narratives in chapter four encounters with CE/ MDT/ patients/ Junior students)

To elicit students’ narratives as a way of understanding their lived experiences

The three narratives presented in chapter four are selected examples of the numerous nested stories elicited within my participants’ interview transcripts (see appendix 4 and 5 for an example interview transcript and Jack’s story respectively). One of the hardest decisions narrative researchers must address is the decision around which stories to include and which to omit. I chose to include Alistair’s, Natalie’s and Jessica’s stories as they offer an alternative perspective from those already offered in the published literature and importantly they resonate across accounts of other participants whose stories (due to space constraints) it has not been possible to include. I have been able to preserve and privilege the individual whilst at the same time show how individual accounts resonate across others. I believe that this thesis offers new and alternative insights into the complex process of professional identity construction in contemporary physiotherapy education. Importantly these findings have the capacity to highlight the importance of professional identity in physiotherapy practice and lift it out of the ‘the silent dialogue’ (Olsen 1964).

I favour interpretive ideas of human existence, where it is accepted that individuals actively construct both their selves and their social world (Berger and Luckman, 1966; Burr, 2003). I propose that the findings of this thesis highlight an important link between students’ performances of their professional role (controlled, constrained and supported to varying degrees by dominant professional discourse in the clinical setting) and their emerging professional identities. I propose that students attempt to enact their professional role in ways which communicates their emerging professional identities to others. As Clouder (2003), Mantei and Kervin (2011) Apker and Eggly (2004) have also observed, this thesis promotes and supports interactional notions of professional socialisation and ideas which are suggestive of professional identities as ‘negotiated in context’. In Foucault’s terms students engage in deviant behaviour
to give the impression of compliance. As Foucault asserts individuals are not
docile bodies, but they are capable of choosing to respond to or resist practices
of normalisation within each specific clinical setting. He argues against searching
for a fixed sense of self.

**Setting the Scene**

As Barker and Galasinski (2001) state, ‘identity is an emotionally charged
description of ourselves, rather than being a timeless essence, what it is to be a
person is said to be plastic and changeable specific to particular social and
culture contexts’ (p28). As McCall and Simmons (2003) suggest constructing an
identity involves ‘aspects of exchange’ namely negotiation, bargaining and
rewarding. The findings of this study support the work of Clouder (2003)
insomuch as they suggest that professional identities are constructed out of
interaction rather than through a moulding process of novices by experts.

Based upon the biographical narratives of three student physiotherapists and
drawing further on data relating to eight participants this thesis proposes that the
process of identity construction occurs through everyday professional encounters
rendering it socially and spatially bound. I propose that student physiotherapists
construct their emerging professional identity through a process characterised by
mediation. Student physiotherapists express their emerging professional
identities through their performance/ enactment of their professional role in
everyday professional encounters. These professional encounters are epitomised
by a series of micro level interactions through which students seek positive
affirmation from others (with whom they interact) of their professional identity.
Professional contexts are dominated by particular professional discourses which
simultaneously support and constrain professional identities, controlling what is
possible. Student’s emerging professional identities are mediated through
professional interactions with others and predicated upon their idealised
professional selves. If clinical placement settings are viewed as a stage it can be
argued that individual students engage in a series of professional role
performances which collectively create an individual’s map of interaction through
which they are then able to construct salient professional identities.
For individuals identity construction involves periods of stability and change. Through this thesis I have proposed that student physiotherapists enter clinical contexts with an individual and idealised version of what being a physiotherapist means. For Foucault ‘the individual defines that part of himself that will from the object of his moral practice, defines his position relative to the precept he will follow and decides upon a certain mode of being that will serve his moral goal and that requires him to act upon himself to monitor, test, improve and transform himself’ (Foucault 1980).

I propose that this ideal self is the comparator they subsequently use to construct salient professional identities. This idealised professional self is then protected, shaped and reshaped during their subsequent learning interactions. This reflects the findings of a number of other contemporary studies for example; Holland (1997); Howkins and Ewan (2000); Jones (2003); Aasland and Granum (2004); Richardson (2006); Kaufman (2006); Johansson and Hamberg (2007); Apker and Eggly (2004). I have illustrated through these narratives the ways in which students’ act out their professional role communicates their developing professional identities/selves to others. I have shown through Alistair’s story how CE interactions are not always as positive as physiotherapy educators we hope they will be and how Alistair and other participants then protect their idealised professional identity through impression management strategies. This I have proposed is indicative of individual agency, supporting the work of others for example; Ballet (2002), Clouder (2003), Gibson (2004), Bathmaker and Avis (2005), Perotta (2006), Payne (2006) Shakespeare and Webb (2008) and as I and others propose supports ideas which view professional socialisation as interaction and not predetermined moulding.

The following narrative summaries are included to remind my readers of the substantive plots arising out of the narratives presented in chapter four.
Narrative Summary

Narrative One: Encounters with Clinical Educators

‘The Me and the Not Me’

Alistair’s story has illustrated the struggles he encountered in clinical settings and his response to the conflict arising out of his negative CE/student interactions. I have shown how dominant physiotherapy discourses enacted through Kate’s CE role and Alistair’s student role created a situation where misunderstandings occurred. These in turn prevented Alistair from being able to perform his professional role in ways which expressed his emerging professional identity. Unable to successfully negotiate his role, he was forced to resort to games of impression management. His story illustrates how he gave the impression of fitting in with the dominant discourse (Goffman 1959). Alistair’s account illustrated how students learnt to deal with the mismatch between their expectations of clinical placements and clinical educators. I have argued that student physiotherapists enter clinical placements with a well formed ideal of what being a physiotherapist means and this ideal forms the comparator against which they judge future professional encounters. It has illustrated how students construct clinical educators in their stories of becoming in ways which allow them to protect and preserve their idealised emerging professional self and render it personally meaningful. This first narrative illustrated the importance of anti-role models or in McCall’s (2003) terms dis-identification in the process of constructing a professional identity. As McCall (cited in Burke and Stet 2009 p44) proposes ‘self-identification and dis-identification can be regarded as the positive and negative poles of identity: the me and the not me’. Constructing a professional identity is a collective endeavour, it involves classification of self against others that already occupy the professional role individuals aspire to themselves occupy. Alistair’s story illustrates how actively students construct CE in ways which go unacknowledged by physiotherapy educators.
Narrative Two: The Multi-professional Team

‘Consider yourself one of us’

Natalie’s story illustrated how student physiotherapists mediate their professional identities within the context of the multi-professional team (MDT). It explored the impact of interprofessional discourses on the construction of a uniprofessional identity. I suggested in chapter one, that the drive for increased interprofessionalism and collaborative working with the associated shift in traditional professional roles and boundaries would complicate the process of uniprofessional identity construction and make it harder for students to construct a salient professional identity. In chapter two, Payne’s (2006) work within the field of social work suggests that the MDT has the potential to have a positive impact on the identity of qualified social workers. Natalie’s story has illustrated the positive effect of multi-professional team encounters and the effect these encounters played on Natalie’s emerging professional identity. Through the inclusion of Natalie’s story I have suggested that the MDT provided Natalie with the possibility of a professional identity unconstrained by rigidly defined role/function boundaries and for a more individualised identity which emphasised collaborative practice. I have shown how Natalie’s lived experiences resonated with the work of Stronach et al (2000) and also the work of Perotta (2006) who suggests that the MDT offers opportunities for a common identity to emerge and McKay (2007) who observes that for qualified occupational therapists interprofessionalism acts as a mechanism for realising new and alternative identities. I note here Perotta’s (ibid) work highlighted the tensions and challenges to professional boundaries team working created, however as I have shown Natalie’s story suggests an alternative view.

Narrative Three: The Patient Consultation

‘Their lives in my hands’

Jessica’s story has illustrated how the interactions with patients are seen by Jessica and other participants as an important site of identity construction. In particular Jessica’s story will show how she sees patient encounters as allowing her to focus upon their technical and professional competency development
rather than worrying about being monitored and assessed by their CE. This narrative highlights the value students place on the validation (by patients) of their professional selves and is reflective of patient and public empowerment discourses as described in chapter one. Jessica’s story has shown how patients more than anyone else provided her with a real sense of professional worth. For Jessica patients are the real gatekeepers of her self-value and self-worth. This narrative falls within dominant physiotherapy education discourses emphasising the importance of real life practice in the education of health professionals. For example see, Adkins 1995, Hodson 2002, Taylor 2003, Mason and Lester 2003, and Murray and Male 2004.

The three narratives in chapter four, are representative of how student physiotherapists express their professional identities through the performance of their professional role about which they subsequently seek feedback from others (with who they interact) as a way of validating their emerging professional identities.

Key Findings

The key findings of this thesis are;

- Student physiotherapists entering physiotherapy education or very early in their professional education have a fairly well formed notion of what being a physiotherapist means.
- Through this they construct an idealised version of their imagined professional self which subsequently becomes the lens through which they then judge their subsequent learning encounters.
- In the process of constructing their professional selves they actively construct ‘others’ in comparison to their idealised professional self
- They mediate their professional identity in and through everyday professional performances of their professional role, actively seeking out opportunities to affirm their idealised professional self
- Where they fail to affirm their idealised professional identities through successful professional role performance they resort to impression management
Everyday professional encounters build up to an individualised map of interactions through which student physiotherapists construct salient professional identities.

The process through which these students construct their professional identity involves a continual cycle of performance, mediation and impression management.

The table below provides a summary of the plotlines identified in the three narratives presented in chapter 4, Jack’s story in appendix 5. Appendix 6 provides an illustration of how these plotlines run through a number of participant’s stories.

