Student and clinician identities: How are identities constructed in interprofessional narratives?

Charlotte E Rees1\*, Fiona Kent1,2 & Paul Crampton1,3,4

1Monash Centre for Scholarship in Health Education (MCSHE), Faculty of Medicine, Nursing & Health Sciences, Monash University, Melbourne, Australia

2Department of Physiotherapy, Faculty of Medicine, Nursing & Health Sciences, Monash University, Melbourne, Australia

3Research Department of Medical Education, University College London, London, UK

4Hull York Medical School, York, UK

\*The corresponding author is Professor Charlotte Rees, Monash Centre for Scholarship in Health Education (MCSHE), Monash University, Room 307, 27 Rainforest Walk (Building 15), Clayton Campus, VIC 3800, Australia; Tel +61 3 9905 9995; Email: charlotte.rees@monash.edu

## **Abstract**

**Introduction**: Although literature on professional identity formation is increasing in medical education, literature is scant by comparison on student and clinician identities within interprofessional contexts. We therefore adopt a novel discursive approach to identities to explore how soon-to-become graduates and workplace-based clinicians construct their own and others’ identities in interprofessional student-clinician (IPSC) interaction narratives.

**Methods:** A qualitative narrative interview study was conducted with 38 students and 23 clinicians representing: medicine, midwifery, nursing, occupational therapy, paramedicine and physiotherapy. Through framework analysis, we identified the breadth of student and clinician identity constructions across 208 IPSC interaction narratives, plus explored how common constructions differed by narrative and narrator. Through in-depth positioning analysis, we explored how student and clinician identities are discursively positioned within two selected IPSC narratives.

**Results:** We identified eleven common constructions of student identities and eight common constructions of clinician identities across the 208 narratives. We found differences in identity constructions across positively versus negatively evaluated narratives, and across student versus clinician narrators, highlighting the rhetorical nature of narratives. Our in-depth positioning analysis of two narratives illustrates how one student and one clinician discursively position theirs and others’ identities during interprofessional interactions, and how identities vary depending on narrators’ evaluations of their stories. While both positioning analyses illustrate how narrators’ language serves to reproduce the common societal discourse of *interprofessional conflict*, the clinician narrative also draws on the competing discourse of *interprofessional collaboration*.

**Discussion:** Despite some of the identities supporting previous uniprofessional research, our findings illustrate a greater breadth and depth in terms of student and clinician identities within interprofessional contexts. We encourage educators to embed identities curricula into existing workplace learning for students and clinicians to help them make sense of their developing professional *and* inteprofessional identities. Workplace educators should facilitate meaningful IPSC interactions to promote interprofessional learning and collaboration.

**Keywords**: healthcare students; clinicians; interprofessional; identities; workplace learning; narrative

**Introduction**

Health professional identities matter: having a positive identity as a student or clinician can promote individuals’ professionalism, career choices and mental health.1 However, overly robust identification with one’s professional identity can lead to developing a *them and us* stance and thus negative attitudes towards professional out-groups.1 Therefore, it is important for students and practitioners to develop positive professional *and* interprofessional identities in order to maximize interprofessional learning and collaboration.1,2 While the literature on identity formation in health professions education is now extensive,3-6 literature is scant by comparison on student and clinician identities within interprofessional contexts.7-8 Although some identities research has recently adopted social constructionist approaches,7-8 previous research exploring interprofessional identities has typically chosen social cognition theories from an objectivist perspective,9 such as social identity theory, self-categorisation theory, or social identity complexity theory. 2,10-15 Instead, we adopt a more novel theoretical approach in health professions education research:7-8 a discursive approach underpinned by social constructionism privileging how identities are constructed through interaction.9 Such an approach highlights what and how identities are discursively produced, plus considers the broader sociopolitical meanings of such identities (Monrouxe & Rees 2015). Therefore, in this current study, we explore how final year healthcare students and workplace-based clinicians construct their own and others’ identities in interprofessional student-clinician (IPSC) interaction narratives. This research should better visibilise how students and clinicians see themselves and others from different professions, thereby providing a window into future possibilities for interprofessional learning and collaboration.

### Identities as social constructions

Considerable variation exists within the organisational literature about how identities are theorised and researched.16 For example: (1) are identities ascribed to individuals through institutional structures or chosen by agentic individuals? (2) are they dynamic/fluid or fixed/static? and (3) are they fragmented/non-coherent or unified/coherent.16 In this paper, underpinned by social constructionism, we see identities as typically co-constructed through a nexus between individual agency and institutional structures, dynamic/fluid and fragmented/non-coherent.16 Indeed, social constructionist approaches see identities as negotiated through everyday social interaction, through the language and paralanguage (e.g. laughter) that we use, through the (non-human) materials with which we interact (e.g. computers) and through our actions.16-18 Language is believed central to our enactment of who: “we seek to be and be seen to be”.17, p. 44 Such interactional aspects of identities are typically present in the narratives we share about our experiences. Through narratives, individuals make sense of their own and others’ identities in order to make sense of their learning, produce a sense of understanding and guide their actions.18 Moreover, the language used to negotiate narrative identities usually draws on well-worn societal discourses.17 For example, students have been variously constructed as tabula rasa, children, apprentices, slaves, workers, and animals.19-22 Nurses have been severally portrayed as caring, skilled, angel, handmaiden, incompetent, battleaxe, female and sexual plaything,22-27 while doctors have been diversely constructed as good, healing, detached, bully, dictator, God and arrogant.18,22,23 In terms of a discursive approach to identities, therefore, we are not only concerned with *what* identities are discursively constructed but also *how* they are constructed, plus their broader sociopolitical meanings.9

### Student and clinician identities

While research exploring student identities largely focuses on professional identity formation,13 some studies have flagged healthcare student identities as, for example, outsider, lay conversation partner, doctor and team-member.4,6,27 Studies exploring clinician identities report that clinicians typically privilege their clinician (e.g. doctor or nurse) rather than educator identities.8,28-32 While various educational identities have been recognized, such as teacher, educator, faculty developer, educational leader, negotiator, diplomat and academic, some clinicians experience tensions between these clinician and teacher identities, while others merge them comfortably.8,28-32 However, despite the workplace learning environment being overwhelmingly interprofessional, this research mostly focuses on student and clinician identities rather than interprofessional practice. Regarding the interprofessional identity literature, professional a*nd* interprofessional identities are often constructed as competing, with studies finding strong identification within professional in-groups but differentiation from out-groups, leading to barriers to interprofessional teamwork.11,13 Therefore, interprofessional scholars advocate for the development of so-called *dual* identities14,33—that of professional *and* interprofessional identities.22 Indeed, Monrouxe & Rees34 have previously argued that *dual* identities are consistent with social identity complexity theory,35 suggesting that individuals have multiple identities operating together in different ways, and thus impacting differently on individuals’ membership of in-groups and out-groups.1,12 But what we are yet to understand from the literature is the multiplicity of ways that student and clinician identities are constructed within an interprofessional context and how, alongside the broader meanings of those identities for future interprofessional learning and collaboration.

