

**FROM LEGITIMATE PERIPHERAL
PARTICIPATION TO FULL PARTICIPATION?
INVESTIGATING THE CAREER PATHS OF
MATURE PHYSIOTHERAPY STUDENTS IN A
CONTEXT OF CHANGING NHS EMPLOYMENT
OPPORTUNITIES**

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Abstract

This research investigates the experiences of 18 mature career-changing physiotherapists over the first three years of belonging to their new profession, employing and critiquing Lave and Wenger's (1991) theory of community of practice in so doing. Such newcomers to a profession bring with them social and cultural capital which can impact upon the new workplace and their progress within it, as might their biographies, atypical for their chosen profession. Very little has been written about the effect of importing people experienced in another occupation into a profession. This leaves an empirical and theoretical gap to be explored regarding both the effect on the individuals and on the practice of the communities they join. No-one has considered what might be involved in what amounts to identity re-construction in the new career, and what impact the employment context (possibly unstable or fluctuating) might have on the process.

Annual semi-structured interviews were chosen as the appropriate mode of generating data from the main respondents, augmented by single interviews with six physiotherapy managers and four established clinicians to provide additional necessary context. The recorded transcripts were analysed using brief interviewee narratives, pro formas and reflective questions.

It was found that previous experience, including upbringing and habitus, were particularly influential in these newcomers' progress, and individuals may be beginning to self-manage their careers, a practice which questions and adds to Lave and Wenger's (1991) theory of legitimate peripheral participation. Other elements that contradicted community of practice theory included the fact that it was with patients and their carers that social interaction leading to learning occurred most, and it was often to this client group that practitioners felt loyalty and a sense of belonging, rather than to any community of fellow practitioners. Also solo workers are often isolated from the newcomer and cannot pass on their learning as Lave and Wenger (1991) suggest. Full participation was found to be difficult to define, equating with proficiency rather than expertise. The thesis as a whole gives some indication of the way in which a profession's traditions may be changing with respect to widening participation and the problems of a context of fractured and uncertain employment.

Glossary of Abbreviations and Physiotherapy Terminology

Access Course - Access to HE diplomas are usually a year long and enable adult learners without qualifications such as A levels to progress to higher education.

Advanced practitioner level – Specialising in very specific high level practice

AfC – Agenda for Change, the name given to the new NHS national pay and grading system (see Bands below) introduced in 2004 to harmonise pay and terms and conditions for all NHS workers other than doctors.

AHP – Allied Health Professional, key members of today’s healthcare team

Assistant - Assistants to qualified physiotherapists

Auxiliary staff – Various assistant posts

Band 4 – Physiotherapy Assistant and Technical Assistant level

Band 5 – Lowest grade of junior qualified staff. Often doing rotations.

Band 6 – Next grade up. Possibly still doing (longer) rotations. The main ‘workhorse’ grade of the profession.

Band 7 – First step on the managerial ladder

Band 8 – Specialist clinician, researcher or manager

Bank work – Casual/temporary staff available at short notice to work for a few days or weeks when work pressures are highest or staff levels are depleted for some reason. Akin to ‘supply teaching.’

“.. If we’ve got a bit of work we can ring them up and say, “Are you available?” and they can just say, “No, sorry I can’t manage it today.” Or they could ring in and say “Have you got any work for us?” you know, so it’s a bit more of an informal arrangement. It’s not as secure: they don’t get paid if they’re not here. But they’re still theoretically employed by the Trust .. if you got sickness problems or ... annual leave bad times .. you can get your Bank staff in and just cover that short notice, rather than your permanent staff or your temporary staff . where you’ve got to find them work every day, or whatever the contract says .. they just get paid for the hours that they work.” (Manager Z: 16)

CE – Clinical Educator, supervisor on placement

CSP – The Chartered Society of Physiotherapy

ESP - Extended Scope Practitioner, “clinical physiotherapy specialist in any recognised speciality with an extended scope of practice” (CSP 2002b)

- HPC** – Health Professions Council
 - HSE** - Health Service Executive (the Irish equivalent of the NHS)
 - KSF** – Knowledge and skills framework
 - LDs** - Learning Difficulties
 - MCSP** - Member of the Chartered Society of Physiotherapy – registered membership of the UK national professional body
 - MDT** – Multidisciplinary team
 - OT** – Occupational Therapist, one who assesses and treats physical and psychiatric conditions using specific, purposeful activity to prevent disability and promote independent function in all aspects of daily life.
 - Physio** – Physiotherapist, one who sees human movement as central to the health and well-being of individuals. Physiotherapists identify and maximise movement potential through health promotion, preventive healthcare, treatment and rehabilitation.
- Practice placements** – Periods spent using professional skills in the workplace during vocational training.
- Professional Networks** – previously known as Clinical and Occupational Interest Groups.
- Senior** – Band 7 (usually), senior member of staff responsible for the newly-qualified practitioner
 - TAP** – Technical Assistant Physiotherapist

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Chapter 1

The Initial Situation

This study investigates the career paths and experiences of mature graduates of one of the allied healthcare professions (AHPs), physiotherapy, in a time of employment difficulties. These graduates have changed career to become physiotherapists and so have already experienced belonging to at least one other workplace culture prior to commencing their new vocational training. In so doing they have acquired social and cultural capital (Hodkinson et al. 2008) which may influence their progress into their new career. In the literature only Fuller et al. (2005) have looked at the impact of importing people with previous work experience into a profession. Exploration of both the effect of this move on the experienced newcomers, and on the practice of the workplace cultures they join, is lacking. The research was triggered initially by particular socioeconomic changes which impacted on these people and drew my attention to their situation, and this introductory chapter provides context for the study by telling of my position as researcher and explaining this initial reason for my interest.

My Position

In order to generate some purchase on the changes that have happened in the field of physiotherapy, I will describe my own path into the profession over 40 years ago. I chose my vocation straight from school, and took a diploma course lasting three years and a term, to become a member of the professional body, the Chartered Society of Physiotherapy (CSP). It was akin to being apprenticed to the National Health Service (NHS), for I had to sign an agreement to work for the organisation for two years following qualification. But staff shortages in the NHS ensured employment and I had no qualms about the future. Indeed in the 1960s physiotherapy was seen as a good career for women in that you could leave the job for a few years to rear a family and return to it without difficulty.¹ A quarter of the women standing for office in the CSP Council elections of 1968 had been absent from the profession

¹ One of my research participants (Beth) did this in the 1980s but felt there was beginning to be a certain stigma attached to the practice (see Chapter 8, page 220)

for some years “because of family commitments”, and one included in her manifesto an intention “to attract married women back to physiotherapy for the value of their experience .. in these days of acute staff shortages in many areas” (CSP, 1968, p 181). There was no reason why I could not happily view physiotherapy as a job for life. However, as will become apparent in the thesis, this is no longer the case.

Physiotherapy can be defined as the use of “physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status” (CSP, 2002a). Thus physiotherapists must coordinate their practice to work closely with patients and their carers, including other health professionals, to help people help themselves. They treat all age groups, and a wide variety of medical and surgical conditions and in a number of situations other than just in the hospital or clinic. Physiotherapists work in private practices, sports centres, special schools and for large firms. There were also the options of going into teaching or management, and at the time I was training research jobs were opening up. It was a varied and stimulating career.

The Changing Student Intake

Since its beginnings in the 1890s² physiotherapy had been seen as “dominated by white middle-class women” (Mason & Sparkes, 2002b, p 277). I conformed to this model. However although the word ‘dominated’ is used by Mason and Sparkes (2002b) it was not entirely my experience, in one respect at least, that of senior leadership. In 1965, the Principal, Vice-Principal, and indeed the majority of the teachers in the School of Physiotherapy which I attended, were male. So too were several of the senior staff in the large general infirmary to which the school was attached. However, among the 26 students of my intake there were only three men. This unbalanced situation still pertained 25 years later, when Davies writes of men as holding “a disproportionate number of senior posts” (1990, p 134).

One possible reason for this situation is the fact that women took career breaks to raise a family, while their male colleagues progressed single-mindedly up the wage ladder, and so women often failed to reach the same level of seniority as their male

² For a brief history of the birth of the physiotherapy profession see the next chapter.

counterparts. However this ignores the initial problems men face in entering a profession that is seen as traditionally female. Men have been said to do this less frequently than women join traditionally male occupations (Williams, 1993). Moving into a female preserve can draw attention to them, possibly questioning their “gendered identity” (Heathcote, 2010, p 48): if they react by emphasising their masculinity, this may be rewarded with promotion and other privileges. But the possibility of attracting negative attention (Heathcote, 2010) might well have decided men against joining professions like physiotherapy. The situation is much improved these days and 40% of my graduate sample were men. Greenwood and Bithell (2005) found more had been attracted into the profession once physiotherapy became a degree course, and negative feelings were countered for many by its ‘sporty’ image.

As far as students being mainly middle-class was concerned, Mason and Sparkes (2002b) were correct, in my experience, though this can only be but poorly judged, by the type of school students had been to. There were a few pupils from secondary modern schools in my cohort, a few more from grammar schools and just two from independent schools. There was, then, a degree of ‘widening participation’, but much less than is met with now. In particular, ethnic minorities were very poorly represented.

Of all applicants mature individuals were accepted least for training (Young, 1990). In my year two of the girls were 20 on entering upon training, having spent the previous two years doing Orthopaedic Nursing, an accepted precursor to physiotherapy training in those days. One of the men had spent a short time in the Inland Revenue, and was thus our only career-changing mature student, at 22 years of age. We certainly had no married students, for marriage during training was strongly discouraged. This was a time before mass contraception and our educators regarded any girl marrying during the course, as risking pregnancy and therefore non-completion of training.

Diploma Training in the 1960s

Learning followed a particular format at my School of Physiotherapy, theory gradually being overtaken by practice. Anatomy, physiology and biomechanics

lectures and practical skills classes filled the day at first. Anatomy teaching was augmented by the addition of weekly dissection classes carried out at the neighbouring Medical School, and occasional lectures were given in the Department of Physiology there, maintaining links with the medical profession that had been present since physiotherapy's inception. At six months we sat internal examinations which effectively acted as the school's gateway to patient contact. If successful, there began a gradual integration into the hospital system, the trainee physiotherapists being treated far more like apprentices than they are nowadays. At first only an hour was spent each morning in the area to which we had been assigned. We were given easier tasks to do, taking electrical applications down rather than setting them up for example, an affirmation of Billett's (2006) findings of novice nurses' practice, where they did finishing tasks before carrying out specific procedures. Throughout our work we were supervised closely by both clinicians and teaching staff. After a few months, having covered more pathologies and treatments in class, this clinical time was extended to half a day in the hospital. Every three weeks we changed venue, from the out-patient department to the paediatric wards to the cardiothoracic surgery unit to the gymnasium, perhaps. In this way we experienced a useful range of physiotherapy work, all in the same institution. Only twice did we have to leave this environment, to do hydrotherapy, as our teaching hospital had no pool, and to experience work with spinal injury patients, who were in a specialist rehabilitation hospital.

Apart from some initial examinations, such as the six-monthly exam, and once a term anatomy vivas at the Medical School in our particular school of physiotherapy, the assessment of the diploma course was under the professional body's central control. The CSP's Education Department set the written examinations and students from around the country went to a handful of major centres for viva voce and practical examinations. My fellow students and I had to travel and take all our examinations on one day. The examiners were unknown to us, as too were the rooms to which we were allocated, and even some of the equipment we were provided with. Once these major practical examinations had been passed, we spent almost all of each day working in the hospital, only having lectures for the first hour in the morning. We were also expected to work a rota of Saturday mornings. By this time we were able to take responsibility for an area, such as an orthopaedic or surgical ward, even doing

some light supervision of first year students. The final examination concentrated on the treatment of two particular cases, and, as in earlier vivas, the examiners were a physiotherapist together with a doctor.

Initial Reasons for Research in this Area

When I chose to do this research it was because of this background: I had been a physiotherapist for nearly 20 years and had then spent almost the same length of time as a physiotherapy lecturer. During the years that I practised as a clinician I was never short of employment. Nor did I hear of others having any such difficulty. Of specific relevance to this study, NHS staff shortages ensured that physiotherapy students gained an NHS post as a physiotherapist on graduating. In an attempt to remedy such shortages, government policy in 1999 supported a 59% increase in NHS physiotherapists over the next decade (BBC, 2005), and the Department of Health encouraged research into recruitment and retention issues (Arnold et al., 2003). People had been tending to move away from the profession after a few years (CSP, 1989) and there were concerns that resources in initial training might be being wasted. There were warnings too of an increasing “need to seek mature entrants to training” (CSP, 1989, p 64) as current demographic changes showed a steady decrease in available 18-year-olds, suggesting that healthcare would be relying more on mature graduates to fill future posts.

In the early years of the twenty-first century the situation began to change. Where in 2000 statistics had shown that 90% of the 16,228 registered members of the CSP in the UK had permanent physiotherapy posts (this number including some 650 members who were either retired or taking career breaks), by 2005 only 15-20% of that year’s 1,523 graduates found such jobs (Turner, 2006). This was happening in the context of financial difficulties in the NHS, the restructuring of the service through Agenda for Change (AfC) and widening participation in higher education (HE). At that time, however, there was no robust evidence of how physiotherapy graduates coped with this situation nor what the longer-term prospects of entering, and progressing in, the profession were.

Some evidence of mid-course dropout and non-physiotherapy destinations on graduation was suggesting a continued retention problem but in a novel context, a

lack of junior physiotherapy posts (Martell, 2005). There was also the risk that such a situation might lead to a fall in recruitment to physiotherapy degree programmes altogether, threatening a future recurrence of the staff shortages that had been the initial problem (Limb, 2006a). The focus of research changed from recruitment to workforce planning.

My interest and sympathies were awakened when I found myself, now an educator of physiotherapists, training greater numbers of students than previously, in a time of uncertain employment. If I had had to face the possibility of unemployment in the first few years of my career, I would have been able to move around the country or abroad in search of a post, but widening participation policies had resulted in substantially more mature students than before. These older graduates were frequently settled in their own homes with a mortgage to pay, and with families to support. Such responsibilities precluded free movement. So in undertaking a mid-life career change to train as physiotherapists, mature students were making an investment in their future that carried considerable risk.

My position as their lecturer made me concerned for the future of these perfectly able graduates, against whom society appeared to have stacked the odds (Hodkinson et al., 1996). For over half my career I had also been involved with local CSP affairs, representing various clinical groups and holding office on regional committees. In particular I had been a Public Relations Officer (PRO) for more than one local Branch of the CSP. This had entailed attending Careers Events where I had been pleased that I could truthfully say that there would always be posts available for those who trained in physiotherapy. ‘That rare degree, one with an ensured job at the end of it’ was how I had phrased it until recently. It concerned me that newly-qualified physiotherapists were facing these difficulties. I felt it would be good to give voice to some of their experiences and feelings.

Relevant Research and My Position as Researcher

The situation required empirical investigation, particularly since there was very limited relevant research. Such studies as had been carried out mainly concentrated on recruitment and retention issues. In Canada, Solomon et al. (2004) looked at

influences on career choices and professional socialisation (described as the process of induction into the culture of a profession) in one cohort of physical therapy students three years post-graduation. The themes that arose included the need for mentoring, a desire for more continued professional development (CPD) and the importance of job certainty. In the UK, Warriner and Walker (1996) investigated factors influencing the first post choices of final year students from five northern physiotherapy programmes, and again found CPD an important attraction. The provision of good in-service training was influential in their choice of post. Finally Dodson et al. (2001), investigating New Zealand students' aspirations before graduation, found geographical location and salary to be the most important factors influencing job selection, but also that only half the respondents considered physiotherapy a job for life. This is a subject I shall be commenting on in the next chapter.

Besides the evident need for more research I found myself attracted by the idea that my position would be one of movement between the medical scientific and social scientific fields, rather as these career-changing graduates had made the transition from being well established in one career to being a novice in another. Such involvement as I had had in research to date had been medical and quantitative in nature, for although Dyer (1982) had described physiotherapy as “both an art and a science” (p 177), there was still a degree of mistrust of qualitative methodology (Heathcote, 2010) in health care. My shift in learning would partially reflect my research sample's ‘outbound’ journey from a past career community and ‘inbound’ journey to achieve membership of a new one. Perhaps it might help me to understand them better as I explored their career path.

My move from clinical physiotherapy to physiotherapy education had encouraged my change in focus to some extent. I was no longer totally immersed in healthcare issues, being placed instead in the position of ‘knowledgeable outsider’ as far as clinical physiotherapy was concerned. My viewpoint had altered and my concerns focused on how to promote learning, rather than on finding the best evidence for the use of clinical modalities. However this meant that so much had changed in healthcare of recent years that I could not expect to easily interpret what was going

on without help from those in the field. There was background to explore, perhaps with the help of middle managers who recruited junior staff.

In contemplating sociological qualitative research I was effectively moving outside comfortable territory, but I was keen to research my mature respondents' career pathways. I wanted to learn of their previous careers and how they had come to decide on a change of occupation, as well as their expectations of a future career in physiotherapy. Then I hoped to learn of their subsequent success, or lack of it, in gaining employment, of what factors influenced their progress and what strategies, if any, they used to counter the difficulties created by a fragile job market. To comprehend my research participants' route into their profession, it would be necessary to review their situation at regular intervals over a period of a few years, and I could not expect the situation to stand still while I conducted a longitudinal study. I should have to reflect that the context at the end of this process was likely to be at the very least subtly different from the initial one.

In summary the aim of my research was to investigate the career paths of those moving from one career to another and their perceptions and experience of integration into their new working community, or indeed failure to do so, at a time of uncertain employment.

Structure of the Thesis

Having outlined my position and the context for my research in this chapter, I now introduce the main issues of my thesis in Chapter 2, including why Community of Practice theory might provide a helpful, if controversial, vantage point from which to view the career paths of my research sample. I shall then discuss the main concepts of Community of Practice theory (Lave & Wenger, 1991) and other theories of workplace learning in Chapter 3, and discuss in some detail how the literature views this theorising. Underpinning my work with the existing thinking, and critiquing it in depth, makes clear the areas that require more attention and the anomalies that I must be aware of. The aims of my study and my main research questions follow from this.

In Chapter 4 I then introduce the methodology I used. The processes of interviewing and narrative analysis are discussed as appropriate methods to use in the exploration of the career pathways of mature entrants to the physiotherapy profession. I continue by briefly describing the procedure I carried out, the ethical considerations involved and how I approached the analysis of the large amount of data I gleaned.

The central Chapters 5, 6, 7 and 8 feature the results of my fieldwork, illustrated by extensive quotation. In Chapter 5 I analyse my respondents' experience of what they perceive as the 'traditional route' into the physiotherapy profession. In many ways this can be seen as resembling Lave and Wenger's (1991) community of practice theory, but there are problems of definition here too. Chapter 6 looks more closely at my career-changing respondents as atypical newcomers to the profession. An idea of the deculturation and acculturation that accompanies movement into a new profession is given. Vocational graduates with prior work experience undergo reconstruction of their identity as they become assimilated into a new workplace, but I shall show that their experience can not only impact on their learning, but upon their workplace too. Chapter 7 demonstrates examples of variation on the traditional route, centring on the story of a graduate who, because of previous experience, chooses a very different route to the traditional one, showing that innovative career pathways can sometimes appear very successful. Finally, Chapter 8 discusses what might be understood by 'full participation', corresponding with the perception of being completely integrated into the workplace culture, using the data I received from the established physiotherapists that I interviewed as well as my mature graduates.

Chapter 9 is the discussion chapter where the various strands of my thesis are drawn together. The impact of previous work experience, the consequent expectations of the workplace and the reconstruction of identity are discussed, together with the potential for change in the workplace resulting from all these in the current climate. The thesis concludes by returning to Lave and Wenger's (1991) theory and considering it in the light of the findings in this study. A summary of results is given and ideas for future research briefly outlined.

Chapter 2

Background to the Study: The Development of a Profession

For the majority of people the workplace is the dominant setting of their occupational adult life (Kielhofner, 1995) and the transition from full-time education to their chosen employment is one of their most challenging times of social change. It is not surprising, then, that the movement of the novice worker into the workplace and their path to become an established practitioner has been the subject of much research (*inter alia* Beckett & Hager, 2002; Benner, 1984; Billett, 2001a; Colley et al., 2003a; Eraut et al., 2004; Guile & Griffiths, 2001; Hodkinson & Sparkes, 1997; Lave & Wenger, 1991; and Schön, 1987). How a young person chooses their career in the first place, and their transition from formal education to more informal learning at work is the focus for some (Beckett & Hager, 2002; Hodkinson & Sparkes, 1997); learning as participation in the workplace context constitutes the brief of another (Lave & Wenger, 1991); and what newcomers learn and how they learn it, is the focus of others (Benner, 1984; Billett, 2001a; Eraut et al., 2004). An area that has been less explored is how mature people from one career have moved into a new one, and what impact their previous experience might have on the path they choose into their new profession and the way they learn as newcomers to that workplace.

In this chapter I shall show how changes in the healthcare and HE systems have impacted on physiotherapy. I begin by briefly discussing how work is viewed in the literature. I then introduce the concept of community of practice as a possible way of envisaging the working situation, while acknowledging that it may be problematic in the context of a healthcare profession. Some history of the NHS and of the physiotherapy profession follows, demonstrating vocational development and the growth of professional autonomy. I shall then discuss the differences between the typical and atypical membership today, and the impact that widening participation and modern attitudes to work might have had on the profession.

The Nature of Work

A recent definition of work provides some initial context for this study. Written by the psychologist Clot (2004), it suggests that work is directed activity, to be

understood in three senses, as directed by the subject, through the object and towards others. The three-fold sense in which this definition is revealed is interesting, for work is often seen only in two-dimensional terms, the worker and the task or the worker and the organisation (Deranty, 2009). For Clot any conception of work needs to be triangular in nature. His colleague Dejours (2002) agrees and delineates this in more detail. The three aspects refer to the psychological, the practical and the cultural and should not be separated. In the first of these the individual worker must face the challenge of the task (the psychological element). Then comes the technical efficiency of the activity, practical and instrumental to a large extent, but also the “product of social judgement” (Deranty, 2009, p 72), for activity depends too on what is being demanded, as a service for example. Finally, the activity has to fit into its cultural setting. Transmission of the activity would make no sense if it were not considered social practice.

This cultural element also points to

“the restricted yet highly significant community of the work collective, the community of subjects who are related on the basis of their knowledge and skill, the special knowledge of the specific techniques involved, which no outsider can truly fathom” (Deranty, 2009, p 73).

Specific tasks carried out by an individual, Dejours (2002) argues, have to be recognised as well performed and effective by their peers sharing in the practice culture of the work. Quality standards must be maintained for the good of all, both the public that require the task to be done and the members of the community that have similar special knowledge and skills to carry it out. It is this that limits and restricts activity, and imposes responsibilities on the practitioner. These ideas of the working community echo those of Lave and Wenger (1991), which I shall now outline, as it might apply to the physiotherapy profession. (These authors’ work will be explored in greater depth in the next chapter.)

The Community of Practice

Physiotherapy vocational training consists of academic education interspersed with practice placements in the workplace, and on professional registration, this has traditionally been followed by employment in a series of different work situations, so that the newly-qualified member of staff gains a thoroughly varied experience. In

investigating this progress of gradual acclimatization to all the aspects of a career, culminating in full professional membership, a text of some influence in the field, that of Lave and Wenger's 'Situated Learning' (1991) has much to offer. The authors concentrate on similar issues to those involved in vocational training. Firstly there is learning in the workplace, the theorising allowing the researcher to view legitimised early practice as participation in gradual movement into the professional community the novice aspires to join. The path the newcomer to an occupation takes over time, incorporating an assimilation of the values and culture of the workplace, is considered, Lave and Wenger (1991) suggesting this is accompanied by identity construction, so that the participant feels they belong in the work setting. There are similarities too in the way that participation is seen to influence reification (the formal regulatory rules of a vocation or profession) and vice versa, exemplifying the relationship between mutual recognition of colleagues for each other, and projection of this to the outside world (Wenger, 1998). Interplay between the two can be clearly seen in the history of the physiotherapy profession (see page 16).

At the time of its publication Lave and Wenger's (1991) monograph presented "one of the most influential concepts to have emerged within the social sciences" (Hughes et al., 2007, p 1), an alternative theorisation countering traditional cognitivist assumptions of learning, for Lave and Wenger realised, during anthropological research into craft apprenticeship, that sophisticated learning could occur in communities where there is no formal teaching. The cognitive processes that help human beings learn work skills and knowledge interested Lave and Wenger (1991) less than the types of social engagement that enable this to happen (Hanks, 1991). The basic concept is that of the novice's legitimate peripheral participation in a community of practice, a group of co-participating practitioners working towards common goals, a concept frequently used by researchers over the last two decades.

Lave and Wenger (1991) are an attractive resource to use as a theoretical framework in this study too, providing the opportunity to investigate physiotherapists' professional development in relation to the concept of learning as socially situated. The main aspects of their theory, the team work of practice communities and early participation supported by those more experienced ring true to someone like myself who did their practical learning in a similar fashion. I was going to be looking at a

very particular form of skilled work, that of physiotherapy practice, comparing theories of workplace learning with data collected from newly-qualified practitioners, and it seemed to have relevance.

But there are critical questions to ask. There is the difficulty that Lave and Wenger's (1991) theory can appear so overwhelmingly positive. There is an assumption that everyone follows an inevitable path into the community of practice towards full participation, and in a time of employment difficulties this has to be contested. Lave and Wenger (1991) do acknowledge that things can go wrong within the workplace situation, but they concentrate on learning as a social process and give very few examples of tension in the workplace (Fuller 2007). It is certainly possible for some people to feel that they do not belong happily in their work community. Others may feel they cannot comply with the regulations and conditions set down, and so fail to come to terms with what is expected of them. I was to find that the empirical data did indeed demonstrate both those uncomfortable in their workplace and those who negotiated conditions of practice to suit their own ends.

Then there is the question of how to define a community of practice. Even in this specific field there is a whole spectrum of types of practitioner groupings, from those physically located and bounded, like the staff in a physiotherapy out-patient department, to the widespread and nebulous overarching professional body. Between these extremes are other groupings within the workplace with overlapping areas of practice that the novice needs to adjust to. It was complicated enough in my day. Today the whole can resemble a universe of planetary systems, with attendant satellites, rather than one compact community. It seems hard to pin down with any certainty what kind of grouping a community of practice might be. Nor is it easy, therefore, to locate or describe full participation in a community accurately, as this may vary from sub-community to sub-community.

I was also looking at more than practice: there was the sense of social belonging and emotional commitment just referred to, built up in individuals as they became assimilated into their working community (Colley et al., 2003a). Lave and Wenger (1991) recognise this as they assert, "learning and a sense of identity are inseparable .. aspects of the same phenomenon" (p 115). Values and attitudes are developed that

give form to the nature of a profession (Evetts, 2006; Lawrence, 1992). My investigations showed these gained strength in newcomers to the profession as they began to feel more secure in their employment, moving from short-term to a permanent contract for example (see the example of Cliff, pages 148/9).

The Birth of a New Profession

Independence and impartiality are particularly valued aspects of professional practice, and discretion in work practices is seen as an essential way of ensuring patients' trust in the healthcare situation (Evetts, 2006). Autonomy embodied in the notion of competence (Fournier, 1999) has also traditionally been seen as key and this can be seen in the physiotherapy profession where it is valued particularly highly, perhaps because it has been so hard to attain (Tidswell 1991). To illustrate this I shall now provide a brief overview of the profession, noting what led to its inception, and how it has progressed and grown in status.

Compared to the long-established profession of medicine, physiotherapy's tradition has been very short, having grown from most modest beginnings. Concerned by reports in the popular press of the misuse of massage "in certain establishments disguised as nursing homes" (Thornton, 1994, p 11A), four "spectacularly courageous" London nurses (Dyer, 1982, p 177) formed the Society of Trained Masseuses (STM) in 1894. Regulation of this skill and its uses led to periodical examinations and by 1910 schools in the discipline had been opened as far afield as Manchester and Dublin.

Beck and Young (2005) tell how the established professions, such as law and medicine, having defined their knowledge base, formed 'schools' in institutions of HE. At this early stage, physiotherapy might be better called a vocation than a profession. Tidswell (1991, p 89) makes the distinction that a vocation is "associated with those occupations that have a commitment to service of others", while a profession is vocation plus "advanced learning". Added to this must be the status given the longstanding respected occupation in the eyes of the public. Medicine is such a profession. The STM, as a newly formed vocation, opened schools near to, or on the premises of, existing hospitals rather than in HE institutions.

It was as early as February 1895, only eight months after the idea of a Society had first been mooted, that the initial practical and written examinations were carried out. A certificate was given to each of the seven successful candidates (Wicksteed, 1948), and these new members had to agree to four fundamental rules of the STM:

- “1. No massage to be undertaken except under medical direction.
2. No general massage for men to be undertaken but exceptions may be made for urgent and nursing cases at a doctor’s special request.
3. No advertising in any but strictly medical papers.
4. No sale of drugs to patients allowed.” (Barclay, 1994, pp 26 & 27)

Rules 1 and 2 show the status and authority the doctor had in the view of those founding nurses. Medical sponsors were important from the start, giving the fledgling group protective endorsement (Wicksteed, 1948). Their patronage lent acclaim, and they were used as examiners and teachers. But they were to slow progress towards the longed-for status of the physiotherapist as autonomous practitioner. These leading medical figures, often promoted to presidential positions on the physiotherapy councils of the first half of the twentieth century, were always male, while the secretaries of the Society were invariably female. From the beginning then, physiotherapy could be considered a feminised occupation, “assistants of the doctor” (Carr-Saunders & Wilson (1933) cited by Sim, 1985, p. 17).

So it might appear that men were not welcomed as practitioners, but despite Rule 2’s implied restrictions to the treatment of men by massage, masseurs were trained to this end from 1905 onwards. The War Office had requested massage examinations for male nursing orderlies in the Royal Army Medical Corps. This was flattering for the STM, but created a problem. The Society’s rules precluded members (all female up to this point) from examining men (Palastanga, 1988). A compromise was reached, where the son of one of the founders became an examiner (Barclay, 1994, p 44). He continued this function until 1918. The men who passed the exam had to be currently employed as army orderlies or asylum attendants however, for they were denied membership of the Incorporated Society of Trained Masseuses, as the STM had become by now.

The change to Incorporation was necessitated by the infringement of Rule 3: in 1898 a Brighton member was found to have advertised in a railway timetable. The Council of the STM warned that such unethical advertising was a disciplinary offence. The member involved refused to return her certificate and was summarily struck off the Roll (Barclay, 1994). She threatened legal proceedings and this led to serious discussion of Incorporation of the Society to give greater security in such circumstances. This was registration with the Board of Trade as a professional rather than a trading agency (Barclay, 1994) and gave the Society more effective power over its members. The STM thus became the ISTM in 1900.

In just six years the core requirements for the profession had been laid down. Certificated registration was in place, regulations had been established and adjustments of boundaries made when these regulations were threatened. Countering that first breaking of the rules must have strengthened the feeling of the 'team'. A growing professional identity was being established (Lave & Wenger, 1991), group memories that would become a shared history of the profession (Wenger, 1998). But such collaborative feelings of belonging are "hedged around with ambivalence and contradiction", Stronach et al. (2002, p 118) suggest: possessing, and being aware of possessing specific knowledge and skills beyond those found elsewhere can give rise to claims of power. And the awakening of power relations is seen here. Claims have been rejected and reification asserted (Wenger, 1998 - see Chapter 3, page 71). Incorporation also entailed the subtle, but crucial, move from 'trade' to 'profession'. Cultural capital (Bourdieu, 1986) had been appropriated.

As the Society's reason for existence in the first place was the dubious reputation massage had acquired, regulations dealing with professional behaviour were of crucial importance in these early years. Masseuses literally had the patients in their hands, and there had to be confidence in a therapist's integrity. The monitoring procedures to evaluate skills were, as we have seen, put in place very early and here again the founding membership were commendably thorough; to ensure the correct standard they examined each other before anyone else was assessed (Wicksteed, 1948). Within a few years the subsidiary skills of the masseuse, medical electrical and remedial exercise treatments, were also being used more. Medical inspection of schoolchildren began in 1907 and underscored the need for remedial exercise

(Barclay, 1994). The ISTM started teaching and examining Swedish remedial exercises in 1910. Thus, due to the external influence of changing healthcare policy, the scope of practice gradually grew beyond the original massage skills.

A lack of practical experience led to some employment difficulties even in those early days. Barclay (1994) notes that by 1911 employment, at 88%, was reasonably high, though the majority of the membership found only temporary daily posts. It is ironic that a century later a similar situation applies. It was perhaps not surprising in 1911 however, for these masseuses' training was extremely short by today's standards and entailed no practice placements. Wicksteed (1948) notes that Lambeth Poor Law Infirmary was eventually persuaded to allow young members to try their skills on the inmates. Thus was the idea of situated learning brought into practice, though it is doubtful if this early legitimised participation was very well supervised.

The First World War brought recognition to the membership of the ISTM. It also increased the numbers of masseuses more than threefold, from 1000 members in 1914 to 3641 at the Armistice in 1918 (Barclay, 1994). There were problems attending this rise in need for rehabilitation. A lengthened period of training had been proposed by Council, but the huge numbers of war casualties needing treatment meant this plan had to be temporarily abandoned. There was a demand for a broader training however, incorporating many extra skills not met with much previously, such as “manipulations .. and .. training amputees to use artificial limbs ..” (Barclay, 1994, p 65). As had happened after the Boer War, there was a survey of the nation's general fitness post-First World War, once again stressing the need for remedial exercise. Physical therapy had grown in status through the War and the qualified masseuse was in demand to aid in “the development of the national physique” (Journal of the ISTM, Jan 1918, p 150, cited by Barclay, 1994, p. 69). Nor would there ever be quite the same restrictions to women massaging men again.

Although the swell in numbers and advances in treatment started in wartime were not sustained during the next decade, a step forward of a different sort was made. A rival group of masseuses in Manchester, the Institute of Massage and Remedial Gymnastics, also sought incorporation in 1916. Anxious that there should be a national gateway to the profession, the ISTM suggested an amalgamation and joint

regulations were discussed. A title of the Chartered Society of Massage and Remedial Gymnastics was decided on, and King George V signed the Charter in 1920, adding a degree of social status and tradition to the emerging profession, in line with those bastions of professionalism, Medicine and Law (Savage, et al., 1992). Speaking of this fifty years later, the then editor of the professional journal (which incidentally also dated from the time of the First World War) explained that “only one professional association in any field [might] be granted such a privilege.” (Whitehouse, 1978, p 197) The newly chartered Society was staking a claim to represent all those involved in physical rehabilitation, and was to amalgamate with several other small groups of therapists in the years to come, finally becoming the Chartered Society of Physiotherapy in 1942. This coincided with another burgeoning in membership and increase of their activity at such hospitals as Stoke Mandeville and Roehampton, becoming known nationally for the rehabilitation of ex-servicemen with spinal injuries and lower limb amputations respectively, as World War II casualties poured in.

The National Health Service Comes into Being

1942 was also the year of the Beveridge Report on Social Insurance and Allied Services, which suggested the establishment of a national health service as a necessary move “to extend the role of the state in the provision of health care” (Berridge, 1999, p 23). For the health care situation was undeniably poor. By the end of the Second World War, “the depression in the 1920s and 1930s, the lack of systematic provision for health care at that time, the experience of communal action in war .. all pointed to the need for a health service.” (Revitt, 1998, p 27) Officials were aware that military personnel had received better treatment during the war than in peacetime. When everyone made an emergency effort, health care worked: in normal circumstances it did not.

The post-war Labour government, encouraged by the Beveridge Report, decided to fund a NHS from general taxation (Ham, 2004) in 1948. The health minister, Aneurin Bevan, achieved a single system of administration, covering both local authority and voluntary hospitals, a service that covered all the population. This seemed a groundbreaking advance in healthcare, for his notion of using regional,

rather than local, authority boundaries in planning the new healthcare restructuring helped solve the problem of specialist interest infighting that had ruined similar ideas before. However Ham (2004) suggests that the original health service was based on a false assumption. The Beveridge Report had held that there was a fixed amount of illness which, once addressed successfully by a national health service, would dwindle away as people became healthier. Expenditure would then level off or even become less.