<table>
<thead>
<tr>
<th>Plotlines</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routines and rituals of clinical placements</td>
<td>Factors which constrain and support how individuals act in context of every day clinical practice and which mediate their professional performance.</td>
</tr>
<tr>
<td>Manifestation of power in the learning contexts</td>
<td></td>
</tr>
<tr>
<td>Occupying multiple roles; enacting multiple identities</td>
<td>The difficulties associated with performing several roles at the same time and the impact on identity salience.</td>
</tr>
<tr>
<td>Disidentification – the construction of anti-role models</td>
<td>Students actively construct ‘others’ in an attempt to construct their own salient professional identities and this involves both identification and disidentification.</td>
</tr>
<tr>
<td>Exercising personal choice</td>
<td></td>
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<tr>
<td>Identification – the construction of role models</td>
<td></td>
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<tr>
<td>Lack of connectedness</td>
<td>Feelings encountered where there is a mismatch between students’ expectations and the realities of clinical practice.</td>
</tr>
<tr>
<td>Power and the MDT Collaboration</td>
<td>Factors which constrain and support how individuals act in an interprofessional working environment.</td>
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<tr>
<td>Belonging</td>
<td></td>
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<tr>
<td>Uniprofessional and interprofessional identities</td>
<td></td>
</tr>
<tr>
<td>Routines and rituals of patient encounters</td>
<td>Factors which constrain and control how students interact with patients.</td>
</tr>
<tr>
<td>Getting it right</td>
<td>Students performances in clinical practice involve acting out certain traits which they associated with their idealised professional self.</td>
</tr>
<tr>
<td>Being competent</td>
<td></td>
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<tr>
<td>Being professional</td>
<td></td>
</tr>
<tr>
<td>Idealised Professional self</td>
<td>Students enter physiotherapist education not as a blank canvas but one which has already been shaped by their past experiences of physiotherapy and physiotherapists,</td>
</tr>
</tbody>
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Discussion

Physiotherapy as a construct is expressed through discourses (see chapter 2) consisting of language and practices that enable physiotherapy to be distinguished from other professions. In order to be accepted as a physiotherapist students are expected to learn, to understand and to internalise physiotherapy discourses. In everyday physiotherapy interactions and practices, discourses consist of not singular but multiple discourses, often competing and creating different versions of the truth. As Foucault observes and as I have discussed in earlier sections of this thesis, professional discourses through language, and practices lay down a set of common assumptions which regulate and discipline members of the profession by privileging some versions of the truth over others.

One of the major themes arising out of all participants accounts was the impact of being in clinical placement settings for short periods of time (within the context of this study placements were between three and six weeks in length). Identity theory suggests that for a salient identity to emerge individuals have to have a commitment to that particular identity (Burke and Stet 2009, Lawler 2003, McCall and Simmons 2003). Commitment in turn arises from individuals receiving the positive affirmation of a particular identity from others. I propose that student’s temporary membership of clinical team has the potential to create a lack of commitment on the part of some students and some clinical educators as illustrated through Alistair’s story.

Foucault’s notions of power and its relationship to discourse and identities has been helpful in interpreting Alistair’s and other participants’ narratives. For Foucault the power in organisations acts to normalise professional discourses to ensure that the status quo is retained. Foucault’s connections between, discourse, knowledge power and identity is helpful. He makes links between knowledge embedded in discourse and the power that enables some discourses to gain more power than others.

When students enter the clinical placement they are unaware of the cultural norms which exist, thus there is a real potential for misunderstandings occur. These misunderstandings are compounded by the temporary nature of their immersion in the clinical setting, they do not have time to work out their place in
the clinical setting. The interactions between students and others is in effect controlled by which communicative practices are allowed to occur, language in this way both reflects the dominant discourse and this in turn creates reality for individuals.

Foucault helps to problematize how dominant professional discourses come into existence and how as Moss et al (2000) observe control professional practices. For Foucault a person’s identity and understanding of himself changes depending upon the context in which he/she finds him/herself. Students find themselves in a number of different clinical settings which demand different things of them whilst they attempt to enact their professional identity under different sets of circumstances.

Individual physiotherapy identities are expressed through habits, activities and behaviours, the differences between individual physiotherapists whom students encounter creates a number of moral dilemmas for students which often if not always go unexpressed. Identities in context are constrained and liberated depending upon what can be said and what can be done controlled and expressed through context specific professional discourses. In the clinical setting, the professional discourses act as situated sources of truth and as such dictate what counts as important and what does not as seem in Alistair’s and Natalie’s stories.

An important constant across three of the narratives presented in chapter four; the clinical educator encounter, the multi-professional team and being the expert student is the apparent importance of difference in how these students mediate and negotiate their professional selves. Much of the identity literature tends to emphasis self-comparisons in terms of similarities and so it is interesting how these participants use a process of differentiation more readily than they do similarities (Jenkins 2004). Gibson’s (2004) work around role models across a career suggests that similarity seems to be an important self-comparator for those in the early stages of a career with differentiation becoming more overt later on. All identity work for individuals involves some kind of self-comparison, from a social perspective identity construction involves individuals defining themselves in relation to others which helps individuals to develop a sense of distinctiveness.
The literature on role models is helpful in explaining the importance of role modelling. As Gibson (ibid) the literature on role models are individuals who others look up to in order to emulate and internalise behaviours and attributes that the role model displays. Modelling suggests individuals match their own cognitive skills and patterns of behaviour on someone because of a position or role they occupy. As Gibson observes, notions of identification involve individuals making emotional and cognitive connections and the concept of role modelling is something that is generally considered to be a good thing.

I have suggested in chapter four that within physiotherapy education there is an assumption that clinical educators are generally accepted a good role models, my inclusion of Alistair’s story is important for a number of reasons. Whilst I have not suggested that counter identification is new or that it has never been observed before within physiotherapy, I am proposing that this counter-narrative is important in illustrating the impact of anti-role models in the pre career stage which is not currently reflected in the published literature.

Difference as a key element, professional socialisation lit perpetuates notions of emulation, positive role modelling and the capacity to mould students in ways which this thesis questions. Literature associated with role models has emphasised the importance of role models in early career but not anti-role models, privileging the similarity aspect of self-comparison. I argue that for these students emphasis on difference and working out what they are not is fundamental to constructing a professional identity.

For Goffman, the self is dramaturgic, he proposes that human beings express themselves through interactions with others and that individuals are always spatially situated. He suggests first impressions are vital for the success of future encounters. His theory of everyday interaction suggests that when we act in social situations we are forced into a situation where our performances will be judged by others, who, because of their expectations of us expect us to perform in a certain way. He views everyday routines as performances and that through these performances individuals negotiate their identity, by presenting a certain image of them for others to accept or reject. For Goffman identification is often a matter of imposition, resistance, claim and counter claims and is particularly
helpful in explaining what occurs when students interact in every day professional practice.

I propose that these findings support ideas of professional identities being socially and spatially situated within communicative interchanges between students and significant others e.g. clinical educators, patients and members of the multi-professional team. I contend that at the point of graduation student physiotherapists remain in a state of becoming rather than being, as Mark recalls, ‘I’m feeling like I’m meant to be feeling like a physiotherapist, but in a way I don’t’. During the course of their undergraduate education they construct multiple professional identities socially and spatially situated in everyday practices and which are constantly being shaped and changed and as such are neither fixed nor complete.

The different audiences to whom student physiotherapists perform their professional role exert a source of power which serves to control which performances of ‘being a physiotherapist’ are acceptable. Acceptability is defined in line with professional discourses which act as mechanisms of professional control and have the capacity to subdue students’ agency.

Professional discourses as laid down in publications such as professional scope of practice, rules of professional conduct, curriculum frameworks and so forth act as tools to monitor and control the profession and individual professionals in the interests of public safety. As chapter one describes in recent years there has been an increase in the accountability of health professionals and student physiotherapists are well aware of the requirement to adhere to the rules and regulations that govern the physiotherapy profession. Not disputing the need to control and regulate entry into the physiotherapy profession (and individual physiotherapists eligibility to remain on the HPC register), these findings suggest that student physiotherapists through negotiation and impression management strategies exercise individual agency within everyday professional interactions which enables them to preserve their idealised professional self despite the influence of established professional discourses through impression management by giving the impression of adhering to established practices and rituals.
I propose that through these student physiotherapists demonstrate individual agency actively negotiating multiple and sometimes conflicting professional discourses and their place within multiple professional worlds. They exercise agency acting deviantly to resist dominant discourses through impression management strategies (see Alistair), where the realities of the practice contexts did not support their performance of their professional identity. Also, where dominant discourses supported their professional identity they were able to perform their idealised self, developing and shaping it in the process (see Jessica and Natalie). Their accounts demonstrate how they are active in the construction of their own individualised salient professional identities, constructing themselves and others as a way of preserving their idealised self. They exercised agency rather than being constrained by dominant discourses they circumvented them.

This supports Clouder’s (2001) work within occupational therapy and further challenges the idea that professional students are wholly constrained and moulded by dominant professional discourses. Notwithstanding the fact that the profession is highly regulated and controlled the findings of this study suggest that contemporary student physiotherapists are able to successfully exercise their individual agency whilst complying with the demands and constraints of professional regulation.

These student physiotherapists were able to negotiate their learning experiences to preserve their emerging professional identity irrespective of whether or not it mirrored that of influential others. They achieved this through effective impression management, reflecting Melia’s (1987) ‘fitting in’ and ‘getting on’ and Clouder’s (2001) ‘playing the game’. In essence these participants engage in a range of strategic activities to construct their emerging professional selves in line with their preconceived ideas about what being a physiotherapist meant.

This thesis suggests that professional identity construction occurs at the micro level of day to day professional interactions and as such is mediated through discursive communicative practices between individuals. This moves away from viewing professional socialisation as a deterministic process where students and newcomers become socialised by being passively moulded by existing professional dominant discourses and adapt themselves to replicate other
professionals in an unquestioning way. This questions the influence of dominant professional discourses to shape and control professional norms and practices. Contemporary students appear to construct individualised emerging professional identities allowing for a degree of difference to emerge between individual professionals.

Theoretical and Practical Implications

The findings of this thesis offer a theoretical perspective that proposes that the process of professional identity construction is characterised by a series of interactions which collectively add up to a map of interactions through which individuals construct their professional identity.

