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Graduates’ development of interprofessional practice capability during their early socialisation into professional roles

C. Jane Morgan

School of Interprofessional Health Studies, Faculty of Health & Environmental Sciences, Auckland University of Technology, Auckland, New Zealand

ABSTRACT

Graduates entering the healthcare workforce can expect to undertake interprofessional practices, requiring them to work at the intersection of knowledge and practice boundaries that have been built over years of socialisation in their respective professions. Yet, in complex health environments, where health challenges go beyond the knowledge and skills of any single profession, there is a growing concern that healthcare practitioners lack capability to collaborate with each other. This article presents the findings from a year-long hermeneutic phenomenological study of graduates’ temporal experiences of practice roles in their respective fields of healthcare and in collaboration with other professions. Research findings emerged through an inductive analytic process using thematic analysis techniques and provides an insight into graduates’ early professional practice in contemporary healthcare contexts and the development of their professional practice at the interface of professional boundaries. The 18 graduates from six health professions developed their professional practice in working contexts where intersecting professional boundaries resulted in strengthening professional identity in their chosen professions, through articulating distinct knowledge and skills to other professions during collaborative work. Concurrently they established flexible working relationships with members of other professions, resulting in expanding health perspectives and extending practice knowledge and skills beyond their distinct professions. The study provides new understanding of the relationship between areas of professionalism, identity, and collaborative practice in an evolving health workforce, through the experiences of graduates in their early work as registered health practitioners.

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Introduction

Graduates transitioning from health science education into work as health professionals may be ill-prepared for clinical practice roles that intersect professional boundaries (Frenk et al., 2010; Green, 2009; Lee & Dunston, 2011; Meleis, 2016; Pecukonis, 2014). Despite emergence of interprofessional programmes, professional education remains predominantly siloed into distinctive professional education programmes and the process of socialisation for professional practice is primarily in isolation from other professions (Adams, Hean, Sturgis, & Clark, 2006; Hall, 2005; Hammick, Freeth, Copperman, & Goodsman, 2009; Meleis, 2016; Pecukonis, 2014; Petrie, 1976; Zwarenstein & Reeves, 2006). This educational approach is of uncertain value in preparing graduates for the collaborative working environment that most will enter as registered practitioners (Green, 2009; Kemmis, 2009; Lee & Dunston, 2011; Pecukonis, 2014; Reeves, 2000). These authors attest to the disparity between professional education programmes in discrete knowledge fields, and the practice contexts requiring professions to work together to utilise new and innovative modes of communication and practice roles in addressing complex health concerns.

In New Zealand, as in other countries, epidemiological risks, environmental change and demographic trends challenge health systems and the provision of healthcare services (Meleis, 2016). Integrating professional knowledge and practices amongst health practitioners is considered significant in the provision of health services and to better meet the needs of healthcare consumers in modern times (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; World Health Organization [WHO], 2010). Given the urgency of worldwide health concerns, and the apparent inability of current health workforces to action effective responses, it appears change is necessary in the way health professions work (Frenk et al., 2010; Pecukonis, 2014; World Health Organization, 2009, 2013).

Research into the first year of professional healthcare practice reports that graduates focus on establishing their identity in their chosen profession, so changes in practice contexts impacting on cementing practice roles in distinct professions may be problematic (Black et al., 2010; Camilleri, 2008; Cowan & Hengstberger-Sims, 2006; Toal-Sullivan, 2006). Undergraduate curriculum and teaching-learning engagement are also brought into question in relation to contemporary health service challenges, particularly given the current protectionism around professions (Brown et al., 2011; Frenk et al., 2010; Pecukonis, 2014; Pecukonis, Doyle, & Bliss, 2008), which remains evident in academic and practice contexts.
In this article, the presented research is aimed to develop understanding of the relationship between professional and interprofessional practice, as experienced by graduates in their early work as registered health-care practitioners. Graduates’ experiences of concurrently developing their professional and collaborative healthcare practice—as a time-based process—has not previously been studied. Graduates from professional education programmes are known to anticipate their future work as situated in a distinct profession (Hall, 2005). In contrast, the way graduates are expected to work pushes them, by default, into an interprofessional way of thinking and practice (Frenk et al., 2010). Thus, graduates face challenges in transitioning from their professional education programmes to professional practice, primarily because they may be ill prepared for working in collaborative practice among professions (Green, 2009; Lee & Dunston, 2011).