Thus the Beveridge Report failed to take into account the fact that medical personnel were likely to work to better their management of patients by the most modern means, particularly the difficult, more costly means that had not been possible before. From the start the NHS' financial demands were insatiable, organ transplantation, in-vitro fertilisation and the management of 'new' diseases like AIDS being just three of the areas of care that increased expenditure over the decades. Despite extremely parsimonious funding by international standards, the NHS "increased by a factor of four the real level of resources it consume[d]" in its first 40 years of existence, increasing the proportion of the gross domestic product (GDP) spent on it from 3.9% in 1949 to 6% in 1992 (Holliday, 1995, p 8). Successive government strategies to curb NHS spending and make the service more efficient and effective have impinged on the working patterns of physiotherapists in many ways through the years since its inception, but, as we have seen, it did not affect employment seriously until the beginning of the twenty-first century.

A Profession Supplementary to Medicine

Meanwhile, centralised physiotherapy training was improving. A new diploma programme lasting three years and one term was set up in 1947. Palastanga (1988) notes this as a first step towards autonomy, for stress was put on the rationale behind treatments and it seems to have been an attempt to move away from only doing treatments as prescribed by a doctor. Doctors still had considerable influence over physiotherapy however. A committee of three medical practitioners and four chartered physiotherapists reported to the Minister of Health in 1949 on the situation regarding the training, qualifications and numbers of physiotherapists as one of the medical auxiliary professions (Barclay, 1994). The resulting White Paper, published

in 1951, stressed that although principals of training schools were to remain physiotherapists, it was doctors, specialists in physical medicine, who should oversee studies and be supervisory in physiotherapy departments. Some of these Physicians in Rehabilitation Medicine were felt not to have the relevant expertise, and leading physiotherapists felt that “the standard of service was .. only as good or as bad as the relationship between the therapist and the doctor” (Dyer reported by CSP, 1976, p 372). The role of physiotherapists, and AHPs generally, was still to assist medical practitioners and this remained the case until well into the 1970s.

More generally the White Paper gave a snapshot of the physiotherapy staffing situation of the day. Of the 4000 physiotherapists working in the NHS, 3637 were Chartered (the CSP at this point had 13,573 members in all). Estimations of supply, based on allowing three physiotherapists per 100 hospital beds, meant that 5500 more physiotherapists were required in the NHS in the UK. It was a shortfall that was to become even more acute in the 1960s (Berridge, 1999, p 46), but, as I have said, ensured employment of the newly qualified. Training more men was advocated, as well as making better use of part-time staff (a quarter of all physiotherapists at the time, most being returners from taking a few years out to bring up a family) (Barclay, 1994). It was also recommended that registration should become the duty of a Council for Medical Auxiliaries, which would be “weighted in favour of the medical profession and include only six medical auxiliaries from eight professional advisory committees” (Barclay, 1994, p 156). This was finally to take effect in 1960 when physiotherapy was one of the first careers to be represented on the newly formed government committee for Professions Supplementary to Medicine. Eraut (1994) suggests this was a milestone that effectively confirmed the subordination of the relevant professions to medicine. Physicians were the ones who delegated power, defining the scope of new specialised medical roles.

In its simplest form, professionalism can be seen as having a degree of “authority and autonomy in work” (Burrage & Torstendahl, 1990, p 115). While satisfying other criteria, for example those of trustworthiness, integrity and a distinctive tradition of practice (Cribb, 1998), physiotherapy had prolonged difficulty in attaining full autonomy during the second half of last century. Like Tidswell (1991) before him, Freidson (1994) makes a distinction between that select number of professions

“possessing very high prestige and a genuine monopoly over a set of widely demanded tasks” and the aspiring occupation attempting to improve its “low prestige and weak economic position” by calling itself a profession (p 27), and one suspects he would have placed physiotherapy in the latter category. There are indeed arguments to support his view, for there is a distinct boundary between medicine and professions like physiotherapy. Eraut (1994) cites Katz (1969) as pointing out that, “The legitimacy of the professional guardianship of a body of knowledge depends not only on having a distinct body of knowledge, but also on acceptance of that guardianship by those beyond as well as those within the ranks.”(p 4) It was not enough that physiotherapists in the 1960s knew themselves to have perfected skills that were unique to their practice. This had still to be acknowledged by those a step ahead of them in the professional hierarchy. In the hospital environment this meant the doctors. Being labelled as members of a profession ‘supplementary to medicine’ only underscored this.

Moving towards Autonomy

Discussion of interprofessional relations of this sort features rarely in theoretical debate of workplace learning such as Lave and Wenger’s (1991) community of practice theory. Hierarchy was evident within the community, newcomers being supported by ‘old-timers’, but physiotherapists had to conform to the requirements of members of another healthcare community of practice. During my training for example, I became adept at accepting often very vague referrals from doctors and translating their requests for services into appropriate physiotherapeutic measures. In 1978, however, a small but significant step towards clinical autonomy took place within the CSP’s reification system. The bye-law concerning medical referral reading that an applicant for membership of the CSP, “shall not treat any patient unless that patient has been referred to him/her by a Medical or a Dental Practitioner” (Barclay, 1994, p 228) was amended to continue, “except in an emergency or for some other exceptional reason or unless he has some direct access to the patient’s doctor” (CSP, 1978). Allowance had been made for possible treatment outside medical prescription. Professional autonomy was in sight.

Gradually a greater degree of equality was established between AHPs and doctors involved in teams working towards the common goal of rehabilitating patients in their care. This concept of the multidisciplinary team (MDT) had become popular, and at its best it works extremely well. But working effectively with a variety of professionals, all viewing the patient's needs from different perspectives, can be a difficult achievement (Firth-Cozens, 2001). Success depends on the various health professionals knowing the extent of each other's roles, and negotiating with, and listening to, each other. Good communication across the team is of paramount importance (Jenkins et al., 2001), for the patient can become thoroughly confused if they receive different messages from different members of the MDT. Such communication is an asset in a close-knit community of practice, but is working with people of different professions really belonging in the same community? Several of my research respondents work within a MDT (notably Mike, whose career path is the main topic of Chapter 7), and some seem to become distanced from their own professional colleagues. It is this kind of situation that might militate against the concept of a single community of practice.

In an effort to enhance communication in these teams, students or newly-qualified staff working with established physiotherapists are usually given every opportunity to spend some time with the different members, so that they learn more of their roles. Doctors who did the same gained a much better idea of what physiotherapists had to offer, to the benefit both of the work of the MDT and thence of the patient. This was to affect the profession profoundly in the long run, for researchers find that a strong association exists between teamwork and autonomy (Raffety et al., 2001). Physiotherapists became more autonomous practitioners as their role became recognised more widely, and this may be attributed in part to improved MDT relations.

Thus the professional body has come a long way from the initial group of nurses in the 1890s. This becomes abundantly clear when reading a résumé of the main roles of the society on the present CSP website (CSP, 2012a). The first of these is to maintain and promote high standards of practice and development. Members are encouraged to connect with one another on clinical and service delivery issues, and to collaborate in research. This is done in a number of ways; through the interactive

CSP (iCSP) website's discussion boards³, regional networks, local branches, and via research networks. Regional and local networks have existed from the beginning of the Society, like the Manchester one that gave trouble prior to the attainment of the charter. Electronic communication is of-course a recent development and has made a significant difference to the task of job hunting. Where once I looked at the advertisements in the Physiotherapy Journal and had plenty of time to write in response, unemployed graduates must now keep a daily watch on the appropriate websites to catch such opportunities as there are, for they appear only briefly and there is little time in which to respond, there being considerable competition for most posts.

The CSP membership is also supported in promoting physiotherapy to others through the communications and marketing role of the society⁴, while the finance, facilities and membership department manage financial affairs and the upkeep of the CSP's headquarters in London. Supervising and coordinating all CSP Council decisions and all reports submitted to Council from standing committees is the chief executive's office. Through the Society's Regulatory Committee it oversees the professional body's information technology (IT), human resources (HR) and industrial relations (IR) teams (CSP, 2012a). For the society now has a trade union function. Negotiations with the Whitley Council over salary structures proved difficult in the late 1960s, and it was felt that "trade union status would give the Society more clout" (Barclay, 1994, p 229). It was therefore registered as a union in 1971, when the Conservative government's Industrial Relations Bill of 1970, that allowed professional organisations access to industrial tribunals, was extended to chartered organisations. A first IR Officer was appointed in 1978, closely followed by the setting up of a network of local representatives or 'stewards' nationwide.⁵ Since then members have been supported in this way both as individuals and collectively, a function that has become ever more important, and its associated reification more

³ These provide interesting insights into the thinking of current members, and I shall be referring to one or two later to augment my respondents' information.

⁴ When that first advertising member who was struck off the Roll in 1898 is remembered, the encouragement, within professional limits, of members to promote what physiotherapy they can offer, must be seen as one of the greatest changes to the reification of the society over the first hundred years.

⁵ One of my participants showed an interest in taking up a steward's post, and his difficulties in this connection will be discussed in Chapter 8.

intensified, with the increased risk of litigation (CSP, 1998) and attempted undermining of terms of employment in a time of financial restraint (CSP, 2012b). Members' interests continue to be promoted at all levels, from the local to the international, for the CSP became a founding member of the World Confederation of Physical Therapy (WCPT) in 1951 (Barclay, 1994).

From Diploma to Degree

The role of regulating education that the CSP had in the 1960s is missing from the website, for it had been made redundant by the advent of the degree course a decade later. Upgrading the basic accreditation for membership of the CSP from the existing diploma to a BSc degree, as a means of improving physiotherapists' professional status, had first been considered in 1956 by the Educational Advisory Board of the CSP, and turned down "on the grounds that it would stress the academic rather than the practical nature of the profession" (Thornton, 1994, p 17A). However, giving the profession degree status remained a goal of the CSP's Education Committee.

Eraut (1994) suggests three reasons for the uptake of degree courses by more occupations in the last half of the twentieth century. Firstly, he is in agreement with Beck and Young (2005) that degree-entry validates the claim of a profession to a specialist knowledge base, and thus to a more professional status. Then recruitment through the HE system was thought to be all important to sustaining and improving the quality of intake. Indeed this might be thought of as self-perpetuating, for the greater the number of occupations that have degree training, the less status those offering only diplomas will appear to have in comparison and the fewer first class applicants will be drawn to enlist in them. Finally Eraut (1994) sees occupational regulators as keen to gain access to government funding, and this tended to follow research, thus exerting more influence in favour of the degree course. To a certain extent HE also benefitted from the addition of more professionally-focused courses. It might seem strange that apprenticeship-type training for vocational occupations should move to HE, but in the knowledge economy the reputation of 'ivory tower' learning needed combating. It "... helped increasingly beleaguered institutions to argue that they do prepare students for employment and make a positive contribution to society" (Eraut, 1994, p 100).

However it was to be another twenty years before the first potential physiotherapy graduates began their four-year programme at Ulster Polytechnic in 1979. Two further degree courses opened the following year in East London and Glasgow. But at this point the government “placed an embargo on the approval of any more four-year undergraduate courses in physiotherapy – for economic reasons, it said” (Brook, 1994, p 20A). This last phrase voices the scepticism and disappointment with which the CSP leadership viewed the restrictions placed on its professional advancement. The diploma course, as we have seen, lasted over three years and joining a university system would bring with it the necessity to undertake research, so a four year degree programme seemed the equivalent length. Also the government had seemed only too happy to lessen the hierarchical power of medicine at this time by enhancing the status of the supplementary professions, rather than prohibiting further progress. “The rise of management within the NHS and the increased role of the ‘patient as consumer’ of health care .. seemed to herald the decline of medical autonomy” (Berridge, 1999, p 76), or so the CSP must have thought.

Reports of a meeting to discuss the findings of a King’s Fund paper on ‘Training for the Remedial Professions’ (CSP, 1976) introduced another strand of argument. ‘Economic difficulties’ are certainly referred to, but stressed too is the fact that physiotherapy was a predominantly female profession. There was a continual problem of staff wastage: a comparison was made with nurses who “tended to work for about two years after qualification, and then .. leave to have families, and if circumstances allowed .. would return two to twelve years later to take up their profession again.” (Mayoh [DHSS representative] reported in CSP, 1976, p 372) It was thus felt to be unwise to prolong the pre-registration training of similar female professions.

Changes on Moving to HE

The expansion into HE from the first three degree programmes did take place nonetheless, although thereafter courses lasted three years rather than four. By the 1990s all Schools of Physiotherapy were running degree programmes rather than diploma courses, a “rise to graduate status” mirrored by most of the other ‘supplementary professions’ (Eraut, 1994, p 3). In physiotherapy the BSc programme

also swiftly upgraded to a BSc Honours degree, another push towards improved professional status.

Two fundamental changes have come with the move to HE. The home university now runs examinations, the examiners being exclusively physiotherapy lecturers that have been involved in the examinees' teaching. The Health Professions Council (HPC)⁶ and the CSP validate and moderate all physiotherapy programmes, but there is otherwise little external input. There are thus variations, not in course content, but in delivery and timetabling from university to university. I shall be describing what happens in just one of these, the one where my respondents trained and I teach: I will refer to it as Northtown University.

The other important change is that students now have two goals in mind as they commence their physiotherapy programmes. Mine had been solely to become a member of the Chartered Society of Physiotherapy (MCSP), an uncomplicated vocational aim. The modern student is aiming for this, but for a BSc Honours degree as well and, vocationally speaking, the BSc Honours, however high grade, is of little benefit without passing practice placements well and gaining MCSP status. Nevertheless this means that students must produce academic work of a higher quality than previously, including an extended research-based piece of written work in their third year. It was this emphasis on the academic rather than the practical that had worried the Educational Advisory Board of the CSP in 1956 (Thornton, 1994), and, as will be seen from my data, the more practically minded students and those who have not studied for some years (my mature career-changing sample) still see it as an obstacle now. However, there was a growing necessity to provide an evidence base for physiotherapy practice in a more competitive healthcare system (Sackett & Rosenberg, 1995), and physiotherapists had been seen as too "traditionally passive, and reliant on doctors for guidance and continuing education" (Titchen, 1987, p 124). It was time to initiate more life-long learning. This appeared to be effective, for soon newly-qualified graduates seemed less attracted to posts where further learning opportunities, such as in-service training (IST) provision, were not provided (Warriner & Walker, 1996). Many hospital departments responded accordingly to

⁶The modern successor to the Council for the Professions Supplementary to Medicine, and so in charge of the Register of membership as well as regulating professional conduct.

satisfy this demand, and everyone on the staff was expected to contribute to IST. This development has proved providential today where NHS staff find external courses can rarely be funded because of financial constraints, at the same time as the HPC started carrying out bi-annual audits of physiotherapists' continuous professional development (CPD) (Brook, 2006) to ensure those registered were keeping up to date.

However the fact remains that physiotherapy is not a purely HE-based academic degree. It is a hands-on vocation, and the CSP still makes it a requirement that almost a third of the programme (1000 hours) be spent learning in the workplace. Thus the individual becomes involved in 'legitimate peripheral participation' in their community of practice (Lave & Wenger 1991). This happens far later in the Northtown training than it did in the 60s, so that more knowledge is expected of students when they go out on their first placements. They spend longer on each placement now too, usually five weeks, though this means they experience fewer specialities within physiotherapy. In fact all my graduate respondents experienced a specially organised similar combination of placements in key areas, two musculoskeletal (as in the out-patient department), one in each of the neurological and cardiorespiratory specialities, plus one other (in such areas as community, paediatric or elderly care). Teaching staff are far less involved now than they were, clinicians being trained in supervision by the HE staff: each student thus has one, or possibly two job-sharing, clinical educators (CEs) responsible for them on each placement. Visiting teachers will maintain the link with the university once or twice per placement, a support for either staff or students should problems arise.

A big difference with the past though is that Northtown students are placed in different working situations in several areas now, not just in one hospital. As well as working in NHS hospitals, still the most common sites for student practice placements, they could be in the private sector, in independent hospital departments or clinics; in a special school for children with cerebral palsy or with learning difficulties; occasionally in sports venues; and often in GPs' surgeries and health centres, moving between there and patients' homes, working in the community. In diploma training the emphasis for clinical learning was on the variety of patients and conditions we would meet and the modalities we might use to treat them. The

background policies and ethos of work were similar because placements all took place in the one institution. The greater diversity of working situations these days imposes the necessity of developing flexibility and adaptability to different types of working procedure and in a variety of staff groupings too. Once more this alerts us to the many different workplace systems that might be labelled communities of practice (Lave & Wenger, 1991). Where I had felt the security of a well-established hierarchy and had indeed been encouraged to see myself as being at the periphery⁷ of a busy community in the teaching hospital where I trained, I now wonder very much if any of my students could envisage this concept in the same way at all. This was something I should be exploring in the research.

One other change is worth a mention. In the 1960s I never worked a full day in the hospital during my training. Theory and practical classes carried on for part of the day alongside the clinical experience. Now students' daily hours on placement are the seven hours the clinicians work. But while we were in the hospital for fewer hours per day, we did experience more variety in this respect than the modern student. We not only worked a rota of Saturday mornings but also spent a week shadowing the physiotherapists on call in the evening. In 1969 students complained about being asked to work antisocial hours and the CSP halted this practice, but with the increasing popularity of seven-day-a-week working it is possible that this may return in the future.

More generally the move from the 'school' of physiotherapy attached to the teaching hospital to the health faculty of a HE institution meant separation from the healthcare field. Northtown's school of physiotherapy was one of the last to move and, as a member of the teaching staff, I noted an important change. Where once the students had only to walk out of the school to be in the corridors of the hospital, mixing with patients and medical personnel going about their business, they were now far from the working life of the community they meant to join. They saw the academic and everyday healthcare as separate worlds. Perhaps it felt as though they were leading double lives as they adjusted from one to the other. Would it be more difficult for them to conform to the necessary working ethos, to feel they belonged in each

⁷ We were actually reminded by one of our lecturers before going into the hospital on placement for the first time, that we were "the lowest of the low" in its healthcare structure.

workplace? Colley et al. (2007, p 9), write of the community of practice as “a process of social participation rather than cognitive acquisition”. It seemed that my students were moving between the two, their placements representing ‘social participation’ and their healthcare faculty representing ‘cognitive acquisition’, and they might at times feel they thoroughly belonged to neither. But was there not an element of social participation in the academic field, and occasional more formal learning in the workplace as well? This formal and informal learning debate (Colley et al., 2003b) will be discussed in the next chapter.

One curious alteration in our timetables was made as the physiotherapy undergraduate programme adjusted to being in an HE faculty. It was decided to teach each year of students in the building on alternate days, allowing them study days in between. Thus the first year students would have classes in the university on Mondays, Wednesdays and Fridays, with Tuesdays and Thursdays for study. This made timetabling of students and staff much easier. But it also enabled the parents among the students to save on two days of child care expenses and allowed students to augment their finances with part-time work. It would be easy to suggest the growth in student jobs was due to widening participation and increased financial hardship among the students, as well as perhaps the decline in HE funding, were it not for two things. Firstly the culture of working alongside full-time education has been growing for a long time, with higher work rates among the more affluent students if anything (Hakim, 1998). Hakim suggests that “the increase in student jobs is driven by the rising proportion of young people in full-time education” (1998, p 148). Where before, they might have been earning full-time, they now had a taste of adult independence by having a part-time job, despite studying for longer. Most of my graduate sample had at least one part-time job, and sometimes several. Secondly it has to be remembered that physiotherapy students receive a NHS bursary (Department of Health, 2012), which should mean that the worse-off student suffers less financial hardship than some other university students. Those with mortgages and childcare to finance were in a more difficult situation however.

Widening Participation

Today, as already suggested, there are more students in post-compulsory education who might fall into that category. Where in the 1950s only about 5% of school leavers entered HE, by 2001 this had risen to 33% (Thomas, 2001). This “widening of the social groups that benefit from higher education” (Bekhradnia 2003, p 1) has been largely driven and supported by government initiatives (NCIHE 1997; Kennedy 1997). Thomas (2001) suggests that two main forms of argument led to the movement to widen participation in HE at this time. First there was the economic argument. Where previously investment had gone into heavy industry, now, when the latter was in decline, there was a perceived necessity to replace it with a knowledge economy, through investment in human capital instead. Increased education and training for a wider section of society might alleviate growing unemployment and further success in the ‘global market’ (Thomas 2001).

Secondly, there were non-economic arguments that aimed to counter the perceived elitism and inequality in the education system (Mason & Sparkes, 2002a) and to encourage lifelong learning. The increased value afforded education, Thomas (2001) points out, could have stemmed from a genuine belief in the good it might do social groups not traditionally participating in HE, but could also be part of “a covert attempt to subsume people into the dominant culture and, consequently, to ‘normalise’ and control them” (Thomas 2001, p 5). If this was indeed part of the reasoning, this study will be found to question its success, in that some of my non-traditional respondents were taking control of their progress and following innovative non-traditional paths rather than being ‘normalised’ to a dominant culture (see the examples of Eric in Chapter 6 and Mike in Chapter 7). Whatever the reasoning, education was viewed as an important means of overcoming social exclusion. However it remained the case that while going to university was seen by those young people with social, cultural and economic advantage as “a ‘normal and necessary’ step” towards a career (Fuller & Paton, 2007, p 3), it could be thoroughly daunting for those who might be the first in their family to consider HE as a possibility.

The first hurdle is seen as preparation to do academic work and this was often achieved by studying for a year on an Access to HE diploma course. These enable adult learners without qualifications such as A levels to prepare for and to progress to higher education. Surveying healthcare workers and how retention of such staff could be improved, Arnold et al. (2003) find Access courses “seem to attract and/or nurture people with positive attitudes and intentions towards working for the NHS as .. qualified .. staff” (p 3). This was indeed the case for several of my respondents, who followed such courses and found them very helpful, but, as McGivney (2004) notes, Access students moving on to HE can still feel the shock of less support. Mature students are usually doing a course they have long wanted to do, they have had to make sacrifices to participate, and there can be an element of wanting to prove to themselves and others that they are capable of learning (Castles, 2004), all of which means they are often well motivated compared to the school-leaver (McGivney, 2004). Yet there are more obstacles to face.

The barriers to be encountered are three-fold: they may be ‘situational’ (costs, time and personal circumstances), ‘institutional’ (attendance, timetabling, procedures and requirements), or ‘dispositional’ (reflecting previous experience and attitudes to learning) (Fuller & Paton, 2007). For a student with children (situational issues), one of whom must be delivered to a child minder early in the day (institutional timetabling issues if unable to attend 9 o’clock classes), and who has only negative memories of school (dispositional aversion to academic learning) HE may seem a real obstacle to progress. And success is by no means guaranteed (Brown & Hesketh 2004). It is not surprising then that some of my mature students had initially considered it an impossible option.

People from previous careers have also been found to have a different attitude to study. Beagan (2001), exploring widening participation on medical courses, finds mature career-changing students to be unwilling to sacrifice other things for the sake of their new profession. For example, they had no intention of abandoning non-medical partners and non-medical social connections. This kept interactions with the new social world of university to a minimum. I was to find this with a few of my graduate sample, in particular one who felt it more important to maintain contact with his girlfriend at a distance than to enjoy a night out with the younger

physiotherapy students. This possibly slowed his integration into the community of his academic cohort at university.

Beagan (2001) points out that working in healthcare means encountering “new social norms, a new language, new thought processes, and a new world view” that will enable the atypical entrant to become a member of ‘the team’. But the expectations of this in physiotherapy fit the young, white, middle-class female best, and present difficulties to minority groups. “Older students, gay students who refuse to be closeted, and students who come from poverty ..” (Beagan, 2001, p 289) behave differently as medical students, and Beagan (2001) wonders if this could mean that they also behave differently as doctors. If they do, she argues, perhaps the profession might change. Could this apply equally to physiotherapy? Might difficulty identifying with the cultural environment of their chosen new profession cause the mature, atypical student to behave differently to the extent that it impacted on the physiotherapy profession in some way? There was at least one of my graduate sample who had some problems adjusting to the ethos of her new workplace (see Chapter 6).

What, then, had been the process that my graduate respondents had had to go through to reconcile them to crossing this barrier, or rather barriers, out of one career and into another that necessitated an academic degree? However much they might have disliked the previous occupation, it was known territory and part of their social and cultural identity (Bourdieu, 1986). The effort required to initiate the move into the desired but less well known situation, and the changes involved, the potential reconstruction of identity as part of the shift to physiotherapy, could act as a deterrent. I was going to find that there were a few factors that enabled or hampered this process.

Today’s Typical and Atypical Physiotherapy Graduate

As I have noted, my research sample is ‘atypical’, in that they are mature students changing from previous occupations, so it is important that I explain what I mean by the ‘typical’ student. Now, as before, this is the school leaver. It still remains the case too that fewer men than women enter the profession: in 2009 27.5% of the 2800

newly-qualified physiotherapists in the UK were men (Clews, 2010). The CSP's records show there are changes as regards ethnicity, however. Gone are the days of having one foreign born student in the three years of students in a School of Physiotherapy. Now people of ethnic minorities born outside the UK make up about 5% of the intake (Greenwood & Bithell, 2005). But the typical student remains white and female.

The CSP keeps no record of social class, but from my knowledge of the students I should say that entrants to the training programme are also still more likely to be of middle class origin. This is difficult to assess with any degree of certainty however, the criteria by which class is categorised being none too clear. Until 1980 social class was judged by the Office of Population Censuses and Surveys (OPCS) according to people's occupation and its "reputed standing within the community" (Marshall et al. 1988, p 18), after which time it became equated more with occupational skill, but it remained unclear how the 'lifestyle and prestige' of occupations related to level of skill. There is also the perception that higher social class is synonymous with increased affluence, and, more subtly, with different social values, expectations and aspirations (Beagan 2005).

In this study the concept of social class is used in relation to both occupational and cultural indicators. I tended to judge my respondents' class by the occupations of parents and, to a lesser extent, by the type of schooling the mature graduates had received. When I asked people about their upbringing, they often volunteered an indication of their social class. For example, two respondents told me their fathers were builders and that they belonged to the working class. They were, however, quite different, one seeming better off than the other financially. These differences can make it difficult to categorise neatly by class. It was easier to differentiate working from middle class in this instance from the point of view of their families' expectations of them, neither respondent being from a background where entering upon an HE programme was a common aspiration. This did indeed set them apart from the typical middle-class school leaver who, as we have seen (on page 30), tends to consider HE a normal step in progress towards a career (Fuller & Paton 2007).

An important change with the past is that today's typical physiotherapy student does not always expect to be in their chosen occupation for life. Dodson et al. (2001) found that only 43.5% of their respondents in New Zealand intended to remain "employed as physiotherapists for their entire career" (p 22) and it seems that a similar attitude pertains in the UK. One reason for this could be the increased emphasis on 'quality of life'. Work is being seen as just one component in work-life balance, and permanent employment can therefore be seen as overly restrictive (Collin & Young, 2000). More than one of my graduate respondents followed an almost nomadic existence, enjoying the feeling of freedom this gave them, before finally settling to physiotherapy as a career.

Also as they grew up, today's young people have perhaps witnessed more fragile employment conditions than previous generations: between 1990 and 1995 there were over four million redundancies in Britain (Noon & Blyton, 1997). For many, lifelong employment has been replaced with "a more fragmented job history" (Noon & Blyton, 1997, p 33). As finding work becomes more competitive, the emphasis moves from employment to employability, with individuals building portfolios of experience in an effort to control their own development (Collin & Young, 2000). Physiotherapy graduates have been fortunate enough to have evaded occupational insecurity until only recently, and the career trajectories of those immediately affected as the problem arose are of particular interest in consequence.

My graduate sample entered their academic programmes in 2005 and 2006. The 2005 applicants to study physiotherapy at Northtown, and many of those who applied a year later as well, had little idea of the possible employment difficulties ahead. They only knew that competition for places was acute and that they needed to assure their interviewers of their commitment to the profession. Prospective students are expected to possess good communication and social skills, and are usually reasonably fit, maybe having an interest in sport. Quite often they, or one of their family, have sustained a sports injury or an illness that has necessitated physiotherapy treatment, this alerting them to the qualities of the job (Clews, 2010). Universities typically describe physiotherapy as "a Health Science vocational degree" (Liverpool University, 2012), and the typical pre-training requirements are five GCSEs at Grade C or above, including English Language, Mathematics and

Science, and at least an A and two Bs at A2 level, the subjects being Biology, Physiology or Physical Education plus two other academic subjects (MMU, 2012). Once enrolled, students follow a three year BSc honours programme.

From the description above of the typical physiotherapy student it can be deduced that the atypical one would be one or more of the following. They might be mature, that is over 21 years of age on beginning the programme; male; from working class origins; black, or belonging to an ethnic minority. As my graduate respondents were mature they came into the atypical student category. In 2005, 58 of the 131 strong cohort were over 21, and in 2006, 51 of 138 students were over 21. Nine of each year volunteered to be interviewed in my study. Nearly a quarter of them had previous degrees, not all of which were science-based. Several preceded the programme with the one year Access course, in which they were required to attain 45 level 3 credits at Distinction level (MMU, 2012).⁸ As far as attributes were concerned there was considerable variation, but some themes appeared. There were several who had been brought up with family members who had a disability of some sort, and so knew something of life in a wheelchair or what happened in special schools. A third of them had worked as a care worker or physiotherapy assistant prior to recommencing study. There was generally some indication that they had worked in, or had a preference for, socially interactive jobs and most of them had prior experience of working in a professionally orientated career.

Changes to Pay Structure and Professional Hierarchy

Because I shall be referring to both today's and older labels given staff in the hierarchical structure of the NHS when I tell the stories of my graduate, and some of my established practitioner, respondents, I shall now explain these terms (see also the Glossary of Abbreviations, page iv). Changes in this system also have a specific place in this study as they have been blamed for some of the initial employment issues that faced my respondents, and thus drew my attention to this area of research.

Restructuring programmes at the end of last century led to reform of staff salary structure, which had been under the regulation of the Whitley Council. Burr (2002)

⁸ A full description of the sample will appear in Chapter 4.

noted that “.. pay is still the single biggest factor fuelling the recruitment and retention crisis within the NHS”, followed closely by stress (p. 1). The concern was that as pressures on staff increased, they would be tempted to look for jobs where they could earn more for less stress. Agenda for Change (AfC), “the largest-ever attempt to introduce a new pay system in the NHS” (Buchan & Evans, 2007, p. 1), addressed this perceived problem. Everyone in the NHS, bar medical staff, was fitted into a new system of banding, combined with a fresh promotion structure. Assistant physiotherapists found themselves at Bands 2, 3 and 4. Where before junior staff had been called Basic Grade and had been promoted to Senior II, Senior I and then Superintendent posts, they now moved up the bandings from 5 to 8. As part of this process, staff had to prove their advance in skills and learning in order to pass through the relevant salary gateways in AfC. AHPs conceded the ‘policing’ of this regulatory system to the HPC in 2002 (Dixon, 2003).

The typical trajectory of graduates into the career had been to start in a NHS teaching hospital with a rotational post (moving to another area of the hospital’s work every three or four months) for preference, at Band 5 level (the most junior level of professional employment on the AfC ladder, equating with the old Basic Grade). Limb calls this traditional pathway into the profession the ‘junior carousel’. “Although it isn't mandatory, most physiotherapy graduates - no matter what their age or experience - get on it. Typically, their first two years practising physiotherapy are taken up by rotations ..” (Limb, 2006b, p 15). Most graduates saw this as a time of professional development and tried to gain as wide a range of experience as possible. After two or three years, they progressed to a Band 6 post (the old Senior II), possibly still rotational but every 6 months now, in the individual’s preferred speciality. If this were a musculoskeletal Band 6 rotation for example, it might mean experience on orthopaedic and rheumatology wards as well as in the out-patient department. These physiotherapists were still going through the process of integrating fully into their profession, so, using the parlance of Lave and Wenger (1991), when does the graduate physiotherapist reach the point of full participation in their community of practice, before this, at Band 6 level, or later? It would be interesting to follow my research sample through this gateway at least, to learn their perceptions of where this point was for them.

Progress up the hierarchy continues to the Band 7 post, the senior position with responsibility for an area of the hospital and possibly some management duties. Paths from this point diverge. For those with particular expertise in a specific area of physiotherapy the Extended Scope Practitioner (ESP)'s role might be attractive, while others might prefer a position in management, as a Physiotherapy Lead in a team of middle managers (the old Superintendent), or as a Therapy Manager leading a team of AHPs. There is even the possibility now of becoming a Band 8 Consultant Physiotherapist, though this tends to follow after many years experience, not just of clinical practice and management of a team, but of considerable research into one's speciality. But this is within the NHS healthcare system and there are several other ways forward from Band 7 level, including working in private practice, for sports clubs or for charities, as well as teaching and full-time research. This raises further questions concerning Lave and Wenger's (1991) theory. Within the NHS there are already some issues about what a community of practice might be. For example, the Physiotherapy Lead will be working with physiotherapists, but also with other senior AHPs. Are they then working across several communities of practice? And those working in private practice could be working in a group or alone. Do the latter still feel they are part of a physiotherapy community? And what are these established practitioners' experiences of full participation? It was this that necessitated I talk to established clinicians as well as mature graduates.

Graduate Unemployment, the Context for My Study

Despite being introduced for the best reasons, its creation of extended promotion opportunities being long-awaited, AfC tended to introduce further problems. Staff turnover dropped from around 22% annually to below 10% in 2005, as physiotherapists delayed moves to a new area, or promotion in their field of expertise, until they saw what level on the new pay scale equated with both their job at present and the one they intended to apply for (CSP, 2005a). This situation meant a reduction in available junior posts that would normally have been freed by promotion to more senior positions. This appeared to be one of the reasons why new graduate unemployment suddenly arose at this time (Toyn, 2006).

Advances in healthcare, expensive new surgical procedures and drugs, constantly add to the costs of maintaining that already financially unwieldy public institution, the NHS. As Redwood (1988) comments, “It is doubtful whether a large organisation employing about one million people can ever run as a successful unified whole” (p 10). AfC only added to these long-standing problems, for extending the pay structure was bound to put pressure on hospital Trusts’ resources. Some major teaching hospitals froze all their junior vacancies in response to their financial difficulties (CSP, 2005a), and soon Assistants began to voice their concern that newly-qualified physiotherapists were being given Assistant posts rather than Band 5 ones (Clews, 2007), making it difficult for them to find employment too. In some areas there were worries that generic Therapy Assistants, shared between OTs and physiotherapists might replace the junior qualified staff (Limb, 2007). Were Trusts employing cheaper staff at the expense of the graduate? In addition workforce planning appeared to have failed to prepare for the higher numbers of graduates being trained in response to the government’s drive to increase AHPs (Toyn, 2006): this author, the Chair of one of the Regional Networks, gained her information from the CSP website and a Graduate Action Group to report on the situation, noting that one of the problems with workforce planning was that Primary Care Trusts (PCTs) had “no cultural tradition of training their future workforce” (Toyn, 2006, p 1), physiotherapists in the community usually arriving as Band 6s from the acute sector. This needed to open up to more junior staff. In these circumstances it was no wonder that many of the newly-qualified failed to find a first post.

Facing this challenge physiotherapy graduates did not welcome suggestions from careers advisory staff in some universities that they might use the transferable skills they had gained from their degree programme to work instead in human resources or management. They had taken a vocational course and wanted to be physiotherapists (Limb, 2006a). This was perhaps particularly frustrating for the mature graduates. They had taken the risky decision to move away from a previous career, several of them preparing themselves further for HE by taking Access courses for a year, and occasionally A levels to boot. Now to be faced, after all that investment in their future, with the possibility of unemployment or of moving into yet another career, one not preferred by them, may well have made them feel they had been let down (Limb, 2006a). Why follow a ‘calling’ if it ended in being directed to practice

something completely different? It certainly made a mockery of the concept of joining a community of practice, as Lave and Wenger (1991) described it.