I propose that Alistair’s narrative has the potential to add to our understanding of the concept of role models in general and in particular in relation to undergraduate physiotherapy education. I would argue that within physiotherapy education whilst the ideas associated with counter identification are not entirely new, the concept of clinical educators as anti-role models is not something which received much attention, nor is it fully understood and as such warrants further research.

On a practical level physiotherapy educators may wish to reconsider how best to prepare and support physiotherapists in their role as clinical educators. Also they may wish to consider how best to manage student expectations of practice prior to their first clinical placement. This may lead to a better understanding of the silent dialogue which takes place between students and their clinical educators and which is poorly understood.

Physiotherapy educators may wish to consider the possibility of students idealised professional selves and how best to equip with students with the tools to deal with differences more effectively. Richardson et al (2006), highlighted similar issues and has suggested that physiotherapy educators should work harder to change these preconceived ideas to fit in with the demands of contemporary physiotherapy practice. I would argue that rather than trying to change these preconceived ideas physiotherapy educators should be more
attuned to their existence and use them as a vehicle through which they can engage students in reflexivity.

Further work is warranted to explore the mechanism for choosing role models amongst student physiotherapists.

Lastly in consideration of the effects of temporary membership in a clinical team physiotherapy educators may wish to consider alternative models of clinical education which support extended clinical immersion to allow students to establish themselves as a member of the team.

**Limitations**

As with any research project I have identified a number of limitations which I will outline in the following section. As I have already discussed at length in chapter three, as with any other research project I have been unable to free myself of my own subjectivity during the process of completing this study. As Temple (2001) asserts it is impossible for any researcher to see from all sides at once and I acknowledge here that the findings presented in this thesis represent my interpretation. I acknowledge that an infinite number of alternative interpretations are possible. However I hope to have assured my readers of the authenticity of these findings throughout the preceding chapters.

In my attempts to privilege the voices of student physiotherapists I am aware that I have in effect silenced the voices of the others inextricably enmeshed within the stories of these participants. There is no doubt that the others enmeshed within these participants’ stories would have provided an alternative view.

As with any qualitative study, in the interests of depth it has been necessary for me to sacrifice breadth. Whilst I have made no claims that these findings are generalisable across other participants in other contexts I hope that my readers will be able to recognise the resonance these findings have in respect of the published literature. This thesis has presented findings that relate to eight student physiotherapists studying in one university in the north of England and
as such may not resonate across into other university settings or across other student physiotherapists’ stories.

Constrained by time I only conducted one interview with each participant and it is this one interview that has provided the data for this project. As highlighted in chapter three I did intend to examine the reflective diary extracts of each participant as another potential source of data for providing insight into professional identity, however on examination of the reflective diary extracts, their brevity and largely descriptive format negated their usefulness.

**Further research**

I have identified a number of potential areas for further research and these are outlined below. As with any other research study, I have raised far more questions than I have answered. As my research is relatively small in scale it would be helpful to repeat the study with other students in other university settings within and across professional groups. As I have already alluded, by deliberately privileging the voices of my participants I have silenced the others. In the interests of acknowledging the interactional nature of identity construction seeking the narratives of CE would provide an alternative perspective on the CE/student dynamic. I am a firm believer in the strengths of narrative as a way of personal sense making, further research into the potential for storytelling as a vehicle for promoting reflection within physiotherapy education is advocated.

**Concluding thoughts**

In line with my own epistemological positioning (believing that human beings construct themselves and the world(s) they inhabit through stories) this thesis promotes and celebrates narrative ways of knowing (Bruner 1990, Polkinghorne 1996, Reissman, 2008, Andrews 2008, Gubrium and Holstein 2000) and the notion of the narrative construction of the self (Bruner 1996) and in McAdams(1993) language the story metaphor is a theoretical construct for the study of identity development.
I propose that my participants’ narratives could become important cultural tools for future students. They have the capacity to bring to life the cultural dimensions of learning to be a physiotherapist in context. As Bourdieu (1977) observes lives to do not consist of data, lives consist of stories and stories are negotiated during social interaction. Throughout this thesis I have attempted to frame professional identity and self, both highly contended terms within the realms of interpretivism. I have attempted to bring together social constructivism, Foucauldian notions of power narrative and identity together to explore professional identity within the context of physiotherapy education.

I contend that professional identity is important. It involves knowing what provides individual professionals with meaning and purpose. It belies what we value as professionals and subsequently how we enact our professional role. As Jenkins (2004) suggests, for individuals constructing a professional identity involves, embodiment, categorisation and boundary work; between who we are and who others are. It involves the dynamic interplay between similarity and difference and self-comparisons. I believe that identity theory has enabled me to explore professional identity from the viewpoint of how the reciprocal relationship between individual student physiotherapists and the professional world of physiotherapy (and physiotherapists within it) shapes their emerging professional self. In particular I believe that this thesis provides new insight into the importance of difference in the construction of professional identities, as already discussed in earlier chapters of this thesis, existing literature postulates the importance of similarity over difference in the early stages of professional identity construction. This thesis provides a renewed insight into how identifying difference for these participants was instrumental in the process through which they constructed their emerging professional identities.

The narratives in chapter four have illustrated how the various roles student physiotherapist occupy in their everyday clinical practice and the professional discourse at play influence how they are able to express their professional identities. Chapter four has presented a view of professional identity as being multifaceted, relational and socially situated and bound in every day professional encounters. I have privileged narratives of experience as a legitimate source of knowledge; narrative ways of knowing offer an alternative to paradigmatic ways of knowing and are I contend a particularly helpful in exploring the complexities
of human interaction (Polkinghorne 1996). By eliciting the biographical narratives of students I have provided them with the space to tell their stories and enabled them to seek something personally meaningful about their professional selves. Collectively these stories provide a rich cultural resource for future students. They include many different features, distinctive narrative tones, thematic lines, personal imagery, ideological settings, pivotal scenes, conflicting protagonists and an anticipation of an ending to come.

So, as Stronach (2002) suggests traditional literature on professions tends to generalise professions into collective ideas of individual such as lawyer, teacher, doctor, the more confident and publically known such abstractions occur, the more the self-identity of the professional disappears, consequently professional narratives have traditionally involved continuums of practice, typical characters and typical roles thus ordering the professional narrative into an ordered story (ibid 2002). Stronach’s uncertain theory of professionalism describes professional identities as a mix of dilemmas, contradictions and compromise. Current literature on professionalism and professionals suggests that professionals are being restructured as advocates and partners as opposed to the more traditional notions of objective expert.

From a social constructivist perspective, conceptions of identity include viewing identity as a construct which is fluid, multi-dimensional and personalised and contextual, in this sense this thesis supports a post-modern perspective of identity; a perpetual state of becoming. In other words our identity is never fixed, certain nor uncontestable. From a sociological perspective identities are constructed through the structures of everyday life and the sociocultural realities in which lives are lived. Identity is never a priori, nor a finished product it is only ever the problematic process of access to an image of totality (Bhabha 1994).

Throughout this doctoral programme I have attempted to problematize the taken for granted process of professional identity construction combining ideas taken from social constructivism, a Foucauldian notion of power and narrative as a way of gaining a greater understanding of the process students experience as they attempt to construct salient professional identities. By privileging the lived experiences of eight student physiotherapists I have used their biographical narratives of learning to be a physiotherapist as the basis for the findings
presented here. By establishing them as a legitimate form of knowledge the findings of this study have the potential to be meaningful across other contexts and for future students. I have been able to take a critical stance towards how student physiotherapists construct and mediate their emerging professional identities during the course of their undergraduate studies. Favoured social aspects of identity has enabled me to focus upon the relationship between individual students and the wider professional world of physiotherapy and beyond which I propose has resonance across other professional groups and contexts.

As this doctoral programme is designed to enable practitioners to explore a particular issue in context I hope that these findings will be useful to physiotherapy educators in reviewing and revising future physiotherapy curricula within my own context and beyond. For the individual participants I believe that taking part in this study has been personally and professionally meaningful enhancing their professional development in ways which otherwise would not have been possible.

On a theoretical level I believe that this thesis supports notions of professional identity as mediated, negotiated in context and interactional. Finally, the findings of this thesis have provided an insight into the day to day interactions between student physiotherapists and others which raise more questions than it answers, I am hopeful that the findings in this thesis may be useful in providing the impetus for more critical conversations about how we as physiotherapy educators can best prepare and support future students for the complex world of clinical practice. I am a firm advocate of the idea that human beings are storied selves (McAdams 1993, Sarbin 1996) and as Holstein and Gubrium (2000) observe I believe that there is a close relationship between the stories we tell and who we are, our stories are the cornerstones of our identities. As McLure (1996) asserts, stories tell how people get across boundaries and narratives of becoming are often told as transformative events. For McLure, life stories are pre-eminently journeys of the self that tend to be told from the inside out, and often serve to provide a constancy across transitions, ‘it grounds the sense of what remains constant in the journey of the self, establishes, that part of who I am and what I believe now can be traced back to who I was and what I believed then’ (1996, p275). Constructing new identities such as a professional identity involves
leaving something behind, involves exits and entries from something to something else I propose that for these participants taking place in this study having the opportunity to tell their stories of becoming a physiotherapist has afforded them with the opportunity to make sense of how they arrived at the point of graduation (a critical juncture) and through the telling of their stories rendered their experiences with meaning. Professional identity is important; it provides professional life with purpose, meaning and unity, bringing these things together in the person (Jenkins, 2004). Exploring professional identity with student physiotherapists has enabled me and my readers to ‘see’ things not possible by any other means and I believe has enabled them to seek a greater understanding about their emerging professional selves as well as providing important cultural tools for future generations of students.
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Appendix 1: Scope of Physiotherapy Practice

2008

Appendix 2: Information sheet

Research study – ‘Student Physiotherapist’ Narratives and the construction of professional Identities’

Researcher – Alison Chambers, University of Manchester

Dear Student,

You are invited to participate in a research study. Before you do it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss with others if you wish. Ask me if there is anything that is unclear or you would like more information on. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

I am studying for a Doctorate in Education (Ed.D) at the University of Manchester and is solely managed by and supervised through the University of Manchester. The focus of my research is to explore how the experiences of studying physiotherapy influence the process of professional socialisation.