If graduates are entering work contexts where they are expected to work collaboratively, it is important to understand their developing practice trajectory towards becoming professionals in healthcare contexts that extend beyond traditional professional boundaries. The aim of this exploratory study into graduates’ early practice trajectory was three-fold. Understanding the process of graduates’ early transition into becoming clinical practitioners in contemporary healthcare contexts informs pedagogy on preparing graduates for practice roles in and beyond their respective professions. Equally, exploring the experiences and perceptions of graduates related to professional practice provides insight into notions of what it means to work professionally, in a specified field and collaboratively with health professions. In addition, the insight into the graduates’ transition from graduate to a functioning member of professional practice—across a number of professions—assists in ongoing clinical education and support for graduates as they navigate their first year of working in healthcare practice.

The research was located in the work practices of health science graduates who were navigating their first year as healthcare practitioners after completion of predominantly uniprofessional education in particular health professions. In addition, the study centred on graduates’ transition into becoming professional practitioners amid a tradition of professionalism premised on specialist knowledge, skills and practices residing primarily in distinct professions (Freidson, 2001; Frenk et al., 2010). Specifically, the research focused on graduates’ understanding of their professional roles in practice contexts requiring interprofessional working relationships. The question for the research project was: how do graduate health practitioners understand their early professional work in an interprofessional context? Therefore, the study aimed to explore multiple experiences, perspectives and the meaning graduates attributed to their first year of practice, situated both in specific professions and in collaborative activity among healthcare professions.

**Methods**

The focus of this study, graduates’ experiences and understanding of their early professional practice, utilised hermeneutic phenomenology as a research methodology; combining philosophical principles of experience (phenomenology) and interpretation (hermeneutics). Van Manen (1997) explains the study of experience, or phenomena, as a process of “gaining a deeper understanding of the nature or meaning of our everyday experiences” (p. 9). Furthermore hermeneutics, the art of meaning and interpretation, addresses the interpretive nature of studying how graduates construct meaning to their experiences of working as professionals in contemporary healthcare contexts (Lincoln & Guba, 2013). Thus, hermeneutic phenomenological research methodology sought to capture both the personal and interpersonal experiences of graduates, their perspectives and the meanings they attached to experiences (Gadamer, 1991). Inclusion of six healthcare professions provided lived experiences (Van Manen, 1997) and multiple perspectives across professions and practice contexts (Gadamer, 1991).

**Context and participants**

The study was conducted in New Zealand, where newly registered practitioners are typically employed in a range of practice contexts, in different geographical locations, across the public and private healthcare sectors. During the graduate year, these practitioners work with, and are mentored into their practice roles by more experienced clinical practitioners and educators in their distinct professions, in the provision of patient-centred care. In addressing the research question of how graduate health practitioners understand their early professional work in an interprofessional context, a purposive sampling strategy was used (Creswell, 2013) to select university graduates from midwifery (n = 2), nursing (n = 4), occupational therapy (n = 4), podiatry (n = 3), physiotherapy (n = 2) or oral therapy (n = 3) professional education programmes.

The particular professions were chosen to represent the “clinical” focused programmes offered within the same university. During the three or four years of undergraduate study, students from these professional programmes were exposed to varying amounts of interprofessional education and practice initiatives, but initiatives were not formally taught or assessed as part of their study programmes. Those who participated in the study graduated at the end of 2011 and commenced working in their chosen professions from the beginning of 2012. During 2012 they recounted their experiences, thoughts and perceptions of clinical practice as they progressed through this graduate year. An overview is provided, contextualising the often implied, yet not always explicitly discussed professional focus of those employed in the public versus private healthcare sector in New Zealand.

**Overview of workplace contexts**

Across the six professions, 11 participants were employed in public hospital settings. This number comprised of four nurses and four occupational therapists who were employed in this capacity. In addition, two oral therapists worked in publicly funded clinics providing oral and dental care to children under the age of 18. One of the two midwives was employed in a public hospital while the other worked as an
the experiences and perspectives of graduates in and across contemporary professional practice, where descriptive accounts revealed their individual understanding of practice in professional and interprofessional contexts as this developed over time.