These then were the people that I hoped to follow through the first few years of their career. From them I hoped to learn more about the concepts of community of practice and full participation therein. Their career experiences made them the atypical examples that highlighted the boundaries of different communities and the nature of boundary-crossing. Also the deliberate nature of their career change might cast light on the social, emotional and political aspects of their vocational commitment. This acknowledged commitment, plus their vulnerability in the present context of fragile employment, made their career paths of particular interest and the focus of this study.

Chapter 3

Literature Review:

What Constitutes a Community of Practice?

In the last chapter I introduced Lave and Wenger's (1991) community of practice theory as a possible framework within which to set my research. It has the advantage of dealing with the situated learning of the individual making a transition into the workplace, incorporating several recognisable elements for those practising physiotherapy, in particular legitimate peripheral participation of the newcomer to a community of practice, while being supported by the more experienced practitioners. It remains to be seen, however, how closely the theory aligns with what is actually happening to my graduate respondents.

In this chapter I shall show how Lave and Wenger's (1991) contribution can be termed "nothing short of a paradigm shift in the study of learning" (Hughes et al, 2007, p 2), focusing on their key concepts, the notion of situated learning, community of practice and legitimate peripheral participation, and how identity and mental attitude may be expected to change as full membership of the community is attained. This, and the expectation of a typical biography among community members, is of particular interest in this study where the mature graduate respondents do not conform to the traditional characteristics of the past. I shall then consider other authors' responses to the community of practice theory, and then broaden the debate to look at issues of particular relevance to my study. Although there are areas where Lave and Wenger (1991) have been found to lack full clarity or have left questions unanswered, in particular what type of groupings can be labelled 'communities of practice' and how we may understand 'full participation', I hope to show that their concepts are of some use to my research.

Lave and Wenger's Key Concepts

Communities of Practice

The first key concept gives a framework for Lave and Wenger's (1991) theorising. They propose that the new apprentice works alongside more experienced participants to become a member of a body they term a 'community of practice', further defined

as, “.. a set of relations among persons, activity, and world, over time and in relation with other .. overlapping communities of practice” (p 98). Their theory is considerably strengthened by the addition of empirical data from actual communities of practice (Engeström, 2007), a wide variety of working groups including Liberian and Mexican indigenous craftspeople, supermarket butchers, and non-drinking alcoholics in an Alcoholics Anonymous (AA) group.

The first two groups of workers were drawn from Lave’s ethnographic research into craft apprenticeship among indigenous peoples (Edwards, 2005). These and the other groups featured may appear very different in background, but can be seen to share a calling, the AA members having a common goal at least, if not a vocation.

Situated Learning

That novice professionals should learn by virtue of their lived experience in the workplace is a central tenet of Lave and Wenger’s (1991) theorising. Newcomers to the workplace practice community activities, rather than being instructed in them, perfecting necessary skills in context. Meanwhile they are gradually being drawn into the working milieu, its customs, routines and regulations, the process of occupational socialisation. Participants hear the language of the workplace community, and develop both a sense of what is expected behaviour and of what actions are deemed inappropriate in that particular social world. Emphasis is laid on the socio-cultural dynamic (Handley et al., 2006), and being motivated to attain a more central position within the community of practice can be a strong incentive to the newcomer’s learning (White, 2010).

Legitimate Peripheral Participation

According to this view, there is a direction to learning then, a trajectory from novice to expert, towards full successful participation. Lave and Wenger (1991) suggest that this occurs through a form of engagement they call legitimate peripheral participation. Part of belonging to the community of practice entails practicing *legitimately*. The newcomer is afforded opportunities to engage in ongoing activities at a basic level, and this is gradually extended to positions of increased responsibility in line with their growing experience. Next, being *peripheral*, according to Lave and Wenger (1991), is both an empowering and a disempowering position. On the one

hand it allows the individual learner the potential to move to more intensive participation in the community; on the other hand, it restricts immediate higher level participation. Lastly, *participation* introduces the concept of learner collaboration with others in the community. There is a distribution of practice tasks among the members of the community, and the newcomer's early work, however small, contributes to the practice as a whole.

Identity Construction through Membership

For Lave and Wenger (1991) though, learning is not simply confined to performing specific activities within a community, but involves the construction of identity. Neither the activities newcomers carry out nor their understanding of their work exist in isolation: they have meaning within a broader set of relations within the community. Lave and Wenger suggest learning thus implies "becoming a different person with respect to the possibilities enabled by" such relations (Lave & Wenger, 1991, p 53). Lave (1996) discusses this in more detail, seeing it as a two-way process. Novices actively conform, as closely as suits their dispositions, to what is going on around them, but they are also passively adjusted by the social environment of the community in which they are positioned. The development of a professional persona in this manner is a useful concept for explaining the changes identifiable in student practitioners as they gain in confidence in the workplace, but it is one which introduces a suggestion of possible social stagnation, or at the very least conservatism. The work done in this transformation appears to be focused on the community's remaining unchanged. In concentrating on the individual's socialisation into the community of practice, Lave and Wenger (1991) neglect the possible impact on the community of the individual newcomer. As the workplace's cultural practices need updating, perhaps the newcomer could become an enabler of necessary change. This is a step further than Lave and Wenger (1991) allow.

Typical Biography

Another sign of possible conservatism shows in Lave and Wenger's (1991) assumption that communities of practice depend on members' "characteristic biographies" (p 55). People of a certain type, they suggest, are more likely to be attracted to a specific community of practice in the first place. Thus novices share a

similar outlook as they begin their integration into the community, their understanding being moulded by the process. But, as discussed in the last chapter, recent widening participation to higher education (HE) has altered perceptions of what is possible and worthwhile (Archer & Leathwood, 2003) and more non-traditional newcomers, like the mature career-changers of this study, are entering professional training. If Lave and Wenger (1991) assume that those with typical biographies move more smoothly inward towards full participation in their community of practice, what happens to those whose biographies are atypical? Do they have more adjustments to make, or is it the community that makes adjustment to such a situation? This will be discussed more fully under 'Identity' (pages 57/8).

Lave and Wenger's Views versus the Traditional Concepts of Education

Lave and Wenger's (1991) key concepts, fundamental to the concept of situative learning, can be contrasted with cognitive learning, the traditional view of education as being "best separated from the rest of our activities and .. the result of teaching" (Wenger, 1998, p 3). Related literature (Colley et al., 2003b; Edwards, 2005; Hodkinson & Hodkinson, 2004a; Rainbird et al., 2004a; Sfard, 1998) uses the metaphors of 'acquisition' and 'participation' to describe the cognitive and the situative respectively. Acquisitive conceptualisations view learning as a stocking up of knowledge in pursuit of qualifications, often seen as the driver for formal education (Edwards, 2005). As in Cartesian dualism, the mind is conceived of as separate from the body, and here plays the superior role, gradually assimilating knowledge (Beckett & Hager, 2002). Such learning, although representing what is happening in the world, is internalised as concepts and propositions which the individual will be able to recall later. Colley et al. (2003b) comment that this formal learning is sometimes thought of as yielding the more objective knowledge, while participation emphasises searching for meaning and learning to act appropriately, within a particular social context (Edwards, 2005). This informal learning is considered concrete rather than abstract, being attained in a more practical and often physical way.

Thus there can be the suggestion that educationalists see learning as happening exclusively in schools and universities, while only “work happens in workplaces” (Boud & Solomon, 2003, p 327), and it is this attitude that Lave and Wenger (1991) seek to counter. For neither formal nor informal learning can be said to be superior. Both have advantages. Formal learning gathered together the recorded wisdom of humanity in university libraries, allowing people to build on previous knowledge (Colley et al., 2003b). Learning in the workplace, though less certain in content than a taught curriculum, appears more aligned to everyday working activity (Fuller, 2007). They also share similar problems. Political argument can suggest that formal learning favours and preserves the social élite (Bourdieu, 1986), but informal learning is often no better, for those more advanced in the hierarchy of the workplace can be afforded more opportunities to progress (Billett 2001a; Rainbird et al. 2004b).

There is some debate regarding whether workplace learning is as totally situative as Lave and Wenger (1991) suggest. They focus on learning through participation to the exclusion of any acquisitional element, and Hodkinson and Hodkinson (2004a) argue in their support, that it is difficult to separate the learner from their working and learning situation. However there is formal planning involved; healthcare students on practice placement complete learning development plans, and Billett (2002) points out that other workplace learning is not without structure. Work values and protocols “shape and sustain activities and interactions .. as in other social practices, such as .. educational institutions” (Billett, 2002, p 59).

The cognitive and the situative, then, differ in four main ways. A major difference is the notion of learning in context. Lave (1988) notes how people learn well in the non-scholastic setting, often showing themselves more proficient with arithmetic in the supermarket than in academic mathematical tests, for example. A second difference is that situated learning no longer involves the passive reception of education via a set curriculum run by an expert teacher. Lave and Wenger’s (1991) newcomer learns their ‘curriculum’ of practice through active participation with other practitioners, by no means all expert, in the relevant work setting (Fuller, 2007). Thirdly, the social relationship of the individual to their co-participants is important, collective learning through practice being in direct opposition to the traditional more rarefied mental activity involved in solitary study. Finally, Fuller

(2007) notes that, instead of emphasising the acquisition of knowledge as a product of participation in the community of practice, “the question of *what* is learned by participants is answered in terms of identity formation” (p 19 - Fuller's emphasis).

The latter is important to Lave and Wenger's (1991) theory, but as an element of a very unidirectional dynamic, a process Colley et al. (2003a) term ‘becoming’. Individuals become orientated towards the vocational disposition as part of their learning, during their inward trajectory to full membership. This begs several questions regarding the ultimate goal of the process: is the attainment of membership a static state, where full participants remain that particular kind of person without change from then on? Colley et al. (2007) find that it is possible to become marginalised or even excluded from a community of practice, so the goal of reaching full membership in the community is not as certain as Lave and Wenger (1991) might suggest.

Responses to Lave and Wenger's Ideas

Areas of contestation thus arise from Lave and Wenger's (1991) work. Nevertheless their theory recognises “the situational specificity of work-based practices” as opposed to the generality and determinism of non-situative approaches (Avis, 2009, p 7), making the opportunity it provides to explore the development and enhancement of skills and knowledge in the workplace extremely popular. Not only educationalists and social scientists make use of it, but also those in the field of organisational knowledge management (Hughes et al., 2007). From a purely quantitative point of view, Lave and Wenger's book (1991) was cited in no fewer than 856 articles in the first ten years after publication (Lang & Canning, 2010). Impossible though it is to consider all this diverse literature in depth, I shall look at the main responses to Lave and Wenger's (1991) work as they affect my study, and also to Wenger's (1998) further extension of the theory, noting areas considered lacking in clarity where further research is warranted.

How Learning Takes Place

The view of learning as social participation, rather than the school system's social selection, has been seen as a definite advantage in highlighting the underlying social process involved in successful education (Young, 1998), though there is contestation regarding what is learnt on work placement (Edwards, 2005; Guile & Griffiths, 2001). Guile and Griffiths (2001) see support as crucial to school-leaving students, for they must learn at work by collaborative observation, a broader form of learning than the methods of the classroom and often quite alien to someone straight out of an educational institution. Edwards (2005) adds that she would like to find out "how learners interpret and act on their worlds" (p 59). This area is not addressed by Lave and Wenger (1991), and is of particular relevance in the career-changing situation, newcomers now bringing with them experience from previous communities.

There is also debate about how new things are to be learnt in communities of practice. If participation is seen in terms of becoming a member of an existing community (Edwards, 2005; Hughes et al., 2007), how are skills and information updated, for it seems there is an assumption that members fit in with existing systems? There may be transmission and reproduction of knowledge, but where, ask Hughes et al. (2007), is the innovation? This is arguably at the heart of any viable, professional practice. It seems that Lave and Wenger's (1991) idea of experience of learning in the lived-in world cannot satisfactorily help us analyse what Arnseth (2008) calls "temporal emergence" (p 300); that is, how meaning emerges and changes through practical activity over time.

Evolving Dispositions

Other authors (Colley et al., 2007; Fuller et al., 2005) comment that Lave and Wenger (1991) concentrate on the work situation at the expense of other aspects of participants' lives. The community of practice is only one element, and for a newcomer a recently added one, of all that constitutes their biography. Hodkinson and Hodkinson (2004b) note that people's dispositions, from the point of view of career and learning, are developing and evolving through their experiences in life generally, both inside and outside work (2004). Dispositions evolved in this way may well facilitate some forms of learning and inhibit others (Hodkinson et al., 2008).

Dispositions are also the focus of debate when Mutch (2003) questions the feasibility of Wenger's (1998) idea that people belonging to more than one community of practice will adopt different kinds of participation and identity construction according to their membership in the different communities. He argues that an individual has a disposition developed through life experience that tends to respond in a similar way despite varied circumstances. Roberts (2006) too comments on this, seeing it as a negation of the concept termed 'habitus' by Bourdieu, "modes of thought .. unconsciously acquired, resistant to change, and transferable between different contexts" (p 629). It would be reasonable to imagine some degree of tension arising for individuals moving between communities. How might this influence their learning?

Neglect of the Individual Learner

Some authors (Billett, 2001b; Eraut, 2000) feel Lave and Wenger (1991) should pay more attention to the "independence of individuals acting within the interdependence of the social practice of work" (Billett, 2001b, p 22). Individuals' work relationships with colleagues and their previous experience, can influence how they engage in participation, as well as the opportunities the community of practice affords them. Arnseth (2008) is perhaps most critical of the lack of the notion of individual experience in Lave and Wenger's (1991) practice-based epistemology, noting how there seems no objective context moulding individuals' actions besides the collaborative culture of the community of practice. Lave and Wenger (1991) do consider how individual newcomers negotiate meaning with their more experienced colleagues in the community, particularly at first when their needs depend on their individual training to date, but Billett et al. (2005) comment that they do not consider how the individual brings their own values and concepts to their engagement and how learning can be subject to individual intentions. As Hodkinson et al. (2008) put it, it is important not to lose sight of 'the person behind the learner'.

Appropriateness of the Case Studies

Lave and Wenger's (1991) choice of traditional indigenous groups of people, Yucatec midwives and Vai and Gola tailors, as their case studies stems from their ethnographic research, and is consequently contested (Eraut, 2000; Jewson, 2007). These peoples' engagement in lifelong work commitment, for few alternative

occupations are available to them, their strong social and family ties, and their hierarchical and disciplined work relations (Jewson, 2007) make them poor representatives of complex modern working conditions. By comparison, today's society has a greater range of social settings, and a wide spectrum of different paths taken between these settings (Eraut, 2000). It is not uncommon to change career and move between different communities of practice nowadays, which requires acculturation to new sets of relations and altered modes of practice, a situation less likely to be encountered among indigenous communities. Lave and Wenger's (1991) case studies deviate markedly from the current drive to gain qualifications that show flexibility and adaptability rather than lifelong commitment to one occupation (Colley et al., 2007).

Power Relations

Some authors feel Lave and Wenger's (1991) benign view of communities of practice as free from any misunderstanding or disagreement should be contested, for there is evidence of power relations resulting in exclusion of participants (Colley et al., 2007; Colley et al., 2003a; Hodkinson & Hodkinson, 2004b). Nor it is only *within* the community that authors find relations unnaturally quiescent. Colley et al. (2007) find that the impact on the working community of institutional and political changes from *outside* the membership is missing. There is an assumption of a harmony of interests between the worker, the community of practice, employers and the state (Avis, 2009). Wenger (1998) goes some way towards countering this, acknowledging that there is always the possibility of disagreement and tension among participants, but he does not discuss the role of external factors.

Lave and Wenger's (1991) focus on unidirectional power relations between the experienced practitioner and the novice is also debated (Fuller et al., 2005; Jewson, 2007), for experienced workers also learn through engaging in the training of newcomers to the community (Fuller et al., 2005). This is further complicated by the possibility of role reversal, newcomers occasionally finding themselves giving advice to older workers (Billett, 2007; Fuller et al., 2005). The more life experience the new employees have, possibly from previous membership of other communities of practice, the more areas of skill they may be able to share with their 'old-timer' colleagues.

Areas Worthy of Investigation

Thus far Lave and Wenger's (1991) concepts, centring as they do on learning through social engagement in the workplace with the goal of attaining expertise, are a useful framework for research such as mine into the career pathways of newly-qualified professionals. Concepts such as the notion of gradual integration into a community of practice through collaboration with more experienced practitioners are attractive, though the term 'community of practice' requires definition. Other elements of Lave and Wenger's (1991) theorising raise questions. For example there is the implication that people training for a particular occupation will have a similar entry path and biography. With widening participation, occupations are now open to a greater variety of people with very varied biographies. This poses questions about how, as newcomers, they will fit into established communities and how smooth, or otherwise, their progression towards full participation will be.

Another of my interests concerns movement from one community to another and the concomitant tensions that could influence individual learning. Newcomers may have an impact on the learning in their community of practice, and their dispositions, evolved through previous workplace experience, may facilitate some forms of learning and inhibit others (Hodkinson et al., 2008). To ensure employment, some may consider flexibility and adaptability of greater importance than lifelong commitment to one occupation or community of practice (Colley et al., 2007; Dodson et al., 2001). Vocational learning is seen as 'becoming' by some, but becoming what? Perhaps a profession might be a stepping stone to other positions rather than the ultimate goal of training. Lave and Wenger (1991) saw the goal as 'full participation', but what does this mean and how will a participant know when they have reached it? It may be unattainable to some, if exclusion from the community is a possibility. Who sets the rules that regulate such exclusion, the boundaries that are difficult to cross on moving onwards into the community? These questions merit exploration in greater depth, and this I shall attempt now.

Meaning and Nature of ‘Community of Practice’

The fundamental issue of how a ‘community of practice’ is to be recognised I shall approach by exploring first what has been written regarding the concept of ‘community’, then the more neglected ‘practice’, and then the whole term, with the concomitant difficulties of categorising communities of practice.

Community

Lave and Wenger allow that a ‘community of practice’ is “left largely as an intuitive notion” (1991, p 42), requiring further exploration, and several authors have accepted this challenge. Some (Arnseth, 2008; Bauman, 2000; Fuller et al., 2005; Jewson, 2007) particularly question the use of the word ‘community’. Jewson (2007) warns that this sociological concept risks degradation to the comfortable dictionary definition, “state of being shared in common” (Sykes, 1976) and other authors tend to agree. Fuller et al. (2005) feel communities appear unnaturally “stable, cohesive and even welcoming entities” (p 53) in Lave and Wenger’s (1991) descriptions; to Arnseth (2008) ‘community’ sounds too “harmonious and free of conflict” (p 299); and Bauman (2000) notes the word conjures up “old-time utopias of the good society” (p 92). If it is to be free from such thought association, the term needs defining with particular rigor, Jewson (2007) suggests. But it is hard to define the imprecise.

Lave and Wenger (1991) emphasise the diversity of forms apprenticeship takes nowadays and the variety of learning relationships involved in communities of practice, but they do not specify the limitations to this diversity. Their case examples are very compact models of communities, quite different to far-flung and varied communities of professionals like the World Confederation of Physical Therapy. Could such a membership ever be seen as a community of practice? Wenger (1998) narrows the definition of the concept to three main elements, mutual engagement, joint enterprise and a shared repertoire of discourses, actions and tools (p 73) and Hodkinson and Hodkinson (2003) note that, according to these terms, widespread professional groups could well be said to belong to communities of practice.

The problem lies in Lave and Wenger's (1991) equivocal attitude to spatial proximity. As Hodkinson and Hodkinson point out, their tight-knit examples of 'community' suggest spatial as well as social integration (2003). Lave in particular emphasises that "theories of situated everyday practice insist that persons acting and the social world of activity cannot be separated" (Chaiklin & Lave, 1993, pp 4-5), and indeed participation positions the individual within the ambient community. Yet together Lave and Wenger insist on neither the participant's immediate presence in the community, a "well-defined, identifiable group", nor any "socially visible boundaries" (1991, p 98). It would appear that their close-knit case communities and a loosely-bound community of professionals such as the World Confederation of Physical Therapy could be acceptable alternatives. How might it feel to experience changing from one community of practice to another if they are so varied in this respect? While it is clear that Lave and Wenger (1991) see a community of practice as an essential for learning, there are still questions regarding the scope of 'community.'

The very malleability of Lave and Wenger's (1991) concept may have led to the success of their theory in a world of global communication (Wenger et al., 2002). Though this area is not the focus of my study, it is worth noting Roberts' (2006) comments regarding the evolution of the term 'community' from the spontaneous, self-organising entity originally described by Lave and Wenger (1991). Building up trust within a community to ensure effective joint enterprise takes time, and this is a luxury modern groups, set up to complete a task quickly, do not have. Roberts (2006) labels the traditional community of practice a 'slow community', in comparison to those that "in the era of 'fast capitalism' .. emerge and dissolve rapidly" (p 633). While many healthcare communities belong to the first category, some specially set up MDTs might be categorised as fast communities.

Practice

Considering Lave and Wenger's (1991) theory from the point of view of the knowledge base in a large organisation, Brown and Duguid (2001) note that "the appeal of *community* has tended to obscure the importance of practice" (p 203 - the authors' emphasis). Being a 'community' suggests close cultural bonds of joint intention, while 'practice' draws attention to the many varied tasks involved in the

activities of a firm, as indeed there are within most occupations or professions. Within an organisation the practices of the Chief Executive and the shop floor technician have “more in common with their peers in other organizations than with many of the employees in their own” (Brown and Duguid 2001, p 201). The term ‘practice’, then, tends to stress difference rather than homogeneity. Yet a culture of practice can bind together members of professional bodies, like the CSP, who may rarely, if ever, meet each other. This Knorr-Cetina (1999) terms an epistemic culture. She explores, as an example, the way in which knowledge is shared and communicated between two such cultures, finding that the practice that binds together microbiologists into an epistemic culture simultaneously separates them from that of physicists, despite their both belonging to the community of scientists. This could similarly be found between the professional members that compose the MDT. Working closely together to benefit the patient does not mean that these professionals’ several practices can be regarded as epistemically homogeneous.

Lave and Wenger (1991) are theorising about smaller, more compact groupings and emphasise the temporal elements of practice in a community rather than the spatial, writing that “cognition and communication in, and with, the social world are situated in the historical development of ongoing activity” (Lave & Wenger, 1991, p 51). A gradual accretion of patterned sequences of routines and methods, builds up a culture and history of practice over time (Arnseth, 2008). Within this framework individuals observe others at work, imitate them and then adapt their own particular practice, to both conform to the wider community norm and suit their own sense of integrity (Handley et al., 2006). The latter point is crucial to the development and continuous updating of work as a whole. Individuals will compare notes, discuss techniques, formulate standard procedures and decide on general maxims to help the newcomer (Benner, 1984). Members work together rather than individually, accepted practices gradually changing as techniques are modified in the light of newly available information, or activity is adapted to particular circumstances.

Communities of Practice

Wenger (1998) provides examples of communities of practice. One such is a group of workers regularly meeting for lunch, who discuss past concerns and plan future issues, within professional guidelines. This group could be a community within their

main community of practice. Thus the meeting workers, the office workplace they belong to and their profession as a whole are all communities of practice. The lunch group, the office personnel and the profession's membership all experience participation, a sense of belonging. However there are factors against each being a community of practice. The group meeting at lunch-time do not really build up a shared history that is separate from broader participation; the office is more an "organizational context for the job than a focus of engagement" for the members working there; and the profession "is mostly an abstraction" (Wenger, 1998, p 124), only becoming a significant community of practice when contacting distant colleagues or seeking a change in employment. Wenger (1998) argues that the concept of a community of practice is a category in the middle of these examples, neither too broadly nor too narrowly defined.

This vagueness of categorisation is contested. Edwards comments that "a joint enterprise, where there is mutual engagement as a social entity with a shared repertoire of communal resources that have developed over time" (2005, p 57) could apply to being held up in the same traffic jam every night returning from work. She argues that a community of practice needs tighter boundaries, and feels that Lave's example from her work with Liberian tailors (in Lave & Wenger, 1991) fulfils this. Similarly Brown and Duguid (2001) argue that only the smallest organisations should be called 'communities of practice'. Larger wide-spread organisations, they suggest, should be viewed as networks of practice, for participants here may well share knowledge, but never actually meet. Yet Lave and Wenger specifically deny that co-presence of participants is a prerequisite of a community, only that they should "share understandings concerning what they are doing and what that means in their lives and for their communities" (1991, p 98). Widespread organisations such as professional bodies come into this category.

Different Scales of Communities of Practice

Of particular use in my study are the refinements other authors have made to Lave and Wenger's (1991) work. An example is the differentiation of the scale of communities of practice discussed by Hodkinson et al. (2008). The metaphor here is drawn from map-making, so the largest scale learning situation is that of the individual learner. The next largest scale down is that which most resembles Lave

and Wenger's (1991) community of practice in size, the workplace area complete with the position normally designated to the individual worker. The smaller scale community would be the worksite where the workplace is located, and the next again, the regional organisation in charge of such work. Smaller still is the national professional body and smallest, the international.

This image of communities within communities at micro- or macro- scale is helpful, although to call the smaller communities 'large scale' is confusing. So for the purposes of this thesis I shall use the term micro-level community of practice for the workplace area, meso-level community when referring to the worksite within which the workplace is located and macro-level community for the professional body. Thus an individual can belong to a micro-level community of practice within a meso-level community, and be a regulated member of a macro-level community of practice.

Identity

Lave (1996) emphasises the range of ways in which learners "come to shape (or be shaped into) their identities with respect to different practices" (p 161). The differences become clear when Lave and Wenger's (1991) case study communities, with their relatively unchanging sense of collective identity, are compared to belonging to a modern complex community, which can involve "the negotiation of a biography that traverses .. different situations" (Jewson, 2007, p 79). The associated ideas of identity construction and 'becoming', the possibility of marginalisation and non-participation, Lave and Wenger's (1991) concept of a characteristic typical biography and individual opportunities for learning are addressed now as central to my study.

Identity Construction

Since this study is based around the experiences of people moving into a professional community of practice, the AA members discussed by Lave and Wenger (1991) might appear less relevant. However they are the community who demonstrate change in attitude and identity most clearly. The aim of the AA group sessions is that newcomers with problems learn from others' similar experiences and begin a journey

of identity construction involving altered self-perceptions and behaviour outside the group. This illustrates Lave and Wenger's view that "learning and a sense of identity are inseparable" (1991, p 115). The suggestion is that one learns to define oneself in terms of the community, registering both past and present learning trajectories, while reconciling new forms of participation with one's identity. Lave and Wenger (1991) might consider this a straight forward process for their craft apprentices, but it becomes more complex if the individuals concerned have been through this learning transition before, sometimes a very different one and perhaps more than once, as is the case with career-changing professionals. What might then be involved in what amounts to identity re-construction?

'Becoming' or Transformation?

According to Hodkinson et al. (2008), Lave and Wenger's (1991) attempt to focus the very broad subject of identity construction on learning alone is problematic. Certainly learning can be understood as a process of challenging, developing and confirming an individual's dispositions, but these stem from natural inclinations, background situation (gender, ethnicity and social class), as well as from learning experiences. Hodkinson et al. (2008) prefer to think of learning as 'becoming'. The individual has constant opportunity to learn and does so according to circumstance (situational, cultural, or dispositional), so that there is "learning through becoming, and becoming through learning" throughout life (Hodkinson et al., 2008, p 41). Becoming in this way is likely to be most significant when a person first makes the transition from education to work, but will be amended with each change in direction thereafter.

Whether this movement is seen as pure transition or more as a transformation is contested. On the one hand, Newton et al. (2009) consider that nursing students undergo a process of transformation rather than transition, when moving from simulation of practice in the academic setting to the real world of the workplace. On the other hand, Eraut et al. (2004) place no emphasis on transformation, concentrating instead on learning to belong to particular cultural groups in the workplace and how this is supported. Colley et al. (2003a) question the way in which such transformation is represented as a relatively passive and 'one-off' absorption of a newcomer into the culture of the workplace. Like Hodkinson et al. (2008) they

prefer the term 'becoming' and see it as a crucial "immersion in the social, cultural and emotional aspects of work" (Colley et al., 2003a, p 475), continuing at the heart of the individual's learning for life. Here again is the idea that such becoming is a recurrent feature in the modern career path.

From Non-participation to Dis-identification

Wenger (1998) points out that a person's identity is as much what they would rather *not* be, as what they are like and wish to be. He sees these as elements of non-participation and participation, both part of an individual's relationship with their community of practice. Just as there are other communities of practice the individual might shun, Wenger (1998) admits there will be relations within their own community from which they will distance themselves. Billett et al (2005) take this a step further, pointing out that the individual can resist or manipulate the regulatory practices of the workplace. An individual's links with their workplace need not be mutual, though they are relational, and this relational interdependence requires constant re-negotiation and adjustment to all kinds of external and internal factors. Personal objectives may take precedence over compliance to the employer's economic goals. Far from resulting in marginalisation or exclusion, this may promote an individual's further participation: Billett's (2006) research gives examples of people who have succeeded in altering work practices to suit their specific needs or beliefs. But this must affect the practice of the workplace. Do people with previous experience of other communities of practice, and perhaps a greater facility, or indeed need, to alter work conditions according to their situation, find such means effective?

Some literature suggests not. Marginalisation and exclusion are discussed most fully by Colley et al. (2007). The authors investigate why tutors leave the Further Education (FE) sector, and tell the story of an extremely committed participant who, when her college was in financial difficulty, declined to change what she believed to be the best way to teach her subject, and took voluntary redundancy. Thus, Colley et al. (2007) warn, those who strongly question new modes of practice, however expert they may be, can find themselves moving in an outward direction from the field of practice of the community. Such situations, though mentioned briefly, are not fully acknowledged by Lave and Wenger (1991).

Nor is the situation that Hodges (1998) recounts. This lesbian author attempted to participate in a primary school teaching community where her identity did not correspond to the very feminine ideal she found was connected to the practice. Her community of practice was organised so that participation was contingent on being of a certain identity, almost a particular typical biography. This dominance of social relations that seemed to privilege her peers at her expense led to her non-participation and eventual dis-identification. Hodges (1998) felt called upon to suppress the difference between herself and the others around her, and was unable to. How, she asks, does a person engage with a community which effectively operates to marginalise people like herself? This leads to an issue at the heart of my study. What happens when people move into communities of practice where their characteristics are considered atypical?

Characteristic Biography and Vocational Identity

The traditional staffing of many health professions with predominantly white, female, middle class school-leavers has changed as widening participation attracts more male, working class, mature people of various ethnic minorities. The mature career changers among these may come from very varied backgrounds, bringing from disrupted career paths all kinds of expertise and specialist training, along with experience of identity adjustments, having belonged to previous occupational communities. If, as Lave and Wenger (1991) suggest, communities of practice depend on members sharing a traditional biography, do atypical learners impact on such a community, and if so, how? Might their difference affect both the newcomers and the ‘old-timers’ in those communities of practice?

The example of Hodges (1998) above seems extreme. Could dis-identification of this sort be a common result in those with uncharacteristic biographies? Colley (2006) investigates the vocational training of nursery nurses, and finds that there is a very clear idea of the kind of women (it is usually assumed they will be female) that should care for small children. It is part of the ‘doxa’ (Bourdieu 1986) of the occupation, “an adherence to relations of order which .. are accepted as self-evident” (p 471). These established qualities are encouraged throughout the course, and effectively act to filter inappropriate people out of the job. Nursery nurse trainees have to develop acceptable attributes (not only of identity, but of dress and

demeanour) in order to succeed. Those who have the ‘wrong’ biography and do not fit in become marginalised and finally excluded. In this way inappropriate behaviour and gender operate to include some while excluding others (Colley, 2006). Hodges (1998) is not alone in finding herself marginalised.

Investigation of the reproduction of occupational culture in vocational training has found similar tendencies, teaching adjusted more to students’ dispositions than to their general ability (Frykholm & Nitzler, 1993); socialization seems to take precedence over qualification. Meanwhile the students’ dispositions are being influenced by discourse peculiar to the given vocation. Thus individual disposition and the culture of the vocational environment (what Bourdieu terms the ‘field’) would appear to be interdependent (Wacquant, 1989). If an individual’s natural inclination to a particular career contributes to making that particular vocational field worth practising in, this could help explain the gradual moulding of identity to the vocational culture of the community Lave and Wenger (1991) allude to. The question remains, how may these ideas provide an understanding of the becoming of those with an uncharacteristic biography as they enter their new profession? Is it incumbent on the vocational field to adjust to their atypical background in some way, and what impact might the employment context (possibly unstable or fluctuating) have on the process?

Horizons for Learning

Hodkinson and Sparkes (1997) would say that an uncertain employment situation is but one of several external factors that can limit career choice. Preferences usually fall within acceptable cultural and social norms, which have since been termed ‘horizons for learning’ (Hodkinson et al., 2008). This useful metaphor depicts the career-choosing individual as being limited to seeing as far as their particular horizon. What is beyond is uncertain; only repositioning would provide more options. Bourdieu (1986) points out that however inclined a person might be to follow a particular career, they may only have the ‘choice of the necessary’, and Hodkinson (2008) uses the situation of the labour market to illustrate such choice. Suppose the individual applies for a much sought-after job. When two hundred others apply, the recruiting procedures become more rigorous. This will then impact

on that individual's career choice, and on those following afterwards, in that the sought-after post will become still more difficult to attain.

Social arenas are made up of unequal forces (Hodkinson 2008). For instance what Bourdieu refers to as social capital counts. This he defines as "the sum of the resources .. that accrue to an individual .. by virtue of possessing a durable network of .. relationships of mutual acquaintance and recognition" (Bourdieu & Wacquant, 1992, p 119). These resources may yield practical help and influence, depending on proximity and status. Several of my graduate respondents were from families with some form of health connection. In a few cases this was in the form of family members who were healthcare professionals, while in others there had been injury or were people with chronic disability in the family. The concomitant knowledge of the health system resulting from such relationships, and the access that might be gained to those within the profession, could be said to yield these respondents a degree of social capital when contemplating a move into physiotherapy. An individual's family and contacts, then, can influence how and where they look for work, so background as well as disposition can allow or restrict opportunities and choice. Similarly learning cultures can limit or enable learning. But Hodkinson et al. (2008) argue further that the interrelationship between disposition and learning culture is dynamic. A person's horizons for learning are ever-changing according to micro-factors such as fluctuations in personal circumstances as well as alterations in the broader social arena, including the employment situation.

That situation has changed considerably over recent years. As already noted (see Chapter 2), careers today are likely to be more fractured along their course than in the past, the individual experiencing more temporary contracts and episodes of unemployment (Collin & Young, 2000). Also, Jewson (2007) notes that, "identity may well lie in successfully traversing many communities of practice without becoming immured in any one" (p 79). Fuller et al. (2005) comment that 'old-timers' involved in change in their community might require not just Lave and Wenger's (1991) modification of identity, but a new learning to become. Current economic circumstances and the planned restructuring in the NHS, where the skilled workforce is threatened with downgrading, compromising career progression (CSP, 2012b),

give a graphic example of change that seems to imply some form of return to peripherality in the community.

Learning in the Workplace

Lave and Wenger (1991) wrote at a time of reconstruction of working practice, with the development of a greater emphasis on teamwork (as we saw with the development of the MDT) and a demand for more flexible specialisation in the workforce (Usher et al., 1997). Thus attention focused on workplace learning and an extensive literature on the subject fills many practical gaps in Lave and Wenger's (1991) approach. From it I aim to examine what learning is envisaged in a community of practice and how learning may be enhanced and any problems alleviated. I shall look specifically at individual learning within the community, as well as the transfer of academic knowledge into the world of practice. Exploration of these factors should help me understand my research respondents' movement towards full participation more clearly.

Factors influencing Learning

There is general agreement with Lave and Wenger (1991) that the context of a practice placement is crucial to learning. Not just location but the nature of the work, as well as the workflow in that area (Boud & Middleton, 2003; Hodkinson et al., 2008) are major influences. Indeed Hodkinson et al. (2008) stress that situation and resources, or the lack of them, cannot be neutral, such circumstances either restricting or enabling learning. Billett (2006) expands on this, commenting that local goals and practices will influence the structuring and sequencing of the activities undertaken. Placement needs, and external influences on them, therefore alter the affordances being offered the newcomer and therefore what is learnt. Even on the same placement, with the same staff and resources, no two participants will have the same experience.