What will happen if I take part?

If you decide to take part you will be required to attend an interview which will last no more than 1 ½ hours. The interview will be semi-structured and you will be asked to talk about and describe your experiences of learning to be a physiotherapist. You may be asked some prompt questions by the researcher during the interview to help you to expand on some of the points. Rather than asking you a set of planned questions you will be asked to consider and about who and what you think has influenced you in your development as a physiotherapist. The interview will allow you to describe in your own words your experiences of learning to be a physiotherapist and how your experiences may have influenced how you see yourself as a physiotherapist.

The interviews will take place in a location of your choice; this can be at the University of at a venue you suggest. It will need to take place in private in a quiet space. The interview will be tape recorded for the purposes of analysis. The actual length of the interview will depend upon how much you wish to say. Following the interview if you decide not to be involved you can ask for your tape recordings not to be used in the study. The tape recordings will be destroyed on completion of the study or on your request should you withdraw from the study.

In addition to the interviews you will be asked if I can have copies of your reflective diary extracts from your professional portfolio. Apart from participating
in the interview no extra work will be involved and participation will not affect your studies or your future career.

**Why have I been chosen?**

You have been chosen because you are currently a physiotherapy student and as such will be able to provide a valuable insight into how your educational experiences have influenced your development as a physiotherapist and therefore your professional identity. As a student you are the best person to speak to, to gain insight into how an individual’s experiences impact upon how they develop professionally. I am particularly interested to explore this in the context of inter-professional working.

**Do I have to take part?**

Your participation is purely voluntary and should you agree to participate you will be free to withdraw at any time without having to give reasons for your withdrawal. At no time will your participation affect your current or future career. For the purposes of the interview you will be allocated a pseudonym. Only the researcher will know your true identity and this will be kept confidential at all times both during and after the study. Anonymity and confidentiality are guaranteed in respect of your personal identity and place of study.

At no time during the study or in any publication will your true identity be linked with the findings of the study; no one will know what you have said in the interview of what you wrote in your reflective diary in respect of the study except the researcher. All tape recordings, portfolios and tape transcriptions will be held securely in a locked filing cabinet in line with current data protection guidelines, only the researcher will have access to these.

**What are the possible disadvantages and risks of taking part?**

There are no risks involved in the study. The interviews will take approximately 1 ½ hours to complete. Your participation will in no way affect your current or future study/employment

**What are the benefits of taking part?**

There are many different ways in which students develop as physiotherapists and many different factors that can influence this. I am interested in understanding more about how you develop your professional identity. I hope to be able to understand more about what factors are influential in your development. This will help practitioners and teachers to prepare future physiotherapy students more effectively. I hope that you also get some personal benefit in taking part in respect of being able to take the time to reflect upon how you have become a physiotherapist. I would hope that this would help to develop a greater personal insight into professional life.
The current health care context with its emphasis on inter-professional working provides the background for this study. The blurring of traditional professional boundaries and the increasing numbers of new roles and ways of working which by definition lie outside of traditional professional boundaries may impact upon how individuals develop a specific professional identity. Understanding more about how you do this will help teachers and practitioners to prepare future physiotherapy students to work effectively within an inter-professional context. It is interesting to see how individuals develop a specific professional identity within an increasing inter-professional context and how this context may influence individuals as they learn to be a particular type of professional.

**Will my taking part in the study be kept confidential?**

For the purposes of the interview you will be allocated a pseudonym. Only the researcher will know your true identity and this will be kept confidential at all times both during and after the study. Anonymity and confidentiality are guaranteed in respect of your personal identity and your place of study. At no time during the study or in any publications will your true identity be linked with the findings of the study; no one will know what you have said in the interviews except the researcher. All tape recordings and tape transcriptions will be held in a locked filing cabinet. Only the researcher will have access. On completion of the study the tape recordings will be destroyed or at any time during the study at your request, or if you withdraw.

**What will happen to the findings?**

This study forms the basis of my EdD and will therefore be submitted in written form for assessment purposes and will therefore be seen by my examiners. Also, I hope to publish my findings on completion of the study in professional journals. You will not be identified in any publications.

This study has been granted ethical approval by the Faculty of Health’s Ethics Committee at the University of Central Lancashire.

You are free to ask any questions you wish in connection with this study. My contact details are 01772 894560 or 07980 982530

Thank you for your time and taking part. You will have been given a copy of this information sheet to keep for future reference

Alison Chambers (Researcher)
Appendix 3: Consent form

**Research study** – Student Physiotherapists’ Narratives and the Construction of Professional Identities

**Researcher** – Alison Chambers, University of Manchester

Please initial boxes:

- I confirm that I have read the information sheet dated April 2008 (version 2) for the above study and have had the opportunity to ask questions

- I understand that my participation is voluntary and I am free to withdraw at any time, without giving reason, and without my studies being affected in any way.

- I understand that my identity will remain confidential during the study and for the purposes of subsequent publications I have been assured that I will be allocated a pseudonym for the purposes of the study and this will be known only to the researcher, which will provide me with anonymity.

- I have agreed to tape recording of my interviews. I understand that the tape recordings will be kept securely during the study and destroyed after completion of the study or my withdrawal from the study.

- I have agreed to provide my reflective diary extracts from my professional portfolio for use in this project. I understand that my reflective diary extracts will be kept securely during the study and destroyed on completion or on my withdrawal from the study.

- I understand that the results of this study may be used for publication purposes on completion

- I agree to participate in the study

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Appendix 4: Interview transcript

Alistair’s Interview Transcript

I: Hello..........., thanks for agreeing to be interviewed as you know I’m interested in exploring your professional identity. What I’d like you to do is think back over the past three years and try to tell me your story of becoming a physiotherapist.

As you know stories tend to have plots and characters and I’d be really interested in hearing about the people and events that you think have been influential and that stick out in your mind as important.

To get you started it might help if you start by talking about why you chose physiotherapy as your career.

P: Alright erm well to start us off I mean I initially wasn’t, I’m straight from school so I did my A-levels and stuff and when I came to (university name) I didn’t really know what I wanted to do when I was in 6th form or was it year 13 year whatever it was. Erm so I just was like right, what am I gonna do and I initially was just going to apply for medicine in the end I applied for medicine and physio and then when it came down to it I didn’t get any offers for medicine and erm I didn’t get any offers from physio so I wasn’t sure what I was gonna do. So I just waited until clearing and thought right well you know I might as well try to get into physio and, I rang up the university and got offered a place.

It’s not that I wasn’t looking forward to coming across and doing physio but I just wasn’t too sure what it all entailed to be honest. I mean quite a lot friends have sort of come from other degrees and have sort of said that they wanted to be a physio since they were 5. I’ve never, it’s never been that with physio, it’s never been like that for me, erm I’ve never had that thing you know, from being 5. So yeah it’s been a bit of an interesting journey.

When I came over from home, it was initially a bit of a shock because I’d just come straight from school and I just sort of trying to get used to everything and moving away from home for the first time properly. I’ve been away from home
for like a few weeks or whatever, just holidays but nothing, nothing as substantial as this so it took a little while to settle in. I think that the small course is really, really good and I that’s one of, probably the best things that’s sort of helped me through my 3 years. It’s being able to get to know people quickly instead of you being one of hundreds. Going into a course with hundreds of people I’d feel a bit sort of daunted, but you know, there’s only 29 or 30 of us so erm that’s probably helped me quite a bit.

The first sort of real stint at physio was erm my first placement and it was a real shock. It was a community placement in (name of placement) and I was a bit, I don’t know, because I was, because I’m quite a practical person I just found it quite difficult I was just sat there in the office answering phones and stuff like that all day….. I just thought this isn’t physio. I think that particular placement it just wasn’t for me. I don’t think community was, you know, it didn’t get me off to a very good start I just thought it was quite boring to be honest. I’m not really, really a big fan of community and my educator wasn’t great. I don’t know everyone else everyone else got on with their educator but personally I didn’t, I didn’t really sort of get on with her that well.

I thought of packing it in right then but thought well I’ll give it the 2nd year and see what happens. Erm so when I went to the second year, the first couple of months was just uni and then I was back on clinical placement in February. That one that first placement was very, very tough. I was doing a critical care placement and it was the educator and the environment it was it was quite intensive. The educator, both educators actually, well all three of the educators were very, very strict and I think it was just because I’d gone from not really doing much in year one then being uni and not really doing much sort of, professional stuff, if you know what I mean. It was basically coming to uni do your work go home again and then going into that intensive environment, your first proper placement, first assessed placement. To be honest I didn’t really know what I was doing and it took me a little while to settle in and it’s just, I found it a very intensive environment. I just didn’t really get on with my educators whatsoever and at the end of the 6 weeks I was so disappointed in my results that I just thought right, I’m going to chuck it.

My personal tutor was absolutely fantastic and she was like you know ‘you can’t just base your decision on one bad experience because you’re gonna get that in clinical practice’ and after discussion with family and friends and stuff I sort of thought ok I’ll give it a bit longer, I’ll see what the next placement’s like and then see if actually physio is for me.
So my second placement was an outpatients placement and that was fantastic, I really enjoyed it, got on with my educator really well, got on with a lot of the staff as well and I just really enjoyed it and it was one of those placements that just sort of picked me up from where I was.

In the 3rd year we had a 2 six week blocks straight away as soon as we got back from our summer vacation and those placements were really good. I had one in neurology and one in rheumatology and they just sort of really confirmed that I was on the right path, the right career and I was able to develop then. I’d had those 2 placements at the start and 2nd year, you kinda get to know what you should and shouldn’t be doing and what you should and shouldn’t be saying to your educators and you just get, get a feel of what you should be doing during placements. You know trying to avail yourself of like all the learning opportunities and stuff. After those two placements I really developed my skills and developed my team work and communication and my treatment skills as well.