### Study aims and research questions

As outlined above, while the literature has begun to explore student and clinician identities in uniprofessional contexts, there is scant literature exploring these identities in interprofessional contexts. Furthermore, the theoretical underpinnings of many published studies are primarily socio-cognitive, thereby privileging identities as largely situated within individual minds.9,18 Instead, we employ a more novel discursive approach to better explore what and how identities are constructed and the broader sociopolitical meanings of those identities. We therefore explore how these soon-to-become healthcare professionals and workplace-based clinicians make sense of student and clinician identities in IPSC interaction narratives to better understand future possibilities for interprofessional learning and collaboration. We aim to answer three novel inter-related questions:

**RQ1**: What student and clinician identities are constructed across IPSC interaction narratives?

**RQ2**: How do identity constructions differ by type of narrative and narrator?

**RQ3:** How are identities discursively positioned in exemplar narratives?

## Methods

### Study design

This paper presents a secondary analysis of qualitative data collected for a study exploring student and clinician experiences of interprofessional student-clinician (IPSC) interactions.36 The study is underpinned by social constructionism, highlighting that meaning is constructed through social interaction (Burr 2015). We employed narrative methods to understand how students and clinicians made sense of their experiences, including how they constructed identities within those narratives. While we employed group interviews to collect narratives wherever possible, because a story from one participant could stimulate a story from another, we also employed individual interviews in order to maximize student and clinician participation.36

### Sampling, recruitment and reflexivity

After receiving ethics approval, we invited students and clinicians representing six healthcare professions located in Victoria, Australia to take part in the study. Using maximum-variation sampling, we employed multiple recruitment methods including: for students, notices on their virtual learning environment and face-to-face recruitment during formal curricula; and for staff, email invites. In total, we interviewed 61 participants across 12 group interviews (6 with clinicians and 6 with students) and 10 individual interviews (5 with clinicians and 5 with students) representing 9 medicine, 7 midwifery, 11 nursing, 15 occupational therapy, 10 paramedicine and 9 physiotherapy participants. This provided us with 10 hours 16 minutes of data from 38 students, and 7 hours 31 minutes of data from 23 clinicians.

The majority of students were aged 20-29 years (n=31) and clinicians were aged 40+ years (n=17). The majority of students and clinicians were female (n=25 and 15 respectively), white (n=28 and 19 respectively) and spoke English as a first language (n=32 and 20 respectively). The majority of clinicians had 10 years or less teaching experience (n=12) and did not have formal teaching qualifications (n=14). Detailed participant characteristics are presented elsewhere.36

The research team was diverse in terms of gender (two females, one male) and nationality (two UK citizens, one Australian citizen), plus profession (e.g. physiotherapy, psychology) and academic roles (e.g. non-clinical educator, clinical teacher, education researcher, leader, manager etc.). While two of the researchers (A1 and A2) were known to some of the clinician participants, student participants were unknown to the researchers and did not have student-teacher relationships with the researchers.

### Data collection

We devised an interview schedule with a strong focus on collecting narratives. We started the interviews (conducted by A1 and/or A2) by asking participants what they understood by IPSC interactions. We then asked participants to share their IPSC interaction experiences using narrative interviewing techniques. If participants needed prompting, we would ask them to share with us a recent or memorable experience. We tried to allow participants to share their stories with us as uninterrupted as possible, but following up with additional probing questions in order to elicit rich details such as: When did this experience happen? Where did it happen? Who else was there? Once participants had finished sharing their stories, we asked them for their suggestions for improving IPSC interactions. We then closed the interviews asking participants to complete a personal details questionnaire. All group interviews were homogeneous in terms of student or clinician participants, and all but one group interview was uniprofessional (one clinician group included one physiotherapist and one occupational therapist—see Box 3 later).

### Data analysis

The primary-level framework analysis explored student and clinicians’ understandings, experiences and suggestions for developing IPSC interactions, and this can be accessed elsewhere.36 We employed framework analysis because of its numerous benefits including: being a commonly employed systematic approach to thematic analysis; being employed for inductive and deductive analytic approaches; and lending itself well to team-based analysis and employing NVivo (Gale et al. 2013). Participants’ experiences (in particular, their narratives) included identity-related themes as part of our initial framework analysis such as own and others’ personal and professional identities. Indeed, quotations coded to these themes as part of this initial framework analysis prompted us to better understand participants’ identity constructions analytically. We therefore decided to extend our original framework analysis for this secondary analysis, 36 to look more explicitly at the construction of student and clinician identities across all IPSC interaction narratives, thus allowing us to account for identity constructions across the full breadth of our data.

 In the familiarization stage of this secondary framework analysis,37 we reviewed all data already coded in NVivo to identities as part of our original analysis.36 First, each author familiarised themselves with the data, independently reading, and identifying sub-themes in the data. One researcher (A1) had substantial experience exploring students’ and educators’ identities in workplace-based narratives,15,22 so we were able to extend our framework deductively, as well as inductively. In the framework development stage, we developed the extended identities coding framework on the basis of our discussion and comparisons of our independent analyses and negotiation of codes. Then, in the indexing stage, one author (A3) coded all identity data using NVivo, thereby answering RQ1. Note that the coding framework evolved as data were coded with descriptors being expanded and refined.

Subsequently, in the charting stage, we employed NVivo to interrogate our data to explore the differences in identity constructions by type of narrative (i.e. positively or negatively evaluated) and type of narrator (i.e. student or clinician) thereby addressing RQ2. Note that narrators’ evaluations of their experiences were interpreted and coded by A3 as part of our initial framework analysis,36 to determine whether narratives were primarily positively or negatively evaluated. This was determined by A3’s interpretation of narrators’ emotional talk (e.g. “fantastic” or “terrible”) and/or explicit declarations of their experiences as “good” or “bad” or “mixed”. In the final stage of framework analysis (mapping and interpretation), we compared our findings with existing literature.