There is consensus that the amount of support provided to the learner is all important. Of necessity this will be as varied as to preferences and values, competence and experience as the staff that support the novices (Billett, 2006). Stories and examples

are valued by students, particularly in situations of low workflow, where there is less expectation of practice than usual. Non-availability of staff support can mean junior staff do jobs normally allocated to the more experienced, and with less supervision (Billett, 2006). This can be influenced by both local policies and procedures, and government regulation in the cases of healthcare and education. Thus ‘frozen’ posts in the placement area can mean a quite different learning experience for the novice, as they may receive cursory supervision from overworked staff.

There are also factors individual to the participants themselves, their attitudes, dispositions and actions; how well they relate to their co-participants, particularly any supervisor; and what experience they may have had on previous work placements (Hodkinson et al., 2008). These authors’ research shows wider social and cultural issues too, such as social class, gender and ethnicity, employment opportunities and perceived status within their work area, social activities and family life, to be influences on learning in the workplace. The way such external factors affect workplace learning tends to be neglected by Lave and Wenger (1991), as is the notion that individuals do not enter a particular social setting as novice learners with “identical cognitive resources” (Eraut, 2000, p 131). Learning experiences can never be completely uniform then, and no one can be certain that individual learners in the workplace will learn exactly what has been planned.

Individual versus Purely Situated Learning

Wenger (1998) makes it clear that he wishes to avoid any separation of individual agency from that of the community of practice, but not all authors agree on this integration of the individual with the social. Billett and Eraut, for example, argue that cognitive learning and social practice can co-exist. Eraut et al. (2004) describe the difference between individual and social learning as analogous to the particle and wave theories of light, two ways of understanding the same phenomenon. The ‘wave theory’, or social perspective, focuses on, “the situation itself - its antecedents, wider context and ongoing interaction with its environment - and the transactions of its participants” (Eraut, 2000, p 132) and accords reasonably well with community of practice theory. The individual (or ‘particle theory’) perspective enables exploration of, “both differences in what and how people learn and differences in how they interpret what they learn” (Eraut et al., 2004, p 4).

Eraut et al.'s (2004) is a questionable analogy. Rather less contentious is the argument put forward by Billett et al. (2005). These authors, similarly defending a dual concept, argue that contributions from both the individual and the social situation make up the process of participation in activities at work; neither is sufficient alone. Workplaces provide affordances, chances to experience and learn, and the individual decides which of these they will engage with and how to integrate these into the accumulation of experiences already afforded them. Similarly the outcomes are dual in nature. The individual and their learning will have changed, and the cultural practice of work will have subtly changed too. Taking account of the individual helps explain some of the different styles of learning in otherwise similar work placements and suggests the process is more complicated than Lave and Wenger (1991) suggest.

The Process of Learning

Billett (2002) investigates the process of learning and concludes that workplace learning experiences are structured towards continuity of the workplace practice. He takes as his example apprentices such as the Liberian tailors Lave worked with and suggests tasks be ordered in rank of difficulty and risk when constructing an effective learning pathway for workers (Billett, 2006). Hard-to-learn tasks need identifying so that they can be given more attention and guidance, and Billett (2006) warns that more experienced staff are not always the best judges of which tasks these are. The newcomer begins by performing finishing tasks, tidying up after the main task has been completed. Next, specific skills and procedures will be learnt; then, tasks where mistakes are allowable. Finally, tasks will be tackled where mistakes would have significant consequences. Involvement in such everyday working activity will gradually extend and refine the apprentice's knowledge of their particular field.

Schön (1987) too views learning in the workplace as essentially ordered, but along what he terms a 'reflective practicum' (p xii). In professions such as medicine, Schön (1987) suggests, learning the technical skills needed for everyday practice follows the learning of appropriate applied sciences. Very much like Lave and Wenger (1991) after him, Schön (1987) visualises the beginner as learning by doing, in a relatively safe environment, with help from experienced practitioners. He agrees with Dewey (1974) that skill acquisition is crucial to the vocational situation. It initiates

novices into the working standards that constitute the tradition of the calling, and “initiation into the tradition is the means by which the powers of learners are released and directed” (Dewey, 1974, p 151). However Schön (1987) considers more than the skills needed for everyday work. There is a need to teach students “how to make decisions under conditions of uncertainty” (p 11). Here the usual standard procedures do not always apply, and reactions in the stress of the moment are notoriously difficult to explain. This kind of instinctive knowledge, Schön (1987) calls ‘knowing-in-action.’ Explanation of what is happening is likely to distort the original pure action, “for knowing-in-action is dynamic, and “facts,” “procedures,” “rules,” and “theories” are static” (p 25). He also considers what happens when the unusual fails to behave as expected. Reflection may take place after, or during a pause in, the event. But if it occurs during action, this will modify and reshape what happens directly, and he calls this ‘reflection-in-action.’ The reflective element here would be twofold: students first ‘reflect-in-action’, afterwards discussing their reflections with their coach, a form of reciprocal reflection-in-action. Thus while starting from a similar premise as Lave and Wenger (1991), that active learning in the workplace is essential, Schön (1987) provides more detail of the process.

Lave and Wenger’s (1991) work has been developed by Wenger et al. (2002) for use in the field of organisational learning, so it is possible to note what this literature has to add to Billett’s (2006) and Schön’s (1987) ideas. Boud and Middleton (2003), in a study across several worksites within a large organisation, find that after mastering processes necessary to the organisation, such as administrative tasks, workers learn to negotiate everyday workplace relationships and position themselves to ensure as successful career progression as possible. They then need to be able to deal with the occasional problem for which there is no set procedure. Boud and Middleton’s (2003) approaches seem very different from the other authors, as *they* concentrate on specific practice in tight-knit groups while Boud and Middleton (2003) concentrate on the smooth running of a larger scale workforce. They have in common the notion that the worker begins with smaller tasks and builds to the more difficult, but while Billett’s (2006) and Schön’s (1987) learners aim to gain proficiency in one occupation, Boud and Middleton’s (2003) seem to be preparing for a more flexible work-style, where career progression could be a move sideways to a new workplace

in the organisation rather than integration into one practice. Lave and Wenger's (1991) notion of centripetal movement is perhaps being superseded.

Enhancing and Hindering Learning in Healthcare

Eraut et al. (2004) similarly find gradual extension of experience in newly qualified hospital nurses' learning. They detail how team-working, deciding priorities of care and of-course working with patients, gradually promote learning, but they find successfully coping with challenge in the workplace provides the best chances of rapidly acquiring new skills, as also implied by Schön (1987). If such challenges are met successfully, confidence will be greatly increased, a factor of some importance among novices. But it takes considerable confidence to seek out challenge in the first place. Really helpful are the senior staff who encourage newcomers in this, such supportive learning making newly-qualified professionals more useful sooner and yielding a better return for the time and effort put into their supervision. Wenger (1998) agrees that "mutual relationships", together with "carefully understood enterprise, and a well-honed repertoire", are an investment that makes sense (1998, p 97).

Unfortunately Eraut et al. (2004) find that recognising learning as an asset to the professional community is offset by a failure to give feedback on progress. In work that presents unpredictable challenge of a dramatic nature (episodes of life-threatening illness) healthcare workers have been documented to require extra support and debriefing following challenging incidents, and stress is shown to be a major source of attrition (Lavoie-Tremblay et al., 2005; Lees & Ellis, 1990). Both timely feedback after such incidents and more measured discussion with an experienced 'old-timer' are found to be useful by even the most confident-seeming newly-qualified professional (Eraut et al. 2004).

Unsurprisingly there is literature that considers effective workplace learning to be dependent on the availability of varied participation opportunities. Billett found that "learners afforded the richest opportunities for participation reported the strongest development" (2001a, p 209). These are not only purely situational, for vocational learning can be much enhanced by the proximity of a good role model, demonstrating skills specific to that vocation and encouraging appropriate

professional reasoning (David, 2010). Hodkinson et al. (2008) add further that if the learning culture is supportive and most factors influencing the working environment are in synergy, then there is a good chance that learning will be more effective. Conflicts and tensions, they warn, have the reverse effect. I shall address possible areas of conflict in communities of practice under 'Relations in the Workplace' (page 67).

The Theory-Practice Gap

Another cause for concern in professions like nursing, where part of the time is spent learning in HE and part on placement, is that the educational section promotes professional values, while the goal of work on the ward is 'getting the job done' (Newton et al., 2009, p 316). This is an issue Lave and Wenger (1991) never consider, for they concentrate on situated learning as found in the apprenticeship model, only exploring the practical 'work on the ward' of Newton et al.'s (2009) example. Transferring knowledge and skills across this 'theory-practice gap', is seen as a problem, but of uncertain causality. Perhaps the difficulty lies in the separation of the two learning sites, conceptually as well as physically, or maybe the student is somehow unable to make the adjustment. Newton et al. (2009) suggest that the academic environment and the world of the workplace are communities running in parallel, and to succeed the learner "must be fluent in the idioms of the language of both cultures" (p 317). They conclude that it is not the learning 'gap' between university and clinical setting that causes problems so much as the difference in opportunities the two communities are able to afford the student. Work skills simulated in the academic setting can fall short in important respects, such as communicating with patients and their families (Levett-Jones et al., 2006). Managing competing demands and priorities, and interacting with the members of the MDT are also poorly achieved. Thus the learning experiences can at best co-exist, at worst be opposed one to the other.

Other authors see academic learning as 'vertical development' and learning in the workplace as more 'horizontal development', affording a broader spectrum of learning experiences (Guile & Griffiths, 2001). Newcomers can request to work alongside the more experienced on low risk jobs (here Guile and Griffiths' ideas resemble Lave and Wenger's (1991) concept of legitimate peripheral participation),

but the transfer of learning may not be easy. Transfer of learning in itself is very questionable to some however. To Hodkinson et al. (2008) the idea of newcomers applying past knowledge and skills when learning afresh in new situations seems very acquisitional. This continual amassing of knowledge suggests once again that unidirectional, vertical approach that Lave and Wenger (1991) hoped to counter with their concept of participation in a community. It would certainly be odd to conclude that, because transfer is not affected well, such new learning is completely interrupted. Hodkinson et al.'s (2008) solution is extremely simple, yet radical. People grow through their experience: if they learn in one situation, they can learn in another. "There is no learning to transfer. There are people who have learned, who learn as they move and learn after they have moved" (p 43).

This indeed seems to be so, for most professional-level vocational training involves first academic education and then workplace experience, and it is generally assumed that people learn reasonably well as they move from one site to the other. Several authors (Beckett & Hager, 2002; Guile, 2009; Hager, 2004b) agree that cognitive, academic learning and workplace learning should supplement each other rather than be alternatives. Beckett and Hager (2002) note that the formal learning component is not sufficient to produce high levels of competency without the addition of more informal workplace learning, while Hager (2004b) wonders if the cognitive might be integrated with the more situative learning in some way. Colley et al. (2003b) emphasise that all learning involves both formal and informal aspects; "the challenge is rather to recognise and identify them, and understand the implications of the particular balance or interrelationship in each case" (p 64). Thus, for example, much pre-registration professional workplace learning is formally negotiated and relies on occasional in-service training input, and the academic vocational training includes learning to socialise with staff and peers, as well as activities that simulate the teamwork found in the workplace. Alterations in balance between the two can thus usefully show up changes in learning.

Relations in the Workplace

Several authors stress the importance of good relations with fellow participants in the community of practice (Boud & Middleton, 2003; Eraut et al., 2004; Hodkinson et al., 2008). Lave and Wenger (1991) see workplaces as welcoming communities of practice, those more experienced encouraging the learning of novices by giving “interpretative support” (p 98). It is possible for relations to be less good however, and then learning may suffer. After considering potential areas of conflict and the tensions in communities of practice, I shall address the subject of the power relations that can affect both newcomer and established participant.

Potential for Conflict

Lave and Wenger (1991) focus on ‘practice’ in their theory rather than profession. This suggests a group of like-minded people with a common problem, coming together to solve it in a practical way. There is little discussion of dissention among participants, though the authors do admit that, as communities of practice are engaged in a generative process, there will be conflict and struggle (Lave & Wenger, 1991). Nor do they consider the potential disagreement that external regulation and policy might cause. A few years later Wenger cautions against over-romanticising communities of practice, noting that people can “make trouble” (1998, p 75) even as they develop shared practice. Despite acknowledging this however, Wenger (1998) continues to assume “a degree of innovation and creativity in their activities that contrasts with the dead hand of bureaucracy” (Jewson, 2007, p 72).

However more recently Wenger et al. (2002) warn that people in communities of practice can go their different ways, specialising and making themselves a reputation in the field. Competition and rivalry can develop and communities can even fail, and then are worse than having no community at all (Wenger et al., 2002). Such a situation is discussed by neither Lave and Wenger (1991) nor Wenger (1998). It is perhaps because Wenger et al. (2002) are concentrating on the development of communities of practice as domains, areas within organisations that can become “imperialistic” or reflect a certain “factionalism” (p 142), that causes them to consider this issue. But power struggles can affect smaller professional healthcare

communities too in a different way, as will be seen when I give the narratives of two established physiotherapists in Chapter 8 (pages 223-4).

Power Relations

Lave and Wenger (1991) do uncover one possible source of tension in the relationships integral to communities of practice, that between newcomers and ‘old-timers’. The authors acknowledge possible feelings of threat, novices being overawed by the superiority of the ‘old-timers’ skills, and the established participant seeing the arrival of the newcomer as a challenge to their continuing supremacy. If those more experienced in practice do not fully give their support to novices in the community of practice, those newcomers’ learning will suffer. Billett et al. (2005) extend this argument to all practitioners in the workplace. They note that institutional practice and individual intention, though based on supportive co-participation, are unlikely to be equally balanced. Hence there is the potential for tension. In a later article, Billett (2006) adds that people tend to guard their own interests, and in difficult times when there might be rivalry for the few jobs available, they will not support those who might displace them (thus reinforcing Lave & Wenger, 1991) or share knowledge with the less well paid or perhaps also with those on short-term contracts. This was indeed noticed by a few of my respondents who still lacked permanent posts (see page 149).

Such power relations can be more disruptive than Lave and Wenger (1991) concede. Novices entering a community of practice may be allowed to participate or not according to the ‘norms’ of that community. Colley et al. (2003a) note that immersion in the social and cultural aspects of practice is central to learning in a community of practice. This means that a newcomer has not only to look and act the part, but *feel* they belong to the membership. Hodges (1998) tells of how her fellow students joined her lecturer in laughing delightedly at the ‘cute’ drawings of a child Hodges (from her own past experience) felt could have been disturbed. Nothing showed Hodges to be other than an ordinary member of her community, yet she felt non-participatory. The reaction of her peers, as well as of the lecturer, made this the uncomfortable experience of the outsider.

Problems and how participants deal with them in communities are discussed by Boud and Middleton (2003). They find that rather than immediately seek their supervisor's aid, newcomers are more likely to approach their marginally more experienced colleagues. Here is an example of what Engeström (2001) terms 'horizontal learning', where peers are consulted in preference to the conventional vertical hierarchy. Boud and Middleton (2003) also find that it can be politically expedient to negotiate with someone higher than the supervisor, a strategy the authors suspect maintains informal connections that may pay dividends in the future, when promotion is considered. This departure from normal lines of communication but poorly reflects Lave and Wenger's (1991) idea of a well-bounded, community of practice. Would those with more knowledge of previous communities of practice negotiate, and so profit, more in such ways? Career planning manoeuvres might yield future personal success, but could conflict with the present participation in a community of practice along Lave and Wenger's (1991) lines, thus affecting workplace learning.

Boundaries of Communities of Practice

Such debate raises issues of boundary-crossing, not only of those round the close-knit communities Lave and Wenger (1991) describe, but also of internal boundaries within communities of practice. These seem to form an obstacle course newcomers must negotiate in moving towards the ultimate goal of full membership. Lave and Wenger's (1991) positioning of the novice at the periphery of the community with an acknowledgement that access to learning opportunities may be constrained is the nearest they come to an idea of boundary. Wenger (1998), on the other hand, devotes a whole chapter to this subject, so here I shall discuss what he and others write about the bounds of practice and reification, the way community members "project [them]selves onto the world" (Wenger, 1998, p 58). In addressing possible membership of multiple communities of practice, Wenger (1998) notes how a participant's learning overlaps, or can set up, boundaries; tensions can then arise when the demands of more than one community make conflicting claims on the individual's time and skills. How these are managed is crucial to continuing participation.

External and Internal Boundaries

Wenger (1998) seeks to correct Lave and Wenger's (1991) notion that communities of practice are isolated and unconnected to surrounding networks, but, despite his emphasis on interconnectedness, Wenger (1998) sees it happening only across boundaries. The image Wenger's (1998) discourse projects is of communities of practice alongside or slightly overlapping with the original: he talks of both boundaries, located between communities of practice, and 'peripheries', windows of connection with overlapping communities of practice. He himself took advantage of just such a peripheral 'window' as a visiting observer of a community during some research, and notes how "elements of boundary would creep in" (Wenger, 1998, p 120). There were expressions not fully understood, comments about a past occasion he knew nothing of. Wenger's (1998) point about language he failed to recognise is reinforced by Edwards (2005). Successful learners, she suggests, begin to interpret their world of practice using appropriate tools, including language to describe important conceptual ideas. For Wenger (1998) this had the effect of marking the boundary he could not cross.

Jewson (2007) is critical of Wenger (1998) for only discussing the symbolic cultural boundaries that, peripherally orientated, separate one community from another, while avoiding the subject of boundaries that can emerge *within* the community of practice, as might be found where there are groups of specialists within a profession, not always agreeing about finer points of practice. Significantly, Fuller et al. (2005) point out that there are those in communities with the power "to reset and relocate boundaries which extend or deny opportunities for learning" (p 54), influenced by both external socio-economic factors and the prevailing culture of the community itself. One recent re-establishment of boundaries within healthcare has led to the curiously isolated situation of the Extended Scope Practitioner (ESP). Here a member of some pre-eminence in one community (nursing or AHP) extends their practice to take pressure off another community (medicine), and risks being marginalised from one, and resented and excluded from the other (Dawson & Ghazi, 2004), for ESPs can feel isolated from physiotherapy colleagues, with concomitant loss of professional identity, while sometimes aware that "medical staff would have preferred another doctor on the team" rather than them (Dawson & Ghazi, 2004, p 213).

Reification

Wenger (1998) uses the term reification to describe the forms this boundary that helps define whether or not an individual has achieved access to, or indeed is becoming marginalised from, a community of practice may take. It can be symbolic in form, as when participants wear a particular badge, giving meaning to the activity they perform. Language or terminology peculiar to a community is a form of reification, as are historical records, such as royal charters, that give status to the community. More concrete forms are the written procedures and regulations used as a tool to argue the best methods of practice. We have seen the priority accorded such reification in the earliest days of the physiotherapy profession, when public trust needed to be built up in the light of the negative reputation masseuses had acquired (see Chapter 2). Members are expected to carry out their duties to qualifications that are credentialised and to documented standards. All these special accoutrements demonstrate the presence and working entity of the community of practice to the surrounding world.

They also indicate the boundaries of the community of practice. In professions of greater social status, reification can take the form of cultural capital, acquired over numerous generations (Bourdieu, 1986), peculiar ceremonies marking the stages of passage through the community. Being ‘called to the Bar’ as a new barrister provides a particularly vivid image of inward boundary-crossing. However, participants that question elements of reification, new modes of practice or realignment of regulations perhaps, can find a boundary before them, the crossing of which moves them out of the community (Colley et al., 2007). When Wenger (1998) declares, “We produce precisely the reification we need in order to proceed with the practices in which we participate” (p 69), he is speaking for the majority of participants at a particular moment in time, but what about those who, for one reason or another, do not fit the ‘norm’ of the community, and what happens when the practice participated in changes, as several authors suggest it must (Arnseth, 2008; Billett et al., 2005; Handley et al., 2006; Hughes et al., 2007)? Perhaps there is a necessity for the individual not only to change initially to integrate with the community, but to change continually to keep pace with community development, especially in an era of constant, so-called, ‘modernisation’.

Peripherality and Participation

Lave and Wenger (1991) use the term legitimate peripheral participation to describe what happens to the newcomer rather than the established member in the community of practice, so it is still unclear, in the face of community change, what legitimate learning the ‘old-timer’ can accomplish. Emphasis is on allowing the novice the right to participate, but there is also the implication that learning is not carried out apart from the community, but only as part of the practice of the membership. I return to this fundamental concept of Lave and Wenger’s (1991) theorising to discuss particular issues in the literature concerning peripherality and participation, before finally attempting to discern what is meant by ‘full’ participation.

Peripherality

Lave and Wenger’s (1991) case study of supermarket butcher apprentices shows that legitimate peripheral participation sometimes fails. Managers were unwilling to neglect the profit-making side of the business in order to train these apprentices in some tasks, and progress was thus considerably impaired, with newcomers reluctant to move into areas where they felt particularly under-skilled. Lave and Wenger (1991) interestingly comment that, “the butchers’ apprentices participate legitimately, but not peripherally, in that they are not given productive access to activity in the community of practitioners” (p 104). This seems confusing, for clearly the apprentices are *positioned* peripherally in the community. It is just that they are being used as assistants to the butchers rather than being trained properly to become fully participating butchers themselves.

Jewson (2007) suggests that the word ‘peripheral’ has a metaphorical rather than a substantive relational meaning in this context, and indeed Lave and Wenger (1991) would appear to bear this out when they state that “there is no *place* in a community of practice designated ‘the periphery’” (p 36 - italics added). Peripherality then, in Lave and Wenger’s (1991) and their followers’ terms, implies access to the initiatory activities, termed ‘affordances’ by Billett (2001a), that can be essential to the novice. Learning may vary; it is access that is important. The more common use of the word ‘peripheral’ as a reference to position in the community is not one they subscribe to. Lave and Wenger (1991) intend the concept of legitimate peripheral participation “to

be taken as a whole” (p 35), in which ‘peripheral’ describes a form of participation within a particular context and has no physical reference to a location in the community.

Thus legitimate peripheral participation, the necessary precursor to full participation, is seen as an “inclusive location” in a community of practice, unlike marginalisation (Hodges, 1998, p 285). Wenger 1998 makes an attempt to clarify this, explaining that peripherality is part of an inbound trajectory towards full participation. Marginality, on the other hand, is restricted participation and is consistent with outward movement. Here he instances people who are not, or not yet fully, on the trajectory to becoming full members, who may yet be provided with peripheral experiences. An example, in the context of physiotherapy training, may be the case of student observation of the workplace. But now ‘periphery’ has a positional meaning: he writes of “a region .. neither fully inside nor fully outside, .. surround[ing] the practice with a degree of permeability” (Wenger, 1998, p 117), of levels of involvement in communities of practice, becoming progressively less binding towards the extreme periphery. This seems to contradict the original meaning of peripheral participation envisaged by Lave and Wenger (1991).

Conflating marginality with non-participation (Handley et al., 2006) can also give rise to confusion in a further way. There are those who, unlike the student observer, have been legitimate peripheral participants for some time but are unable to move on towards full participation. Examples would be newly-qualified staff on short term contracts. The fact that they are to move away from the community when their contract ends, keeps them in a marginal position vis-à-vis the permanently employed. Handley et al. (2006) suggest only those successfully completing the path from peripheral to full participation should be labelled as ‘participating’ in Lave and Wenger’s (1991) terms. This would mean there were a lot more people restricted to a marginal position in communities, voluntarily or otherwise, than are acknowledged in the literature (Handley et al., 2006). Should marginality of this sort really preclude full participation? The majority of my respondents spent some time in this situation, so did they perceive their position as one of participation or not?

Participation

Participation is a core element of workplace learning, but Lave and Wenger's (1991) viewpoint is limited to that of the immediate community of practice and any overlapping neighbouring communities. From this micro-level up to the macro-level community of the professional body, learning is enhanced by the introduction of newcomers (Fuller et al., 2005). It is not only the novices that learn. Their "constructively naive" outlook (Lave & Wenger, 1991, p 117) can prove stimulating. 'Old-timers' refresh and review their knowledge and refine their skills as they practice alongside their less experienced colleagues. Similar affects are noticeable at macro-level. People moving from one position to another in the workforce provide a form of internal audit, their fresh perspectives on their new situations influencing future practice. Such change, continually occurring as learning happens at different levels, confirms the benefits of investment in training. Not only will the newcomer become a useful member of the workforce, but their presence may be a useful catalyst to enhanced activity.

There is a paradox here however, as Hodges (1998) points out. Participation supports the continuity of novices in the community of practice, yet at the same time they experience displacement within the community, as they move nearer the centre, and thus, thanks to their contribution, the structure of the community is ever-changing around them. For they will impact on the learning culture of their community. Hodkinson et al. (2008) enumerate three ways in which this happens: by their position within the culture (social impact), their dispositions towards the culture (cultural impact) and the capital in various forms (social, cultural and economic) they bring with them (economic impact). In the first of these, newcomers have a particular social impact on the community, for they will require supervision and support, and this may alter the power relationships that exist among the more experienced members. Then the novices may find it easy to work in this cultural environment, or take time to integrate into it, to learn to belong. The learning culture will change them, just as they, in their turn, can change the culture. It forms a part of the individual's life and will influence what they do, but it is not their whole life. Again, it is noticeable that Lave and Wenger (1991) consider other aspects of participants' lives much less than their engagement in the working community. Both Hodkinson et al. (2008) and Billett et al. (2005) stress the importance of seeing the learner as a

whole. How they feel about work, the activities that are important to them outside work, and the experiences they have had before taking up that job at all, may well impact on the learning culture of the community, as will be seen in the case of several of my respondents. Newcomers can aim intentionally to change the learning culture of a community to preserve their preferred practices, but usually just their presence will have an effect, whether they will it or not.

When Handley et al. (2006) question the difference between participation and “mere engagement in practice” (an expression used by Wenger, 1998, p 57, suggesting a lack of commitment and belonging to the community), the answer may be that participation means having an effect on the shared life of the community. Indeed a person engaging in their community in appearance only may be on their way to marginalisation. Handley et al. (2006) note that, far from allowing this to be an option, Wenger (1998) points out that people do not switch off their participation as they leave work. Activities outside the formal workplace are influenced by vocational participation, and presumably vice versa. Though this last point is not followed up by Handley et al. (2006), the idea that outside activity could affect participation is a salient one, as has been mentioned above. Instances of this being the case will be explored in Chapters 6 and 7.

The Meaning of ‘Full’ Participation

As Hodkinson et al. (2008) refine Lave and Wenger’s (1991) work to add scales of communities of practice, Handley et al. (2006) attempt to categorise variations in participation. Their lowest category is *marginal* participation as exemplified by the case of the supermarket butcher apprentices. Next they suggest *contingent* participation, where a newcomer decides to participate longer at a more marginal position in a community to ensure better adaptation to the practice of the community. While Wenger (1998) might call this a form of marginalisation, Handley et al. (2006) argue it to be more like voluntary marginal participation. The third category is *legitimate peripheral* participation, and the final one is *full* participation as practiced by ‘old-timers’ within the community of practice. Lave and Wenger (1991) assume members are aiming for this ‘full’ participation, but how it is to be recognised seems

unclear. Does one ever really arrive there? In discussing these issues, I shall consider the appropriateness of the term 'trajectory' for the path from novice to full participant, how authors define full participation, steps along the path to skill mastery and finally what is meant by expertise.

'Trajectory' Questioned

The term 'trajectory', with its image of upward and inward movement towards a hypothetical plateau of full participation, implies some form of eventual elevated stasis, an end to vocational development. Fuller et al. (2005) note that in a thriving and developing professional atmosphere, full participants in a community of practice would be expected to continue to learn and to refine their skills. A community's patterns of practice are influenced by surrounding cultures, societal factors and national economic issues, such as labour market conditions. The career path in such an environment follows a progress that is by no means certain and can be but poorly controlled by the individual. In a world where work has become fragmented into episodes of employment and the individual is uncertain of their future, Collin and Young suggest that careers will develop "strong horizontal .. characteristics" (2000, p 94), rather than appear to have a definite onward and upward direction. People will try to accumulate broad experience and qualifications as a more secure basis from which to demonstrate adaptability to whatever opportunities arise. For Arthur et al. (1999) such preparation allows the crossing of multiple community boundaries, what they term the 'boundaryless career'. If opportunities appear at the right times careers can advance, but if future job prospects are unpredictable, there may be no incentive to "work hard, and invest in self-development" (Collin & Young, 2000, p 93). This, the authors argue could lead to stagnation. On the other hand, if a junior member of staff has achieved the difficult job of securing a temporary post, they may well work harder to try to assure their recruiting superiors that they are worth retaining and promoting. In neither situation is the term 'trajectory' appropriate, with its connotations of inevitably upwardly inclined onward progress.

Defining Full Participation

The goal of 'full' participation is thus problematic. Lave and Wenger (1991) view alternatives to the word 'full'. 'Central' would imply a central position in the community of practice, which they do not envisage, any more than they do a

periphery. 'Complete' participation could suggest "a closed domain of knowledge or collective practice for which there might be measurable degrees of "acquisition" by newcomers" (Lave & Wenger 1991, p 36) and the authors want to avoid any such intimation of cognitive learning or finite knowledge. They therefore restrict full participation to being the antithesis of partial participation, the goal of fully belonging to the community, which is a key driver of early learning. In his foreword to their book Hanks (1991) is more explicit. He sees full participation in terms of "ability to anticipate, a sense of what can feasibly occur within specified contexts .. a prereflective grasp of complex situations .. [and] the ability to improvise" (p 20), all features which suggest an easy mastery of practice, born of repetition in multiple diverse situations. Using an expression of Bourdieu's, Hodkinson and Hodkinson (2004b) summarise this as 'having the game under the skin' (p 179). The general impression is of an essentially subjective concept, feeling different for each individual, but recognisable to colleagues.

This recognition is seen as an important step on the way to full participation by Boud and Solomon (2003). To be viewed as a 'learner', they say, is associated with still being a novice and "can position one apart from the group" (p 330). Such an attitude to an established community member's innovative learning might be seen as a sign of ultra-conservatism however. New learning can dramatically move a profession forward, and this is implied by Billett (2006), who writes of full participation as "being able to participate effectively in, and potentially transform" the work practice (p 33). If the individual performs effectively but as full participants have always performed, there can be no transformation. Such practice may fit in with the case studies of craftspeople Lave and Wenger (1991) chose, and indeed fits well with much everyday professional practice, but it is the effective performance of more risky procedures that gives participants higher status with their employers, the refinements of skills that can move practice on. There may be a case for counting everyday proficient skill as full participation, while labelling refined high-level practice 'expertise'.

Stages of Skills Acquisition

There is literature that attempts to categorise the levels of proficiency of the individual as they progress towards mastery of their skill (Benner, 1984; Dreyfus & Dreyfus, 1980). Dreyfus and Dreyfus' (1980) five-stage model details changes in perception of a task recorded by performers acquiring complex skills. Their five stages are novice, competence, proficiency, expertise and mastery. The novice understands basic information but it remains context-free. Competence brings awareness of common situational patterns, and how to act appropriately to correct minor error. Proficiency allows a holistic view of a task, and maxims appropriate to most typical situations have been memorised. The maxims become less needed by those with expertise. This model is questioned by Eraut (2002) however, from the point of view that there is an assumption that learning will be extended throughout the process, as he notes “.. the development of expertise in one aspect of professional practice .. might sometimes be at the expense of another aspect of practice” (p 377). The established practitioner data from this study does indeed suggest that practice will have narrowed as expertise grows (see Chapter 8, page 228).

Dreyfus & Dreyfus (1980) instead concentrate on how, for the expert, “each specific situation immediately dictates an *intuitively* appropriate action” (Dreyfus & Dreyfus, 1980, p 12 - authors' emphasis). Again this study's data finds that the word ‘intuition’ commonly appears when expertise is discussed (see Chapter 8), but is difficult to analyse. Although acknowledging no higher level than that of expertise, Dreyfus and Dreyfus (1980) choose to add a final stage of ‘mastery’, in which they attempt to explain this intuitive element. During “moments of intense absorption”, they suggest, the master of a skill can find the mental energy used before to monitor their work is channelled into producing “almost instantaneously the appropriate perspective and its associated action” (Dreyfus & Dreyfus, 1980, p 14). It is almost as though they were no longer aware of their actions. This rings true in as far as it resembles the acquisition of a new skill like driving. The novice has to think about every step of the procedure to follow in changing gear, but eventually, after much repetition, does it without conscious thought.

The five-stage model was adapted and popularised for healthcare workers in Benner's (1984) seminal work for nurses, 'From Novice to Expert.' Here the stages have become novice, advanced beginner, competent, proficient and expert. The novice has learnt about clinical situations in terms of objective measures such as a patient's temperature and blood pressure. This nurse's behaviour is governed by rules, a situation which "... legislates against successful performance because the rules cannot tell them the most relevant tasks to perform in the actual situation" (Benner, 1984, p 21) The added stage of advanced beginner refers to a nurse who has enough experience to recognise some situational attributes, such as the patient's readiness to learn or cooperate. This individual can follow simple guidelines but needs help to decide clinical priorities. Benner (1984) suggests that any nurse moving to a new area of work tends to revert to this level in the new area, however experienced they have been in the previous one. This is arguable, for if the nurse has been proficient in one area they are likely to be nearer the position of the 'knowledgeable outsider' (see my position, page 7) in their next, different speciality, than that of the uninitiated novice. There is every likelihood that they will soon become at least competent once more.

Benner's (1984) competent practitioner has been two or three years in the same area and has thus begun to be aware of long-term goals for their actions. This gives perspective to what they do and is based on "considerable conscious, abstract, analytic contemplation of the problem" (Benner, 1984, p 26). This individual will be functioning fully in clinical work, an efficient and well organised member of the nursing team, so perhaps their level is equivalent to Lave and Wenger's (1991) 'full participation'. Or does the term apply better to the next stage? As with Dreyfus and Dreyfus' (1980) model, Benner's (1984) proficient practitioner is perceiving a more complete picture of the clinical situation: they thus note early warning signs more quickly than the lower level, competent nurse and can modify management appropriately. Benner (1984) generalises that it probably takes nurses about 3-5 years in one area to become proficient.

Expertise

Yet again Benner's (1984) expertise remains infused with the magical aura that Dreyfus and Dreyfus (1980) give it. Their example of an expert nurse speaks of not

always being able to justify how she knows something, but that she is ‘never wrong’. Her inability to express her knowledge in words and the lack of logical explanation in her certainty has drawn criticism (Gardner, 2012). It does not help that Dreyfus and Dreyfus (1986) later reinforce this when they assert that, “competent performance is rational .. experts act arationally .. in a manner that defies explanation” (p 36). It appears that though such expertise can be learnt from experience in the workplace, it would be difficult to teach it. And as Gardner (2012) comments, this model of the path to expertise also challenges Schön’s (1987) concept of the reflective practitioner (see page 63), for how can arational, intuitive decisions be reflected upon effectively? Dreyfus (2007) has since asserted that as soon as someone coping well in a difficult situation (where an expert would act to best effect) steps back and tries to explain why they have answered a particular tension with a specific activity, “the tension is transformed into an object and it’s motivational character is lost” (p 107). This indeed appears to suggest that no consciously rational decision has been made, and thus that reflection is not possible for many of the ‘advanced’ activities humans perform.

Elsewhere, Edwards (2005) defines expertise as being able to interpret complexities in a social situation and having the ability to respond to them. She describes it as a process of ‘expansive learning’. This term, initially defined by Fuller and Unwin (2003), includes experience of a variety of learning affordances, some planned outside the workplace in more formal settings; gradual rather than fast attainment of full participation; and some opportunities to cross boundaries to extend identity construction. The presence of such features, Fuller and Unwin (2003) argue, enriches the opportunities in that community and fosters what they term ‘deep learning’. They compare it to ‘restrictive learning’, comprising access to competence-based qualification only, over a short time and without the benefits of dedicated individual support.