I got on quite well with my first lot of clinical educators and the staff and the same with the second, got on really well with the team. So then, that was, that was the end then basically that’s it. So my elective I did amputee rehab and I really enjoyed that again you know, so it was a really good placement and the educator was fantastic the team was really good, I got on really well with the OTs and even the general physio team as well. So that was the, that was my story and then takes us up to present day.

I: Ok, so thinking about today can you describe how you feel in terms of feeling like a physio or not?

P: I think so, I think it’s you know I’ve gone through 3 years, I can you kind of see where you I am in the whole standing of things I’m not really a student anymore to be honest I’m a graduate. I’ve gone through it I formed a camaraderie with my friends you know I think that’s one of the main things that I’ve got that I’ve got a good group of friends and we just sort of, don’t really know what I mean to be honest it’s kind of I’m with friends, you know where you are we’re all physios and that’s a big thing. I think just because everybody, everybody’s kind of erm you know, together. I’ve got a broad range of skills, you need to be good at majority of things to be a physio, you need to be good at communication, you need to be good at team working, you need to be good at your treatment skills and you need to be nice to patients. I think with regards to being a physio you just need to have that extra little to be able to put a patient at ease and obviously be effective in your treatments.
The majority of the time I develop all those skills on clinical practice. Because when you’re in uni you don’t really speak to a lot people. But when you’re out on in practice you are generally by yourself but it’s all about you being out there, you being pro-active and getting out there and you just chatting to patients and being part of the team and making patients feel at ease with you and being at ease yourself and you know, knowing where you are, knowing where you are and knowing how to react to various professionals. You have a laugh with patients and I think that if you have a laugh with patients it just puts them at ease. If somebody’s funny with you or somebody’s just sort of having a laugh with you, you get quite comfortable with them quite quickly and hopefully did that. I tried to do that, just to kind of put patients at ease.

I think I’ve grown a lot in confidence, that’s one of the major things that I’ve really developed and I think that’s sort of become apparent that.......shy and timid guy I was has completely changed I’ve been part of the CSP as well being the CSP rep and having that has, improved my confidence tenfold. Just being able to do that I know I can deal with the next challenge I can do that. I don’t think there’s one single thing that happens it’s a collection of your placements, it’s a collection of your interactions with others, it’s a collection of how pro-active you are because I know some of my mates, some of the people off the course they just sort of do what they have to do and that’s it and they don’t give that extra little 10% or whatever and I think you need to give that extra bit of enthusiasm extra bit of pro-activeness to kind of get as much as you can you need to make the most out of those clinical placements. So it is being pro-active and spending time with nurses and other professionals developing your team working spending time with other professionals so you know you’re developing your team work and communication.

I: You talk a lot about developing your confidence can you describe how that helps with you feeling like a physiotherapist?,

P:Oh its massive, I wasn’t confident to go up and talk to patients, to talk to other health professionals. Treating a patient that wasn’t a problem but you know in first year I couldn’t talk to patients to be that confident. I think improving my self-confidence helped because I wasn’t bothered about going in and speaking to somebody or a patient I didn’t know. because you know you at first I don’t really know them, I didn’t really know if I was saying the right things. And then if you don’t say the right things, you don’t say the right things at the end of the day we all make mistakes, we’re all human but its having that sort of confidence in
yourself and knowing what you’re talking about. I mean if you’re making stuff up then that’s not right but if you know what you’re talking about and you’re able to discuss it you know you can do it rather than just sitting back.

We’ve had a mentoring thing, I suppose I should’ve mentioned that, we’ve had a mentoring thing within the last year where we’ve mentored a 2nd year student and that’s been really good. I think because you can kind of review and reflect on your practice, see how you’ve developed cos these guys are just going out on their first clinical placement and you’ve had 4 placements so you’re able to give them hints and tips and stuff and I find the mentoring scheme really useful because I was able to kind of see where I was and I was able to give advice and to explain my experience because my particular mentee in the 2nd year was very, he was a fantastic, well he was a good student but he was just lacking in that self confidence that I’ve developed and so I was able to say look, don’t worry that’s fine cos, you know, I was there and I’m looking back and you know hindsight’s a wonderful thing but you know, I was able to say don’t worry be pro-active find out give that extra, extra 10% as I said. I think he found it really helpful getting advice from another student, he said that’s really useful because tutors come and say you’ll be fine but, you just think oh well they don’t really know what they’re talking about its been 20 years since they did a placement you know what I mean but having somebody whose just a year older than you or maybe not a year older age wise but a year older in physio wise, you know, you’re degree wise just to say look you’re alright, where you are at the moment is good and its not to put that extra pressure on yourself to kind of you know, there’s obviously pressures within clinical placements because obviously you’re being assessed you need to do well but its having that ability to come to another student and talk about things and see that you’re not doing too bad and that things will get better it will just happen and you just sort of have to let nature take its course. I used to do that I used to be very much oh I don’t know this, I don’t know that and I’m going to make a crap physio but you just need to sort let things happen

I: One of the things you talked about was spending time with other professionals can you tell me a little bit more about that

P: I’ll give an example my second placement of 2nd year I had time to spend with the clinical ESP, extended scope practitioner they’ve got this level of well knowledge they’ve impressive You think to yourself, I could be just like that if I work hard enough. With regards to OTs and doctors and nurses its being aware, it’s getting a greater awareness of what they actually do because a lot of people say oh you know, OTs do home visits, doctors treat them with drugs and nurses
look after patients but they do so much, so much more than that and its being able to kind of learn as much as you can from them you know, especially if they’re treating patients of yours because you can kind of see, what do I do as a physio, what do they do as an OT, what do they do as a nurse or a doctor and its being able to, to work collaboratively and seeing what they do and realising your own limits then because you kind of say right well I don’t really know what that is but I know somebody who’ll be able to answer that question for you if the patient’s asking you something about their medication then you say right I need to be honest I don’t really know that much but I can speak to so and so who’ll be able to come and speak to you and I think then you kind of develop an awareness of what your role is within, within the team and it’s just knowing your limits and not just making it up and saying well yeah you take 20 of those and 10 of those and you’ll be alright.

One of the OTs made a reference to me....she said I had personality and stuff and I think that helps as I said have a laugh bit of a banter with other professionals they they’re more likely to like you. Because it’s quite difficult when you go onto clinical placement you’re only there for 6 weeks and they’ve had established relationships with your educator or somebody else for years and it’s so difficult because you can’t just wade in, that’s years’ worth of friendship or a years’ worth of professional working they have you can’t just go in and then start being pall-y, pall-y with them So it’s just being, I think it’s just being comfortable with who you are at the end of the day just being able to be comfortable with where you are and where you’re at. I think it is quite important for other professionals to input into your learning erm because then that’s the only way you can get a greater awareness of everything that’s happening with regards to a patient rather than just thinking right I’m physio I’m only interested in the physio, I’m not interested in anything else because you can’t be like that in, in healthcare.

I: So working in a team seems quite significant for you in terms of how you see yourself as a physiotherapist?

P: Definitely cos I think if you’re able to improve those skills then that contributes to improvements in your own professional life, in your own professional career and then in your practice so you know working with other professionals and learning from them yeah I think is quite important

I: You talked about an extended scope practitioner you’d worked with can you tell me a little bit more about why they stick out for you?
I think knowing that there is life beyond being a band 5, there is obviously band 5, band 6 and band 7 but you know I don't really want to be 30 years down the line in a band 6 job just because being able to say right well you know you've built up that experience, you've done all those things and you know there is an extra element that if you work hard enough and, and you're lucky you can get to that level and you know have that experience and being able to come up with diagnoses and being able to differentiate diagnoses without a problem I think is quite impressive to be able to do something like that and being able to give joint injections and stuff and being regarded as a bit of an expert, you know, by GPs and by what are deemed medical professionals who are deemed higher than us you know being able to kind of say you know I'm able to do that as well you know. Basically it's because I wanted to do medicine in that first place. I don't know it's a bit of a macho thing I don't know but being able to say you know, you're not as much of a hotshot as you think you are cos a lot of medical students are basically up their own arses so being able to kind of put them in their place I think is quite important

I: So, you really wanted to do medicine? can you tell me about that?

Yeh, my dad’s a doctor and that played a bit of an influence but he’d always said to me from a young age you know, just because I do medicine doesn't mean that you have to and I think I just didn’t really know what I wanted to do and I just thought right I'll just go for it and see what happens. And there was never, as I said there was never a thing about wanting to physio since I was 8 and I think you know, they were fantastic it was just sort of like right well what else is there out there and I had a look at it ( medicine).

Then I thought right well if obviously, if I haven’t got into med school this time then why not look at other professions and see what they’re like and then I thought right well physio. Initially I thought physios were just working in sports fields you know magic sponge and stuff and then when I actually got into it in 1st year I was like right you know we were learning about the musculoskeletal system we’re learning about the nervous system, we’re learning about the cardiovascular system which obviously, obviously all plays an influence. I didn’t realise that physio was working in hospitals and working in respiratory and working in neurology and what they actually do and the wide specialities there are within physio.

I knew from a young age I never wanted to do 2 things. I never wanted to be in an office job because that’s not me and I never wanted to wanted to do anything
in a lab cos I just find that boring so I knew I had to do something with people and it was like right well what professions work with people and it was med school at the start but then didn’t get in and I got in to physio through clearing just coming in and realising, there’s a lot of scope within physio and that’s probably one of the reasons why I stayed. Because at first I just thought I’m going to have to go and work with sports teams. But then I found I can do outpatients, I can go in and work with stroke patients and stuff and I think working with those kinds, especially the stroke patients you can see the difference. I mean I only had 6 short weeks but I was able to see quite, quite a progression in a number of people that I treated. I think it’s quite impressive whenever somebody who couldn’t stand before is able to, with your facilitation, is able to stand and I was able to help them do that. I think that plays a major role, that really lifts your spirits just being able to bring those experiences every week or everyday or whatever coming home and then re-telling them.