**Data collection**

In this article, data were collected at four evenly spaced intervals during the 2012 graduate year (see Table 1). Although all 18 participants anticipated contributing at each interval, this was not achieved due to unforeseen personal or work commitments during the year. This was noticeable at interval three, 8–9 months into graduate practice, when only 15 participants were available. However, data collected through three focus groups at this time, attended by a total of 11 participants from among the six professions, in addition to written responses from a further four participants provided a rich array of contextual information related to this temporal stage in the graduate year.

The primary data collection methods comprised of individual and mixed profession focus group interviews, where participants were asked to recount clinical experiences of both professional and interprofessional collaborative practices during the intervening months. Semi-structured guiding questions included: What does it mean to work as a health professional, what does it mean to work in a distinct profession, and what does working with other health professionals mean to you?

Focus group interviews from among the professions purposefully brought participants from a number of professions together to recount their individual experiences. Undertaking focus groups with a number of professions participating provided data that was rich in comparative experiences among participants. Specifically, through participants sharing both personal experiences and attached meaning in a group context that included professions other than their own, they were exposed to and considered the perspectives of others present. This led to vibrant conversation amongst those present, as participants drew from the narratives of each other in recalling both similar and distinct experiences. Gadamer (1991) describes this process as a fusion of multiple perspectives, integral to the hermeneutic art of interpretation.

Table 1. Form of data collection according to intervals of graduate practice.

<table>
<thead>
<tr>
<th>Form of data collection</th>
<th>Interval one Prior to commencing practice</th>
<th>Interval two 2–3 months into graduate practice</th>
<th>Interval three 8–9 months into graduate practice</th>
<th>Interval four 11–12 months into graduate practice</th>
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</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>8</td>
<td>16</td>
<td>–</td>
<td>5</td>
</tr>
<tr>
<td>Focus groups</td>
<td>–</td>
<td>–</td>
<td>x 3 (n = 11)</td>
<td>x 2 (n = 6)</td>
</tr>
<tr>
<td>Written responses</td>
<td>10</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Participants (N = 18)</td>
<td>18</td>
<td>18</td>
<td>15</td>
<td>17</td>
</tr>
</tbody>
</table>

Table 2. Graduates’ emergent interprofessionalism: time-based process.

<table>
<thead>
<tr>
<th>Professional dimensions</th>
<th>Temporal process</th>
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<tr>
<td></td>
<td>Interval one</td>
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<tr>
<td>Graduates’ emergent interprofessionalism</td>
<td>Prior to commencing practice</td>
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<td>Practice</td>
<td>Graduates Self in…</td>
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<td>Professionalism</td>
<td>Profession centric</td>
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<tr>
<td>Collaboration</td>
<td>Evolving notions of professionalism</td>
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</table>

In New Zealand, there appear to be distinctly different approaches to professional practice observed between those employed in the public fully government funded sector, versus the private fee for service, with possible government subsidy, sector (Barnett & Barnett, 2004). Those employed in public hospital facilities are inclined to discuss their professional role as focused on returning patients to optimal health status so they can leave hospital. Their interaction with patients is generally transitory with variable investment beyond the duration of a practice shift.

In contrast, those working in private practice appear to have a vested interest in developing professional credibility in narrowly defined health fields. Treating clients occurs over elongated timeframes but does not generally require extending professional knowledge or practice expertise beyond designated scope of practice boundaries. This contrasts with those working in the public health sector where the complexity of patients’ healthcare issues and close geographical proximity of various health professions working from different health perspectives generally requires a distinctly different orientation to healthcare and understanding of professional roles.

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Written responses to the same semi-structured guiding questions were collected from participants if they were unable to attend either individual of focus group interviews, due to geographical or work-related reasons. Although this form of data was somewhat static in comparison to the vibrancy of conversational focus groups and individual interviews, it did allow all participants to have a ‘voice’, and so contribute to the collective experiential narrative. All individual and focus group interviews were audio-recorded and later transcribed.