Beckett and Hager (2000) pinpoint a particular aspect of ‘expansive’ learning as signifying expertise. Managing situations in the workplace is characterised, at all levels from the individual to the macro-level community (Hager, 2004a), by judgement-making ability. This capacity, representing “a paradigmatic aim of workplace learning”, is achieved in a variety of different scenarios and grows as

learning advances (Beckett & Hager, 2000, p 302). This is a helpful way to evaluate the degree of learning an individual has undergone. According to Beckett and Hager (2000), the development of judgement-making capability comprises three stages. People first learn to separate the need for a judgement from the process of judgement itself; they then “‘read’ the conative, emotive and ethical considerations in the light of that separability”; and finally comes the stage of “de-centring .. [their] sense of identity” at one of the previous stages, though not in both of them (Beckett & Hager, 2000, p 310). This analysis implies both a considerable degree of discrimination on the part of the expert, and also that they can separate themselves from the judgement to some extent, suggestive, Orr (2009) points out, of collective rather than individual decision-making. This means apparently ‘intuitive’ sophistication of practice can be demystified “by placing it within an everyday framework of informed decision-making” (Orr, 2009). Given expert role models, newcomers may help perpetuate specialist skills that enrich the whole community and perhaps career-changing graduates can add subtle distinctions to this learning thanks to previously developed expertise they can contribute.

Summary and the Focus of the Investigation

Lave and Wenger’s (1991) influential work gives due credit to the important learning novice professionals undergo at work, and celebrates the contribution of front-line workers to the effective running of their employing organisations (Hughes et al., 2007). As far as my study is concerned, the authors provide a useful framework for understanding the working situation, the notion of participation in the community of practice being helpful in analysing how an environment influences ambient learning. As Colley et al. (2003a) point out, a situated approach allows in-depth questioning of people’s preparation to become members of a profession, or in some cases their movement away from doing so. However, it leaves unresolved issues and raises questions which will be explored.

The key issue here is to elicit whether my mature respondents’ biographies, atypical for their chosen profession, might affect their progress. They have already been positioned in at least one other community of practice prior to commencing

physiotherapy vocational training and bring with them a wealth of social, cultural and economic capital (Hodkinson et al. 2008). The idea that learning as becoming can be a recurrent feature in the modern career path has been explored in the literature (Colley et al., 2003a; Hodkinson et al., 2008). Colley et al. (2006) have considered how the ‘wrong’ biography can be used to filter out individuals in some occupations, but only Fuller et al. (2005) have looked at all at the effect “import[ing] ‘old timers’ from elsewhere” (p 51) might have, and these were imported from the same profession. This leaves an empirical and theoretical gap. There is a need to explore both the effect on these already experienced individuals and on the practice of the communities they join. No-one has considered whether the vocational field has to adjust to the newcomers’ atypical background in some way, what now might be involved in what amounts to identity re-construction in the new career; and what impact the employment context (possibly unstable or fluctuating) might have on the process. This is what the thesis will go on to investigate.

Much of the literature reviewed in this chapter (*inter alia* Bourdieu 1986; Eraut 2008; Lave & Wenger 1991; Wenger 1998) implies that the career path involves movement, as exemplified by the term ‘trajectory’, and indeed travel along a ‘path’. There is a perception of travel in three senses, temporally, spatially and metaphorically. Over time newcomers become comfortable with the kind of work expected of them and gain practical skill; spatially they move from small-scale, supervised group work to larger more diverse groupings where they have more responsibility; metaphorically there is the sense of moving inward towards the centre of the community, as Lave and Wenger (1991) suggest by noting the initial phase in the process to be *peripheral* participation. This requires investigation to see what is actually happening during this process from the point of view of the people experiencing it and to try to understand what the proposed implications might be for the concept of community.

The ‘community of practice’ itself has also been shown to exist in many different forms. Using Hodkinson et al.’s (2008) scales I have identified the following. At sub-micro-level is the individual learner, be it novice participant or solo practitioner; the micro-level, or occupational community, is in the workplace and most resembles Lave and Wenger’s (1991) concept; above this is the meso-level community of the

organisation or institution that recruits individuals in the first place; higher still, yet at much greater distance positionally, is the macro-level community, the professional body, influencing practice at micro-level by means of what Wenger (1998) termed reification; the last level is the body connecting professionals worldwide, the super-macro-level community. But there are many sub-categories of community: compare, for example, the close-knit micro-level community of the physiotherapy out-patient department with the multidisciplinary team of workers on a hospital ward, where physiotherapists are but one of a number of minority groups. There could even be occasional 'fast' communities of this type (Roberts 2006), set up to discuss and eradicate a specific patient's problems (see Appendix I for a table of possible categories).

Imagine, too, how a group private practice of physiotherapists might be categorised, for one of their number is the employer, so that individual would appear to be both a member of the micro-level group and, with their accountant and any sponsors, in a meso-level community as well. This pertains for hospital staff who are both practitioners and managers, an example or two of whom are among my established physiotherapy respondents. It is a confusing picture and newcomers may need to adjust to, and focus on, more than one healthcare sub-community as they begin their career afresh.

This will have begun in university, however, for communities in the academic environment and on practice placement exert an influence in parallel with each other during vocational training (Newton et al. 2009). The Northtown students who participated in this study carried out their skills classes and tutorials in teaching groups of 28 or so, and worked most closely with these people within their cohort of over 130. They had common goals and often supported each other in attaining them, under the supervision of their lecturers. Though not yet part of the working environment, in many ways this resembled the community of practice Lave and Wenger (1991) describe. Distanced from the healthcare communities of the hospital setting, this was the community students belonged to before going on their first practice placement. Not only was there a physical displacement and a change of personnel and organisational reification, but it required an epistemological shift in thinking when moving between the two environments, an acclimatisation from

theory and simulation of skills to real practice with patients. This transition, then, accustoms the novice to the fine-tuning of identity required in moving between communities in their new career, but the respondents in this research were career-changers, so perhaps they could already adjust with ease, having experienced similar transitions in the past.

All such newcomers to physiotherapy experience legitimate peripheral participation during student placements and, according to Lave and Wenger (1991), should move on into the community towards full participation. But as newly-qualified staff they are still arguably in a peripheral position. Their experience on the career path onward, their perceptions of full participation, that term that is so difficult to define, and the factors that affect their progress, are all of interest. Part of the context of the study is a degree of unemployment, so all graduates, irrespective of their previous histories, are vying for relatively few jobs, and many begin in posts with short-term contracts. The impact of this situation on people with lifestyle constraints, parenting or other financial responsibilities outside work for example, will be explored, as too will be whether factors such as previous knowledge of the world of work and individual disposition can affect occupational success. Any factors, structural and individual, which either facilitate or hinder progress will be investigated.

Main Research Questions

Thus my main research questions are:

- What are the experiences of physiotherapy graduates who have been members of a previous workplace culture as they seek to become members of the community of practice of physiotherapy?
- What is the nature of these graduates' movement from legitimate peripheral participation onwards?
- How do they conceive of full participation and what factors enable or constrain their movement towards this?
- Is the concept of a 'community of practice' a useful way of making sense of transitions from one career to another?

Chapter 4

Methodology:

The Design and Conduct of the Study

In the first three chapters the context and main issues of the research were discussed and the literature reviewed. This chapter now addresses the philosophical positions and methodological issues leading to the study's design and the procedure employed to answer the research questions given above. The design of the study was directed towards answering these questions, which had arisen from the contextual framework built up by reviewing the salient literature on community of practice theory and workplace learning, and initially from the experience I had as a lecturer, of training physiotherapy students who then failed to find appropriate first posts. This was further augmented by my memories of working as a PRO promoting physiotherapy as a career with ensured employment, and frustration that this was no longer the case. Thus this study arose not so much from any particular ontological view of research based on *a priori* premises, but from my experiences, the changes I had witnessed and my desire to learn how those I had taught were coping with the situation. As well as giving a voice to the mature graduates affected, the findings would hopefully inform those providing education, guidance and employment in the field of physiotherapy in ways that should benefit NHS users.

However as I read the literature my focus also started to encompass whether or not theories of workplace learning, and in particular Lave and Wenger's (1991) theorising really approximated to what was happening in the field. There was a knowledge gap concerning what transpired when people changed from one career to another, not only regarding how the individuals themselves might have to change, but also how it might introduce change into their chosen new profession. Thus I hoped that my investigation of these questions might further develop understanding of the dynamics of participation in communities of practice. The study was thus exploratory and essentially qualitative and descriptive in nature. I aimed to explore key issues in a novel and increasingly changing situation. In this chapter I mean to demonstrate how my study evolved from these opening aims to achieve a coherent methodological approach.

I shall begin by discussing the underpinning paradigm as it relates to the research questions, and justifying the research design. Piloting the study is then discussed with a brief section on the recording of data. An explanation follows of how the three samples, of mature students, middle managers and established practitioners, were chosen and how the main groups of research respondents were recruited. This involved ethical issues which are discussed here and the procedure of data collection documented. The chapter concludes with sections on data analysis and its interpretation.

The Question of Paradigm

Belonging to a medico-scientific profession I had been used to entering into research in order “to come to a better understanding of the natural world” (Elman, 1995, p 77) and in particular the effect of various treatments on my patients. Research is relatively new to the AHPs, though more has been done in nursing, and “research funding availability and an NHS climate of outcome measures, protocols for treatment and objectivity in research has tended to reinforce an experimental bias in physiotherapy research” (Heathcote, 2010, p 98). My colleagues and I had most commonly employed quantitative methodology. I was now researching to gain a better understanding of social activity, and this signalled a shift in focus. Positivist experimentation entails manipulation and control of measured variables to prove or disprove hypotheses: universality is sought, one verifiable truth. In the social sciences more exploratory and naturalistic approaches are required.

The focus of this more naturalistic or qualitative methodology is on understanding social phenomena, on collecting the opinions, feelings and experiences of the research sample rather than more quantified answers to research questions (Meadows, 2003). An objective of this study is to identify the variety of pathways into a profession, including the perceptions and experiences of the professionals involved (Miles & Huberman, 1994), so such a qualitative approach is appropriate. Inductive methods were employed where conclusions are “drawn directly from the data” (Meadows, 2003, p 465).

To explore the particular situation of the individual's path into their new career requires a means of judging what counts as a reasonable conclusion from the data gleaned. To this end I needed to acknowledge a working paradigm, a "worldview built on implicit assumptions, accepted definitions, comfortable habits, values defended as truths, and beliefs projected as reality" (Patton, 1978, p 267). It was not enough to consider and reflect on the situation: action must be taken, data collected, to give evidence of what was transpiring. However it has to be acknowledged that such action occurs against a background of unquestioned assumptions that, if untested, could submerge reflection. It is all too easy to forget to ask why certain things are as they are, because it is so socially accepted that they are so. Sparkes (1992) describes this as seeing the world through a particular set of lenses and making sense of what is seen in the light of the set of lenses worn.

I have already referred to an ontological position, that I became interested in doing this research because of my experiences. My view of what was happening was not "a given 'out there' in the world" (Burrell & Morgan, 1979, p 1) but a product of my own perceptions. I thus took a subjective rather than an objective view 'through my set of lenses'. I had been a typical entrant to the physiotherapy profession and felt very much part of its culture. Now I was looking at people similar to myself, yet also other than myself, atypical entrants to the profession, and attempting to empathise with their particular 'internal worlds', their thoughts and feelings. These were not definitive entities that were visible as part of the external world, and I was viewing them through the 'lenses' of my internal world. Also the investigation was context specific, my graduate respondents' career paths sometimes barely recognisable from the viewpoint of my experience of what might be considered the same journey 40 years before. Nor were they easily comparable to each other in the same historical context, each individual feeling what was happening in a subtly different way and from a slightly different perspective according to their specific backgrounds and experiences: they could not present a unified whole. This pointed to a relativist ontology (Denzin & Lincoln, 2005), a worldview of multiple and shifting realities.

Closely linked to ontological position is epistemology, ideas of what truth can be gleaned from an investigation and what forms of knowledge can then be communicated to others, for assumptions of knowledge underpin both the procedure

used to attain information and the analysis of the data collected in any research. My knowledge of the changes in career paths of my graduate sample and why this was happening was based on what I had read in CSP and other healthcare literature and on what graduates and clinicians had told me. I had observed that graduates were following career paths that were different to the ‘traditional’ route most followed in the past, and by inductive reasoning I reached the conclusion that my career-changing mature graduates would be of their number. It is important to acknowledge that the information I had received might not be totally objective. Physiotherapists, including myself, felt strongly about some of the changes afflicting the newly qualified staff. There was a broad range of factors blamed for the situation (Toyn, 2006). It dealt with people in social situations and as such would tend to be subjective and unique to the individual. My graduate sample’s discourses of truth, their individual narratives, would be highly subjective, and influenced by the political, social and economic discourses around them.

Nor could I trust myself, as the researcher, to be completely impartial. As Sparkes (1992) puts it,

“.. we cannot, and do not, enter the research process .. as blank slates that data imprints itself upon .. the researcher’s basic assumptions concerning the nature of reality, truth, the physical and the social world infuses all aspects of the investigative process” (p 14/15)

It was necessary that I bear this in mind as I researched this situation. I wanted to explore individual experiences in all their variety, to look not only for similarities but also for those elements that did not fit into a pattern. This meant accepting that there would be several different ways of viewing the same phenomena. It was reassuring to read that “there [was] no ‘value-free’, neutral, free-standing objectivity” in other respected social scientists’ method (Grenfell & James, 1998, p 176) for, strive as I might, I did not expect to attain it in mine.

Methodological Approach

In summary, I saw the world as construed in very different ways by different individuals (Walliman, 2011), understood through personal perceptions of reality, which in turn were “influenced by .. preconceptions, beliefs and values” (p 22). My

initial aim, then, was to tell my graduate research respondents' stories, using an interpretivist approach. In other words, I aimed to show a little of their different interpretations of the world. The approach has a "central research interest in human meaning in social life and its elucidation and exposition by the researcher" (Erickson, 1986, p 119). In order to answer my research questions I should ask my respondents about their experiences, their feelings and their perceptions of what it was like to enter a new community of practice. I was then going to interpret what was told me as best I could. This meant that when using interpretivist methodology I could not expect to gain a dispassionate, objective view of the situation. By contrast, I was moving into a position of interaction with my respondents. This was a standpoint that recognised the "'embedded' nature of the researcher" (Walliman, 2011, p 173): I was seeking "transactional knowledge" (Denzin & Lincoln, 2005, p 184) and must be prepared for a potentially complicated and 'messy' picture of what was happening (James, 1996).

Interpretivists can have one of numerous different perspectives on methodology, among which are some that could be appropriate for this study. The graduate sample might have been treated as case studies, in-depth portraits of individuals undergoing transformation from one community of practice to another. But while two or three of them have been studied in more depth than the others (Barbara and Gwen in Chapter 6 and Mike in Chapter 7), several have only received a mention, so it was not my perspective in general. It is possible to conduct anthropological case studies in a single setting (Stark & Torrance, 2005), for example of the situation in a university or workplace, but that would have been a long-term observational type of study inappropriate to the two or three 'snap shot' interviews during the course of an individual's career journey carried out in many different settings during this study.

It could also have been possible for me to research from a feminist point of view, for as I commented in Chapter 2, physiotherapy has been a feminised occupation from its inception. However some 40% of my respondents were men, so the view gained of the profession through my graduate sample's eyes was almost equally that seen from both sexes. Nor was it appropriate to focus on any one group, however much a minority, to the exclusion of others. Widening participation was suggested to be one of the precipitating factors for my graduate sample's employment difficulties, and I

wished to see its effect by viewing all in the same light. If all were given equal status in this study, I might gain a kaleidoscopic image of the situation in all its variety.

Narrative Inquiry

Thus nearest to my perspective was narrative inquiry. Since I am investigating the career paths of mature graduates over a three year period, listening to the narratives of their careers before training as a physiotherapist and gradually piecing together their experiences since then, it is most appropriate that this particular perspective be chosen. But it is not solely the individuals' narratives that are important here. Together they give a broad picture of the state of a profession, what elements are changing, what members' aspirations are, how they live outside work and how they perceive potential further change in the future. It is also a record of a moment in time. Investigating teaching, Goodson (in Goodson & Numan, 2002) argued that "researchers had not confronted the complexity of the schoolteacher as an active agent in making his/her own history; many of them still treated teachers as interchangeable types unchanged by circumstance or time" (p 270). Looking at the lives of physiotherapists could give a picture of what was happening at this particular time in the health professions more generally.

A life narrative "involves a dialogical interactive situation in which the course of an individual's life is given shape" (Corradi, 1991, p 106). It has been criticised as purely tale-telling and thus low status in academic terms (Sparkes, 1992), but it is a methodology that gives the insider's story, "the perspective of the people in the situation being studied" that interpretative work strives to accomplish (Marsick (1989) cited by Sparkes & Templin, 1992, p 121). This is reminiscent of Lave and Wenger's (1991) stress on the *situated* membership of the community of practice. My graduate respondents, unlike myself and the established practitioners I was eventually to interview, were experiencing movement along a new career path at a difficult time. They were the ones affected and it was their story, in all its subjective uniqueness, that I wanted to tell.

Using narrative inquiry in a way that focused too intently on the individual might not allow me to gain an understanding of the wider political and socioeconomic scene

however. I needed to be aware of these issues as the historical context for my research, and it was for this reason that I also interviewed the middle managers (to give present context) and the established physiotherapists (to show change through time, and to add the context of the private sector in which several of my graduate sample saw themselves working in the future). Thus by using these other interviews I hoped to broaden the temporal field within which the newly-qualified respondents were working to attain full participation. The data I gleaned from them should be seen as elements of the wider field.

Judging the Methodology

When interviewing people from different backgrounds and with individual experience and opinions there will be contradictory views expressed. Kvale (1996) argues that this is a strength of the method, for it captures “the multitude of subjects’ views .. to picture a manifold and controversial human world” (p 7). Whilst in positivism intrusion of the subjective is heavily protected against, the research environment is controlled and methods are “taken to be guarantors of truth” (Sparkes, 1992, p 24), interpretivism allows a “freeing [of] the imagination” (Denzin & Lincoln, 2003, p 210) from this methodological strait-jacket. The world is viewed in all its haphazard diversity. But if the truth is to be seen in this liberated way it must be judged rather differently.

In positivist research strong reliance is put on reliability and validity. Reliability refers to the consistency of regular measurements performed by different observers on different occasions. In interpretive research it is used more to qualify instances in data rather than actual measurement, referring to whether or not data can be trusted and is authentic, and the conclusions warranted. Validity, in sociological terms, refers to the extent that an account accurately represents the social phenomenon to which it refers (Hammersley, 1992).

In analysing my data I needed to demonstrate that my method was to be relied upon and that the conclusions I drew were legitimate. There is much debate in the literature regarding what criteria to use however. Silverman (2005) argues that a thoroughly critical approach to qualitative data is the first step in ensuring validity.

Riessman (2008) agrees and adds, with specific reference to narrative research, that memories and meanings can change over time and “conclusions across a number of narratives [cannot] be evaluated necessarily by individual participants” (p 198), so that verification is liable to error. The resultant chaotic diversity of means of validating qualitative research can be daunting, but is generally seen as preferable to “the spectre of everyone ... being forced to speak a social science version of Esperanto” (Sparkes, 2001, p 544). However, those who consider interpretivism as an alternative tradition to the positivist one see the necessity for different criteria. Lincoln and Guba (1985) suggest using a parallel set of criteria, such as “credibility, transferability, dependability, and confirmability” (pp 42-43).

Authenticity

Wolcott (1994), among others, represents yet another strand of the argument. He sees no necessity for validity, but seeks “something else .. something one can pursue without becoming obsessed with finding the right or ultimate answer, the correct version, the Truth” (pp 366-7). Other authors ask questions to test the validity of their work: “How useful would this story be as a guide if you encountered a similar experience in your life?” (Ellis, 1995, p 319) and “Does it generate new questions .. or move me to action?” (Richardson, 2000, p 15) Whatever criteria are chosen, should involve an active engagement on the part of the researcher, a “deliberation .. characterized by .. interpretative insight, relevance, and rhetorical force along with beauty and texture of argument” (Sparkes, 2001, p 550).

This suggests that at the least some recognition of authenticity is necessary. As with a realistic novel, the reader should have the feeling that something like this could well have happened, or maybe has happened, to them and that they have glimpsed something of the world of the individual they were reading about. The reader need not have derived the same meanings but should recognise that such meanings are possible: this gives the passage the power “.. to redescribe reality” (Sparkes, 2001, p 547).

Credibility

Simply relying on prolonged and thorough interviewing does not ensure that the respondents' views have been appropriately collected and "faithfully represented" (Guba & Lincoln, 1989, p 245). An interviewer has to listen carefully for every nuance of information that an interviewee can give. As Geertz puts it, "We must .. descend into detail .. if we wish to encounter humanity face to face" (1973, p 53). It is necessary to report what the interviewees say verbatim, as quotation, and to analyse it in some detail if anything approaching veracity is to be attained.

One way of ensuring believability is to test the resulting account of what happened with the respondents or with others that know the background to the study. Does it sound true to them? I did not do this, nor, as already mentioned in the case of Riessman (2008), do some other researchers choose to. Hammersley (1992) considers respondents' opinions of ethnographers' accounts give useful data, but their agreement with those accounts should not be treated as a criterion for assessing the credibility of the research. To do so would be to risk ending up with the bland and flattering accounts with which most would all too easily agree. Also in verifying reports of research with the interviewees, it must be remembered that they too are not free from bias and prejudice, any more than is the researcher themselves. Social agreement alone cannot count as the basis of truth (Hammersley, 1992).

Design Decisions

An interpretative study can be said to have four main components. First there is the decision on the kind of relationship that will be established with the respondents whose lives are being studied; alongside this are the issues of who will participate and in what setting; data generation and collection then needs addressing; and finally will come data analysis (Maxwell, 2005). The first of these involves negotiating with those giving permission for contact to be made and maintenance of the contact once forged. In the next section I shall address decisions on type of relationship. Negotiations with 'gatekeepers' will be discussed mainly in the Ethics section and how contact was maintained will be found within Data Generation.

The overarching goal of my research was to explore how people coming from previous careers become integrated into, or indeed have failed to move into, a new community of practice and what their perceptions of this transitional pathway were in a time of uncertain employment. To this end I needed to hear their individual stories, their attitudes and opinions, and their reflection upon what had happened to them. The question was how best to achieve a relationship with the respondents that facilitated the sharing of information of such a personal nature. The possible suitable methods for obtaining data of this sort were a questionnaire or survey, focus groups or an interview in one of its forms. Whichever method of collecting data I chose it would be my responsibility to encourage and listen to these narratives, attempting to comprehend the intricacies of thought behind people's decision making. Rather than simply record what the majority did, I should be "doing justice to what [was] genuinely different" (Sparkes, 2001, p 550). Interestingly in a time of socioeconomic uncertainty and flux, the 'different' might be not so much what had changed, but what had *not* changed (Dunker & Parker, 2009).

Questionnaires and Surveys

To encourage interview participants to divulge information, a set of research based questions would be useful. Questionnaires organise such questions into a user-friendly format and can be sent as a survey, with no necessity for face-to-face contact, to a large number of geographically widely spread research participants. They are usually "faster to administer, analyze, and report than interview studies" (Kvale, 1996, p 104), are less personally influenced by the researcher and "embarrassing questions can be asked with a fair chance of getting a true reply" (Walliman, 2011, p 97). Everyone receives the same questions however and their format is often not prepared for more complicated individually-specific answers. If the researcher feels that there is a lack of clarity in responses, there is no chance to amend the situation. Some questions may not be answered at all, for there may be individuals whose personal circumstances render those particular questions inappropriate or too complicated to answer. As the researcher is distanced from the research sample, there is no strength of relationship built between them and rate of response "is difficult to predict or control" (Walliman, 2011, p 97). In a study like mine I felt I wanted both a firmer relationship of trust with my respondents and the

opportunity to gain in-depth reasons for answers to my research questions. A questionnaire format could not encourage my respondents to tell their full narratives.

Focus Groups

There has been a resurgence of interest in focus groups over recent years. They are defined as interviews that aim to collect data “through group interaction on a topic determined by the researcher” (Morgan, 1996, p 130). Used in many of the areas that interest sociologists, as well as in commercial marketing, there is literature that writes of their use in the field of research into work practices (Bobo et al., 1995), and focus groups are often said to be a method of obtaining information that can ‘give a voice’ to marginalised people (Morgan, 1996). When compared with the data collected from surveys on the same topic, focus groups have been shown to gather more in-depth information (Ward et al., 1991), but in comparison to an equivalent number of individual interview results, the interviews were shown to produce a greater number of ideas and of a better quality per individual than those gained from the focus group (Fern, 1982). It seems that the difference here can be dependent on two main factors, researching an appropriate topic for group discussion and having good group dynamics in the focus group (Morgan, 1996). Some individuals discuss topics differently when in a one-to-one situation compared to the group situation. For example, even given an appropriate research sample who have met all the inclusion criteria required, power relations within a focus group can mean that more assertive individuals will be heard at the expense of quieter, perhaps more reflective people. Social status and gender differences can also be influential here. The researcher usually takes the position of independent chair for the group, but may have to work hard to see that minority opinions are adequately voiced and that all views have been represented fairly. On balance then, it appears that the individual has more chance to give their ideas without reservation in a one-to-one interview.

The Interview

The interview can be viewed as “a professional conversation” (Kvale, 1996, p 5), a method of getting to know people’s hopes, concerns, opinions and perceptions of their world. It is an attempt to understand everyday life from the point of view of another person and as such resembles the subjective assessment that medical

professionals carry out when first meeting a patient. It is a very popular form of enquiry and method of collecting qualitative data. Types of interview range from the structured to the unstructured format. The structured interview has the most rigid and standardised format: all the questions are decided in advance and asked in strict order at interview (Walliman, 2011). A proportion of these may be closed questions, and the whole format resembles a questionnaire, though in oral form. It is often used in market research to determine opinions in the general population.

At the other end of the spectrum, unstructured interviews are extremely flexible. The interviewer can decide the format and tends to allow the interviewee to talk through their thoughts and feelings at some length in response to open-ended questions (Streubert & Carpenter, 1999). An example of this kind of broad question in the context of this study might be, 'Tell me about your experience of training for a new career.' Rather than follow a set list of questions, the interviewer will allow questioning and prompting to take "the direction of the participant's story-telling in response to the opening question" (Moyle, 2002, p 267). Thus the resulting narrative is participant-led, and little influenced by the interviewer.

Semi-structured interviews come between the structured and the unstructured forms of interview, using the framework of a schedule of open questions focused on the topics of interest, but allowing the interviewee freedom of response. There is the possibility of improvisation in response to respondents' unusual or unexpected answers, and the balance between interviewer input and interviewee's contribution is very definitely in favour of the latter. A fully structured interview would set out my agenda but allow little accommodation to the range of reality my interview sample could disclose. It would be preferable to use semi-structured interviews, where an interview schedule gave "a sequence of themes to be covered, as well as suggested questions" (Kvale, 1996, p 124), arising from the literature review (for examples see Appendix II, Middle Manager and Graduate respondent semi-structured schedules). Built-in flexibility in such a schedule was all important to ensure a suitable variety of responses to individual narratives.

There was system in the method of interviewing I used, however. First the interviewees were allowed, with as few prompts as possible, to narrate their history

as they saw it: this was the descriptive phase. Next they were asked to explain these occurrences in greater detail, the phase of analysis. Lastly they were encouraged to comment upon and evaluate their feelings about what had taken place, the interpretative phase (Wolcott, 1994). Basic to this method, then, was narrative. But I argue, along with Smith (1998), that it is necessary to move beyond story-telling to some form of conceptualisation, interpretation and explanation, to attempt to look for theories within the data.

Although I organised questioning around the main research questions, I developed a set of sub-questions from them that might enrich the data, in the light of my reading of the literature for Chapter 3.

From: What are the experiences of physiotherapy graduates who have been members of a previous workplace culture as they seek to become members of the community of practice of physiotherapy?

.. came:

- How may previous experience impact on the paths mature students take into their new career?
- What are mature students' expectations of their future career in physiotherapy?

From: What is the nature of these graduates' movement from legitimate peripheral participation onwards?

.. came:

- What happens when people move into communities of practice where their characteristics are considered atypical?

And from: How do they conceive of full participation and what factors enable or constrain their movement towards this?

.. came:

- How will a participant know when they have reached 'full participation' in their chosen profession?
- If full participation is recognisable, will it be recognised by the participant, and/or by others?

- What sources of influence may impact on the path towards ‘full participation’?

The implications of being an atypical member of a community of practice and what it might mean to reach ‘full participation’ were areas that seemed to require exploration in greater depth.

Searching to interpret and explain the findings from such questioning does not produce neatly systematic and standardised results across a group of the interview sample, for looking at the individual’s experience in depth means seeing a more complex situation, quite possibly including contradictions (Bathmaker & Harnett, 2010). Interview participants might be reasoning aloud for the first time why certain events took the path they did, sorting out their thoughts as they did so. Hodkinson and Hodkinson (2001) write that specific narratives “retain more of the “noise” of real life than many other types of research” (p 4). I wanted to capture this ‘noise’ of what was happening to, and being experienced by, the mature graduates I was interviewing.

Interviewing

Qualitative interviewing can lay stress on different aspects of the process. Elliott (2005) writes of ‘conflicting’ approaches. In the naturalistic approach interviews are mainly resources for gathering detailed information from the interview sample. Attention is paid to narrative as being the content of the interviewee’s stories. On the other hand, the constructivist approach focuses upon social interaction during the interview, seeing the interviewee as “artful narrator.” Interest is focused now on “the interpretative effort required to construct coherent life stories” (Elliott, 2005, p 21). According to Elliott (2005) these approaches are often regarded as mutually exclusive, but although mainly gaining information in narrative form, as in the naturalistic approach, I am bound to note the manner in which it is conveyed to me, and the elements of the interview situation that hinder or facilitate the process, as in the constructivist approach. As already noted, there must be interpretation of the surrounding context (Hollway & Jefferson, 2000), as well as analysis of content.

An interviewee is on stage, briefly the centre of attention (Goffman 1971). As people present their narrative, there will tend to be a defensive element: they are explaining themselves and their actions, and the way in which they do this can be of particular interest to the researcher. Indeed interviewers are not just acting as a passive audience, but need to react appropriately to what is being told. They may find themselves similarly keeping up an act, looking serious when the interviewee regards what they are saying as serious and showing amusement when the interviewee treats their story as humorous, whether or not they see these things in the same light. This too is where the interviewer's role is worthy of note, an approach Elliott (2005) terms reflexive.

This made me consider what my interviewees expected of me at interview. When they agreed to be 'centre stage' in this way, what did they imagine I, as researcher, wanted to hear from them? Informants usually assume something is known already, or the research would not be being carried out (Jovchelovitch & Bauer, 2000). They also know they are one of several informants. I had stated my research situation in the information sheet given them (see Appendix III) and was known to be approaching retirement after 40 years in their profession. Feigning naivety regarding professional matters was not a possible position for me to take, but at least one issue my graduate interview sample faced was completely alien to me. I was unaccustomed to their background context of uncertain employment, so my interview sample would certainly expect me to question them about this experience. It was important to consider how I might be biased, how my outlook could impinge on how I saw my journey, as well as how the journey might affect me. Reflexivity has to do with being prepared to criticise oneself and question one's own judgements. If I were to approach the truth when I was carrying out fieldwork, I should be wary of accepting things as I had always thought them to be, of making too many assumptions.

My background and life experiences were the filter through which I viewed the world, and awareness of this while interviewing was important. Indeed this could be used as a subjective means of checking the histories of the respondents whose experiences were similar to mine. Jefferson (in Hollway & Jefferson, 2000) questioned what his working-class interviewee told him about the pleasures of being

brought up in a large impoverished family, in the light of his own hard working-class upbringing. On the other hand, it was possible when interviewing those with a very similar background, to assume too much knowledge. It had been my experience to interview a physiotherapy manager during previous research, and since we had experienced such similar changes during our career trajectories, there was an undercurrent of agreement, and it seemed possible that some questions had *not* been asked simply because we assumed we understood each other's positions. As Blackmore points out (in Somekh & Lewin, 2005, p 100), carrying out research "within one's own workplace, the research requires high levels of reflexivity, to ensure adequate critique when you're so close to the situation."

Jefferson's case (in Hollway & Jefferson, 2000) had been different to mine in an important respect, however. His interviewee was not aware that the university researcher interviewing him came from a similar background to his own. Jefferson could act as a check without his respondent realising it. In my case, my previous interviewee knew me well. I found her referring often to matters in which she knew me to be involved. She might not have done this, or might have approached these issues in a different way, if another person had been interviewing her. An interviewee may tend to give you what they think you want to hear (Sikes, 2000). The perceptions the interviewee has of what is demanded of them are important and were doubly so in my research as I aimed to interview my own students. My status as lecturer could definitely affect what they allowed me to hear, as well as what I actually thought I had heard.

Bourdieu, trying to capture the French working-class experience, termed the influence he found he could have wielded over his respondents 'symbolic violence' (Bourdieu, 1999). This is "the violence which is exercised upon a social agent with his or her complicity" (Bourdieu & Wacquant, 1992, p 167). The supposed extra status, power and knowledge, that an interviewee can imagine are invested in the interviewer, can be used to manipulate the interview, either in an unscrupulous way, but more often quite unconsciously. The interviewer must continually bear this in mind and so reflexivity becomes all-important. At the same time, if they listen in a way that mirrors the manner and language of the interviewee, as Bourdieu suggests, it could appear condescending. It can be a delicate tightrope to walk, taking account

of envy, feelings of inferiority and biases due to dominant class, gender and ethnicity, on both sides. However objectively the interview is conducted, the ultimate “reality is contested” (Grenfell & James, 1998, p 176).

But Bourdieu goes a step further and introduces the idea of different types of bias and thus different types of reflexivity to counter them (Bourdieu & Wacquant, 1992). The first and most obvious is that of nationalism and the class, gender and ethnicity just mentioned. The interviewer’s background (and that of the interviewee as well) colours the way they see the world around them and must be taken into account when conducting fieldwork and analysing results. The second is that linked to the *academic* situation of the researcher, rather than the social one, their position in the hierarchy of power. This point had particular relevance to me as the one-time lecturer of most of my interviewees.

Goals of Interviewing

An interview should begin with the individual’s relatively uninterrupted narrative, giving the context for what follows. But Bates (2004) notes that a research interview will consist of several narrative units, rather than the question and answer format so often used by other enquirers such as journalists. In sociological research there should be a more conversational style, interviewees relating their experiences in the way they favour and the interviewer probing where necessary to guide them through the topic. So the interviewee will have longer turns at talk than are usual in everyday conversation. Stories lead one to another, and “as shifts occur, it is useful to explore, with the participant, associations and meanings that might connect several stories” (Riessman, 2008, p 24). Details of such relational narratives, including specific incidents and turning points, are important.

Language being central to narrative interviewing, the language the interviewer uses can encourage or discourage the flow of conversation. They need to facilitate the construction of these narratives along with the interviewee. Interruption of such stories, which occurs throughout normal conversation, and trying to keep interviewees’ contributions short and to the point, are extremely problematic here (Mishler, 1986). If this happens it can mean that the interviewer has been carried

away with their own agenda, and is not really listening to what the interviewee is telling them. Rather than interrupt the flow of narrative, the researcher can take note of any item that requires clarification so that it can be returned to later (Jovchelovitch & Bauer, 2000). Whenever possible, interviewees' opinions, attitudes and justifications should appear spontaneously. Respondents may all too readily give the interviewer what they imagine they want to hear, but the context should be theirs, not the interviewer's (Wolcott, 1995). Simpler, more open forms of question can elicit longer narratives and provide more detail. 'What are your feelings about ...?' is a question that cannot elicit a quick 'Yes' or 'No' response, and, while as part of an interview schedule it tells little about the subject of the interview to the uninitiated outsider, will yield plenty of data. Wolcott (1994) states, as one of his basic axioms of interviewing, "Talk little, listen a lot" (p 348), stressing that the interviewer must not become their own best informant but concentrate on what the interviewee has to say. This can prove difficult, when having, as in my case, a professional interest in the points raised by my interviewees, and often wishing to share experiences with them.