I live with two other physio lads and I think that’s something that’s helped me as well because you’re able to bounce ideas off each other when you come home from placement discussing little bits and bobs and being able to kind of say oh you know I treated this and how would you go about it and you know show me what way, you’d do it. One of the lads has got a massage one of those……things erm a massage table and you’re able to then actually see what it is and what they’re doing and I think that helps a lot as well because you’re kind of getting another person’s view and sometimes I feel that if you don’t know something and you’re asking somebody else they’re like ‘oh I don’t know either’, and then you’ll go and look it up and then its having that knowledge. If I was living by myself or living with complete strangers or even living with people who I knew but were doing a different course I wouldn’t be having that input I wouldn’t have done as well as on my placements. I was able to ask them I was able to say ‘oh you know, I’m really struggling on this bit of erm the assessment document, can you give me advice on you know, what I should be doing’ they’d tell what they’d done and then I tried it and the clinical educator thought it was great and they gave me a good mark because I’d done that too. I wouldn’t have got that idea unless I’d spoken to somebody else about it. Just being able to knock on their door 5 minutes in and then you’re away so erm I think that’s contributed to me developing as well as having that peer/mentoring yeh by living with friends and stuff.

I: Can I ask you to think back over your placements and think about the people you met and worked with do any of them stick out in your mind and if so can you tell me about that?
P: I don’t think there’s been one solitary educator that has sort of been the one, the person I’d like to be cos they’re all totally different within their specialities. I know one particular educator I don’t want to be it was my first one. With regards to patients, a couple of people stick in my mind I remember them not because they’ve helped me develop but because they’ve been a good laugh and they’ve done well Cos that’s the only bad thing about placements you never find out what actually happens to the patients. Nobody’s really sort of, just working through my head now who I can think of who’s really helped me develop?

I: You mention a couple of patients can you tell me more about why they stick out in your head?

P: I mean No-one really from the 2nd placement I don’t think, But I’ve got patients for example this one was on my neurology placement where I’d had a patient with dysphasia and the communication with him was, was obviously really difficult, he’s receptive and expressive. He sort of helped me I suppose, it was really difficult he was very de-motivated he’d been in hospital 2, 2 and a half months and not really progressed to be honest, very sleepy didn’t really want to do much. The first time we saw him he was very, he had a very over-reactive left side so he’d be really pushing with his left. Being able to take him into the therapy room and work with him and then eventually we got him stood up one day and I was kind of facilitating from the front and then, obviously you know, you try and even though he can’t express himself, you’re obviously still communicating with him cos you just don’t think well he doesn’t know what I’m talking about so you’re still doing that and then he tapped my head and when I stood up he smiled and stuff and that was probably the first time I’d ever seen him smile that really lifted me up cos I’d helped him do that and he knew that and I think from then on he trusted me. Cos he wasn’t very trusting, he didn’t really trust me at the start, that sort of happened in the 2nd to 3rd week and from then on he trusted me a bit more and we tried to help him out that way and being able to work with him was really good.

On my elective I had a guy erm, there was a couple of people there that were absolutely fantastic, amputees you kind of think they’d be really depressed because they’ve obviously lost a leg or whatever but erm there was a guy that was just, he was a below knee amputee and he’d done really well. He’d been going for about a year or so to an outpatient class. He was a bit of a laugh he’d always be making jokes and I think that helped the other patients as well because it was a really friendly atmosphere, other new patients that had obviously just had their amputations done were coming down to the gym and getting involved and you know they were made welcome, they weren’t made to
feel as if they were an outsider but they were made to feel one of them kind of. He was good because he just made everything, he made it all light-hearted cos you kind of think, they’ve lost their legs and you know they’re gonna be fed up. There’s another, she was an old lady she was a bilateral below knee and being able to kind of see her progress and even simple things that we would, we would just assume oh it’s not a big deal and then we had a walk on the carpet cos she wanted to try that and she loved it she, she loved being able to walk on a different surface rather than the lino floor because she’d never been able to do it since she’s had her amputations done so you know, she really enjoyed that.

So I think those are the kind of patients that kind of make you think right I’m obviously doing a good job because these guys are happy and you know one of the 2 of them said you know ‘If you ever need a reference or anything like that there just give me a shout we’ll do you one ‘ and so those, those kind of times especially, I got to know them, I got to know them a bit better even though I was only there for 4 weeks I think out of all the patients that I’ve ever treated they were, they were probably the best, the most interesting I really enjoyed that but so yeah, I mean maybe I don’t really, maybe it’s a subconscious thing they have contributed to my development but when you kind of think of it like know it’s difficult to say Mr X he was fantastic he was the one who got me through physio, he you know, because I don’t think you can, for me personally, maybe different experiences for other people but for me, there’s not been one person or anything, anybody who’s really erm been you know there to kind of say keep going, keep going.

Although one person my tutor, my personal tutor has been just fantastic over the last 3 years and she’s been really, you know, every time I’ve had a problem on placement or whatever I’ve been able to go and speak to her about it without a problem and she’s been able to help me out in a way she’s probably aided my professional development just because she’s given me the confidence to do things that I probably wouldn’t have done just by being able to chat to her and the fact that she’s available that you can kind of go up and sort of say look do you have 5 minutes to go over a few things she’s probably helped me out quite a bit, definitely.

I: Can I take you back to that clinical educator who you described as being someone you didn’t want to be like, can you describe why that is?
P: Just if I was to ever mentor a student in practice she was very, she was very, she was very, just not a nice woman. She wasn’t a nice woman personality wise even out of the clinical environment she wasn’t very nice, she wasn’t even nice to her own colleagues to be honest and it was the team ethos that they had there it was very difficult. I’d been told before I went out on placement was that they don’t like boys you have to be a girl and you have to like dogs and horses to get on and I had none of those things so I was a bit screwed.

She, you know, she was just not a nice person and I think being my first placement, I mean the university’s acknowledged they didn’t prepare us as they should have. There was this one particular day and I still remember it, it was the first day, maybe it was the second day and she’d brought us into the office and it was me and another student that was on placement at the time and she said where’s your learning documents where’s all this stuff I want to see it. I was like “learning documents, what learning documents?” to this other student and she was like “oh I don’t know” and I said I don’t really know and the first thing she said was ‘that’s not a very good start to your placement is it?’ she wasn’t very, she wasn’t understanding whatsoever. Other students had the same experience with her, not from my cohort but from the year below and also from like a few friends that I’ve known from the CSP from Manchester they found the same thing. She’s really, really arrogant, she’s not there to help you. Criticises you a lot and that doesn’t do well for your self confidence, that, after my first block of 6 weeks. It damaged me it really knocked, knocked me down to be honest. My self confidence and everything and I just thought you know and that I kind of realised that I don’t ever never want to be like that, I’m never gonna be like that.

I remember speaking to one of the 2nd year students and her educator was a previous student of this lady I’m talking about and she knew me and obviously knew I’d be on her placement......whatever and she was agreeing, she was my educator, she was an absolute nightmare. I’m now teaching my students that come to me and doing everything opposite to what she did and obviously the students are doing well.

I think if you create that just the extra pressure that she put on, that she would put on you she’d, she’d put up an x-ray film of somebody’s chest this is my first proper placement, I’m not really confident in chest x-rays whatsoever, I find them really difficult actually and then not being able to just pick out all the anatomical points and she’d be like ‘what’s this?’ ‘say something’ ‘no, it’s wrong’ and then there’d be a long pause and then you’d just be like ‘what is it, what is it, what is it?’ and start coming up with this other stuff because you just don’t want that silence do you and then she’d be like ‘no, no, come on you know this,
you know this, why aren’t you telling me about this?’ and then those kinds of things and it wasn’t just the one off it was everyday and you’re getting absolutely hammered. It was my fault, it was my fault as well I mean I’m not blaming it all on her I mean I didn’t know my stuff before I went out but then I think, being the first placement you don’t know what to learn.

She did give me tutorials but it was always in the afternoon you just have your dinner and you’d be just falling asleep and it wouldn’t be very interesting and then they’d assess you the next day and say ‘what’s this we talked about it yesterday’ and I were like ‘oh, forgotten already’. I obviously didn’t do well and then, I don’t want to blame it on the second student but a part of the whole process this second student was a bit of a flake, didn’t really turn up a lot of the time it doesn’t do you well either because having somebody not pulling their weight makes it more difficult for you in an already difficult situation. so I mean that placement, I kind of realised that not every physio is like that there’s some bad eggs in every society and every profession as some so I thought if I just work hard I’d be alright, that placement’s probably been, even though it was a rough 6 weeks at the time it’s probably sort of helped me to know what do I actually need to do. I don’t regret being put in that situation because I think I’ve kind of realised how much it has helped me in a way to realise that I’m not going to be like that whenever I get a student. And I said that to one of the 2nd years we had our physio ball and I was speaking to one of the lads that was out there on placement and I just sort of said to him I know you’re looking at it as a really bad experience, you probably didn’t do very well and he was like ‘no’ and I said to him ‘you don’t know what you’re talking about’, I said ‘honestly, you get into your 3rd year and you’ll look back and you’ll kind of realise that that experience has helped you and the fact that you know, you know what your limits are and you’re not, you aren’t afraid to express them’ I think I was quite, I didn’t feel as if I could ask any questions because the response would be ‘why don’t you know that, you should know that already’ and then when I should’ve been asking questions I didn’t because I didn’t really know and I going to be told that I should know it already in which case there’s no point in embarrassing myself further but then I had problems with patients, not detrimental problems with patients but just you know, they’d know, you didn’t know, they’d see you speaking to somebody about them and that you didn’t know what you were talking about and you’d be like well you know, I’ve asked you questions in the past and you couldn’t, you couldn’t even say that because they would just really difficult just a very difficult learning environment.

It was a very intensive placement and you know, I thought maybe that’s just intensive care. but I’ve had friends that have done it, it is difficult cos they’re
critically ill patients but other educators aren’t as bad and they’re a lot more interested in how you learn rather than seeing you as a bit of a nuisance really and bullying you. Bullying is a very strong word but it sort of felt as if that was what happening when I was on that placement. That was significant definitely, cos then you kind of realise that’s what I’m not going to be and then you can kind of see where, sort of work out what you are going to be and seeing how other professionals work and seeing how you’re friends work as well sometimes it helps you kind of see right they do that really well I’m going to use that. You learn little tricks, tricks of the trade as you go.