Finally, and to address RQ3, we conducted positioning analysis (a type of narrative analysis) of two selected narratives (from one student and one clinician) in order to bring together fragmentary findings from RQ1 and RQ2 to present a more holistic and coherent analysis.38 Importantly, positioning analysis takes a discursive approach privileging how identities are constructed through talk and interaction. It considered: (1) how characters were positioned relationally within the selected narrative though their assigned actions, motivations and tropes (Level 1 positioning); (2) the interactional world in which the narrative was shared and therefore how positioning practices were culturally embedded (Level 2 positioning); and finally (3) the wider sociopolitical implications of the narrator identifying with existing discourses (Level 3 positioning).9

## **Results**

As outlined in our primary analysis,36 we identified 208 different narratives of IPSC interactions across our 22 interviews/transcripts. Due to word count, we cannot present all identities constructed across 208 narratives in this paper, so we employ commonality firstly as a way of focusing on selecting which identities to present. We secondly use commonality as a way of exploring differences for RQ2. We found that 91/44% of narratives were mostly evaluated positively, 58/28% were mostly evaluated negatively, 31/15% were mixed (with roughly equal proportions of positive and negative evaluation) and 27/13% were unclear. We identified eleven common constructions of student identities and eight common constructions of clinician identities across the interprofessional student-clinician (IPSC) interaction narratives (i.e. in 50% or more of the transcripts). We first outline the range of these identities before later providing detail about how such identities are discursively positioned within the context of full narratives.

**RQ1. Student and clinician identity constructions within IPSC interaction narratives**

Students were most commonly constructed as learners within the narratives, learning through participation in the workplace (Table 1, quote 1). Also common was students’ identities as novices, where they were described as inexperienced and unsure how to navigate the interprofessional workplace (Table 1, quote 2). Regarding competent identities, students were constructed as knowledgeable, useful, valued and professional. For example, they were sometimes talked about as though already qualified, and thus able to perform healthcare tasks (Table 1, quote 3). Concerning motivated learner identities, students were constructed as eager seekers of interprofessional learning opportunities (Table 1, quote 4). Students were also constructed as observers, either being given or taking observational roles and observing actively or passively (Table 1, quote 5). Students were also constructed as outsiders, being described as peripheral to the interprofessional team (Table 1, quote 6). Regarding team-worker identities, students were constructed as working as part of the interprofessional team to provide patient care and therefore positioned in the role of colleague (Table 1, quote 7). Students were also constructed as incompetent, being described as unskilled and/or stupid, sometimes because of basic mistakes (Table 1, quote 8). Furthermore, students were constructed as bothersome; students sometimes invoking negative reactions from clinicians through their intentional or unintentional actions such as adding to clinicians’ workloads (Table 1, quote 9). Similarly, students were constructed as wrong-doers, either because they failed to listen and respect others’ opinions or because they pursued self-oriented actions against others’ best interests (Table 1, quote 10). Finally, students were constructed as insiders, being described as central and valuable to the functioning of the interprofessional team (Table 1, quote 11).

[Insert Table 1]Clinicians were most commonly constructed as wrong-doers, being described negatively through their self-interested behaviours against patients' best interests or through disrespecting others’ roles and opinions. For example, clinicians were described as rule breaking, lazy, judgmental, dismissive, angry and abusive (Table 2, quote 1). Clinicians were also constructed as educators facilitating interprofessional students’ learning deliberately by providing skills teaching, feedback and assessment to students (Table 2, quote 2). Clinicians were also constructed as specialists, representing their particular specialty and promoting their profession by highlighting its significance in healthcare delivery (Table 2, quote 3). Clinicians were also constructed as kind, being described as pleasant, friendly, approachable, caring and supportive (Table 2, quote 4). Clinicians were also constructed as healthcare experts and this was sometimes contrasted with students’ novice status. Clinicians were described as knowledgeable and experienced (Table 2, quote 5). Clinicians were also constructed as heroes in terms of them resolving unpleasant situations across professions and going above and beyond the call of duty (Table 2, quote 6). Clinicians were also constructed as team-workers, being described as team-member, team-worker or team-player (Table 2, quote 7). Finally,clinicians were sometimes constructed as superordinate, that is, having higher status within the workplace (Table 2, quote 8).

[Insert Table 2]

**RQ2. Differences in identity constructions by type of narrative and narrator**

We found interesting differences in how identities were most often constructed by narrative (positively versus negatively evaluated) and narrator (student versus clinician narratives):

**Student identities**: Students were commonly constructed as observer in positively evaluated narratives, but more often as novice in negatively evaluated narratives. In positively evaluated narratives, students were commonly constructed as competent and team-worker by students but observer and motivated learner by clinicians. In negatively evaluated narratives, students commonly constructed themselves as learner, whereas clinicians commonly constructed them as incompetent.

**Clinician identities**: Clinicians were commonly constructed as kind and specialist in positively evaluated narratives, but wrong-doer and superordinate in negatively evaluated narratives. In positively evaluated narratives, clinicians were commonly constructed as kind and wrong-doer by students, but specialist and expert healthcare professional by clinicians. In negatively evaluated narratives, students commonly constructed clinicians as superordinate, whereas clinicians commonly constructed themselves as student educator and team-worker.

**RQ3. Discursively positioned student and clinician identities**

To bring together these fragmentary findings and to illustrate more holistically the discursive positioning of student and clinician identities within full narratives, we next present the positioning analyses of two illustrative narratives. These two narratives were selected because they represent diversity in terms of narrators, professions, settings, identity constructions, and evaluations. Our first example considers how a medical student discursively positions their own and midwives’ identities during his obstetrics placement, and our second example considers how a physiotherapy clinician positions their own and two occupational therapy students’ identities during a treatment session.