Hence the perspective of the interviewee should be revealed "using his or her own spontaneous language" (Jovchelovitch & Bauer, 2000, p 61), their own vernacular norm and terms of reference, and emphasising what they consider important and relevant. The interviewer does well to mirror this style in questioning to some extent too. This did not mean changing my normal form of speech, a device that would have immediately seemed artificial to these mature graduates who knew me well. But my interviewees were not social scientists. It was of little use to ask how they would define 'full participation' in their 'community of practice'. Interviewers have gained permission to study those things they find interesting about other human beings, but this does not give them a licence to parade their knowledge unduly (Wolcott, 1995). To overcome such language barriers, it was better to phrase questions in a way more easily understood by respondents. An example might be using 'becoming a fully-fledged physiotherapist' instead of 'full participation'. Such changes might allow me a chance of hearing the life histories that Smith (1998) argues to be "important "touchstones" for considering any abstract theory of person and community, and the testing of implicit assumptions about human beings"(p 208), like the theories Lave

and Wenger (1991) propound. Do people really move seamlessly along a path from legitimate peripheral participation to full participation, for example?

Sampling

Selecting the best people to provide the information needed to answer the research questions is arguably the most important decision in any qualitative research study (Maxwell, 2005). A purposive sample was used, defined by Maxwell (2005) as, “people who are uniquely able to be informative because they are .. privileged witnesses to an event”(p 88). Final year students from the BSc Honours programme on which I taught were thought most likely to be the best informants in this study. Eighteen of them formed the main group, mature undergraduate physiotherapy students of the Department of Health Professions in the university, who had had a previous career prior to physiotherapy training. They were thus people who were witnesses, not so much to ‘an event’ as to the experience of transition from one career to another, and could inform me of their perceptions of professional progression and of what full participation in a community of practice might mean. As the aim of my research was to provide evidence of the career paths followed by mature physiotherapy students in the current NHS context I decided to interview as many of them as possible annually over the next three years. In actual fact I interviewed four of them these three times; six were interviewed twice and eight only once (Table 1, page 104).

Other people were also interviewed to enrich the data collected, by giving context to the study. Six physiotherapy middle managers, used on a regular basis by the practice placement organisers of the university faculty to provide work experience for students, were also interviewed in the first year of data collection, 2008, to explore institutional issues and the local implementation of national policy in relation to recruitment and career prospects. Four well established physiotherapists, who had been qualified at least ten years, were also interviewed, this time towards the end of data collection in 2011. By adding these interviews I hoped to explore perceptions of progress into the profession that might augment the information given me by the main career-changing interviewees. They were physiotherapists on the contact list of

Table 1:

Graduate Sample Interviews

Cohort 1: 2005-8 (58 of 131 students were over 21 years old)	Age at first interview	1st Interview (Prior to graduation)	2nd Interview	3rd Interview
Barbara	38	April 2008	July 2009	
Cliff	30	April 2008	July 2009	May 2011
David	43	May 2008	July 2009	
Eric	34	June 2008	June 2009	March 2011
Fay	32	June 2008	June 2009	
Gwen	35	June 2008	July 2009	May 2011
Hilary	29	July 2008	June 2009	June 2011
Susan	39	April 2009		
Tim	37	February 2010		
Cohort 2: 2006-9 (51 of 138 students were over 21 years old)		1st Interview (Prior to graduation)	2nd Interview	
Jean	38	February 2009		
Kenneth	26	February 2009		
Lionel	26	March 2009	April 2011	
Mike	35	March 2009	May 2011	
Nancy	29	March 2009		
Oliver	32	March 2009		
Pat	47	March 2009	April 2011	
Annabel	36	March 2009		
Ruth	26	April 2009		

one of the CSP's Regional Networks, of which I was currently the Chair.

The purpose of the research gives an indication of the appropriate number of interviewees to use, the general consensus being that one should “interview as many subjects as necessary to find out what you need to know” (Kvale, 1996, p 101). I was looking at the gradual progress of belonging (or failure to belong) to a profession over a three year period. It soon became clear from the variety of previous career pathways my initial graduate sample had followed that I only needed to interview a small number of people to demonstrate a diversity of background situation. As the context for my study was one of fragile and shifting employment, I also gained information regarding a wide variety of newcomers' career pathways into physiotherapy, by virtue of the very fluidity of the field.

Interview Sample Recruitment

I was the tutor and lecturer of those of my interviewees still in the university and the ex-teacher of some of the middle managers and established practitioners I was to recruit later. I knew their backgrounds and characters, in the classroom at any rate, and, in the case of those I had personally tutored, outside it. I therefore needed to think carefully about my relationship with my interview sample, as my position vis-à-vis them was (or had been) one of authority, so it could be said that I might wield undue influence and power. This had implications for how I interviewed them. That I felt I had their trust was in my favour, but I also had the extra weight and responsibilities of my social capital (Bourdieu & Wacquant, 1992), status pertaining to my belonging to the group of lecturers in the university. Questioning without due care in this situation might mean that I swayed argument in particular directions I assumed to be true. Interviewees could also be seduced into telling me more than they meant to (Malone, 2003), seeing me, as they perhaps had done as a first year student, in the role of friendly mother confessor.

It also meant that I needed to ensure non-coercion when asking students to volunteer in the first place; it would be best to go through a third party, to distance myself from the procedure. If I approached my students myself, they could easily feel pressured

into agreeing to help me (Brunner, 1999). By the time I received final ethical approval to do the study, it was three months from graduation in 2008 and the third year physiotherapy students, my potential main interview sample, were to sit an examination in a few days time. I therefore organised that one of the administrative staff at the university should send out the recruitment email I had prepared for the Ethics Committee (Appendix IV) straight afterwards, before the students became too embroiled in work for their next exam three weeks later, inviting any who were interested to contact me if they wanted to participate in my study. The administrator sent two attachments with this email, the Information Sheet and the Consent Form (Appendices III and V), that prospective interviewees might be clear about what the study entailed.

The potential interview sample needed to be told exactly what would be happening to them in my study and why I thought it necessary, if they were to give truly informed consent. This created difficulties, for it meant being certain of the procedure I should follow, and as Malone (2003) comments, “the inductive, emergent nature of qualitative design precludes researchers being able to predict where the study will take them” (p 800). I was following my graduate interviewees over three years and could not be sure of the focus of future questioning nor what information would eventually be used. The formulated information sheet thus answered frequently asked questions regarding the initial interview situation, including any possible disadvantages to becoming involved, but was flexible to amendment of questioning to suit future occasions.

It was important that my potential participants read and deliberated on the information I sent them for at least 24 hours before agreeing to take part in the study. There were issues I must make sure they understood. How the information would be retained (voice-recording) was one, and how it would be used once the study was complete was another. The potential interviewees might not realise that some of what they said could end up verbatim in an academic paper. This needed stating clearly in the information sheet.

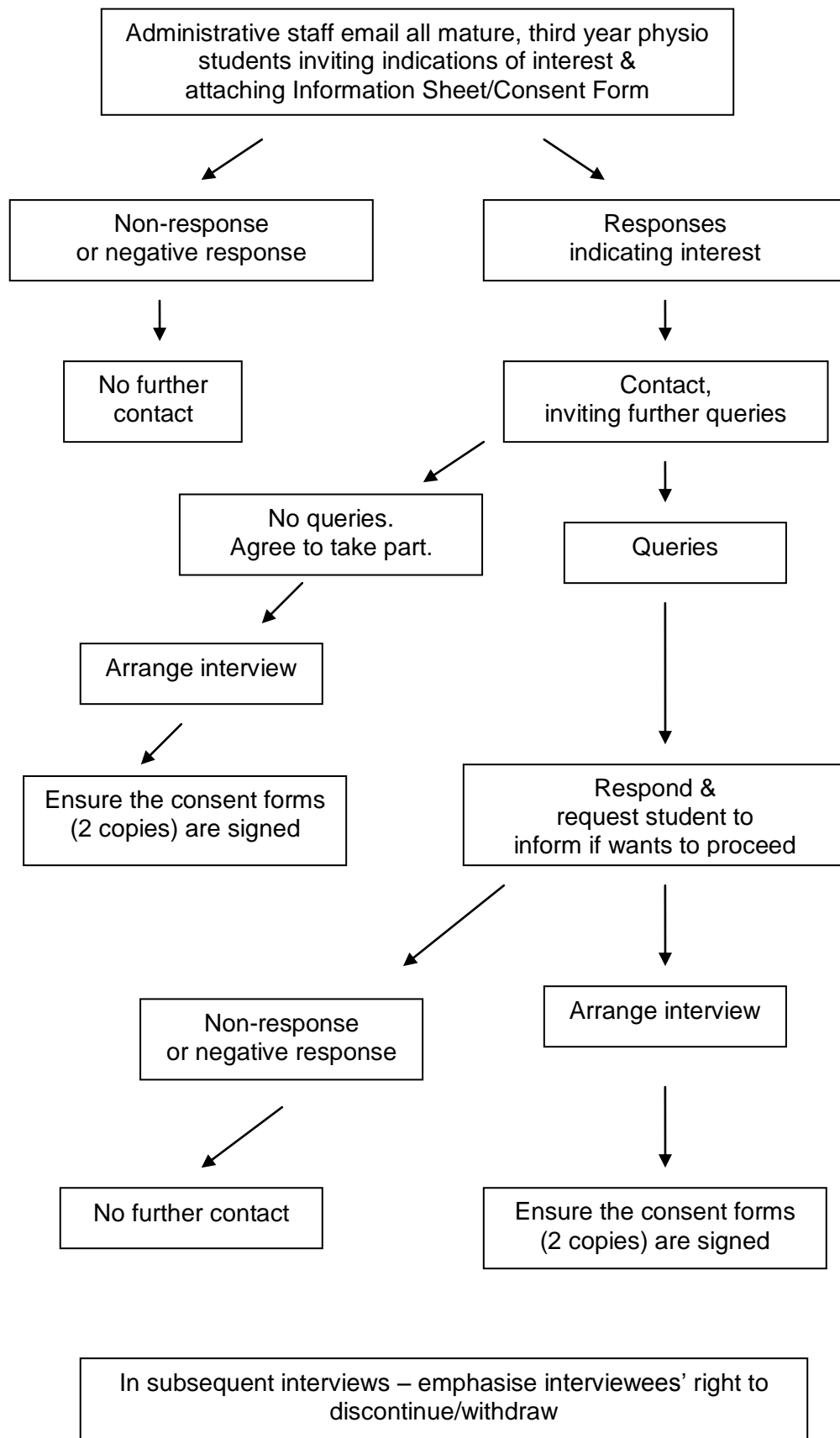
A couple of days after the recruitment email had been sent out in April 2008 my first volunteer, a woman in her thirties, contacted me and two others, both men,

volunteered to be interviewed during the course of the next month. This was slow progress but no more than I expected, for the students were working hard, not only to prepare for exams, but also to complete their extended research proposals, the largest piece of written work they did during the physiotherapy programme. The disadvantage of sending out the paperwork for my study at this particular time was that I was approaching them at their busiest. In my favour was the fact that this was a time when they might view the chance of an interview as invaluable practice for when they applied for their first post.

As soon as all academic work was completed, I asked the administrator to send my email once more in reminder form, in the hopes of collecting a few last minute interviewees, for the students were to spend four weeks on their elective placements prior to graduation. I was aware that many of them would return to homes at some distance, or maybe even go abroad, to complete their electives. This meant that I was more likely to collect research respondents who were staying locally, the advantage being that these might be ones more likely to remain in the vicinity for the next three years, which would mean my travelling less far for follow-up interviews. Four more people came forward, one man and three women. Thus I had an initial research sample of seven from the 2005-2008 cohort. For a flowchart showing this initial research protocol see Table 2, page 108.

Preparing to interview my graduate sample had entailed undergoing the university's ethics procedure. But a wish to set the work in context by interviewing a small number of NHS physiotherapy middle managers meant undergoing the procedure of medical ethics, for they were under the protection of both their Trusts' Research and Development (R & D) governance and the local research ethical committees (LRECs). Once I had gained ethical approval, I emailed a number of managers, taking their contact details from a list of people providing practice placements for our students during their training. I made sure they belonged to different NHS Trusts and that at least one worked in a Primary Care Trust (PCT) rather than a hospital, so as to gain a range of perspectives on the current employment situation locally.

Table 2 Flowchart of the Research Protocol (Graduate Sample)



Six people volunteered, one of them from a PCT. When I had their agreement to be interviewed, I went through the R & D ethical procedure in each Trust to enable the research to proceed. This took some time in one or two cases, so these interviews took place between July and November 2008.

To enlarge my main graduate sample I followed the same procedure of recruitment that I had in order to recruit my initial graduate respondents from the 2005-2008 cohort. Nine people from the 2006-2009 cohort responded (see Table 1). A late graduate from the 2005-2008 cohort, Susan, also contacted me and was interviewed. Then the graduates who had been interviewed in 2008 were re-contacted and interviewed for a second time.

By 2011, the last year of data collection, I had decided to interview a few established members of the physiotherapy profession to see how they conceived of 'full participation' and to hear of their experiences of the career pathway. This counted as a minor amendment with the LREC and would not involve R & D procedures if they were not interviewed on NHS premises. Thus this recruitment took less time than that required for the middle managers. I sent an email advertising the study to 26 contacts in the region, who lived within easy travelling distance, making sure I did not contact the middle managers that had helped me before.

My other inclusion criteria were generally designed to ensure approximation to my previous respondents' ideas of fully participating physiotherapists. These clinicians should have trained in England, like all my other respondents, and have been qualified for at least ten years (one of my graduate interviewees' idea of how long it might take him to become 'fully fledged'). They should be full-time workers still treating patients rather than fully managerial or part-time in education or research. From the initial six people who responded I finally interviewed four women in 2011. One worked in a private hospital, two in private practice (one in her own and one as a freelance between practices) and one worked for a sports organisation. The last one was nearest to the situation of my graduate sample, for in her thirties she too had changed career, having been a PE teacher before she trained in physiotherapy.

Ethics

When carrying out social research it is important to achieve as reliable a picture as possible of the truth of the situation and this must be approached with integrity and honesty (Walliman, 2011). It is also important, when dealing with people, that they should come to no harm and that they should be treated with respect. It is to satisfy these ends that ethical issues must be addressed.

I have already mentioned two ethical issues that were of immediate importance as I recruited my graduate sample, those of gaining informed consent and the avoidance of coercion. I also needed to consider the chances of misinformation. The graduate sample knew some of my preferences and opinions and might alter what they said to please me, and I would have to be vigilant and self-reflective regarding this myself too. But I did not envisage this becoming a major problem. Sikes (2000), telling of the rare case of an interviewee aiming deliberately to deceive her, spoke of “faulty memory or erroneous perception” as by far the more common reasons for misinformation (p 257).

Satisfying the ethical committee regarding the interviews I carried out with physiotherapy managers and clinicians was more formidable. There are plenty criticisms of the medical ethics procedure. Complaints suggest that it can badly impede and delay research (Warlow, 2004), and it is felt that people can be put off doing perfectly reasonable research on finding the paperwork involved to be unwieldy and daunting (Beardsmore & Westaway, 2007). It can also be rather unclear why the process is necessary, for LRECs are checking for any hazardous proceedings (Jamrozik, 2004), and the obvious medical problems to look for, such as untested medications, are concerns that have little bearing on the normal remit of the social scientist. Ethics committees involved here require detail that can seem to threaten unbiased participation and appear unduly paternalistic (Garrard & Dawson, 2005; Miller & Wertheimer, 2007). On the other hand there are signs that possible harm is generally reduced and that the optimal balance between harm and knowledge that ought ideally to be gleaned during research is in fact achieved.

The researcher should care about several main ethical issues. An interview sample is cooperating with researchers to give all kinds of interesting information. It is crucial that it should be analysed thoughtfully and the story told clearly, coherence and internal consistency being thoroughly checked (Wolcott, 1994). But the ethics procedure is there primarily to protect those participants involved in the research, and the effect of the process on their lives should be considered at all times. Academics also have responsibilities towards their fellow researchers and those sponsoring their work. Others' reputations should not be tarnished by our errors.

Despite the delay to my work that the medical ethical procedure undoubtedly caused (it took almost a year to complete), there were useful lessons to be learnt from it, among them the mental ordering of the process, the discipline of preparation and the elements of judging interpretative research. It seemed there might be problems however. There was in particular the unpredictability of the outcome. In qualitative research the significance of information gathered often only becomes clear as the research proceeds. It is thus quite reasonable for Wolcott (1994) to conduct fieldwork with an open mind, "observe and look for nothing" (p 161) being his ethnographic observation strategy of choice when researching new situations. The idea is to note everything and try to work out what the issues are. This makes it difficult to plan ahead appropriately and to foresee the ways in which the respondents might be involved in the future.

In this regard Miles and Huberman (1994) delineate ethical issues that require consideration. First comes worthiness. Was this research doing any more than further my publication opportunities and my career generally? I could answer this in the negative with a clear conscience, for I was approaching retirement. I also needed to reflect whether I was supporting democratic values and working for equality. I believed so. Could the research be used in any way to further values I didn't believe in? There seemed little chance of this. My competence might be in question however, for I was new to this type of research, but I felt that I could find adequate help if I needed to.

Benificence

The main point of going through the ethical procedure was that I should do good and no harm to my interview sample. The good I might do was to give people not normally heard (the mature students) a voice, to allow them to say what worried them or was an obstacle to their learning on their path into their new career. To this end I should respect their autonomy and ensure that I treated all fairly: there was to be no favouritism or bias towards particular people. There was little chance of my doing actual physical harm to interviewees, but I might take up their time unnecessarily when they were already busy people. Thus I tried to contact my students when they were less involved in writing assignments and taking exams. This was also something the NHS R & D governance was strict about: I should not interrupt the middle managers' working day unduly, nor involve them in my study without good reason.

It was just possible that I could also be reminding my career-changing students of unhappy past events, sensitive issues regarding past employment for example. To avoid upsetting them, I should at least demonstrate that I had thought of this contingency, both during and after the study procedure. Thus I included the telephone number of the university's counselling service in their information sheet.

Confidentiality

Then came issues to do with privacy, including confidentiality and anonymity. Confidentiality concerns what happens to the data collected. I had to keep information gained about my interview sample safe and not divulge it to other unauthorised people: this I was used to, for I upheld the confidentiality of patients' information as a health professional. But interviews were to be recorded, so any sound recordings were to be kept safe, password-protected on computers and filed under lock and key if in disc form. Medical ethics also required that data should be kept for ten years after the study was complete, allowing time for any further writing on the subject. After this time I should have to ensure that all electronic data was deleted and all paperwork pertaining to the interview sample shredded.

I also prepared for the possibility of unexpected disclosure during my recorded interviews. An interviewee might begin to give me very useful information, but

immediately regret doing so. Should I transcribe this, but bracket it off as unusable material, or cut it out altogether? I decided to use such material to inform understanding only, without quoting it or referring to it directly (Burgess, 1989), and certainly not linking it to any individual. More seriously, what if an interviewee disclosed that her husband assaulted her or that she felt like committing suicide? This would place me in an invidious position, if I had promised to maintain confidentiality. There was a need to plan ahead for such events, saying in my information pack that some disclosures would be directly followed up, for instance. But I knew I could still occasionally be faced with the unexpected.

The other issue here was that all this recorded material was, after the first few interviews, to be sent to a transcriber, for I did not intend to transcribe more than a handful myself. I should have to be certain that this person did not know my interviewees and was utterly trustworthy. They too needed to maintain strict confidentiality.

Anonymity

Assuring a lack of identifiers, the issue of anonymity, was covered to some extent by encoding all names of people, interviewees and others, appearing in recordings, as well as the names of towns and institutions, such as previous places of work. But attempts to anonymise everything are known to be fraught with difficulties (Lincoln & Guba, 1985), particularly in this case, since physiotherapy is a small profession and many of my colleagues are recognisable from their career path or specific work situation alone. I was also looking for what made the mature students different from their peers, and that was likely to be unmistakable to colleagues and friends alike. There were many clues to a person's identity in an interview transcript too, even without hearing their distinctive voice and accent. My potential interviewees came from every area of the British Isles, and often had distinctive speech mannerisms recognisable to those who had known them. Changing too many identifiable elements from such data to ensure anonymity not only removed its ring of truth, but could "mislead readers attempting to determine transferability" (Malone, 2003, p 809). However much I hoped that people's data would be absolutely safe with me, I could never be entirely certain.

Piloting my Study

Pre-pilots

The quality of narrative data is dependent on a robust sampling strategy, but also on the preparation carried out before interviewing begins (Kvale, 1996, p 146). The research questions initially formulated focused on the transition of mature graduates into their new profession, what influenced their decision-making and their expectations of the future. Such questions were best managed in the semi-structured interview setting, but I needed to try out the schedule of questions that I had planned and also gain experience in interviewing from this format, enhancing my ability “to create safe and stimulating interactions” (Kvale, 1996, p 147). This piloting would also identify any problems that could be rectified before commencing on the actual research with my graduate respondents. I therefore interviewed three people whose history approximated to that of the graduates I aimed to work with later. Regarding the task ahead at a very basic level, I was to interview the student physiotherapists about how they had chosen their first jobs and how they had then decided to change career, so I purposely looked for people I knew that might be able to offer information of a similar sort.

It was perhaps significant that relatively few people of my acquaintance had changed career in mid-life: the ‘baby boomers’ of my generation, unlike those I would be studying, had expected permanent, full-time employment for life (Collin & Young, 2000). Some of them had experienced the transition to retirement though. I spoke with two such among my friends, the first an ex-teacher and the second an insurance inspector. Having gained their permission, I interviewed them from the point of view of how they had moved into their professions, particularly asking them about their career pathway and the changes that came with their transition into retirement.

A few things became clear. Narrative interviews have been referred to as conversations “between two partners about a theme of mutual interest” (Kvale, 1996, p 125). My first pre-pilot interviewee was very happy to talk in the comfort of her own home, but subtle guidance was needed to prevent her moving away from the topic, our interests not always mutual. I heard her story without interruption, then gradually probed to greater and greater depth, but wondered if I had clarified

everything sufficiently as I went along. With the second interviewee I found myself interrupting more, in part because I understood his experiences less than those of the teacher (or thought I did). Perhaps this would be different again when I was dealing with physiotherapy, a career I professed to know well.

The interview schedules seemed to work well, but other small matters needed deciding. I wore reading glasses, which meant that the interviewee became blurred, though it allowed me to read my crib sheet and take notes on occasion to jog my memory later. I wondered though if I was losing the nuances of facial expression so integral to the interaction that underpins the interview relationship. Observed non-verbal communication could make a difference to my analysis of the recorded narrative (Riessman, 2008). I was also aware that I presented myself as more official than usual to these friends, perhaps a good thing in this instance for it made them take the situation more seriously, but I should perhaps try to appear more at ease with the actual students.

Pilot

A friend, Alison, had changed profession to become a physiotherapist, and so came nearest among my contacts to my career-changing respondents. She agreed to a full pilot interview with me in her office. Both the pre-pilot interviews had happened in the more relaxed atmosphere of a sitting-room, so this immediately increased the formality of the occasion. I had also arrived straight from a visit with a student on placement and so was in uniform. I wondered what difference the clothes I wore made. An interview is something of a staged event (Goffman, 1971), so the actors' appearance and behaviour can be said to count towards the performance. Here I felt it important to "minimise social dissonance" (Myers & Newman, 2007, p 15), that the interviewee might feel completely comfortable and tell her story quite naturally. I agreed with James (1996) that it is "the interviewee's definition of the situation that most determines the nature of the interview" (thesis section 6.4.3). It was fundamental to its success that a good relationship be established in which the interviewee felt no social embarrassment (Myers & Newman, 2007). But while Alison, as a fellow clinician, was unlikely to be uncomfortable with me in uniform, I should give more attention to the possible effects of this on final year students.

As already suggested, I had drafted a semi-structured interview schedule and this I had with me in the form of a crib sheet. It was used most during this interview and I noted down more points. While generally the interview seemed successful, I had learnt lessons from my interactions with Alison. On listening to the recording I noticed that I appeared to be too much in control. At least once I believed that Alison read my non-verbal signs as “Oh, I must ask about that” and stopped politely to hear what I had to say! I had wanted her to be more prominent in this relationship, agreeing with Bertaux that, “a good interview .. is one in which the interviewee *takes over the control of the interview situation* and talks freely” (1981, p 39 - the author's emphasis). Neither my interruptions nor any non-verbal signs must restrict my participants' discourse. There was more clarification needed than expected too. How had I mistakenly come to the conclusion that I should understand my own profession with ease? This at least had put me more neatly into the less informed, less prominent position I preferred vis à vis Alison.

Recording Interviews

Hand-Written Notes

One method of recording what is said during an interview is to write as much of it down as possible there and then. For most people this is a full-time occupation and there is the risk of not being able to concentrate properly on what is being said. Certainly there is a risk of losing eye-contact with the interviewee, and thus missing non-verbal cues of importance. Researchers with short-hand skills are able to produce a reliable record, but it is bound to affect the interaction between interviewer and interviewee. However, if reminded of something while the interviewee is talking, it is useful to note this down to return to later in the interview, rather than interrupt the flow of the conversation. Such obvious movement away from the conversation to the crib sheet or writing pad needs to be excused though. It was helpful that I had explained to Alison beforehand that I might need to make the occasional note. Such notes are often scribbled rapidly, with plenty abbreviations, so early processing, while the interview is fresh in the mind, is needed to make them really useful (Walliman, 2011). I took my research diary with me to the interview with Alison, so that I could go somewhere quiet immediately afterwards, to record my initial

thoughts. Thereafter I made a point of giving myself at least another half hour after an interview, so that I could note down relevant background information and my immediate impressions of the interviewee's responses.

Recording the Interview

Using a recording device was a better way of capturing the full conversation of an interview and was much less disruptive than writing notes, but the interviewee has to give permission for this to happen. Therefore it had to be mentioned in the Information Sheet (Appendix III) and was one of the items initialled by interviewees on the Consent Form (Appendix V). Having a recording device prominently on view can make some people nervous: for example, one of my interviewees asked me to move it out of his sight-line. Usually it was possible to place it on a lower shelf so that it was not so obvious, but then care was needed that it was not knocked or kicked, or that it did not pick up sounds from elsewhere in the room or from outside, as well as the interview conversation.

As I turned on the recording machine I would remind the interviewee that they had agreed to be recorded and made sure they were still happy that this should happen. On a couple of occasions an interviewee suddenly realised that something they had just said should be treated as 'off the record'. What they had said was clearly on the CD of the recording and appeared in the written transcript, but was bracketed off in red here as 'not to be quoted' (see Appendix VI). Interviewees commonly relaxed a little once the machine was switched off at the end of an interview, thinking what was said at this point might be 'off the record' too. This was a good time to clarify issues they may have seemed reticent about during the recording, for this sometimes yielded very useful extra detail.

Transcription

The main disadvantage of recording the interviews was that they required transcription afterwards and this takes considerable time. To have a really detailed transcript of the recorded interview is an all-important start to data analysis though (Jovchelovitch & Bauer, 2000), so I was grateful that piloting interviews allowed me to accustom myself to the recording equipment and to complete some transcriptions.

Decisions had to be made regarding the standard transcription format I would use, how to denote different lengths of pause and moments of emphasis in speech for example. These were shown by number of dots and underlining of stressed words respectively in my transcripts from then on (see Appendix VI). Pauses could be significant, a brisk response suggesting the interviewee was sure of what they were saying, just as a long pause tended to denote a degree of uncertainty. Some repetition and false starts were edited, though these could occasionally be left in to show the interviewee's deliberations as they started to see something afresh. The choice of words an interviewee used could tell a great deal about their attitudes and beliefs too.

Right from the start I was influencing data collected in significant ways. In semi-structured interviews this is bound to happen in a number of ways. First there is the selection of the theme and topics for discussion: then questions to be asked are ordered in a particular way that seems most appropriate to the researcher: and finally those questions are worded in the researcher's own language (Hollway & Jefferson, 2000). But in making decisions on what elements of the transcript to abbreviate and edit, on the length of pauses, where paragraphs were appropriate and what punctuation should be inserted, I was extending my influence still further. I shall return to this in the Data Analysis section.

As already mentioned, I employed the services of a professional transcriber for the majority of the interviews. She worked to a standard format we had agreed, but did not always correctly transcribe what had been said, and occasionally had to leave gaps. Her comments on the process were interesting.

Sometimes a person can appear to speak very clearly but when you try to transcribe you discover surprising things .. some kind of mind reading that goes on when you're speaking to someone directly, so that when they don't finish a sentence, or sometimes before they begin a sentence, the person opposite them knows what they have said or are going to say .. Sometimes of course there may be visual clues, but often it's clearly not the case. (Email with transcriber: 8.9.11)

This once more underscored the importance of non-verbal communication and how difficult it can be for a third party to decide, from an audio recording alone, exactly what is being said. Thus text had to be checked thoroughly post-transcription. Nor was I at all unhappy to do this, as it effectively immersed me in my data and drew

my attention to the finer points of interaction between myself and the interviewees in the recorded conversations (Hollway & Jefferson, 2000).

Data Generation

Research interviews took place between Spring 2008 and Autumn 2011 in three main groups which I shall call early (2008), mid-term (2009) and late (mainly 2011) interviewing. When initially interviewed, the main interviewees in the study were students soon to graduate, and in subsequent interviews they were graduates, but for ease I shall call them all 'graduate interviewees'. (See Table 1, page 104, for how the two cohorts of graduates were interviewed over three years.) So 'graduates' and then middle managers were interviewed in the early 2008 interviews, only graduate respondents were interviewed in the mid-term 2009 interviews, and graduates and then expert physiotherapists were interviewed in the late interviews.

Early Interviewing 2008

First interviews: Cohort 1 (2005-2008) Graduates

I was surprised to find these interviews felt more difficult than the pilot work at first. It seemed a hindrance to have been the interviewees' teacher. It was not a huge barrier, but there had been a certain sense of professional hierarchy in my previous conversations with these students. In our new situation, I wanted them to take the lead, and it probably felt slightly strange to them as well. But this did not last long; during the second interview I was already beginning to feel more at ease.

Although I had imagined these mature students would have had varied experiences, I was amazed just how different their backgrounds were. While their social class and age range showed some diversity, it was their previous work that showed most. Among the seven of them there was an electronics engineer, a supermarket worker, a sky-diver, a civil servant, a laboratory analyst, more than one had been a builder's labourer at some point and one was a professional dancer. Several had tried more than one area of work during career pathways that ran anything but straight. All kinds of twists and turns had brought them to physiotherapy. It was a challenge to adapt my interview schedule to such intriguingly multifarious narratives.

Logistically the initial interviews presented few challenges. It was usually easy to organise a small quiet room in the university. James (1996), in very similar circumstances to mine, writes of wanting first interviews to be conducted on familiar ground, presumably to put both himself and his participants at ease, and I hoped for the same. However, one interviewee was doing his elective in his home town further away, so I journeyed to interview him at home after work. I had been aware that this might soon happen, but noted that there was a noticeable shift in power relations here that meant I felt less at ease at the start. I was learning that such small changes could make a difference to initial ambiance.

Arranging suitable quiet interview locations proved more problematic later. One interview was conducted in the ‘snug’ of a hotel bar, which was perforce quite noisy, and interviews in interviewees’ homes were occasionally interrupted by family members, particularly children. I felt the absolute necessity in the research relationship for mutual trust and respect, but was reminded more than once of Wolcott’s (1995) question about the power strategies inherent in the interview situation: “When we ourselves are not doing the conning, are our informants conning us?” (Wolcott, 1995, p 149). There is a need to be constantly sensitive to the “interpersonal dynamics within the interaction” (Kvale 1996, p 35), changes in which can subtly alter the data generated.

On Being Interviewed

I got the distinct impression with a few of my interview sample that they enjoyed intellectual self-scrutiny. One of them admitted as much. He had had counselling in the past and this he said had made him much more self-aware. It was not a feeling common to most though. It seemed more common that people had difficulty stepping out of their normative way of thinking. There were initial hesitations and calls for explanation in one or two instances. These usually occurred within the first few minutes as people settled down to talk. This was another reason for beginning with questions regarding their past story, of what they had done before coming into physiotherapy. Most seemed to relax as they found me willing to listen to details of their lives they may not have told others for some time, if ever. There was a sense of release, of catharsis even, in the rare case where the past had been difficult.

Middle Managers Recruiting Newly-Qualified Staff

Information gained from the first interviews helped build up a picture of the diverse pathways people followed in moving away from previous careers and deciding to train for the physiotherapy profession, as well as their expectations of future employment. Now I needed background to give context to my findings. Soon after interviewing the last of the graduates, I commenced interviews with half a dozen NHS middle managers who were actually, or potentially, involved with the recruitment of newly-qualified physiotherapists. These interviews were all located at the interviewees' places of work, timed to cause as little disruption as possible to their working day.

These interviews showed me how ignorant I had become regarding my own profession's management. I began to realise how much my movement into education twenty years before had marginalised me from the issues of importance in the workplace. After the first of these interviews, I made a note in my research diary that I should have made more effort to prepare for all the acronyms and specialist terminology associated with healthcare policy making. It was not always easy to comprehend the language used by my interviewees. It reminded me of Wenger's (1998) experience as a visiting observer of a community, when he had failed to recognise some of the language used (see Chapter 3, page 70).

Where my graduate informants' narratives had appeared extremely diverse, the managers' histories and viewpoints varied but little. The one exception here was the person who worked for a PCT rather than for a hospital Trust. His experience of healthcare and his predictions for the future and how junior physiotherapists might be employed in the community (he had not yet recruited any) were quite challenging. The findings of this interview, coming third in the order, questioned my growing assumptions of what was happening in the field so that I not only altered the questioning in this interview, but also in the three interviews that followed, since I checked these later managers' attitudes to what he had said.

Mid-term Interviews (2009)

First interviews: Cohort 2 (2006-2009) Graduates

The following year, as soon as the 2006-2009 cohort of students returned to university from their last practice placement, and thus well before they became encumbered with their final academic work, I asked the administrator to send my email again. Eleven mature students agreed to participate and I interviewed all but two of them between February and April. The remaining pair failed to keep their appointments with me. A response of only 40% is considered reasonable (Hicks, 2009), so, despite a general impression of good attendance for interview in much of the literature, I was prepared that some interviewees should decide against participating in the end.

The remaining interview sample comprised five women and four men. Again they were an extremely diverse group, including two women from environments normally associated with male workers, a bicycle cooperative and professional football (this interviewee had worked in the United States, as female professional football was not available as a career in the UK). Earlier academic learning featured degrees in German and Music, while workplaces varied from a bookmaker's to a fashion boutique. The age range was even wider than with the first interviewees, yielding both the youngest and the oldest participants.

By this time I had realised I needed to draw up a simple database to ensure that I had the same basic knowledge of the interviewees' backgrounds. At the very least I needed to know my graduate sample's dates of birth and contact details, and I decided to gain other information regarding external factors that might impact on their transition between careers. I had this information for only some of them, and it seemed to be giving rise to themes of note in the data. I formulated a table (Appendix VII) and got each to fill this in during the 2009 interviews. Not all categories turned out to be useful, 'type of schooling' being one, for I was unsure of how the education system in Scotland and Ireland (I had more than one interviewee from each country) compared to that in England. Nevertheless this database was helpful, acting eventually as the pro forma advocated by Hollway and Jefferson (2000) as a fundamental element when commencing data analysis.

A first interview: Cohort 1 (2005-2008)

A last respondent approached me in late March 2009. Susan (see Appendix VIII for brief details of the interviewees) was not certain she fulfilled the entry criteria. “Do you consider being a mother a suitable full-time previous job for one of your participants?” she asked. She was being modest when she described her situation as simply full-time motherhood, for she had a child with learning difficulties. The stresses of her family life had already led to her taking four years rather than three to complete the programme, so she belonged to the 2005-2008 cohort. I thus now had eight interviewees from Cohort 1 and nine from Cohort 2, a total of 17 volunteers from two consecutive years (see Table 1, page 104).