I: If you had to describe yourself as a physiotherapist to someone what would you say?

P: Erm I would say I’m a pretty easy going nice guy that has an interest in patients, interested in what’s happening with the overall picture of somebody and not just interested in you specific things . Erm a good communicator, good team worker, taking an active interest in what’s happening with your patients I think cos then they kind of think you know, they’re not just a lot of patients feel especially with the medical profession they’re just poke, prod them get the bloods, drain them of their bloods and then they leave and they don’t really give an explanation as to what’s going on.

I think being able to do that explaining why, what’s happening and being able to give examples. There was a young chap, no he wasn’t a young chap he was about 60 and ah he didn’t realise what was happening he was a bit confused and stuff he didn’t realise that he was going for surgery and he burst out into tears he didn’t really appreciate what was happening.

I think giving that extra bit of time and kind of realising that you may have 20 patients to see but it’s being able to kind of think about that, that guy needs an extra bit of help and other patients they’re alright they can be easily mobilised or whatever it is and spend an extra bit of time it’s quite important for us and I think that’s why we’re valued as well because we do explain these things we just don’t automatically assume right you’ve consented to being here therefore you’ve consent to having your leg chopped off for an unknown reason if they don’t really know. Just being able to explain things for patients that bit further.
I can look back on my 3 years and kind of realise you know, I am a physio now because I wasn’t in first year I didn’t know much but its having that extra thing with regards to your placements getting that extra experience throughout all that time and then you’re able to say right well I actually am at that level because I’ve had the placements and I’ve got the experience now and that’s not to say you know, that’s the end of the learning there’s obviously plenty more learning to go and as I said the ESP guys are your sort of role models as such because they are the people that will…..you can, you know you can get up to that level if you attend courses and if you do those extra little bits you know you can become that within the next 10-15 years however long it takes.

I didn’t really know what to expect when I started but you know, it’s been, it’s been hard work the past 3 years, it’s not an easy degree but you know, I think it’s worth it in the end because you can kind of realise that from that hard work that you’ve put in, this is the fruits of your labour really, you’ve got, got a degree in physio and you can go and get a job and, and earn a decent wage. I know I’ve got to develop from a junior to a senior 2 then a senior 1 and then on to the likes of the ESPs as well so ah yeah, I’m a looking forward to it now because it’s been a long time in the coming and now it’s just sort of here

I: Thinking about the future can you tell me about your aspirations?

P: What for the future? I think just being able to practice without, all that input. I’m still not as experienced as I’d like to be obviously I’ve only had a limited experience but being able to get in and I see myself in the future hopefully working, in hospital and also doing my private work as well and just having that flexibility in the future and I’d like to get into research erm because I just think that for the profession, research around physio is very sketchy and I think we need to develop through the profession as well and making sure that physio is kept in as a high regard as it is already and improving the literature around it because I know in previous practice or previous experience I’ve spoken to, people who’ve spoken to other people who’ve then told me that doctors say there’s nothing about physio, physio’s all a waste of time, but it’s a lot more than that and I think the research needs to reflect that so that other professions view us as highly as sort of patients view physios because I know a lot of patients view physio as a good thing and um I think it’s important that, to ensure that we maintain our professional identity and keep that going rather than just falling through and kind of just letting it slide that we’ve, that we’ve got this level at the moment. I think it’s just important for us as new graduates coming in to keep, keep the profession alive really and keep it as interesting as possible..
I: You talk about patients holding physios in high regard can you explain what you mean?

P: I think we can give them a lot of, if they want to get it, if they’ve got a shoulder injury for example we can get them back if they’re a tennis player we can get them back you’re able to give them specific strengthening exercises or whatever and get them back to their performance. With regards to being in a hospital environment to get the people out of their beds cos a lot of people will just sort of stay in bed and nurses, and nurses are very busy and they’ll just sort of say get out of bed but that’s maybe a very difficult thing maybe they weren’t able to do that at home without a lot of assistance and then us being able to go in and helping them, teach them little, little tricks that they can do to help themselves, I think that’s important as well because you’re able, they’re able to say that you really helped them because they’re able to get moving again.....they sort of say I’ve been stuck in this chair all day and now you’ve come and seen me and now I’m moving around’ being able to help them, help them that way and I think they’re grateful for any help they can get especially the older ones.

I think with us they kinda think, oh you know those physios are really good because they can help me out especially, and the OTs as well because there’s a lot of overlap between us and OTs. In my experience, in my elective placement they (patients) absolutely loved my educator just because of what she was able to do with them because a lot of the doctors have said ‘right well you get your prosthesis and the physio will sort you out’ and then they come to the physio and kind of realise that actually with the aid of a prosthesis they can get walking again.

I think with regards to amputee rehab, that’s probably, that’s an interest of mine because it sort of involves really getting in there, brain and spinal injuries is also an interest of mine and something I’d like to go into and delve into a bit the complexity of it all and being able to kind of get in and work with a patient and build up a rapport with them which is really important and being able to kind of get them moving and people who are able, aren’t able to walk, being able to get them walking again. That’s a hugely important thing for your own sort of gratification, being able to think I’ve been able to do that and being able to assist them, to do that and they’re very grateful for all the help you can give them so yeah, I think we are held quite highly at the moment and it’s just important to keep that going in the future.
I: You made an interesting point when you said there’s um, there’s some overlap between physiotherapy and occupational therapy could you talk about a bit more?

P: When you look at these, I mean us and OTs it depends what field you’re talking about. In my experiences so far it’s been neurology and amputee rehab that we really worked quite closely together, we’re looking at different things like for example transfers, you can speak to the OT, maybe the OT’s seen them and you haven’t got round to seeing them yet because you’re dealing with another patient or maybe things haven’t worked to plan and you can go and either they’ll ask you or you can ask them how do they transfer then you know between two or one? And then you can co-ordinate effectively who you need and what time, and what people you need. If they’ve got extra help for example if two people have phoned in sick or one’s off and one’s off sick then being able to say look can I borrow you for two ticks? I need to do a stand with this patient’ and if they’ve got time then yeah they’ll say ‘that’s not a problem’

I think we can, we work quite closely its establishing a rapport with an OT it’s really good because you can kind of ask them questions about the patients home environment and ask them for ideas especially for treatments. I know with one patient on my neurology placement I can’t remember what exactly happened but basically the OT and the physio had, had gone away for half an hour and I’d come with a plan of action for how we were gonna treat the patient. It’s having that, sort of work, collaborative working and kind of saying ‘right well how are we gonna do this’. My elective placement I mean that’s probably where I’ve seen the strongest link between the physio and the OT, they got on really well they were good friends which obviously helped, helped the professional relationship. We were able to work with them I treated numerous amounts of patients with the OT because we just said ‘right we’ll go in together’ or ‘where are you going now I’m going to see Mr Y, oh right I’ll come with you’ and then they’d get 2 helpings of professionals and you’d be re-iterating a lot of the same things because you’re looking at the same things I mean with amputees you’re looking at transfers, you’re looking at being able to get them mobilised in a wheelchair, obviously we’re looking a bit more at quad strength and exercises and stuff but they’re looking at a lot of the inpatient stuff they’re looking at a lot of the same things and so being able to work with them was really useful.

They would sort of say ‘oh you know, have you thought about this’ and ‘you know previous students have done this’ so maybe even just ‘(name) would do this or what do you reckon’ then I would say ‘that’s a pretty good way of doing
that’ if I was struggling or whatever they’d be there to help you out and not just there to just kind of watch and cast and eye over you.

As I said we do work quite closely together not you know in a couple of different things but probably amputee rehab and neurology in my experience are where we’ve worked really closely together. I think that’s been, because the patients need that intensive input, outpatients obviously you’re by yourselves you’re on your own.......in outpatients, well you are in every field but you know what I mean it’s a bit different and then in rheumatology there wasn’t a lot of overlap and in critical care there wasn’t a lot of overlap but in those where the patients needed that extra little bit of support and help from those 2 fields then you know, I worked quite well with them, I enjoyed those bits.

I: Ok I’ve just got one more thing to pick up on if that’s OK, when you were talking about your dissertation (subject: yeah) and this is idea you mentioned of keeping physiotherapy alive and the evidence behind it, could you talk about why that sticks out for you?

P: Yeah because I think that I’ve got an interest from doing my research proposal I’ve got an interest in osteoarthritis that was my topic that’s something I’d like to maybe even do my trial on. It needs a bit of tweaking and stuff I’d love to have done that actually in practice and I think taking that forward and I’d like to see what, what this research’s stuff’s all about and seeing if I can actually do it. I think being able to be a part time researcher is going to help as I said, it’s going to help the profession in forms of evidence behind physio or exercise or whatever but also being able to develop me so I can kind of say I’ve gone and added an extra bow to my string or whatever. You know there’s been a particular couple of guys that are really impressive in a professional sense, we had a tutorial from them a couple of weeks ago and oh just the stuff that he knows about the knee is amazing, he would be someone that I look up to he’s quite obviously knows a lot about this stuff and knows a lot about MSK and he’s very experienced and these are the kind of people that are taking the profession forward. But they’ll retire within the next 20 years and I think learning from them as much as you can while you’re there and taking that interest forward into a job would just be really good I’ve got the interest at the moment I just don’t want get into a bit of a lull and rotational post and then lose that cos then life takes over and while I’m free you know I’m footloose and fancy free being able to learn as much as I can while, whilst everything’s ok that way and being able to move around as well, being able to kind of go to different places and learn instead of just going to one job and then staying there. Getting that experience from different clinicians meeting different professionals and more experienced professionals and people
you talk to I think it’s important to get that overall picture before you can progress further in your career and you develop as you look to those people and you probably emulate them whenever you get through it. But yeah the future’s looking interesting so hopefully it’ll all work out.
Appendix 5: Nested Stories

Jack’s story - Being the Expert Student

**Beginning/ introduction** 'In our final year we did mentoring and that’s like been a really good experience I think to take that with us, I’d like to be a clinical educator erm pass on the sort of ways I sort of developed and help another person.