**Exemplar 1: the medical student and the midwives**

Greg (pseudonym) is a fifth-year medical student who describes his experience of learning obstetrics on a hospital maternity ward with midwives in his fourth year. We chose this narrative because Greg shares negative *and* positive experiences with the midwives. He first describes his negative experiences with the midwives, thereby hindering his learning (see Box 1 for Part A). However, after giving the midwives a batch of muffins, he describes improved interprofessional working with them, leading to him caring for a woman delivering her baby, facilitating his learning about birth *and* midwives’ roles (see Box 2 Part B). What is interesting in this narrative is the multiplicity of ways that Greg positions himself and the midwives, and how these constructed identities vary before and after gifting the muffins.

[Insert Box 1 about here]

**Level 1 positioning**: As seen in Box 1, before Greg gifts the muffins to the midwives, and as he describes his negative experiences with them, he positions his identity as outsider in terms of the midwifery team (lines 12-16, 17-21, 21-22 and 28, Box 1) but insider in relation to the medical team (lines 17-18, 22, 32-33, Box 1). He also repeatedly positions himself as learner (lines 4, 5-6, 12-16, Box 1), motivated learner (lines 12-16, 17-21, Box 1), and subordinate (lines 15-16, Box 1). In Part A of his narrative, Greg contrasts his medical student identity with that of the midwifery students, constructing them as learner but also insider in relation to the midwifery team, and also superordinate to himself (lines 13-15, Box 1). He also variously constructs the identities of midwives in Part A. He primarily constructs the midwives as wrong-doer (lines 21, 28-29, Box 1), insider (lines 18-21, Box 1), reluctant educator (lines 15-16, Box 1), and team-worker (line 2, Box 1).

[Insert Box 2 about here]

However, we see a different pattern of identity constructions after Greg’s gift of muffins and as he recounts his then positive interprofessional working with the midwives (see Box 2 for Part B). Here, he variously constructs himself as insider of the midwifery team (lines 7-13, 16-17, 18-24, Box 2), team-worker (lines 5-6, 18-24, Box 2), kind (lines 5-6, Box 2), motivated learner (lines 5-6, Box 2), learner (lines 10-12, Box 2), and competent (lines 18-24, Box 2). Furthermore, he constructs the midwives as medical student educator (lines 7-10, 18-19, 19-24, Box 2), specialist (lines 14-16, Box 2), and kind (line 19, Box 2). So, we see a shift in this obstetrics placement narrative—from Part A to Part B—from outsider to insider for Greg and from wrong-doer and reluctant educator to kind and student educator for the midwives; a shift in identity constructions triggered by the gift of muffins.

**Level 2 positioning**: Greg shares his narrative about 14 minutes into a 50-minute mixed-gender group interview including 4 other final year medical students (3 males and 1 female) and a female interviewer who is a physiotherapist, educator and researcher. Greg knows his fellow students but has not met the interviewer previously. Early in the interview Greg articulates his understandings of IPSC interactions as ones that facilitate learning, and are mutually respectful and beneficial (e.g. “it’s kind of a mutual kind of respect and also benefit for both parties”). Throughout the group interview he expresses his positive attitudes towards interprofessional learning: both informal learning with nurses, physiotherapists, occupational therapists and nurse managers (e.g. “I've found [it] really, really useful to have the ANUM [Associate Nurse Unit Manager] as someone to go to”); and formal learning with nursing students (e.g. “I think it’s [interprofessional workshop] a really valuable potential learning opportunity”). Therefore, Greg positions himself as pro-interprofessional throughout the group interview.

Greg’s story is sandwiched between two others from different male students—Charlie and Jamie (both pseudonyms). Immediately preceding Greg’s story is Charlie’s negatively evaluated IPSC interaction where he recounts his experience of being told by theatre nurses to never treat them badly like his surgeon does after the surgeon is rude to the nurses. After Charlie has finished his story, the interviewer asks the group for any other stories, suggesting negative, positive or memorable stories, to which Greg offers his story (which he later describes as “negative”). Immediately following Greg’s story is Jamie’s positively evaluated narrative, where he describes how he learnt about tests to diagnose BBPV (a type of vertigo) by shadowing a physiotherapist.

**Level 3 positioning**: In Part A of Greg’s narrative, he draws on the common discourse of *interprofessional conflict* (including *in-groups* and *out-groups)* using the terms “them” and “we/us” repeatedly to refer to midwives and medical colleagues respectively. Furthermore, near the end of the group interview Greg reflects: “it became very us versus them in my… negative story I gave before”. He also uses the reported talk of a medical colleague to flag that interprofessional conflict may exist between his consultants and midwives (“it’s a particular issue that the consultant has with them… we’ve never seemed to get on”, lines 26-27, Box 1). Greg further highlights the *interprofessional conflict* discourse by describing the competition between medical and midwifery students for birthing experiences, with midwifery students’ needs being privileged by the midwives (*in-group*). This *interprofessional conflict* discourse is continued in Part B of the narrative, where he describes his relationship with the midwives in his first couple of weeks as “toxic” (line 25, Box 2), and how without the positive turnaround he could have left his placement with the understanding that: “medical staff and midwives don’t get on” (lines 29-30, Box 2). He comments that animosity between medical students and other members of the interprofessional team would be “disastrous”, as it could potentially foster future feelings of animosity (lines 32-35, Box 2). So, we see that while Greg explains his positive learning experiences with midwives, his narrative largely re-produces the common *interprofessional conflict* discourse.

**Exemplar 2: the physiotherapist and the occupational therapy students**

Michael (pseudonym) is a physiotherapist who describes his shared patient consultation with two third-year occupational therapy students, when he was working with the patient on a standing task and they simultaneously facilitated upper limb tasks. We chose this narrative because Michael’s evaluation of his experience is mixed: although it is primarily negative as he describes the joint consultation as “awkward” and “disjointed”, he positively evaluates the behaviour of the OT students (e.g. “politely”, and “professional”).

[Insert Box 3 about here]

**Level 1 positioning**: As illustrated in Box 3, Michael positions his identity in several ways in relation to the two occupational therapy students and their OT teacher Sara (pseudonym). Firstly, Michael constructs himself as an outsider in relation to the OT team, describing the occupational therapy students repeatedly as belonging to Sara (lines 1-2, Box 3). Secondly, he constructs himself as a reluctant educator, first by explaining that he rarely interacted with the OT students (line 1, Box 3) and second by explaining that he mistakenly failed to give Sara feedback about how the two students approached the upper limb task (lines 8-9, Box 3). Thirdly, he positions himself as specialist (line 10, Box 3) and expert healthcare professional (lines 1-2, 9, Box 3). Finally, he constructs his team-worker identity repeatedly in the narrative (lines 7-8, 20-21, Box 3). Michael variously constructs the identities of the OT students as insiders (lines 2, Box 3), competent (line 2, 5, 6, Box 3), motivated learner (line 7, Box 3), team-worker (lines 2, 8, 20-21, Box 3), learner (lines 1, 2, 20 Box 3), and outsider (line 23, Box 3).