Second interviews: Cohort 1 (2005-2008) Graduates

Once this round of interviews was completed, I approached the initial seven 2005-2008 cohort graduates I had interviewed the previous year to arrange their second interview. This time employment issues and other professional entry topics were to be discussed (see Appendix IX). I prepared to re-interview them by listening to their first interview while scanning the associated transcript. I made specific notes of points that needed clarification or that I particularly needed to ask about, worries they had voiced or plans they had told me of on the first occasion. I interviewed them during June and July 2009, in one instance using a first interviewee to contact the next one, to make last minute arrangements. This was the only time I had to resort to what James (1996, thesis section 6.4.2) called the ‘grapevine’ approach to locating a respondent.

This was of note in two respects. Firstly it reminded me that there was communication between some of my interviewees. It was possible for me to hear (and I did on several occasions, without my having particularly requested it) of the progress of others of my interview sample, even those I had lost contact with. The question was, however, how much respondents spoke to each other about their interviews with me. Did it affect what I heard from those I interviewed last each time? There was no way of checking this. Secondly this interview with David was to be my first and only interview in a place of work other than one orientated to healthcare, for this interviewee had failed to find employment as a physiotherapist

and had returned to his previous job. Perhaps unsurprisingly he failed to make contact with me on the third occasion I wanted to interview him and again I heard through others that his employment situation had not changed.

Late Interviews (2010/2011)

Another first interview: Cohort 1 (2005-2008)

Between the mid-term and late interviews, during 2010, a last person volunteered to be interviewed. This was a male student, Tim, who had taken five years to reach graduation due to financial difficulties during his training. Like Susan the year before, he belonged to the same 2005-2008 cohort as those I had interviewed first in 2008. This gave me a total of nine interviewees from Cohort 1 along with the nine from Cohort 2, making 18 volunteers in all from the two consecutive cohorts (see Table 1, page 104).

Second/Third interviews: Cohort 2 (2006-2009)/Cohort 1 (2005-2008) Graduates

The second interviews for Cohort 2 graduates (in their second year of practice) and the third interviews for the Cohort 1 graduates (in their third year of practice) explored how interviewees had coped in their search for employment, and their route towards full participation in their new professional community of practice (see Appendix X). Three people (David, Jean and Susan) had failed to find physiotherapy employment, so they could not respond to questions regarding the path into the profession and were withdrawn from the study. Three others who qualified in 2009 and gained immediate employment (Kenneth, Nancy and Oliver) were also withdrawn from the study, and the research thus focused on as varied a cross-section of pathways onwards as possible. Contact was eventually lost with some graduates, so that the final group was seven in number, four from Cohort 1 (Cliff, Eric, Gwen and Hilary) and three from Cohort 2 (Lionel, Mike and Pat). See Table 1 and Appendix VIII for details.

I prepared to re-interview my graduate sample for the last time as I had before, by listening to the recordings of their previous interviews and scanning the transcripts, but now I ordered the content to compile a narrative of what they had told me of themselves, complete with quotations I judged important. This chimed well with

Hollway and Jefferson's (2000) advice to compile a descriptive pen portrait of the interviewee. It not only reminded me of the salient elements of their history, but also of those points that required greater in-depth analysis in this next interview. The questioning this time was focused more on the integration of those with atypical biographies into the community of practice and on interviewees' perceptions of full participation.

Established Physiotherapists

Interviewing practitioners of some years standing who worked in the private sector gave me the opportunity to learn about healthcare environments I had not worked in. Three of them I interviewed in their places of work, which showed me a spectrum of situational context from solo clinician with a receptionist (a questionable 'community') through a group practice (where shared work closely resembled Lave and Wenger's (1991) theory), to the physiotherapy department of an independent hospital, resembling the NHS model. The fourth person was interviewed at her home, her work entailing travel between a number of sports venues around the country (a very wide-spread 'community', if it could be counted as one). I explored these clinicians' career pathways into physiotherapy, which I hoped to compare and contrast with the relatively new graduates' career pathways, and concentrated on their perceptions of what 'full' participation might mean.

Data Analysis

Qualitative data analysis is a heuristic 'conversation' between the researcher and their data, seen in the light of relevant literature. My research questions had indicated the topics that I investigated during interviews and therefore I began my initial analysis by noting individuals' responses and ways of understanding these particular topics. In doing so I tried to remain as objective as possible in that I bore in mind biases I tended to hold and assumptions I could easily make. It was important to note subtle nuances in responses though. For this reason I not only worked with the transcriptions of interviews but repeatedly listened to the sound recordings to pick up changes in tone, specific language and how it was used. Though not concentrating on

the use of discourse analysis in the interpretation of my data I found it useful to note interactions interviewees particularly stressed.

There are several methods of documentary analysis of a transcript. I have already mentioned the use of the research diary for immediate memo-taking. There are also categorising strategies (Maxwell, 2005), such as content and thematic analysis. These note common patterns, aided by the use of coding, and those themes that appear in the text. There are computer programmes that can assist with coding data in a similar way, so that a number of interview transcripts can be compared for particular themes and categories. While comparisons are commendably efficient, this analysis has its drawbacks. Coding schemes are based on a particular set of categories providing a strong framework “from which it is difficult to escape” (Silverman 2011, p 146). Uncategorised material can be overlooked. I hoped to gain some idea of the complexities of the area I was exploring, particularly of the elusive concepts of community of practice and full participation. As Geertz (1973) notes, “.. explanation often consists of substituting complex pictures for simple ones while striving somehow to retain the persuasive clarity that went with the simple ones” (p 33). In many authors’ views Lave and Wenger (1991) had over-simplified the situation in their theorising and I expected to have to portray an altogether more complex picture. Thus, despite temptation, I avoided the methods of electronic data handling schemes that are available and concentrated on listening to the recordings, and highlighting points in the transcripts of the interviews.

Content analysis has similar drawbacks for it quantifies qualitative data by assessing how frequently specific categories occur in a text. This thoroughly systematic method is criticised by Joffe and Yardley (2004) for “.. removing meaning from its context” (p 57). It too can over-simplify the more complicated situation and fail to report on more subtle change. Thematic analysis, on the other hand, describes the meaning of the data by collecting specific themes in the original context and providing a more detailed account of the data. I had done this to some extent, using themes drawn from questions posed in my literature review. For example, I had questioned whether the attainment of full participation meant remaining that particular kind of person without change from then on (Chapter 3, page 45). I found

there was a strong perception among my respondents that this was not so, that one adapted and learning continued (Chapter 8, page 210).

Sometimes, however, I became aware of contradictions and differences, either from what I had assumed to be the case or from what other respondents had told me. Labelling chunks of transcription text too early as belonging to a specific theme can prevent one “being surprised by .. complexities” within that material (Silverman 2011, p 70). To find such new and less expected patterns and themes in the data I addressed some questions Hollway and Jefferson (2000) suggest are fundamental to the analysis of qualitative data. These are, “What do we notice? Why do we notice what we notice? How can we interpret what we notice?” (p 55). (See Appendix XI for a brief example of this method.) The consensus in the literature seems to be that the researcher needs to become immersed in the data and these questions are a useful way to start this process.

For the seven of my interview sample that I interviewed last I had compiled what Hollway and Jefferson (2000) term a descriptive pen portrait beforehand as an aide memoire. This brief narrative was written as though to inform someone who would like to understand their story, but had no access to the raw data (see Appendix XII for two examples). This summary acted as one structural reference for an interviewee.

The second one Hollway and Jefferson (2000) suggest was to complete a brief pro forma. I annotated the basic information I had on each participant, adding comments about my perceptions of interviewees’ particular competences and any important influences evident in their lives. While reading the transcript, notes were taken, ranging from life data to themes and ideas noted. Highlighting particular extracts was useful. The notes collected descriptive detail, while the summary of the pro forma began “to convey some kind of whole” (Hollway & Jefferson, 2000, p 70), but as Smith (1998) comments, there is a tendency to interpret as you analyse, and it tends to be your own point of view that you write. Literature explaining the interpretivist position on the analysis of data suggests that reality should be understood as mind-dependent, that there are several interpretations of events and so “multiple realities” (Sparkes, 1992, p 27). But this is exceedingly difficult: “.. one cannot think at all

without a recognition and realignment of ways of thinking and seeing we have learned over time. We all remake the world as we see it ..” (Byatt, 1995, p 131). The interviewer’s perception of what they hear during the interview plays a commanding role, the editing of transcripts as deemed appropriate, the decisions on categories and themes within the data, and the organisation of the final narratives. It is therefore impossible to find true objectivity, and, as noted above, knowledge cannot be based firmly on hard data.

Wolcott (1995) adds to this debate by questioning how much researchers can really know about their participants with any certainty. Method, and therefore knowledge, can never be interpretation-free. The interviewer sees the world from their own point of view, so any analysis must perforce reflect the attitudes, opinions and reasoning of both the interviewees *and* the interviewer. The research questions and understanding of background theory commence the research process, but “researcher values .. and a need for sociological reflexivity in research [are] inextricably interrelated” with them (Colley, 2010, p 406), as all kinds of decisions, problems and omissions in the fieldwork will shape findings in many ways (Ball, 1990).

Data Interpretation

In the coming chapters I shall be attempting to interpret the data I collected from my research sample. In this I mean to follow three pieces of advice given by Wolcott (1994). Firstly he noted how important it was to report everything as fully as possible. It could even be useful to point out the things that were puzzling and that could not be easily understood, if they appeared to have some equivocal relevance. Perhaps they could be read in several different ways, in which case it could be worth mentioning a couple of the most possible interpretations. Secondly, it was important to avoid undue judgement of interviewees or biased views in writing their stories up. If it is necessary to reveal any professional judgement it is important to make a clear distinction between the researcher and the professional voice. Finally I made every effort to write accurately. This meant checking that conclusions I had drawn from the data were really evidenced there and, according to Wolcott (1994, p 355), making sure “points of conjecture [were] marked with appropriate tentativeness.”

Summary

This research concentrates on the experiences of mature career-changing physiotherapists over the first few years of belonging to their new profession. In this chapter I have presented my research design and shown the decision-making involved in the methodology process. Semi-structured interviews were chosen as the appropriate mode of generating the data required to answer the research questions and three sets of individuals, 18 graduates (ten of whom were interviewed more than once in a three year period), six middle managers and four established practitioners volunteered to participate in the study. Interviews were recorded and transcribed, and analysis carried out using brief interviewee narratives, pro formas and reflective questions, as advocated by Hollway and Jefferson (2000).

The next four chapters of the thesis present and discuss the findings from four different points of view. In the first of these chapters, what is commonly regarded as the 'traditional route' into the profession, Limb's (2006b) 'junior carousel' (see page 36), is addressed, as well as the concept of 'community of practice' as it might apply to physiotherapists in different locations. The 'atypical newcomer' to the profession is the subject of the second chapter, viewing how difference, in this case previous work experience and the possible added responsibilities pertaining to the mature newcomer, can impact both on the individuals concerned and their path into the community. Some 'non-traditional routes' into the career are the focus of the third chapter, and various perceptions of 'full participation' the main topic of the fourth.

Frequent reference is made to empirical data, quotations being indexed by letter (see Appendix VIII for individuals' codes) and, in the case of people interviewed more than once, the number of that interview (Table 1 on page 104 gives relevant dates), followed by the page of the transcript. 'B2: 15' refers to page 15 of graduate Barbara's second interview, for example.

Chapter 5

Data and Analysis 1:

Expectations and Assumptions of a Traditional Route into Physiotherapy

I had followed the careers of the physiotherapy graduate respondents as newly qualified staff between 2008 and 2011, interviewing several of them more than once during the three years. This gave me the opportunity to learn about their previous career paths before training as physiotherapists and subsequently to hear what their experiences had been as they sought to become members of the physiotherapy profession, or in Lave and Wenger's (1991) terms, to learn the nature of their movement from legitimate peripheral participation to full participation in a community of practice. What soon emerged was that these mature graduates felt there was a general professional expectation that the newly-qualified should follow a particular route to this end, a continuation of the rotational experience begun during their placements. In this chapter I shall show to what extent this 'traditional' route into the profession resembles Lave and Wenger's (1991) theory of situated learning and also reinforces other workplace practice literature I referred to in Chapter 3. I shall also explore some of the areas where the theory fits less well, in particular the nebulous concept of the community of practice. I shall illustrate my findings with empirical data from the interviews with graduates I conducted over the three years, as well as with occasional comments from the managers and established clinicians.

In looking for similarities and differences between the theory and the paths taken by my graduate interview sample, I considered specific elements that might be found. These were, firstly, that there should be a community of practice, a workplace as a socio-cultural environment that motivates individuals' learning and ambition (Handley et al., 2006; White, 2010). Lave and Wenger (1991) write of novices entering such communities of practice in a position of legitimate peripheral participation, allowed to practice with support given by more experienced members of the community, before moving gradually to full participation. Wenger (1998) further suggests that there are three main constituents of such a community of practice, mutual engagement of participants, negotiation of a joint enterprise and the

development of a shared repertoire. Finally Billett (2006) speaks of the importance of the affordances offered the newcomer. These were the features of workplace learning that were either recognised or challenged by data drawn from the narratives of my respondents.

The Traditional Way into the Profession

Until recently there has been, and to a large extent still is, an expectation that to move forward in physiotherapy after graduation people should seek a rotational Band 5 post, usually in the environment of a NHS teaching hospital. During training, practice placements lasting five weeks each allow the student legitimate peripheral participation (Lave & Wenger, 1991) in a selection of clinical areas and the assumption is that something similar should continue once the students have qualified, but for rather longer periods of time. Thus rotational posts, providing three or four months of experience in each of several specialities, allow the junior to gradually accrue the greater knowledge and more finely tuned skills that make them useful in almost any clinical setting. An established clinician, Cathy, described the process in the following way.

It's like a pyramid isn't it? You start off at the base of this pyramid and then you go towards the pinnacle but you don't reject everything that you learned on the way up the pyramid, so .. it's all there to be drawn on.
(Expert C: 18/19 - see Appendix VIII for brief details of all interviewees)

This concept of building professional learning, akin to Lave and Wenger's (1991) theory of a trajectory from novice to expert, assumes an upward progression, and also a continued dissemination of professional knowledge downwards, from those more experienced.

Once Band 5s have gained an idea of which speciality they are peculiarly suited to from the variety of rotations they have tried, they are expected to apply for more senior Band 6 posts in that area. But in times of economic uncertainty people count themselves fortunate to attain a stable position at all in some parts of the country. Now many available posts are non-rotational and, as juniors had perforce to accept such positions or face unemployment, traditional routes to seniority began to be questioned at national level (Limb, 2006b). The CSP's Education Officer was concerned that this pathway into the profession was regarded as the only acceptable

one by many clinicians. Students on placement soon noted this attitude, and on graduation their thinking was, “.. unless we can get a first post with a structured rotation, it’s not worth going for” (Limb, 2006b, p 15). The rotational route was beginning to be seen as an insurance towards gaining further employment.

A few years later this perception tends to remain, as Eric’s comment below shows. He had been lucky enough to be offered two posts, a static one and a rotational one.

I think for future jobs and future career paths, I think even though it is changing and people are getting more static positions .. and not rotating, I think in the back of the management’s mind .. they’re all thinking that rotations are needed. So I think you’re sort of shooting yourself in the foot if you don’t do eighteen months at least rotation (E2: 8).

Eric is always planning ahead and calculating what manoeuvres will progress him most effectively. Though he is, of necessity, thinking carefully in this way because he has a wife and family to support, there seems to be more than “solely .. calculation of economic returns” (Ball et al., 2000, p 18) here. He is positioning himself in an expansive learning environment (Fuller & Unwin, 2003), taking his time to acquire the widest range of skills, in order to become a thoroughly adept and versatile clinician.

But it also makes economic sense for it would appear that Eric is correct to argue in this way: there are certainly practitioners that think along these lines. One of the managers I interviewed is married to someone who owns a private practice.

.. my husband .. will only employ physios that have been qualified for five years, partly because of the insurance recommendations, but also because he’s very aware that they should have rotated before they’ve been to him, and had an all-round experience .. it’s better to have staff who can cover all areas and can be a bit more flexible (Manager U: 12)

Here is the thinking that Eric has recognised in managers. Ensuring flexibility is important when staffing a private practice as well as a physiotherapy department.

Hilary voices this economic importance too.

.. everybody wants .. your key rotations, because that makes you more flexible and likely to get up to the Band 6 position that you want .. a much better chance of getting work .. (H2: 14)

The 'key rotations' that Hilary refers to here are those forming the basis of undergraduate clinical preparation, musculoskeletal work, and the cardiorespiratory and neurological specialities (see Chapter 2, page 27). Job seekers need to be capable of turning their hand to any form of physiotherapy, if they are to be attractive to employers. Both Hilary and Eric thus support Collin and Young's (2000) idea that peoples' careers will develop "strong horizontal .. characteristics" (2000, p 94) when there is uncertainty regarding future employment. Broad experience brings security of tenure: an onward and upward direction in the career based on narrow experience carries risk.

My interviewees' perceptions of the best grounding for professional life generally reflected this thinking. It appeared time and again in the data. At the start of her career path, Barbara needed to get a job quickly for financial reasons. She preferred to get a rotational post and

experience of everything (B1: 21)

but she knew she would have to consider static and even Assistant Physiotherapy posts too. Gwen aimed to gain

.. a broader experience in more areas. And then try and hone those skills down (G3: 14)

She felt she needed this

because I think .. patients are very complex and they very rarely tend to have one thing (G3: 14/15)

Knowing a great deal about just one speciality was not sufficient. Pat too felt the need to broaden her experience.

.. continuing to think more holistically about patient care .. if I can do more intermediate care and community stuff, then I think I'd feel more rounded about the whole patient journey (P2: 13)

Pat is aiming to widen her experiential scope beyond the key specialities here, implying that it is necessary to be able to address patient issues in all areas and throughout the whole of their life journey.

The respondents' circumstances could impel them to consider innovative solutions in a bid to continue on the traditional path. Susan, the lone parent of a child with special needs, realised that her employment options were restricted by her desire to stay with the excellent Children's Services in her area.

Hopefully, I'll get a rotational post. If not, again, it's not the be all and end all. I will do my own rotations. I will take temporary contracts and I will do a rota and rotate myself (S: 20)

So sure is she that the traditional rotational route into the profession is the best one, that she is willing to create her own version of it, should the need arise. A few years ago this would not have been necessary, but newly-qualified physiotherapists may now have to string together many short-term contracts, and if they are lucky they may gain posts in an appropriate variety of work areas, so that this could indeed be a substitute for the traditional rotational route.

Susan's response to her situation could suggest that those resourceful enough will prepare to organise themselves to make some sense of what is happening in their environment (Littleton et al., 2000). Such self-organisation may cumulatively result in new shaping of the career over time. This could be particularly so in the cases of these mature graduates who thanks to a, sometimes erratic, career path in their youth have "a fund of experience and are acquainted with several worlds, endowing them with considerable adaptability" (Boltanski & Chiapello, 2005, p 117).

The Advantages of the Traditional Route

Fuller and Unwin (2003) attempt to modify Lave and Wenger's (1991) theory to fit apprenticeship to a context recognisable today. They present an expansive-restrictive continuum of workplace learning, comparing expansive learning favourably to restrictive learning. On the one hand, with expansive learning, time is taken to reflect on present progress and to perfect new skills; a breadth of learning, affording a variety of experiences is built into the learning situation; and the primary workplace community has a culture of "shared 'participative memory'" (Fuller & Unwin, 2003, p 411). On the other hand, in restrictive learning the transition to full participation in working practice is as fast as possible, there is narrow access to opportunities, and little tradition of apprenticeship. The traditional route into physiotherapy thus shows signs of expansive rather than restrictive learning. It will be seen that newly-qualified

staff are given time to reflect on their work with 'problem' patients and encouraged to perfect new skills rotating through a range of speciality settings.

There is also an evident culture of learning that graduates like Eric can tap into. Among the senior staff in the physiotherapy out-patient department where he worked were extended scope practitioners, physiotherapists working at a high level who have specialised in one particular area of musculoskeletal work. It was their ability to cope in all circumstances that Eric envied. These practitioners had reached a position where

.. they seem to know everything that you ask them .. to a degree. They don't know everything but they've sort of .. got enough experience and mileage under their belts to be able to deal with most things. So that's what I'm aspiring to become. (E3: 13)

It was not the fact that these practitioners knew everything that impressed Eric. He aspired more to be able to cope as they did whatever came his way, that he might have the strategies to allow him to at least attempt to manage most situations.

Eric analysed musculoskeletal work in the following terms.

.. you have to go through an assessment to make a diagnosis, to know what it is, as well as then to go on to treat that .. And to do that effectively you need to .. have the hands-on experience and to be able to recognise .. the patterns ... you're recognising what the diagnosis is with the patients a lot sooner with experience .. (E3: 9/10)

Thus Eric introduces the idea of looking for patterns in work, here as a well-known aid to diagnosis. But it is not just in work terms that such patterns manifest themselves. There are socially and culturally constructed patterns to adapt to in any workplace (Billett et al., 2005). They are part of the 'participative memory' that Fuller and Unwin (2003) discuss. Eric, coming from forms of previous work that have of necessity firm procedural structure and pattern to ensure safety (fire-fighting and sky-diving) might have been making more effort than some to structure his present work a little along those lines. There is a cultural tradition here that he would recognise from previous experience.

Support in a Community of Practice

Several graduate interviewees identified phenomena that seemed to show that an important element of that cultural tradition was the presence of a supportive community in the workplace. Gwen for instance found her first place of work, an out-patients department, stressful, but was full of praise for her senior there.

I used to have a problem patient session every week, where I could take my case notes .. anybody that I was feeling that I was struggling with. And .. that was my time to sit down and to talk through any cases that I had, which I really, really .. think . as a junior, it's fantastic to have that .. when you're first learning. (G2: 9)

Thus, in her early days in the job, when she might be expected to be feeling most vulnerable, those more experienced had set aside specific time for her to voice her concerns and reflect on how her practice could be improved. This kind of support is not just helpful at an early stage but may well be copied by Gwen when she is working with junior staff herself at a later date. Lave and Wenger (1991) write of the community as an entity, a learning environment in which Gwen will eventually take her place as one of a number of 'old timer' resources. As an initiation process into the culture of the workplace, early support is also the means of perpetuating and invigorating its practice. Dewey speaks of, "the customs, methods, and working standards" of a vocation as constituting a 'tradition', initiation into which allows "the powers of learners [to be] released and directed" (1974, p 151). These are the moments in everyday work that Hodkinson et al. (1996) argue can confirm original career choice, the 'routines' that promote skill development.

This tradition of shared routines also mirrors Lave and Wenger's (1991) notion that in the workplace situation, "social practice [and not learning per se] is the primary, generative phenomenon, and learning is one of its characteristics"(p 34). This idea was echoed by Cliff, as he compared formal learning with the learning that came from practice.

.. when I was doing the orthopaedic in-patients I would be coming home and reading stuff all the time, but .. nothing's going in. You've just done a day's work and you've probably learnt more in that day's work than you would in any eight hours of sitting and reading a book .. a lot of reading will only take you so far if you're not able to practice. (C2: 17)

Cliff's endorsement of putting learning into practice echoes what literature has to say about the importance of learning actively in the appropriate social setting (Edwards, 2005; Fuller, 2007; Lave & Wenger, 1991). Textbooks on practice play an important part as mediating artefacts (Eraut, 2008) in transferring knowledge between members of a community, and are labelled as reified knowledge by Wenger (1998). Eraut (2008) questions how much of the knowledge resides in the artefacts themselves however, suggesting that "much lies in the conversations that take place around the artefacts" (p 5). Reading about a condition and its treatment provides helpful background, but is no substitute for the actual use of that information in context, working closely with a patient, and then discussing this further with a senior colleague. Like Gwen, Cliff praised this aspect of his experience. He felt thoroughly supported; it was

a real atmosphere of learning .. you can ask anyone anything .. (C2: 17)

His impression was of a group of physiotherapists mutually engaged, as Wenger (1998) suggests, in joint enterprise, having developed a shared repertoire.

How People Worked Together

One of the questions I asked interviewees who seemed to agree that teamwork was important, was how people worked together. It intrigued me when Eric replied that this didn't happen, as though his immediate understanding had been that practitioners did not physically work together, side by side. But he immediately corrected himself, continuing,

.. if we have a problem patient we come into the writing room and we then almost open it up to the floor. You say, "I've got this patient, this, this and this, what do you reckon?" .. We sort of sit and chat and socialise but not working obviously. (E3: 15)

Again social interaction predominates in this learning, the individual now bringing problems to the whole group, his immediate colleagues, as they sit writing up their patients' records. Eric is working at a higher level than Gwen was however. He has now been qualified for two years. It would be a brave newcomer that would face a group of their more experienced colleagues with their difficulties, rather than just the senior member of staff directly responsible for their work in the healthcare team. Perhaps Eric's particular working environment though, with its room where staff

tend to congregate and discuss any issues they are facing, might be more congenial to this than most. It appears a very relaxed environment for what could be seen as the more formal aspect of situated learning. Colley et al. (2003b) note that all learning involves both formal and informal aspects, the balance between the two being important. Here Eric did not immediately regard the writing-up room as a working environment at all, yet, while separated geographically from his clinical interaction with patients, it is where a good proportion of his learning takes place.

Language of the Community

Of interest in these examples is that both Gwen, very early on in her career, and Eric, as he started work at the higher level of Band 6, talk of the 'problem patient.' Gwen, encountering a variety of conditions for the first time, has perhaps been guided by her senior to use this term; the patient here may present little of a problem for the more experienced practitioner. But Eric, at his later stage, can recognise for himself that one of his patients is in the different category of those that merit group discussion as patients that are out of the ordinary, that do not respond to treatment as might be expected. It is well known that professional language accompanies practical skill acquisition (Schryer & Spoel, 2005), but this is not a case of the use of medical terminology. The word 'problem' is being used in a slightly different way to the norm, one that is understood one way within the working community, but another way by the outsider, who might erroneously understand it quite differently, that the 'problem' patient showed aggression for instance.

Eric's recognition of the situation is worthy of note. To be able to do this Eric has to be confident that he is sufficiently skilled to have treated the patient appropriately in the first place. He then has to realise that the normal way of addressing the condition is not making the difference that would be expected. There must be a questioning of unthinking assumptions, and maybe, with a more experienced practitioner, some immediate reconstruction of strategies for action, the process Schön calls 'reflection-in-action' (1987). In Eric's case, it is time to pause and ask for colleagues' advice. He is at the level of the competent practitioner, managing in most situations, but deficient as yet in speed and flexibility and needing to plan carefully to achieve efficiency (Benner, 1984). On returning to the patient, he can test and hopefully

affirm the strategies that have been suggested, noting if things change for the better and to what extent, for future reference. That he has reached this level of work gives the impression that he is well on his way to Lave and Wenger's (1991) suggested goal of full participation in a community of practice.

Opportunities to Learn

Some of my respondents, then, spoke of experience in the early years in their new career that supported community of practice theory. Another among them, Hilary, also pointed out the motivating effect of learning opportunities that Billett (2006) writes of.

.. in some places where you work they might be very good at what they do, but they kind of say, "Oh well, I'm facilitating because I know everything, so I'm going to facilitate", whereas you're not going to learn unless somebody gives you that opportunity to learn. (H3: 13)

It was not sufficient to just watch the expert handling the patient in such a way as to encourage particular movements (often referred to as facilitation). It was important to practice the handling oneself in context. But as Hilary has discovered this encompasses more than simply carrying out the technique. Compared to individual learning, social learning focuses on, "the situation itself – its antecedents, wider context and ongoing interaction with its environment - and the transactions of its participants" (Eraut, 2000, p 132). There needs to be an accommodating relationship with the clinician who would normally have performed the manoeuvres. It is this negotiated sharing of the work that Hilary appreciates as an opportunity to learn.

As well as the chance to try things out, some even appreciated the learning that came from doing things wrong. Pat was a graduate who pinpointed mistakes she had made as moments that particularly helped further her learning. A key instance was when she deemed a patient fit enough to progress in treatment despite knowing that this should have happened only a week later in his management. She had been roundly corrected by her senior colleague.

.. on one level you think why is she being so over . melodramatic about this, but on another level it really made me think I have to be very specific when I'm following a protocol even if it's someone who's very young and active and acting as if they're further down the line. I have to

observe these specific things. So those are big developmental moments for me .. (P2: 23)

Here is a newcomer who appears to be pushing the boundaries of what is accepted in her community. She has reached the stage in participation when she has been set tasks where mistakes are just allowable (Billett, 2006), but if they do happen she must learn from them if she is to progress. Following the protocol is part of the ethos of not only her chosen profession but of the multidisciplinary network connected to it, part of the reification associated with the community of practice she now belongs to (Wenger, 1998). Any successful mutual engagement she has with the MDT depends on the transfer of such learning to further similar situations.

However, it is interesting to note that some researchers have found that professional experts do not always follow ‘the protocol’ that they teach to newcomers. Dreyfus and Dreyfus (1977), cited by Benner (1984) learnt, by watching their eye movements, that flying instructors taught their budding pilots to follow a sequence of instrument checking that they themselves bypassed. The expert pilots were then asked to follow the sequence more closely, whereupon their analytical and corrective skills actually deteriorated. It thus seemed that deviation from the rules improved performance in the expert’s case. I shall be exploring what is meant by expertise in Chapters 8 and 9. Suffice it to say that the newcomer like Pat has not reached this stage and so dare not risk any shortcuts.

Optional Routes, and Barriers to Progress

Legitimate peripheral participation (Lave & Wenger 1991) and the learning opportunities (Billett 2006) afforded by the ‘traditional route’, though available to some, are not available to all in a time of fragile employment. Optional routes of entry into the profession are only just beginning to open up, in particular the static post which can be favoured by recruiting managers. One Professional Lead noted that some individuals applying for posts had more than one job and therefore made requests that would have been unusual in the past.

.. one [newly qualified applicant] this year .. said “If you get anything that’s three days a week, can you let me know?” So sometimes three days a week static may well suit and if you’ve a pot of money in an area, maybe out-patients, or something like that, that you just need . just to

plug that gap. I can see why some managers feel that rotations are ... challenging. (Manager V: 12)

It is paradoxical that while newly-qualified staff, like Eric, feel certain that managers require them to have rotational experience, the managers recruiting them might feel the need to employ people into static posts on a short-term contract, because of local financial constraints. This could be despite a wish to see more rotational junior staff in the workforce so that they may be trained to eventually fill senior positions. While seen as a welcome option for the few, such restrictions to workforce planning can act as a barrier to others then.

There are also more entrenched barriers that have come to exist as subsidiary limitations to career progression alongside the traditional route into the profession. One is that community work tends to be given to experienced staff. There are three main arguments to support this reasoning. Firstly the practitioner in the community, moving alone between patients' homes, is in an unsupported position, seen as unsuitable for a junior member of staff. Then they should have a good network of connections in the multidisciplinary team in order to liaise with appropriate members to enhance patient management, and newcomers have yet to learn all these connections and how communication works best in that particular team. Lastly it is helpful if community workers have the general experience needed to deal with all the conditions and unexpected situations they may meet, and, until they have completed several rotations, novices are not considered to have sufficient experience.

Recent attempts to open up this area to junior staff in a time of poor job opportunities have only been partially successful. A contributor to a CSP discussion website compared her more favourable experience in community work with that of a fellow graduate's.

.. I do see patients on my own. I am very supported in this and we [she and her senior] discuss what I plan to do before I go .. and then discuss this when I get back .. I feel that without strong support the use of juniors in the community is a little questionable. A friend that qualified the same year as me had a community post as his first rotation .. and only had a meeting once a month with a senior! (Stowe, 2008)

This suggests that adequate support is not always available, but it is interesting that one of my respondents who had the opportunity of a rotation in the community, Eric,

complained of other difficulties. The pace there was too slow and repetitive for him, and he did not feel he achieved as much as on his hospital rotations.

.. it doesn't feel like you're actually being a physio. It was more just chasing .. and managing other people, so you'd be chasing OTs or missing each other or you'd be having to then report back to social workers. It felt to me like I was wasting a lot of time and because you're travelling around so much as well .. (E2:11)

It is these networking niceties that are awkward for the newcomer, making them feel uneasy working in such a different environment. That Eric felt confident enough to embrace this semi-management role is to his credit, but it is curious that, surrounded by other professionals, he did not perceive his work as being specific to physiotherapy. He saw his ideal role as being in closer contact with his patients, and in action not negotiation (Eraut 1994). When he saw less of them it felt as though he was wasting his professional time.

Staffing community positions yields still more complications. The position of Band 5s in the community has been largely ignored in some areas, as one community manager explained.

.. you train up your .. auxiliary staff [Assistants] to a higher level to enable your .. degree level [Band 6 Physiotherapy] staff to basically move up to a higher level. So .. the physios in effect, would move up to an Advanced Practitioner level and go and do an MSc or whatever, and become that sort of level. Your Assistant Practitioners are coming up below them. The major problem that no one ever looked at was .. the Physiotherapy Band 5 [newly-qualified] .. (Manager X: 6)

On hearing of this situation, another manager, from an acute hospital Trust, responded,

But how will they recruit to Band 6 easily, if they don't work them up from Band 5? (Manager V: after interview)

This barrier may take some time to remove, for there are now financial restraints to consider and Assistant Practitioners are cheaper to employ than Band 5 graduates.

The other area, already mentioned by Manager U on page 132, that does not accept newly qualified staff is that of private healthcare, where the insurance companies running such hospitals insist on their staff having several years experience. Beth

explained how the private hospital she worked for had helped unemployed newly-qualified graduates by employing them at a lower level.

.. they [newly qualified] come here as .. a Technical Assistant, and then gone to a junior, and then gone to a senior .. To be BUPA registered . they ask for three to five years qualified, so everybody here is of a standard that's able to teach a junior member of staff. (Expert B: 16)

Though legitimate peripheral participation for junior staff here is restricted to work at a lower status than the newcomers might find elsewhere, this does ensure good workplace support. It is interesting to ponder why these restrictions (in the community and private healthcare areas) have come into force. There are pragmatic reasons for those in the community which appear to be protective of newly-qualified staff. It would seem preferable to arrange a better support system and at least some junior engagement in community work however, if appropriate experience is to be gained in an area that will require increasing attention as more and more elderly patients are encouraged to recuperate in their own homes rather than in hospital. There seems less reason for the private healthcare restriction, though stemming presumably from greater fears of litigation in the private sector. Once more financial inducement may also play a part.

These internal boundaries then, obstacles on the way to a more stable position in the workplace, can cause difficulties to newcomers, and Lave and Wenger's (1991) idea of a well-bounded, community of practice, where there is no impediment to the individual's progress once allowed to practice, begins to seem something of an ideal. Both the prevailing culture in the workplace community itself, with its restrictions to other routes of entry than the traditional, and external socio-economic factors, where less well-paid staff are preferred to the graduate, reinforce Fuller et al.'s warning that those with power to "reset and relocate boundaries" (2005, p 54) within a community of practice can impact on participation and therefore the learning available to the individual.

Communities of Practice Questioned

As has been shown there are many forms of workplace in which health professionals like physiotherapists work, including out-patient departments, hospital wards, private clinics and the community setting of patients' own homes. Lave and Wenger's

(1991) theory of a 'community of practice' might apply to any of them. Nor must it be forgotten that the overarching professional body has a strong claim to be considered in a similar light. So how is this concept of 'community of practice' to be understood?

I shall consider the last of these groupings first. Graduation as a physiotherapist allows membership of the Chartered Society of Physiotherapy. This official body upholds core standards of practice and professional rules and regulations, what Wenger (1998) refers to as 'participation' and 'reification'. It also enables members to discuss clinical and service delivery issues through the website, and aims to support CSP members, both individually and collectively, in the workplace and at local, regional, national and international level (CSP, 2012a). This is certainly not the close-knit intimate grouping envisaged originally by Lave and Wenger (1991), though in this age of advanced communication technology, such organisations are being labelled as communities of practice (Wenger, 2007). All my respondents belong to this body; in fact it could be said to be the only professional link between them all, working as they are in different parts of the world and in very varied areas of physiotherapy.

Professional membership, and the forms of reification, like the badge, that accompany it, can be seen as a positive advantage in clinical work. Eric noticed even the slight change when he was promoted to Band 6, and was ready to use it.