Data analysis

Data were analysed through an inductive thematic analytic process (Braun & Clarke, 2006), underpinned by a constructivist-interpretative theoretical perspective (Lincoln & Guba, 2013). Taken from this perspective, in accepting researcher subjectivity as integral to the analytic process (Cousins, 2009), I aimed to produce a holistic account of how others perceive and make sense of their reality (Merriam, 2009). This was achieved through careful and methodical organisation of data sources, and through close attention to the iterative inductive process of progressing from data sources to interpretation and conceptualisation of findings. Commencing with raw textual data, information was progressively organised, managed, and coded into broad categories from which themes or patterns emerged (Merriam, 2009). The use of Nvivo 10 computer software aided the process of managing and organising the textual data.

Thematic patterns resulted from increasing familiarisation with the data, identifying commonalities among and across the participants’ experiences and combining information into clusters that could be conveyed as findings (Braun & Clarke, 2006; Silverman, 2001). The addition of narrative examples from graduates’ experiences, with pseudonyms attached to ensure participants’ anonymity, provided a vicarious entry into the world of the participants in their early graduate healthcare practice (Merriam, 2009; Sharkey, 2001).

Ethical considerations

University Ethics Committee in New Zealand approved the study. All participants gave their informed consent prior to data collection.

Findings

The key findings from this article related to graduates’ adaptive learning over the time, to become a professional in health-care practices requiring professional and interprofessional capability. During the graduate year, the participants’ narratives were increasingly inclusive of their experiences of both working in and among professions, progressing from initial profession-centricity, through comparative experiences at 6 months to becoming increasingly interwoven among the professions later in the year. Alongside recounting their clinical practice experiences, participants also reflected on the meaning they attributed to these; how they made sense of their practice roles developing and evolving during the first year of graduate practice in contemporary health contexts.

Three interrelated themes emerged from the key findings: first, graduates’ identity in their designated profession strengthened through communicating distinctive health perspectives among professions, prior to, during or after practice interventions. Second, through increasing opportunities to communicate specific perspectives and related practice roles among professions, graduates expanded their individual health perspective, and this influenced their practice roles both in and at the interface of the professions. Third, graduates developed evolving notions of professionalism, where collaborative practice was viewed as creating flexible “space” that promoted both expanding of perspectives and extending knowledge and associated practice opportunities beyond distinct professions.

These themes, of strengthening professional identity in a distinct profession, expanding health perspectives and evolving notions of professionalism beyond distinct professional knowledge and practice boundaries, resulted in conceptualising the interrelated, intersecting temporal process as one of emergent interprofessionalism in early graduate practice (Table 2).

Strengthened professional identity

As a temporal process, the ability of participants to navigate their graduate roles in a variety of healthcare settings was initially premised on clinical reasoning and judgements from profession-centric perspectives. Although there was some variation across the practice environments, specifically between those working in public as compared to private practices, each of the new practitioners, regardless of profession, initially viewed their professional role as confidently encompassing sound decision-making and subsequent tasks that endorsed their competency to practice in their chosen field:

> Having a degree, getting that education formalised, you’re part of a network and there’s an acceptance in that. It’s completely different, even from being part way through fourth year [as a student]. You still have got the same academic knowledge, but not having that student label and having become fully qualified, people look at you differently. There’s an acceptance and it’s not only within members of the public coming in for treatments, it’s within and around other physios as well. They automatically say, “You’re qualified.” (Aimee, Physiotherapist, individual interview at interval 1)

This view of graduate practice was further reinforced through mentoring programmes and support from experienced colleagues who scaffolded graduates’ early months of practice. A participant explained this as developing confidence to relate to both patients and other professions from a profession-centric orientation:

> I need to have a sound understanding of my role as an OT to not only ensure the patients have a clear understanding of how I can help them, but to be able to back my OT corner with the medical team, and to be able to do this in a professional way. (Amelia, Occupational Therapist, individual interview at interval 2)

Strengthening voices

It appeared that in interprofessional team meetings the need to articulate a professional perspective forced participants to situate at the borders of professional boundaries through explaining a distinct professional role and associated scope
of practice. In doing so, participants’ sense of professional identity strengthened as they become adept at communicating their specific professional practice perspective to others:

As I’ve developed my understanding of their roles [other professions] that also helps to clarify my role, because there are overlaps and I think there will always be overlaps. But, it’s becoming clearer in my mind as to where the lines are drawn and how much of an overlap there can be. (Amelia, Occupational Therapist, individual interview at interval 3)