**Level 2 positioning**: Michael shares his narrative about 8 minutes into a 21-minute mixed gender group interview including a female occupational therapist Sara (pseudonym) and a female interviewer who is a physiotherapist, educator and researcher. Michael and Sara work together on the same ward, and they also know the interviewer. Michael positions himself as an interprofessional practitioner throughout the group interview stating that “we all work in a team and I expect communication with everyone”, plus he describes encouraging his physiotherapy students to interact with other healthcare professionals during their placements: “I want them [my students] to talk to the nurses, the doctors, the OTs, social workers…”.

Michael’s narrative is the second story narrated in the interview, sandwiched between the first story provided by Sara and a second story from Michael. Sara’s story is a negatively evaluated IPSC interaction where Sara recounts her two OT students failing to liaise with Michael about a patient’s mobility despite her asking them to do so, explaining that they instead spoke to Michael’s physiotherapy students about the patient. Michael’s narrative immediately follows on from this story because his story features the same two students from Sara’s narrative. Immediately following Michael’s narrative is a second story from Michael. This time, he shares a positively evaluated IPSC interaction narrative with an “interested” and “motivated” nursing student coming to observe a 45-minute exercise session with one of his patients in the gym.

**Level 3 positioning**: Like Greg in the previous narrative, Michael re-produces the common discourse of *interprofessional conflict* in his narrative in two ways. Firstly, by employing the term “I”/”we” to refer to himself and other physiotherapists and “them”/”they” to refer to the OT students (e.g. “they achieved their objective, we achieved ours”, lines 14-15, Box 3). Secondly, by Michael explicitly referring to the barrier and/or distinction between the two professions each with a different focus for the patient consultation and skill set (e.g. “there still was this barrier of “I was this physio and there was this OT”…”, line 10, Box 3). However, unlike Greg, Michael also draws on the discourse of *interprofessional collaboration* within his narrative when talking about how healthcare students should be better prepared for IPSC interactions within the healthcare workplace. Not only does he employ the term “we” in the latter part of his narrative to reflect the interprofessional team, but he states explicitly that patients are treated by multiple professions working together (e.g. “we’re all going to be working within a team. We’re all going to be communicating and… at times, treating together”, lines 20-21, Box 3). So, Michael’s narrative is interesting because it simultaneously draws on two competing discourses: (1) *interprofessional conflict*, when talking about his experience with the two OT students; and (2) *interprofessional collaboration*, when talking about how healthcare students should be better prepared for interprofessional learning and future interprofessional working.

**Discussion**

**Summary of key findings**

In terms of research question 1 (what student and clinician identities are constructed across IPSC interaction narratives?), we found a multiplicity of common identities constructed for students (either reflecting their learner, soon-to-be graduate and/or problematic identities) and clinicians (either reflecting their clinician, educator and/or personal identities) across the breadth of our 208 IPSC narratives. Regarding research question 2 (how do identity constructions differ by narrative and narrator?), common identity constructions for students and clinicians differed according to whether narratives were positively or negatively evaluated and whether narrators were students or clinicians, highlighting the rhetorical nature of narratives. In terms of research question 3 (how are identities discursively positioned in exemplar narratives?), we again found a multiplicity of student and clinician identities but this time illustrating how such identities are relationally positioned discursively within two exemplar narratives. While our positioning analysis illustrated that both student and clinician narrators reproduced the common *interprofessional conflict* discourse, they did so despite their espoused positive attitudes toward interprofessional learning and collaboration. The clinician narrator also drew on the *interprofessional collaboration* discourse, thus offering a window into future possibilities for interprofessional learning and collaboration.

**Comparisons with existing literature**

Regarding our first research question, some of the student identity constructions found in the current study are consistent with previous research.4,6,27 That numerous identity constructions related to students’ learner status was expected given the focus of our research on workplace learning.36 That various identity constructions related to students’ team-worker status was also anticipated given the active engagement of many students in the team-based delivery of patient care.34,39,40 That some student identities were constructed as problematic is probably accounted for by well-known tensions in balancing education and service, with some clinicians’ demonstrating antipathy towards teaching students while simultaneously caring for patients.34,36,41 Furthermore, many of the clinician identities found in the current study are consistent with previous research.22,42 That clinician rather than educator identities were dominant in our data reflects previous research.8,28-32 We would however surmise that the relegation of educator identities may be more acute within an interprofessional context, whereby students might perceive limited value in the education offered by professions outside their own.43 That clinicians’ personal identities were either glorified (e.g. hero) or demonized (e.g. wrong-doer) also mirrors previous research.15,18,22,34,42 However, what is novel about our findings pertaining to RQ1 is that: (1) we have found these student and clinician identity constructions within an interprofessional context, whereas previous research is primarily uniprofessional; and (2) we have identified a broader range of identity constructions than has been previously found.

Relating to our second research question, we found differences in common student and clinician identity constructions according to how narratives were evaluated and the narrator. In terms of the narratives, students were commonly constructed as novices in negatively evaluated narratives but observers in positively evaluated narratives, which contrasts with previous uniprofessional research describing student observer identities as negative, particularly when coupled with outsider identities.44,45 Furthermore, clinicians were more commonly constructed as kind and specialist in positively evaluated narratives but wrong-doer and superordinate in negatively evaluated narratives, aligning with previous constructions of clinicians in the context of professionalism lapses.22 In terms of narrators, students were commonly constructed as competent/team-worker (positive) and learner (negative) by students but more often as observer/motivated learner (positive) and incompetent (negative) by clinicians. Furthermore, clinicians were commonly constructed as kind/wrong-doer (positive) and superordinate (negative) by students but specialist/expert healthcare professional (positive) and student educator/team-worker (negative) by clinicians. To our knowledge, our study is novel in exploring such identity constructions by different types of narratives and narrators. Interestingly, our study illustrates how students and clinicians are likely to construct their own identities more favorably, while constructing others’ identities more disparagingly, consistent with a rhetorical perspective on narratives, illustrating that narrators are motivated to position themselves in a positive light compared with others, particularly while narrating negative experiences.46,47