**Evaluation** I think the mentoring really helped me sort of think about that. ‘looking at your characteristics as a mentor you know, how you feel that you did erm and what you can change and erm actually understand what the role of the mentor is and cos like when we did the presentation the other day erm mine was sort of based on dealing Jason’s (his mentee) emotions.

**Middle the telling** ' I remember meeting up with Jason one day and he’d received some, some quite bad news about a relative I erm think, that meeting was quite unpredictable, walking into the room and how I dealt with that, it was a really positive outcome. On previous occasions he ( Jason) was really bubbly and smiley Jason was really vacant and somewhat withdrawn and disengaged from what was going on. I was like, I was kind of anticipating him not to be like, you know, quite unhappy cos of recent news but he was worse than that,’ Jack remembers thinking that he could not ‘just walk in and start asking about their portfolio and how they’ve developed it, what marks did you get on your placement it just wasn’t you know appropriate in that time so it was about asking the real important questions like, how Jason was feeling you know how his relative was and asking if it had affected his placement.

**Turning point** I had to be quite tactful as well cos luckily Jason responded in a really positive way but he could have responded in an aggressive way you know ‘why you asking me that?’ they don’t really
know you erm or even on a really emotional and have floods of tears it’s hard to deal with that.

**Turning Point** It’s looking at how I dealt with those situations that split second and being able to use that in that circumstance.’

Yeah erm I think the way I sort of saw myself as helping Jason looking at my past experiences you know where I’d done an assessment (patient) that didn’t go too well and you know not to getting down about it. I explained this to Jason to not let it get him down not to get himself down about it to just reflect on it cause then you’re drawing out the experience, you’re drawing out, you know, well why did it go as it did, why did it not go so well and how could I make it better and I think providing Jason with the reflective sheets to use as well erm

**Evaluation** I think they actually found the benefit of that you know, they started to do it more and this, this there was sort of the feedback from them and just providing them with sort of advice on how I did things, not to take that as you know gospel you must do it like that but just offering them and, and suggesting ways of improving their marks you know and I think like just showing them that you’re actually doing the reflections’.

‘Showing them (clinical educators) that you’re learning about certain pathologies cos your clinical educators not going to know if you’re doing work at home you have to take it in to say I’ve researched this you know, is there any more guidance you can give me and they look at that positively and, that comes through your marks and they’ll say oh yeah you’re really good at that and you’re always keen to learn making it sort of certain that he must sort of express how much he’s doing so he can impress his clinical educators.

**Ending/Denouement** ‘you know, you see a difference from when you first meet them when they first going out on placement to at the end of it when they’re going on their second placement, you kind of see how you were then’
## Appendix 6: Summary of Research Findings

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<th>Plotlines</th>
<th>Participant narrative excerpt examples</th>
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<td>Routines and rituals of clinical placements</td>
<td>“I would write down proformas, then it was structured, I knew I would get it right” (Jessica) That was my job, that was my diary, my responsibility, keeping it full managing my own diary was a big thing You start to feel like a physio when you go on placement when you get your uniform on (Natalie) Feeling like a student in my head, where I try to look like I know what I’m doing, but in my head I’m like oh my god I haven’t got a clue.... it’s just mumbo jumbo in my head (Mary) I was nervous about talking to patient about leading assessments about leading treatment sessions I managed my own time, managed my own case load (Lydia) She left me to a 20 bedded unit, I’d prioritise patients, I was involved in the MDT on my own (Mark) I’ve been referred to many times by clinical educators as the student I don’t like that I felt very much the student not allowed to sit in the staff room (Natalie) You’ve got to constantly impress someone (Jessica) The man marking me expected me to do it his way it all got very confusing (Mary) It’s a kind of test isn’t it to see whether it’s for you (Lydia)</td>
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<td>Manifestation of power in the learning contexts</td>
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<td>Occupying multiple roles; enacting multiple identities</td>
<td>It’s being comfortable with who you are and where you’re at You kind of see where you are in the whole standing of things You develop an awareness of your own role Knowing where you are and knowing how to react You develop an awareness of your own role within the team It’s quite difficult when you go into a clinical placement you’re only there for 6 weeks, they’ve got established relationships, you can’t do that (Alistair) I ended up just thrown in and just treated like a physio, then again on the next (placement) after that I’d feel like a student again Feeling like a student in my head, where I try to look like I know what I’m doing, but in my head I’m like oh my god I haven’t got a clue.... it’s just mumbo jumbo in my head (Mary)</td>
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<td>Disidentification – the construction of anti-role models</td>
<td>I got my own standard of what being a physio should be, I sometimes compare other physios to that and sometimes think you know you should be doing more, they don’t put in as much effort (Natalie) He (CE) took a long time to warm up it was a seen as a</td>
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weakness to ask questions so you don’t ask *(Mark)*
Before I went I was told they don’t like boys, erm you have to be a girl and you have to like dogs and horse to get on and I had none of those things so I was a bit screwed I didn’t feel I could ask any questions, bullying is a strong word but it sort of felt like that You sort of learn what you should be doing and what you should be saying to your educators *(Alistair)*
I’ve had to deal with unpleasant situations quite a lot I’ve learnt from that *(Lydia)*
They had the ability to make you feel small. You couldn’t ask things .... the divides something that’s there *(Mary)*
The things I didn’t like, certain things the way they presented themselves, the way they did things *(Natalie)*
I don’t remember any feedback unless it was bad. If I did something wrong or could have done it better I knew about it I didn’t want to go home and that be all I got the impression that’s what she did *(Jessica)*
It was really unpredictable, really demanding it was quite tough Pressure was massive just on your back all the time *(Jack)*
You tend to just want to get through There was a lot of politics , not committed to students not enthusiastic *(Chris)*

| Identification – the construction of role models | There was an OT, she was amazing, knowledge wise unbelievable, she fascinated me, the level of knowledge she had *(Jack)*
She was so significant to me she was like a fresh pair of eyes, she wasn’t willing to settle for what everybody else was doing *(Jessica)*
She showed me it was possible to get people to do what you wanted them to do *(Lydia)* |
| Lack of connectedness | I didn’t want to get involved in the politics sometimes I felt a bit like a relay between them *(Natalie)*
I don’t remember any feedback unless it was bad. If I did something wrong or could have done it better I knew about it ‘I had no personal relationship with her…. I had to show her.…. always having to impress her’ *(Jessica)*
I’ve seen what people say about physios behind their back ..... sometime people don’t see what physio’s all about, they just don’t understand what we’re doing and why we’re doing it *(Lydia)*
You tend to just want to get through There was a lot of politics , not committed to students not enthusiastic *(Chris)* |
| Power and the MDT Collaboration Belonging Uniprofessional and | I’d volunteer to help them change beds I was valued an active member, helping out, standing up and stepping up *(Natalie)*
Coming together in the MDT you can sort of see how the physio fits in as part of a jigsaw... get to see how |
| interprofessional identities | different people work (Lydia) 
We’re not all separate (OT and physio) and I’m no better than anyone else as a physio, I was always biased towards physio and I'm not now I feel like everyone’s equal Understanding the role of other team members, I didn’t understand I feel stupid for thinking that because it’s obvious (Mark) You develop an awareness of your own role within the team (Alistair) |
| Routines and rituals of patient encounters | She (patient) gave me a big hug and little things like that that’s a confidence boost I said (to a patients wife) sure things aren’t that bad are they? I didn’t mean it like that and she said you try standing where I am (Mary) I did find it difficult, he (patient) was feisty, he saw I was a student and a bit vulnerable (Lydia) He (patient) tapped me on the head and smiled and stuff that was probably the first time I’d seen him smile it really lifted you up (Alistair) I didn’t do much of the treatment but I was thinking that I would love to have been able to have that impact on this patient ... working with him for 4 weeks we went to his house, he hadn’t been in his house for months...... he got back in the car and burst into tears I was filling up myself..... for me that’s what it’s all about (Mark) |
| Getting it right Being competent Being professional | Getting patients to cough up sputum so for an hour they’re not wheezing.. that was a big thing for me Understanding blood gases just clicked, listening with my stethoscope I could actually hear things, when you improve the patients it’s really rewarding (Mark) You need a standard of knowledge, you can’t just dive in head first with a patient you need to know what you’re doing (Mary) Being able to come up with diagnosis Seeing progressions in the people I treated I think it’s quite impressive whenever someone who couldn’t stand before is able to with your facilitation, I was able to help them... it lifts your spirits She loved being able to walk, I think those kinds of patients that kind of make you fell right I’m obviously doing a good job (Alistair) Creating strategies and actions plans for patients, setting time frames and challenges Having a tool box (Jack) People recognising you as that figure, coming to you for advise You feel that you’ve conveyed that image to other people and they believe you in that role (Natalie) |
| Idealised Professional self | ‘She was someone with a fresh pair of eyes, not willing to settle for the same routine, not a coach and not a teacher’ (Jessica) ‘We had a physio come in to my A level class, I really
liked him as a person the way he spoke, I wanted an active job, being active I wanted to work with people I’m very sociable he was similar to me’ (Natalie)

’It all started when I was 15 and I loved watching ER, that’s the truth and I thought I’d like to work in a hospital ... what grabbed me was the sports end of things’ (Mary)

’My mum’s best friend came into my primary school, she came in to talk about her profession, all those years ago when I was in primary I remember her talking about what her job involved’ (Lydia)

’I decided I wanted to do this profession when I was in year eight, one of my friends had a severe back injury he had a physio and it was like whoa what’s that’ (Mark)

’I wanted to do medicine in the first place, I thought well physio working is sports, magic sponge and stuff. I had to do something with people’ (Alistair)

’I did sports therapy for two years working in semi pro football, I was advised to do physio,’ (Jack)

’When I was in my engineering job, my girlfriends grandmother had MS, the community physio came it that was a major spur to give up my job and give it a go’ (Chris)