The data suggested that a strengthened identity resulted from graduates’ interaction at the interface of the professions, where they learned to overtly endorse their respective professions by articulating a distinct perspective and related specialist knowledge and skills they could contribute to collaborative practice. As a result of continually communicating this information, graduates reinforced their identities as distinctive and situated in defined professions:

If there were just a whole lot of OTs, we’d just be doing our thing. But working with everybody else makes me hyper aware of that and I’m constantly thinking, ‘what’s my view on this, why have I got this view?’ (Elizabeth, Occupational Therapist, individual interview, interval 2)

Although initially challenged by their workplace experience, these graduates learned to articulate their professions’ orientation, priorities and corresponding contribution to collaborative activity through the actual practice of collaboration. In fact it was at the interface of professions that they became consciously aware of what their distinct perspectives were. Thus, graduates’ professional identity appeared to strengthen through explicit and frequent articulation of their profession’s orientation to healthcare, reinforcing their profession’s values and beliefs underpinning their practice in a chosen field.

Validating professional self
Towards the end of their first year of professional practice, as new professionals, the participants in this study intentionally positioned their primary affiliation in their chosen profession, while concurrently working in complementary roles:

Being in the team, working with the other professions, having to actively put up my hand and say “I think this client needs this” has really helped me to become more confident in articulating what my own profession can bring to that. (Elizabeth, Occupational Therapist, focus group at interval 4)

So even though graduates developed interprofessional capability through their collaborative work, they orientated their professional practice from within their separate professions. In doing so, graduates enacted practice roles of both professional and interprofessional work, whereby their professional identities were nourished in their chosen profession and strengthened through collaboration among professions.

You can’t value yourself more highly than them [other professions] and you have to have an appreciation for what they do. I think also an awareness of your own limits; I can’t actually do this for the patient and that’s why we need these [other professions] to do that. I think that’s part of professionalism, knowing your limits and knowing what to do when you are faced with that. (Steph, Nurse, focus group interview, interval 4)

Through acts of verbalising distinct practice orientations and related knowledge and skills during collaborative work contexts, graduates in this study were shown to further bind their identity to their respective professions. The work in their respective professions nourished their developing professional practice. Concurrently, collaborative work among professions extended their knowledge, and expanded their health perspectives to encompass multiple ways of viewing and responding to complex health environments.

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

I’ve asked a thousand questions of the nurses that I work with at a few of the out-clinics. They ask me lots of questions and I learn so much from them and hopefully they’re learning a bit from me. It’s definitely changed the way that I approach patients because I wasn’t really sure of what the nurses were doing. But now I kind of understand how they thought processes, with a few of the things that I see in conjunction with them. So it’s changing the way that I treat them [patients]. (Sophie, Podiatrist, focus group at interval 3)

Extending practice roles
Consequently, participants’ practice roles extended through interprofessional interactions. So, while professional identity was strengthened through communicating a distinct professional perspective to other health occupations, practice boundaries appeared increasingly permeable through interprofessional collaborative healthcare, as the graduate year progressed. One participant (Sue, Nurse) likened her extending practice boundaries to a “sponge” whereby she was continually absorbing knowledge from others and was cognisant of this knowledge when making clinical judgements:

I’ve learned from working with the social workers. They see things that I didn’t but now I know the signs. I know how to sometimes ask those difficult questions. . . I did not want to go there… [now] I’m going there. Things like asking about domestic violence and things like that. I would not go there. I just did not think it was in my scope of practice whereas now I know how to be tactful around some questions. I’ve learnt from the social workers and other people. (Sue, Nurse, focus group at interval 4)

Additionally, through extending knowledge and practice boundaries, participants expanded their professional perspectives and scopes of practice:

You start taking on their views [other professions], because once you see what their point of view is, you approach someone and think, “I should probably think about this as well; I can’t just think about that. Then you have a set of skills that you didn’t know you had before, that you automatically just start using. (Mia, Nurse, focus group at interval 3)
By working as collaborators at the interface of professions, graduates in this study expanded their health perspectives. The data indicated that expanding health perspectives resulted in a broader orientation to complex health concerns and willingness to engage in joint decision-making around provision of healthcare support. Work at the interface of professions involved sharing of information and subsequent overlapping roles during collaborative work. Additionally, negotiating roles during collaborative activity influenced notions of professionalism towards more flexible interprofessional relationships.