Finally, with respect to our third research question, we see our student and clinician narrators discursively position multiple identities for themselves and others in their IPSC interaction narratives, and we see how those identities shift according to negatively and positively evaluated elements of the narratives; consistent with social identity complexity theory,35 and so-called *dual* identities of professional and interprofessional. 14,33 However, what is really novel about the current research is that our positioning analysis of these exemplars moves beyond *what* identities are constructed to consider *how* those identities are discursively positioned, alongside the broader sociopolitical meanings of those identities.9 For example, both Greg and Michael position themselves as interprofessional advocates and yet re-produce the common *interprofessional conflict* discourse. They both achieve this through their direct talk about interprofessional conflict and their indirect talk of conflict via the use of “them” and “us” language, which has been found in previous interprofessional narratives within the context of professionalism dilemmas.15,22 However, Michael also produces a competing *interprofessional collaboration* discourse, thus offering a window into future possibilities for interprofessional learning and collaboration.

**Methodological strengths and challenges**

There are several methodological strengths in the current study. First, we collected a relatively large amount of qualitative data from both student and clinician narrators representing six professions. Second, we conducted a rigorous team-based approach to qualitative data analysis, exploring the breadth of our data through framework analysis, plus the depth of selected narratives through positioning analysis, which is relatively novel in health professions education research.9 However, our study is not without its methodological challenges and these must be taken into account when interpreting our study findings. First, despite our range of professions and narrative settings (e.g. hospital, community), our study was conducted with students and clinicians affiliated with one Australian University, limiting the transferability of our study findings beyond our Victorian context. While our overall qualitative sample was relatively large, our sub-sample of clinicians was smaller than students, making comparisons between student and clinician constructions tentative. Finally, the identity constructions identified in the collected narratives are cross-sectional in nature, so offer little insight into the professional identity *development* of students and clinicians longitudinally.

**Implications for educational practice and research**

It is clear from participants’ narratives of IPSC interactions that they discursively construct a multiplicity of identities for students and clinicians, demonstrating how important informal workplace learning experiences are for identity construction. Therefore, we believe that identities curricula should be developed and embedded as part of existing workplace learning curricula for students and clinicians to help them: (a) better understand the importance of IPSC interactions in developing professional *and* interprofessional identities; and (b) make sense of their own and others’ identities.1 Regarding students, we believe that identities curricula could be situated within longitudinal themes such as professionalism, interprofessionalism and/or clinical learning and incorporated within students’ workplace learning. Small group learning methods employing narrative, for example, could be employed to explore how students’ interprofessional workplace learning experiences interplay with their developing professional *and* interprofessional identities.1 With respect to clinicians, we think that continuous professional development to enhance their educator roles should attend sufficiently to their developing educator identities. Again, collaborative learning approaches employing narrative should help clinicians to better understand their educator identities, plus sensitize them to the opportunities afforded within the workplace for both professional *and* interprofessional supervision. Indeed, these workplace educators should be more cognizant of the impact of their interactions with students from other professions, and to actively facilitate meaningful IPSC interactions to promote interprofessional learning and future interprofessional collaboration.

 We think further research is now needed based on ours and others’ study findings, plus enduring gaps in the literature regarding the development of professional *and* interprofessional identities. For example, we advocate the use of qualitative longitudinal research based on narrative inquiry such as audio diaries to explore the development of professional *and* interprofessional identities in healthcare students. Such methodologies and methods would also suit further exploration of the development of educator identities in clinicians, including both their intra- *and* interprofessional supervisor identities in the workplace.

**Contributions:** CER and FK designed the study and secured funding. All authors secured ethics approval and helped recruit study participants. CER and FK conducted all individual and group interviews. All authors participated in the preliminary analysis of data to develop the coding framework. PC coded the data using NVivo. CER led the writing of the paper with PC contributing to the results and FK to the discussion. FK and PC edited and commented on various iterations of the paper. All authors approve the final version. CER is Principal Investigator and acts as guarantor for the paper.

**Acknowledgements:** We would like to thank all our student and clinician participants for sharing their experiences with us so candidly. We would also like to thank our Monash University co-investigators for the preliminary study on which this secondary analysis is based (in alphabetical order): Ted Brown, Kerry Hood, Michelle Leech, Jennifer Newton, Michael Storr and Brett Williams.

**Funding:** This study was funded by a grant from the Monash University Faculty of Medicine, Nursing and Health Sciences Learning & Teaching Research Grant Scheme 2016.

**Conflicts of interest:** None.

**Ethical approvals:** We received approval for this study from both Monash University (CF16/622-20160000301) and Monash Health (RES-16-0000547XL) Human Research Ethics Committees.

**References**

1. Rees CE, Monrouxe LV. Who are you and who do you want to be? Key considerations in developing professional identities in medicine. Med J Aust 2018;209(5):202-203.e1.
2. Mitchell RJ, Parker V, Giles M. When do interprofessional teams succeed? Investigating the moderating roles of team and professional identity in interprofessional effectiveness. Hum Relat 2011;64(10):1321-1342.
3. Clandinin DJ, Cave M-T. Creating pedagogical spaces for developing doctor professional identity. Med Educ 2008;42:765-770.
4. Vågan A. Medical students’ perceptions of identity in communication skills training: a qualitative study. Med Educ 2009;43:254-259.
5. Frost HD, Regehr G. “I AM a doctor”: Negotiating the discourses of standardization and diversity in professional identity construction. Acad Med 2013;88:1570-1577.
6. Wong A, Trollope-Kumar K. Reflections: an inquiry into medical students’ professional identity formation. Med Educ 2014;48:489-501.
7. Warmington S, McColl G. Medical student stories of participation in patient care-related activities: the construction of relational identity. Adv Health Sci Educ 2017;22:147-163.
8. van Lankveld T, Schoonenboom J, Kusurkar RA, Volman M, Beishuizen J, Croiset G. Integrating the teaching role into one’s identity: a qualitative study of beginning undergraduate medical teachers. Adv Health Sci Educ 2017;22:601-622.
9. Monrouxe LV, Rees CE. Theoretical perspectives on identity: researching identities in healthcare education. In: Cleland J, Durning S, editors. Researching Medical Education. West Sussex: Wiley-Blackwell; 2015: 129-140.
10. Ajjawi R, Hyde S, Roberts C, Nisbet G. Marginalisation of dental students in a shared medical and dental education programme. Med Educ 2009;43:238-245.
11. Lloyd JV, Scheider J, Scales K, Bailey S, Jones R. Ingroup identity as an obstacle to effective multiprofessional and interprofessional teamwork: findings from an ethnography study of healthcare assistants in dementia care. J Interprof Care 2011;25:345-351.
12. Sims D. Reconstructing professional identity for professional and interprofessional practice: A mixed methods study of joint training programmes in learning disability nursing and social work. J Interprof Care 2011;25(4):265-271.
13. Weaver R, Peters K, Koch J, Wilson I. ‘Part of the team’: professional identity and social exclusivity in medical students. Med Educ 2011;45:1220-1229.
14. Khalili H, Orchard C, Laschinger HKS, Farah R. An interprofessional socialization framework for developing an interprofessional identity among health professions students. J Interprof Care 2013;27(6):448-453.
15. Rees CE, Monrouxe LV, Ajjawi R. Professionalism in workplace learning: understanding interprofessional dilemmas through healthcare students narratives. In: Jindal-Snape D, Hannah EFS, editors. Exploring the Dynamics of Personal, Professional and Interprofessional Ethics. Bristol: Polity Press; 2014: 295-310.
16. Brown AD. Identities and identity work in organizations. Int J Manag Rev 2015;17:20-40.
17. Monrouxe LV. Identity, identification and medical education: why should we care? Med Educ 2010;44:40-49.
18. Monrouxe LV. Theoretical insights into the nature and nurture of professional identities. In: Cruess RL, Cruess SR, Steinert Y, editors. Teaching Medical Professionalism: Supporting the Development of a Professional Identity. 2nd ed. Cambridge: Cambridge University Press; 2016: 37-53.
19. Haidet P, Stein HF. The role of the student-teacher relationship in the formation of physicians. J Gen Intern Med 2006;21:s16-20.
20. Vandermeersche G, Soetaert R, Rutten K. “Shall I tell you what is wrong with Hector as a teacher?”: The History Boys, stereotypes of popular and high culture, and teacher education. J Pop Film Telev 2013;41(2):88-97.
21. Chan ZCY, Tong CW, Henderson S. Power dynamics in the student-teacher relationship in clinical settings. Nurse Educ Today 2017;49:174-179.
22. Monrouxe LV, Rees CE. Hero, voyeur, judge: Understanding medical students’ moral identities through professionalism dilemma narratives. In: Mavor K, Platow K, Bizumic B, editors. The Self, Social Identity and Education. Hove: Psychology Press; 2017: 297-319.
23. Rudland JR, Mires GJ. Characteristics of doctors and nurses as perceived by students entering medical school: implications for shared teaching. Med Educ 2005;39:448-455.
24. Kelly J, Fealy GM, Watson R. The image of you: constructing nursing identities in YouTube. J Adv Nurs 2011;68(8):1804-1813.
25. Setchell J, Leach LE, Watson BM, Hewett DG. Impact of identity on support for new roles in health care: A language inquiry of doctors’ commentary. J Lang Soc Psychol 2015;34(6):672-68625.
26. Jinks AM, Bradley E. Angel, handmaiden, battleaxe or whore? A study which examines changes in newly recruited students nurses’ attitudes to gender and nursing stereotypes. Nurse Educ Today 2004;24:121-127.
27. Wilson I, Cowin LS, Johnson M, Young M. Professional identity in medical students: pedagogical challenges to medical education. Teach Learn Med 2013;25(4):369-373.
28. Sundberg K, Josephson A, Reeves S, Nordquist J. May I see your ID, please? An explorative study of the professional identity of undergraduate medical education leaders. BMC Med Educ 2017;17:29.
29. Starr S, Ferguson WJ, Haley H-L, Quirk M. Community preceptors’ views of their identities as teachers. Acad Med 2003;78(8):820-825.
30. Smith C, Boyd P. Becoming an academic: the reconstruction of identity by recently appointed lecturers in nursing, midwifery and the allied health professions. Innov Educ Teach Int 2012;49(1):63-72.
31. Lieff S, Baker L, Mori B, Eglan-Lee E, Chin K, Reeves S. Who am I? Key influences on the formation of academic identity within a faculty development program. Med Teach 2012;34:e208-e215.
32. Sabel E, Archer J. “Medical education is the ugly duckling of the medical world” and other challenges to medical educators’ identity constructions: A qualitative study. Med Educ 2014;89(11):1474-1480.
33. Thistlethwaite JE, Kumar K, Roberts C. Becoming interprofessional: professional identity formation in the health professions. In: Cruess RL, Cruess SR, Steinert Y, editors. Teaching Medical Professionalism: Supporting the Development of a Professional Identity. 2nd ed. Cambridge: Cambridge University Press; 2016: 140-154.
34. Monrouxe LV, Rees CE. Healthcare Professionalism. Improving Practice through Reflections on Workplace Dilemmas. West Sussex: Wiley Blackwell; 2017.
35. Roccas S, Brewer MB. Social identity complexity. Pers Soc Psychol Rev 2002;6(2):88-106.
36. Rees CE, Crampton P, Kent F, Brown T, Hood K, Leech M, Newton J, Storr M, Williams B. Understanding students’ and clinicians’ experiences of informal interprofessional workplace learning: An Australian qualitative study. BMJ Open 2018;8(4):e021238.
37. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, editors. Analysing Qualitative Data. London: Routledge; 1994: 173-94.
38. Bamberg M, Georgakopoulou A. Small stories as a new perspective in narrative and identity analysis. Text Talk 2008;28(3):377-96.
39. Hood K, Cant R, Leech M, Baulch J, Gilbee A. Trying on the professional self: nursing students' perceptions of learning about roles, identity and teamwork in an interprofessional clinical placement. Appl Nurs Res 2014;27(2):109-114.
40. Lindquist I, Engardt M, Garnham L, Poland F, Richardson B. Physiotherapy students' professional identity on the edge of working life. Med Teach 2006;28(3): 270-276.
41. Sholl S, Ajjawi R, Allbutt H, Butler J, Jindal-Snape D, Morrison J, Rees C. Balancing health care education and patient care in the UK workplace: a realist synthesis. Med Educ 2017;51(8):787-801.