Evolving notions of professionalism

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

I’m realising that I cannot just stay working from my midwifery perspective. I’ve actually got to expand now and up skill myself to become this very knowledgeable, clinical sort of nurse/midwife… in order for me to know I have a future job and not be an independent midwife, I will consciously up skill myself. (Sue-Anne, Midwife, focus group at interval 4)

From a temporal perspective, these graduates entered professional practice with distinct practice orientations towards patient or person-centred care. Although they began their transition into practice idealising professions and their respective roles, their respective underlying health perspectives drove their actions towards focusing on persons in their care. Thus, duty of care priorities overlaid self-interest across all professions:

Taking little aspects of every different discipline and it just becomes part of who you are in your role. You don’t necessarily do it intentionally but just the way you talk or the way you write things… I think everything about what you do, just tiny little parts of it, is part of another profession but you’ve still got your hat on as your profession. (Jessica, Occupational Therapist, focus group at interval 4)

Creating space for collaboration

It also appears perspective sharing among professions enhanced learning and confidence to practice in new ways, through graduates forming flexible working relationships, over time. One participant suggested her professional “shape” was altering (Mia, Nurse) while another described the multifaceted nature of her work becoming “less black and white”, when treating someone (Charlotte, Physiotherapist). Elaborating on this Charlotte stated:

There are all sorts of different pieces to the puzzle and your communication with other professions helps you put those pieces in the puzzle together and it helps you deliver a better package of care to the patient. (Charlotte, Physiotherapist, focus group at interval 4)

Overlapping knowledge and practice boundaries among professions was viewed positively in creating space for discussion on practice possibilities.

If only one person looks at a problem, they can miss things really easily but if you have different points of view on the same client, then you can get a better outcome; usually with different points of view. (Sophie, Podiatrist, focus group at interval 4)

The flexible spaces graduates constructed during collaboration among professions did not, however, encroach on their primary practice identity. Although participants remained centred in their chosen profession, they increasingly recognised the value of interprofessional collaboration, specifically related to strengthening their sense of belonging to a distinct profession, while broadening their professional perspectives and extending healthcare provision capability.

Discussion

The first year of graduate practice in healthcare professions is crucial to the development of practitioners who are competent and confident to work both in their respective professions and interprofessionally. This exploratory study, which examined the interface of professional and collaborative practice, provides unique insight into graduates’ understanding of working in and beyond their respective professions. This reveals an emerging interprofessionalism, whereby novice practitioners navigate a role in a particular profession while concurrently negotiating practice roles at the interface of professions. Emerging interprofessionalism is comprised of both professional and negotiated roles, previously identified by Reeves et al. (2009). These authors found that role negotiations at the borders of professions were frequently terse, and dependent on traditional professional hierarchical structures. As such, interaction between professions was often avoided. Yet, in the current study, the relationship between professional and negotiated roles are shown to be complementary as graduates strengthened their professional identity in their chosen field through the collaborative interactions they experienced.

Communication at the interface of professions also reinforces professional identity. Graduates’ clinical experiences of working at the interface of professions has established a link between communicating unique professional perspectives at practice boundaries and reinforcing their affiliation to, and sense of identity in a single profession. This finding runs counter to research that has reported the risk of identity threat when working at the interface of practice boundaries (Baxter & Brumfitt, 2008; Brown et al., 2011; McNeil, Mitchel, & Parker, 2013; Mitchell, Parker, & Giles, 2011) and to cautioning that interprofessional collaboration may destabilise professional values, normative behaviours and identities (Brooks & Thistlethwaite, 2012; Edwards, 2010; Hall, 2005). Participants in the current study do not share these views, perceiving instead a positive influence of collaboration on strengthening professional affiliation and identity in chosen health fields.

As graduates’ early practice focus is reported to be on establishing membership into their chosen profession (Black et al., 2010; Camilleri, 2008; Clark & Springer, 2011; Duchscher, 2009; Kelly & Courts, 2007; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001), it is understandable that introducing collaborative activity during transition into practice may be viewed as weakening graduates’ developing identity with their respective professions, in favour of a more generic health practitioner identity (Baxter & Brumfitt, 2008; Brown et al., 2011; Mitchell et al., 2011).
This study, however, indicated that graduates’ professional identity is strengthened through collaborative practice among professions. In contrast, when working with colleagues in their chosen profession, graduates may be unaware of their developing identity. Rather they focus on mastering the knowledge and clinical skills required to competently practice their profession (Freidson, 2001; Pecukonis, 2014). This is not only a defining characteristic of professionalism, but can also be viewed as a source of competition among occupations vying for societal trust and respectability (Abbott, 1988). Collectively, members of professions demonstrate observable uses of knowledge abstraction in their work. Yet among professions, historically members have closely guarded knowledge and practice domains: out of self-interest in maintaining a professions social status, but also in preservation of knowledge claims and discretionary judgment in the services provided. Preservation and advancing knowledge to benefit human lives and conditions are seen as a key attribution in favour of societal support of professions (Freidson, 2001).

During interaction with other professions, graduates are required to address their affiliation to their respective professions every time they meet others at, or beyond the boundaries of the respective professions (Pecukonis et al., 2008). They are also expected to clearly communicate profession related knowledge, terminology and skills when interacting among professions and this is challenging for graduates. It is the work that is required at the boundaries, or borders of professions that will challenge how professions work together in the future (McCallin & McCallin, 2009; Wenger, 1998). Challenges include professions’ ability to understand different orientations to health and negotiate practice roles (McCallin & McCallin, 2009) additional to constructing mutual enterprise, or engagement among professions (Wenger, 1998). Working at the borders of professions may be problematic for graduates who have been socialised predominantly in profession-centric education (Reeves, 2000), and have limited understanding of experience of working with other professions. The findings from this study identify the value of graduates working at and beyond the borders of their distinct professions, where they develop their ability to work collaboratively with other professions.

Insight into health science graduates’ emerging interprofessionalism adds to the current knowledge in the areas of interprofessional education and collaboration. This study has shown the developmental trajectory that graduates from a number of health professions experienced during their first year of professional practice in their respective professions. Specifically, the study has identified key features of graduates’ practice that are attributed to working at the interface among professions: strengthening professional identity, expanding health perspectives and evolving notions of professionalism. Future study could explore the influence of interprofessional practice on possible changes to graduates’ affiliation to their specific profession beyond the graduate year. This could draw on the current findings to investigate longer-term effects of collaborative practice on profession-specific perspectives, specialist knowledge claims and areas of expertise.

In relation to study limitations, the 18 participants in the study were socialised into a faculty that was in the early stages of introducing interprofessional education during 2009–2011. Encountering elements of interprofessional education during their professional education programmes may have influenced their initial interest and perceptions of collaborative practice and later impacted on their graduate experiences of working interprofessionally. On occasions during the study timeframe, a number of participants voiced their increased awareness of collaborative activity among professions. They reasoned this was due to the research questions they were asked, which inadvertently assisted their developing ability to reflect on their own professional practice and the practice of others. A further possible study limitation is the skewed number of participants from each profession, with greater numbers participating from nursing and occupational therapy, as compared to the other four professions. This led to increased contribution from these two professions over the duration of the study but was tempered by coding of data both across and from within the six professions to provide a credible final description of the graduates’ developmental trajectory of professional work in interprofessional contexts.

Concluding comments

This article has provided insight into the interface of professional and interprofessional practice for graduates from a number of healthcare professions. It adds to a growing body of knowledge on interprofessional collaboration, suggesting multiple benefits for graduates, including enhancement of professional practice, more flexible interprofessional relationships and enrichment rather than weakening of professional identity. Continuing development of collaborative education and practice opportunities is required in both undergraduate and graduate programmes, to promote collaboration and graduate capability for working in interprofessional teams. Specifically, this article has shown that attention to the interrelated features of roles, including identity, perspectives and notions of professionalism, at the interface of professional and collaborative practice will assist in developing education and practice initiatives to better prepare graduates for clinical practice in contemporary healthcare contexts.

Note

1. To ensure participant anonymity, participants’ names were replaced with self-selected pseudonyms after individual verification of transcript authenticity.

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Declaration of interest

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References