## Courtney-Pratt H, Pich J, Levett-Jones T, Moxey A. “I was yelled at, intimidated and treated unfairly”: Nursing students' experiences of being bullied in clinical and academic settings. J Clin Nurs 2018;27:e903-e912.

1. Yang K, Nisbet G, McAllister L. Students’ experiences and perceptions of interprofessional supervision on placement. Int J Pract Based Learn Health Soc Care 2017;5(2):1-18.
2. Dornan T, Boshuizen H, King N, Scherpbier A. Experience-based learning: a model linking the processes and outcomes of medical students’ workplace-learning. Med Educ 2007;41:84-91.
3. Berry LE. Creating community: Strengthening education and practice partnerships through communities of practice. Int J Nurs Educ Scholarsh 2011;8(1):1-18.
4. Riessman CK. Narrative Methods for the Human Sciences. Thousand Oaks, California: Sage Publications; 2008.
5. Rees CE, Monrouxe LV. Medical students learning intimate examinations without valid consent: a multi-centre study. Med Educ 2011;45:261-272.

**Table 1. Illustrative quotes for student identity constructions within IPSC interaction narratives**

|  |  |
| --- | --- |
| Learner | 1. “They [social work/multidisciplinary team] knew I was a student but in saying that… I always introduced myself as a student anyway…” [F24MidS3][[1]](#footnote-2)
 |
| Novice | 1. “Sometimes our [midwifery and social work] scopes can fold and blur over each other… So, sometimes they’re [social workers] good at saying, “Well actually, [F22MidS1], you can actually make that phone call, were you aware of that?”... certain parts of my scope that I might not even be aware…” [F22MidS1]
 |
| Competent | 1. “It was… quite nice knowing that she [physiotherapist] trusted me… my opinion and my knowledge was needed” [F9OTS2]
 |
| Motivated learner | 1. “Anything that… was within my scope of practice, I wanted to… try… we had trouble stopping… the bleeding… you know cause we need to learn to deliver a baby so… we were there with… midwives…” [M4PS1]
 |
| Observer | 1. “watching somebody who’s experienced with mental health to communicate with the patient… the CATT [crisis assessment and treatment team]… it’s not really appropriate for just some random student to start coming in and trying to… It was much more about… well just observing and… taking in the sort of interactions… there’s not lot of education for me coming there… they just [do] their job and I watch them” [M4PS1]
 |
| Outsider | 1. “I understand maybe the first week… they’re [healthcare team] not gonna look to me to sort of get information, but by the fifth and sixth week, they still were looking at the OT to sort of gain that information… and then she’d just answer instead… Cause you’re sitting there with another ten, eleven, twelve other health professionals… it’s kind of hard to work your way in” [M1OTS1]
 |
| Team-worker | 1. “So when I was working in the children’s uhm… group sector with all the other clinicians [doctors/nurses/physios], we were working together” [F2OTS1]
 |
| Incompetent  | 1. “I’ve also had a bad experience with a different nurse… they sort of accused me as being a student I didn’t know what I was doing… sort of as in like your recommendation wasn’t good enough, like as a student, you shouldn’t be sort of giving that recommendation” [F18PHS1]
 |
| Bothersome | 1. “… because some [students] have a very poor work experience, depending on the person they’re tasked with… sometimes, it’s their [nurse staff] world that’s being intervened, so you see that in… nursing staff, “Oh, I got another student today, you [paramedic student] just stand over there”, and when you hear those stories from the students, it's not, not nice” [M4P3T6]
 |
| Wrong-doer | 1. “I'm probably gonna be working with these doctors later on the day and I don't want it to be like, ‘Oh, that's the midwife that kept stealing my births’…” [F23MidS2]
 |
| Insider | 1. “I was doing a standing with a particular patient and your two [OT] students came in and politely joined in… their job was to do upper limb tasks… they approached me and… said ‘Can we, while you’ve got the patient standing, can we implement our task?’ And so, it ended up being a joint session based on that.” [M3PT3T4]
 |

**Table 2. Illustrative quotes for clinician identity constructions within IPSC interaction narratives**

|  |  |
| --- | --- |
| Wrong-doer | 1. “The doctor was not willing to listen to anyone, shut down every single person, every single nurse that tried to talk to him. He was just not willing to listen to anyone” [F11NS2]
 |
| Educator | 1. “he [obstetrician] sort of facilitated my learning of, you know, next time I do this, this is what I should add… they [obstetricians] kind of teach as they go… I think they’re quite used to having students, especially medical students as well… they treated us very much the same” [F23MidS2]
 |
| Specialist | 1. “… midwifery traverses both so, because we have dual degree [nursing and midwifery] students… we spend quite a bit of time talking about what’s the difference?” [F14Mid2T10]
 |
| Kind | 1. “There have been times when we’ve had to look after the medical students who’ve been about to faint… so it’s usually our role to put a chair behind them, take them to the back of the theatre, get all their hot gowns and things off them… take them for a walk out in the tea room… have a chat with them and make sure they’re okay” [F6N1T5]
 |
| Healthcare expert | 1. “Then he [consultant] said ‘All right, you’re gonna count pulls’… so, I counted pulls with him… and he said ‘Okay, so because I’m a consultant, I’m allowed to do five [pulls]’, so he did two more and the baby was born” [F23MidS2]
 |
| Hero | 1. “she [female doctor] was amazing, she wasn’t just amazing to nurses, she was amazing to junior doctors… she just work[ed] as a nurse sometimes… If she found anything on the floor, even poo, she [would] just wipe it. She’s just fantastic. I haven’t seen [a]… consultant like that. Yeah, she’s just so fantastic” [F12NS2]
 |
| Team-worker | 1. “Every so often, I will just remind her [medical student] that I was there and I had a role… so that she [medical student] wasn’t completely disengaged from my part of the anaesthetic team” [F6N1T5]
 |
| Super-ordinate | 1. “I kind of feel… like going back to the whole hierarchical structure, so it has your doctors and surgeons up top and then your allied health professionals… lumped together underneath them… it made me feel more comfortable working with other allied health professionals versus the medical team” [F5OTS1]
 |

1. F24MidS3 = Female, Number 24, Midwifery student, Interview 3 [↑](#footnote-ref-2)