.. the badge of senior physiotherapist .. I see it more as a tool than a title, that if when I walk into a cubicle and the patient's there, you see them look at your badge .. they see 'Senior Physio' and they tend to get better because they feel relaxed, they feel at ease, they trust you more than they would do if I'd walked in with just 'Physio' .. (E3: 18)

Wenger (1998) contends that in the effort to negotiate meaning in life, participation denotes our action and connection directly with colleagues and clients, while reification indicates how we are seen by these others. Eric, his awareness probably sharpened by his recent rise in status, perceives an alteration in his patients' reaction to him which is thoroughly useful. He is already aware that being older than most newly qualified practitioners sets him ahead with some patients. They tend to trust him more, and being a professional can be defined as having the trust of clients, and

maintaining behaviour which is worthy of that trust (Evetts, 2006). This is of particular importance in healthcare, for it has been acknowledged that, “Trust in the healer is essential to healing itself” (Goold, 2002, p 79). Eric now sees his senior badge as an addition to his professional toolkit that might achieve particularly beneficial effects.

Alongside his senior physiotherapist badge Eric will probably be wearing his CSP badge, a significant emblem of the distant community of the overarching professional body, but it is the change in status of the local badge that has an effect on his practice. The out-patient Physiotherapy Department is a much nearer approximation to Lave and Wenger’s (1991) theorising about the community of practice, the micro-level compact set of practitioners working towards shared goals. Eric belongs to both, and rather than see the two overlapping each other, it is tempting to imagine the local community as encompassed and surrounded by the remote professional community. Wenger’s (1998) suggested three constituents are present in both. The chief difference between them, from Eric’s point of view, is that he will never meet the majority of the CSP membership but he knows his colleagues in the Department very well indeed. The scope of the two communities differs widely, yet they have much in common.

Complicating the picture still further is the fact that in healthcare, people very commonly work together in multidisciplinary teams (MDTs). Here mutual engagement and joint enterprise exist, but there is no truly shared repertoire as Wenger (1998) understood it. Each healthcare professional has their own methods of managing the patient, pieces of a jigsaw that together should provide total holistic care. And this team will not be the same for every patient. The MDT for one patient may need the addition of a Dietician, while in another this clinician will be replaced by a Social Worker. The concept of a community of practice becomes ever-changing and nebulous, to the point where its very essence as a reliable entity comes into question. Bourdieu (1987) writes of social structures having “no more clear-cut boundaries .. than there are in the physical world”, an appropriate image being that of “a flame whose edges are in constant movement ..” (p 13). This seems a useful analogy for communities of practice, which can exist sometimes very briefly, to be

supplanted by others and then overlapped by still more. The reality is by no means as clear-cut as Lave and Wenger (1991) can make it seem.

One of the mature graduates, Hilary, equally felt her practice to be constantly altering slightly as she developed.

.. by tailoring your own development and depending on what area of work that you're in, like obviously through different courses, and through the people around you, then your treatments are going to change with time, based on what you know at that point. (H3: 10)

Hilary seems to be noting how parts of her practice extend while others diminish according to the opportunities afforded her and the influence of different people around her. In this she is echoing Hodkinson et al.'s (2008) comment that the working environment and the provision or otherwise of learning resources must affect the learning that occurs. Thus the state of development and progress of the individual reflect the changeable patterns of practice, of the constantly flickering flame as Bourdieu (1987) pictured it, of the ambiance of their working community.

It is of interest though that Hilary feels she has some control over her development. It is not just because of the influence of the workplace environment that her practice is changing; she is 'tailoring' it to some extent. As Billett et al. (2005) noted, both the individual's and the social situation's contributions are needed to complete the participatory process. Hilary is making decisions about which opportunities of those afforded her she is going to seize and integrate into her learning. In this way not only will she change but the workplace may too, as it must when different people with various expectations and styles of learning mix into its culture.

Hilary gave a good example of how certain people can change the practice of a department. She had experienced working in an out-patient department with two seniors who had then moved on, one in particular having specialist knowledge she appreciated.

I'm glad I did it when he was around, because he was very approachable and he was Mr. Electrotherapy man. And so we're going to lose him, and in some ways I think that's going to be a big loss because nobody else will have that knowledge really .. he was a good source .. And from a cohesion kind of view within .. an area, if you lose too many good people

that people are used to in one go, I think it kind of puts a void in there and it makes things possibly unsettling for a while .. (H2: 21)

Stable teamwork has been recognised as crucial to effective workplace learning (Boud & Middleton, 2003; Eraut, 1994), while temporary groupings that have not yet developed firm relationships and patterns of practice lack ‘cohesion’, as Hilary puts it. Her use of the word ‘void’ too suggests that every member of this community usually works well with the others. The lack of one specific person in such a case leaves a hole that will need work to refill.

Identity Reconstruction Matters

In making some of the decisions about what they learn, individuals do not always intentionally or uniformly work well with the group (Billett et al., 2005; Eraut et al., 2004). People learn in different ways. Cliff, for example, is not satisfied if left to learn on his own. In his previous career he had “a nice cushy job” (C3: 9), well paid and under little pressure in a big company, but found himself becoming frustrated.

I never felt out of my depth or anything, which is something you need to feel. You need to scare yourself a bit .. to push on .. (C3: 9)

Eraut et al. (2004) would agree that “for novice professionals to make good progress a significant proportion of their work need[s] to be sufficiently new to challenge them ..” (p 9). Cliff seeks out testing situations in his present work, finding it an obstacle to his progress if work is too easy.

Nobody’s stopping me, going “Do you know this? Do you know this?” And who’s got time to be doing that like? Nobody does; I have to stop myself and go doing all this. But then there’s so much kind of going on in life and .. you want to spend time in the evenings with your friends, your family. (C3: 39)

Cliff is someone torn between a physically stable career and family life, and a psychological yearning to continually move on and be stimulated by new learning (Sullivan & Arthur, 2006). His narrative showed him to be something of a nomad for the six years between his two main careers, travelling across the globe, doing whatever work came to hand. During this period Cliff might be said to have had a boundaryless career (Arthur et al., 1999) for he rarely settled for long at any particular job. His wish to settle down now seems at odds with his vigorous

perception that he can still better his learning. One senses a thwarted striving after a boundaryless future career despite the physical restraints of his present workplace situation. He exemplifies someone who has moved from a high physical but low psychological mobility situation (the wide-ranging geographical movement but low commitment of the 'nomad' life), to a low physical, yet high psychological mobility situation (Sullivan & Arthur, 2006). These authors suggest that someone like Cliff might introduce new ideas into his workplace community, and indeed one of the attractions of his current employment for Cliff is that he finds his colleagues motivated to continually work to improve the service. He has an expectation of change, of practice moving forward.

I think that's something that I probably would have found difficult ... if somebody comes up with a good idea, and other people are like, "Aw . no." And I'd be like, "Well why not? What's the problem?" (C2: 39)

He is certainly not, any more than Hilary is, the passive recipient of community culture Lave and Wenger (1991) tend to suggest a novice participant will be.

But Lave and Wenger (1991) are concerned less with how the individual learns and more with their identity construction, their feeling of belonging within the community of practice. Bathmaker and Harnett (2010) define identity as the struggle between one's situation in life and one's own feelings of where one is in oneself, the latter concerned with choices one makes about how one presents oneself to others. This could be another view of the problem Cliff is facing, as he seeks to integrate with the culture of his new career, while staying true to values he holds dear, in particular the greater nomadic freedom and autonomy he had in his previous life. A readiness to change and to adapt his working style for the better is something he is keen to present to his superiors. It is also a useful feature to demonstrate in a time of threatened unemployment.

This is a further layer of complication to add to the changeable concept of the community of practice. Cliff had been given a permanent post, and it had made a difference to how he viewed his work.

.. it just changes your feeling about the place. You've a definite pride and respect in your own work which you should have when you see everyone, but then . you see the department as a reflection of yourself ..

where what happens in there is what you've done. You're part of that. How the department is viewed is how you're viewed .. (C2: 18)

This sense of emotional commitment is a factor Colley et al. (2003a) note accompanies an improved experience of learning. Cliff feels that his contribution is important to the department, that he is part of the 'shop front' demonstrating the best the team can offer to the outside world. He seems to have developed the notion of being in the right place that is part of belonging to a vocation. And it appears to be security of tenure that has completed his transformation.

Pat, on the other hand, is a respondent whose experience and view of 'belonging' at work brings attention to the backdrop of a fragile labour market. Her difficulty finding anything but short-term employment has influenced her forward planning, causing her to lack commitment.

.. something at the back of me makes me think if I felt settled, and settled is closely linked with a permanent contract, I would feel I could identify with the whole process more. Because at the moment I'm thinking, "Well, if I don't get a job in June, then I'm going to have to look around for something really quickly, anything to earn money." (P2: 12)

Progress has been restricted by the fragility of her employment situation. This is the situation exemplified by Lave and Wenger's (1991) supermarket butcher apprentices, practice without proper peripheral participation in the community. Marginalisation is sometimes affecting Pat's learning, for in one Trust she found ..

I had to be very proactive and I noticed that the permanents [those employed on a permanent contract] had .. very organised supervision .. There was a specific filing cabinet with all their files inside and everything was recorded and popped into their files .. Whereas I had no such thing .. (P2: 3)

This seems an example of what Billett (2006) notes regarding less support for those on short-term contracts in times of economic recession. The struggle for security hinders her progress.

I can't branch out .. because I'm dealing with the basics, which is trying to get the permanence first. And then I can sort of sit down and relax and engage more with the employer and the whole Trust and where it's going .. [which] would be an extension of your role and an extension of how you identify with your .. whole area really. (P2: 19/20)

The mention of identity here is most apposite. The terrain into which newcomers are supposed to be integrated, where membership is built up and professional identity developed, here presents real uncertainty. Unhappy with her tenuous position, Pat sees real engagement as giving her a chance of becoming a full participant.

Pat may feel this more than most because she has previously spent 17 years in a very close-knit team of workers, people who shared her views in ways not to be expected in her new professional life. A

.. long standing interest in leftwing politics and alternative methods of working and more empowerment in the work environment (P1: 1/2)

caused her to join a workers' cooperative. It is unsurprising that she can find little of the sense of belonging she once knew in the cooperative in her new career of physiotherapy, where she is constantly moving from one job opportunity to another. Yet Pat is a member of the CSP, a full participant of the macro-level professional community of practice. It is clear that the notion of belonging to the professional body in this instance is not enough. The importance during the early career of feeling part of a group of workers that will be supportive and encouraging is again underscored (Eraut et al., 2004). As individuals progress into the profession, their relationships with fellow professionals in the micro-level community will alter, as they need less support and become truly autonomous practitioners. For many there will be a strengthening of the involvement with a MDT at this point, which as we have seen is a very fluctuating and varied community. The vocational body could become more important at this stage. This will be discussed in Chapters 8 and 9.

Summary

This chapter has outlined what might be termed the normative expectations of the traditional route into physiotherapy professional practice. Supported by more experienced members in their workplace community, newcomers can take advantage of helpful affordances (Billett, 2006), discuss more challenging situations they have encountered and gradually amass experience by rotating through a number of areas, thus making them more adaptable and flexible and widening their horizons of opportunity in today's job market. The tradition of carrying out such rotations,

experiencing different specialities in selected areas of practice, continues to be the expectation of junior physiotherapists despite both long-standing (in community and private care) and more recent discontinuities and challenges to it in a time of financial restraints. Such a traditional route into the profession resembles Lave and Wenger's (1991) theory of workplace learning. However it has been shown that the 'community of practice' Lave and Wenger (1991) position at the centre of this theory is too nebulous a concept to be always useful.

In the next chapter I shall explore what difference it makes to the transition into a new career, and to the workplace, if the newcomer is atypical, the mature graduate who has prior knowledge and experience of the working world. Because Lave and Wenger (1991) were conducting observational research of more typical newcomers to the workplace they did not take this kind of difference fully into consideration. In what ways might previous work experience and lifestyle impinge on acculturation to, and practice in their new community? Might varied backgrounds and external influences alter their perception of movement towards full participation?

Chapter 6

Data and Analysis 2:

The Atypical Newcomer

Lave and Wenger (1991) write of the community of practice's dependence on "a membership, including its characteristic biographies/trajectories, relationships and practices" (1991, p 55), implying that people with similar backgrounds enter the workplace in similar ways which tend to confirm the characteristics of the membership already established there. This could indeed be said of the majority of my longer-established interviewees, the managers and expert practitioners, who had entered the profession straight from school. Their opening narratives were very alike: Shirley for example spoke of her route as "the traditional" (Manager Z: 3) career pathway of Basic Grade for 2 years, Senior II for 2 years, arriving at her present hospital Trust as a Senior I, 26 years before. As more senior positions were advertised she applied for them. Ian too started as a

.. rotational physio, then a Senior II physio, then a Senior I in Orthopaedic in-patients (Manager Y: 1)

and Cathy told a similar story:

I worked through the usual pathway. I did junior rotational, Senior II, Senior I. By the time I'd done Senior I, I was in a static post .. (Expert C: 2)

Beth differed from the others only in taking a seven year career break to raise her 3 children, after completing her rotations and attaining a Senior II post.

A Change in Employment Opportunities

Established practitioners' narratives also had the common theme of having little difficulty in finding employment. Shirley stressed how ludicrously easy it had been when she started.

.. when I qualified .. I was just literally . I went to have a look round .. and she said, "When do you want to start?" And that was my interview .. and even the Senior II job there, I didn't have an interview. (Manager Z: 21)

Andrea's experience in the 1980s had been similar.

.. in those days you just chose a town and then you just got a job (Expert A: 3)

When I asked Beth whether she had noted much competition for posts around this time, she replied in the negative.

No I don't think there was. There were maybe two or three other candidates but not very many, no. No. It certainly didn't seem to be a problem to move. (Expert B: 3)

My graduate respondents tell another story. Some were to find it impossible to move into the profession at all. David, who in graduating from Northtown University was far from home and wished to return, found the situation there extremely frustrating. Several issues restricted his transition into, and progress in, the profession. First, many local hospital Trusts were freezing posts because of financial pressures so that there were fewer jobs there than around Northtown, and jobs were being advertised Trust by Trust, rather than centrally. It took him time to learn the rules of the 'game' (Bourdieu & Wacquant, 1992) in applying for posts. Then, the local university graduates were better known to interviewers, having done their practice placements in the region. Lastly, he felt his age to be against him, for he was over forty and most of the other applicants were in their twenties.

I .. feel at the minute that I'm just sitting outside. Because I haven't graduated here and I haven't had any luck in getting a job. You just sort of feel that, "Well, OK, you've graduated." And . you start to feel a bit useless .. (D2: 10)

Despite being registered as a member of the macro-level professional community, the CSP, David now found himself marginalised to a more peripheral position than the one he had held as a student on placement, a situation alien to Lave and Wenger's (1991) concept. He was clearly becoming discouraged and was worried that he was becoming deskilled. He had seized the opportunity widening participation offered him to change career, only to find his way blocked on graduation. The promise of a new flexibility had resulted in thorough insecurity (Boltanski & Chiapello 2005), vindicating Brown and Hesketh's (2004) contention that graduation only permitted an individual entry to the tough competition for jobs rather than certain employment.

The Atypical Newcomer

Atypical newcomers to physiotherapy like David come from socially, politically and culturally varied backgrounds. They all differ from the typical applicant, the school leaver with an initial ambition to work in healthcare, in that they are older and can therefore have more responsibilities, financial and social. They chose, or had thrust upon them, another path from school, even when they had some knowledge of the caring professions; and they have followed other careers for some years before considering physiotherapy. Their past career experiences are unique to their situation, as are the varied paths they have followed into the profession.

Sociological studies have tended to focus on the topic of initial professional acculturation, or indeed its failure (Colley et al., 2007; Colley et al., 2003a; Filstad, 2004; Hodkinson et al., 2008), but rarely address what happens to those with an atypical biography and trajectory. Lave and Wenger's (1991) concept of a characteristic typical biography certainly does not fit easily within this picture of atypical newcomers entering a community. In this chapter I shall use my empirical data to show that not only do atypical newcomers with prior work experience undergo reconstruction of their identity as Lave and Wenger (1991) would suggest, but their previous experience impacts on their acculturation. The assumption that such newcomers are 'novices' is questionable, for they know something of the nature of work and the workplace, and have experience to draw on. Furthermore acculturation is a two-way process, for not only does the practice of the physiotherapy workplace change these people, but they also have an impact on their workplace.

Two Contrasting Initial Pathways

In researching career decision making Hodkinson (2008) finds there are commonly held assumptions, which he labels 'folk theory' (p 2), that career-choosing decisions are made by the individual seeking a career, that these are rational and cognitive in nature, and that decision making belongs to the start of a process of linear career progression. Both his research findings and mine suggest this to be incorrect. A couple of contrasting examples from my research sample demonstrate this, as well as

showing “the obdurate diversity of data”, as Ball et al. (2000, p 16) put it, that confronted me in attempting analysis.

The first example is Barbara, who left school at 16, there having been little initial expectation of her academic attainment.

I wasn't given the chance for 'A' levels. You were just .. told, “No, you won't achieve them.” (B1: 2)

Although her mother was a nurse, she had not wanted to follow that career, and thus found her horizons for learning (Hodkinson et al. 2008) limited to catering, hairdressing or an office job. When she became pregnant and moved in with the father of her child, her opportunities were further restricted. Her partner expected her to stay at home and care for her children, as his mother had done. This effectively prevented her from going to college.

.. it sounds awful but you fall into this stereotype of 17, having a baby, no job .. and it's quite hard to get out of at that age. (B1: 4)

This is the situation of locked-in early motherhood commented on by Ball et al. (2000). Barbara's choices had been considerably diminished: she found part-time work in a supermarket and any idea of career was put on hold for some years. Contrary to the ideas of ‘folk theory’ (Hodkinson 2008), this was not the path she would rationally have chosen; it was influenced by others and by financial circumstances; and career progression was anything but smooth.

Gwen's is a different situation. Like Barbara she comes from a working class family, and they never thought of her taking up a profession.

.. they'd never sort of socially interacted with .. health professionals or anything .. (G1: 1)

However Gwen showed herself to be gifted in other ways. She took dancing lessons from the age of 7 and at the suggestion of her teacher, was sent to a vocational ballet school from 11 to 19 years of age, finally doing her teacher training there. She did well in her GCSEs and took an A level, but because the education was geared towards vocational dance, academic attainment was not stressed. Thus Gwen

.. never had a normal job. (G1: 6)

It was only when

my body had started to get quite tired .. it was just physically very hard ..
it was getting more and more .. demanding (G1: 5)

that she considered a change of career. Authors have recognized such turning points (Strauss, 1962) or ‘epiphanies’ (Denzin, 1989) in the career path, and Hodkinson et al. (1996) suggest categorizing them. One of these categories corresponds to the forced turning point in Gwen’s career, when factors beyond her control compelled her to reconsider her vocation.

Noting comparisons with ‘folk theory’ in Gwen’s case, it might be argued that as it was her talent that decided the initial choice of career, it had also been her decision. But it would not have been possible without the influence of her teacher and the consent of her parents. From her point of view it was also more an emotional than a rational choice.

I was the child that was stood there at the front, completely to attention ..
I wasn’t one of the ones playing in the background, you know, I loved
every single second. (G1: 11)

However, it was a hard life physically. The ballet school staff made it clear to students that no-one danced forever. Having been embedded within a vocational community of practice from childhood, Gwen is the most similar to Lave and Wenger’s (1991) indigent examples of apprentices among my respondents, but her case differs from theirs markedly in this respect. Although destined from an early age to follow a particular course in a specific community of practice, Gwen knew ahead that she would have to change course eventually. Again there could be no smooth linear progression in her career path after a certain point. This trajectory rose only to fall again when she could no longer dance at the required level. Her identity development now lay more in learning to successfully traverse the boundary between communities rather than progress further in just one (Jewson, 2007).

Thus because of life circumstances and special physical ability these two women only considered their eventual vocational training in their thirties. Their biographies and learning trajectories through and after school were very different, and neither of their initial occupations led directly to physiotherapy. Personal circumstances,

happenstance, outside influence and changes in social context impacted considerably on my interview sample. This challenges the notion of inevitable and straightforward acculturation of a characteristic individual's identity to the ethos of the workplace (Lave & Wenger, 1991). These career-changers had first to deculture themselves from their previous working and social environment, and they had varying experience that would impact on how they coped with integration into their new situation.

Deculturation

The term deculturation is generally used to refer to the way in which emigrant or native people move away from their original cultural traditions, but Ryan (1992) positions this discussion in the field of healthcare. Native American nursing students, "taught to use direct eye contact, observation, and inquisition to aid in diagnosis" were suffering deculturation as such techniques would be considered disrespectful in their culture (Ryan, 1992, p 91). Similarly my interviewees' original work cultures required change as they moved towards a new career culture, so I am using the term 'deculturation' to refer to adaptation away from an initial social and physical work environment.

At its most traumatic, the work culture may be deformed or terminated, as when someone is suddenly made redundant, and this is well known to have a potentially psychologically de-stabilising effect on the individual concerned (Stokes & Cochrane, 1984). Hodkinson et al. (1996) refer to the less traumatic but critical process for the school-leaver of career decision making, where a pragmatically rational path may be taken, allowing for emotion and natural inclination, decisions being made for many reasons, not all of them fully conscious. Barbara and Gwen were re-deciding their future career at a later date but following a similar process.

The beginning of this deculturation begins well in advance of the transition process to the new career, certainly before the atypical newcomer begins to accumulate essential professional knowledge and skills. Barbara thought returning to study and taking up vocational training out of the question, so the first step was learning that it

was a possibility, and serendipity played a role here. She chanced to hear of someone;

He used to work in a gym, and he'd gone on to be a physio and he was a mature student. And it sort of caught me attention. (B1: 8)

Barbara was interested enough to ask her mother about physiotherapy, looked it up on the internet and researched the literature. It was not until over a year later though that she heard of someone else who had taken an Access course and gone to university.

I was quite shocked. I thought, "Well, I didn't think they'd take you, 'cause you're old." (B1: 8)

She immediately enquired into Access courses, registered for the Health and Nursing one, altered her hours to 'lates' at the supermarket, and she was on track for her new career.

Serendipity appears in many of my interviewees' narratives and is influenced by the individual's position at the time. Barbara was feeling bored with her job. She had also by now separated from her partner, and her children no longer needed as much care, so she had more freedom. The field then, the providential relationship of economic, cultural and social resources that allowed Barbara to progress, was also influential (Hodkinson 2008). Her mother's knowledge was a cultural asset few of my respondents shared, for as Hodkinson (2008) notes, individuals' ability to progress is unequal. Most importantly her own agency came into play: she seized upon the chance information she received, did some research and acted on it. This, as I have already suggested (see Chapter 1), can be a risky endeavour for career changers, and several of my respondents were careful to test their suitability to the prospective physiotherapy role by taking part-time posts in a related occupation. Barbara realised better what the future might entail when she did some voluntary work in a hospice. She immediately compared what she saw in the healthcare situation with the work she was doing in the supermarket.

These people were terminally ill and nothing was a problem, nothing was a major disaster. Whereas in my other job, somebody complained because .. a tin of beans is dented or you can't have a break on time .. it just seems so petty .. I don't want to work in that environment. It's ridiculously silly. (B1: 21/22)

She could now affirm her unhappiness at work and reflect on what lay behind her feelings. Working alongside healthcare professionals had shown her how dissatisfied she was with the everyday issues she faced in the supermarket. She was becoming aware that her attitudes and values were more in tune with those of healthcare colleagues. Her affiliation to her previous community of practice was weakening and she was beginning to feel more at one, even that she belonged more, to the healthcare community. It was where she felt she should be.

Gwen went through a more tortuous process, even unsure at first how to correct her work patterns at all.

I've always had something where I was very disciplined and very focused, and, very much from a young age, knew what I wanted to do and I felt quite at a loss when I came home. (G1: 1)

She missed colleagues

.. from what I call my other life" (G1: 11),

her choice of wording here showing the abrupt nature of her disruption from the previous career. She was not only aiming for a fresh start in a new career, but moving into a whole new world.

I'd only ever been in this sort of bubble, this theatrical bubble . of feathers .. and make-up and high heels and glamorous costumes and .. I was a bit bored I think, when I first came home. (G1: 9)

It is worth noting at this point that Gwen was not the only respondent to refer to her former occupation as being in a form of protected 'bubble'. Kenneth spoke in the same way about his life in the RAF.

.. it's like living in a bubble at times in the forces. It's not like real life .. (K: 5)

He saw Air Force life as removed from reality in that bills were paid, food and living quarters were provided and it felt like

a society in itself (K: 5).

Entering a healthcare profession meant assuming more personal control and perhaps a more routine lifestyle, as well as having particular professional responsibilities. For

Gwen the lack of reality was instanced by the glamorous theatrical costumes and make-up, but also by the absence of the necessity to commute daily, never having experienced the mundane routine of work. Such language might be indicative of the sort of close-knit community of practice Lave and Wenger (1991) envisaged and will be discussed more in Chapter 9.

One aspect was initially attractive to Gwen. She had more stability; being settled was attractive, but even when she focused on this, working life did not go smoothly. After some short term jobs as an air hostess and selling cosmetics,

I thought, “Well, maybe what I’ve been doing is I’ve been going in the wrong direction .. Maybe what I need is a regular job 9 to 5, Monday to Friday, in an office.” .. maybe I needed to .. hang up my heels, and put that part of my life behind .. well and truly ... and it didn’t suit me at all and I should’ve known that really. (G1: 10)

But Gwen had made a decision to move forward, away from her previous existence. She felt she needed more of a challenge, and discussed this thoroughly with her partner. Perhaps further training might be best at this stage, though it would mean extra preparation, an Access course, and she lacked the confidence to start.

I was giving up a full time wage .. and at an age where we were potentially going to be starting a family, you know. There were lots of things to be put on hold, but .. and I believe, and this is the discussion that I had with my now husband, was that if I didn’t do it then, I really don’t realistically think I would have done it at a later point in my life .. (G2: 13)

As Hodkinson et al. (1996) suggest, people’s ideas and preferences are individual, but set in the context of, and permeated by, the social framework of that person’s life. In Gwen’s case her whole being, including her body, acted as the means through which her lifestyle was chosen, and modified as her body tired. But it was a difficult and painful process, the whole deculturation taking Gwen several years. Unlike Barbara she had trialed several occupations before she settled to the university vocational course. A major difference here was that Barbara was ready to move on while Gwen was reluctant to leave a career she enjoyed, even though it was becoming very hard. Also unlike Barbara she had had to ensure that her partner too was happy with her choice.

Acculturation to the Academy

Once the decision was made, both women prepared for higher education, neither having studied for some years. Barbara found herself facing an attitude she'd experienced at school. When she told those running the Health and Nursing Access course that she wanted to be a physiotherapist, they advised her to do nursing instead. It made her feel she had come full circle, as though she had indeed returned to "the potential self that was left behind on early cessation of education" (Hughes, 2002, p 415), memories of her last year at school when she was told that she could not take A levels. But no longer was she going to passively accept the verdict of others. This she saw as a challenge, and motivating rather than the reverse.

.. I'd realised by this age that .. you can't be told you can't do something .. I think the more people was telling me, "No you can't do that", the more appealing it was becoming anyway. (B1: 9)

It is as though Barbara was trying to prove something to herself here, an 'investing in self' as part of her identity formation (Ball et al., 2000). It was also perhaps a case of making up for lost opportunities.

The Access course took a year, and Barbara had to study Maths as well as Biology A level to prepare for university. She attempted the latter at home in just seven months, but only got a D grade. Nothing daunted, she then approached a sixth form college and persuaded the Biology tutor there to teach her to A level in a year. It meant studying with people her eldest son's age.

"That was quite scary at first, because there's a considerable like 20 year age gap between us. But no, they was fine. It was just .. home from home really .. Some of them would be, "Have you got a pen? Have you done this? Have you done that?" And others would just talk to you .. just normally .. like an older .. sister." (B1:11/12)

Despite being very well used to communicating with this age group, Barbara understandably felt worried at first about studying alongside teenagers. It is a lesson in humility to acknowledge ignorance before a younger generation, but this was a lesson that was needed if she was to feel adjusted to the university learning situation later. There, one fellow student was to call her 'Aunty', but by now this was not a problem. There were other mature students around.

During the degree course Barbara soon noticed that she had more difficulty retaining what she was learning than she had had in the past. There were good reasons for this, other than her age.

As the three years have progressed, it's getting easier and easier .. it's just training yourself really .. to get into the two separate modes of home life and student life. Sometimes it can be a bit of a juggle, because I still work at [the supermarket] on Sunday, so it's fitting all three of them in.
(B1: 12)

Here is an underscoring of the point Gwen had made about feeling she had two lives. For Barbara life was being experienced on three levels, home, academic and even a little of the old culture at the supermarket. There is evidence that women in similar circumstances feel most themselves at university, when not having to be someone's wife or mother (Adams, 1996). None the less there is little doubt that learning becomes complicated in such circumstances and requires careful organisation. That it became 'easier and easier' suggests that Barbara was becoming acculturated to her new lifestyle. A possible advantage here is that this preparation develops the flexibility and adaptability Barbara might be expected to demonstrate in an uncertain job market (Collin & Young, 2000) later.

Gwen too had difficulty adjusting to learning for she was working three nights a week and alternate weekends in a department store, as she studied on an Access to Healthcare course. She found the guidance provided extremely useful.

.. just the whole process of sitting down and writing something or managing my time .. you know I had to work as a mature student, so I had to be really quite strict with my time. This is my time for work: this is my time for study. If I don't get it in in this block, that's done here, I don't have another couple of hours later on in the evening. I've got to decide when I can do it .. (G1: 8)

It is clear that although Gwen felt the course gave her time for her own study, she also felt pressured to use this time effectively. Time management was crucial to her acculturation to academic study.

Gwen had experienced a brief period of study when she had started to work as an Air Hostess.

I had to learn quite a lot of codes and things. That got me in a sort of process of having to sit down in one place and think, "Well I need to

learn this .. So that was the nearest thing that I'd done really from leaving school .. but it was hard .. because you're automatically in that frame of mind, when you're at school. You're used to studying and you don't think anything of it. (G1: 9)

It is interesting to note that Gwen thinks of study as sitting and thinking, quite alien to her work as a dancer, which had presumably involved learning in motion. Frequent repetition of movements to music facilitated coordination, balance and timing. Now concentration and commitment were the only features in common as she tried to learn, without the aid of muscle memory and external stimuli, restricted to the seated position once more, so reminiscent of school. It might have felt like a backward step. Even the physical effort of writing was difficult. She had to work it up before an exam or her hand would go into cramp. Of one thing Gwen was sure:

.. it was hard .. getting back into education (G1: 9)

but she

.. felt like it was an investment in myself. (G1: 15)

Here again are echoes of Ball et al.'s (2000) finding that among those deciding on a new career, "the decisions and strategies of those who plan do not appear to be solely or even primarily related to the calculation of economic returns." (p 18) Capital of a different sort is to be gained.

Are These Really Novices?

But deculturation from a previous career does not mean that all experience gained there is of no use in the new career. Students of vocational programmes in HE, like physiotherapy, have to learn to belong to two worlds, the world of study and the world of work. There are strong links between the training programme and the eventual professional practice, but they require different social skills and there are different sets of rules. The forms of reification that Wenger (1998) speaks of are quite different in the two communities, and my findings suggest that although the world of work presents some difficulties to the mature graduate, these are not of the same magnitude as those of adaptation to academic work for those without previous degrees and who have not studied for some years.

Barbara had worked on the customer services desk of the supermarket, managing complaints.

You're going to have a bit more .. worldly knowledge of how to communicate .. and how to handle people. (B1: 14)

She could persuade and cajole those who were unhappy. And Gwen had taught dance:

.. this is why I love physio because you get to teach .. (G1: 11)

She could instruct clearly and perform with confidence before strangers, giving an appearance of poise even when things went awry. In these respects they had added talents that were thoroughly useful in the new context. Lave and Wenger's (1991) assumption that newcomers are novices as they enter a workplace must therefore be contested. If atypical newcomers bring valuable assets across the boundaries from one job to the next, can they be truly called novices? Neither Barbara nor Gwen, nor indeed any of my interview sample, seem to fit neatly into this category.

Nor is it as straight forward as saying that there are either novices or people with some experience of work. Let us look at the various forms of new learner that Lave and Wenger (1991) are labelling 'novice'. First there is the individual straight out of school with 'no experience of employment'. This is probably not the case nowadays as many have experience of part-time work while at school. The youngest of my interview sample, Lionel, speaks of having had

something like ten jobs .. by [the time he had completed his first degree] because I've worked since I was thirteen .. on market stalls, a paperboy, loads of shop jobs, bar work .. so I've had lots of experience working with people and all that, but all of those are .. not career jobs (L1: 11)

Here is an individual who has experienced the world of work then, and it is likely in the present economic climate that many school-leavers will have his breadth of experience of part-time work (Howieson et al. 2012). For financial reasons the majority of students are engaged in temporary employment alongside their degree courses.

Secondly there are those with previous degrees who have not yet been employed, and so are used to the world of the academy rather than the workplace. Again it cannot be

assumed that they have not had a similar experience to someone like Lionel. If they have not, their academic practice may at least enable them to adapt to the university situation and focus more quickly on the key academic elements the second time round. As he neared graduation, Cliff pointed to the differences he had from his younger peers in this respect.

.. [the school-leavers] have something that you don't .. they've got youth and lack of fear .. I've got something, I've been to university and I've had all my fun, you know .. and I didn't come here to .. make new friends and party and things like that. (C1: 17)

Cliff saw the advantages of being a newcomer to HE: he had enjoyed himself thoroughly the first time round. But he also noted the newcomers' 'lack of fear'. They do not realise the importance of success to their future and the full implications should they fail, in the present economic climate. It is not that they are unaware of the possible future struggle for jobs, but it gives a certain freedom to be able to put off the time when it has to be faced. Cliff had experienced this ephemeral sense of freedom: it is *his* advantage now that he is more realistic. He has a serious goal in view, and means to concentrate on this. That he associates 'fear' with academic learning suggests that he has moved on since his last degree and become much more focused on his studies since his return, seeing poor marks as real failure now.

In the workplace the first degree will count for less than workplace experience. It is in the last situation, that of people already established into one career that take the step of becoming a newcomer in another, like my graduate respondents, that we find better adaptation to the workplace environment. They certainly do not appear to be novices. There can be times in fact when they feel they are more experienced than their superiors. Tim, an ex-policemen who had specialised in domestic violence and child protection cases, sensed the discomfort of Band 6 staff supervising him as a student.

I think it's just a general feeling you get that they're not quite comfortable in .. knowing how to explain a situation .. to somebody that's a little bit older than them .. they may have been qualified two or three years .. I spent eight years dealing with the public in situations which they'll have never come across themselves .. I've got far more experience than them dealing with the public and complex situations and situations of a sensitive nature .. (T: 13)

Tim's previous experience of difficult domestic situations meant that he not only coped far better than the school-leaving 18 year old in the acute situation of an intensive care unit (ICU), but felt he had an advantage over junior qualified staff.

I've probably still got that element of being hardened up that I've got from the police and, you know, going onto ICU and seeing people die just didn't seem to . didn't upset me at all. (T: 13)

While being prepared for such situations is useful, the idea of being 'hardened' to this field of healthcare is slightly worrying. What might be acceptable in a scene of violence is not in acute care. To the newly bereaved relative Tim might appear to be lacking in compassion. In dealing with the dying patient, "... involvement and openness to complexity are sometimes critical" (Benner, 1984, p 234). There was perhaps a need to guide him towards a subtly altered perception of such a situation, in his new professional culture. Such modification of existing capability developed in previous work situations will be discussed further in Chapter 9 (page 238).

Acculturation to the New Career

Literature has concentrated on the theory-practice gap between the worlds of HE and the workplace (Greeno, 1997; Lave, 1988; Levett-Jones et al., 2006; Newton et al., 2009), failing to ponder any difference there might be should the learners involved have had previous practice in another occupation. Lave (1988) explores how the individual adapts to a new social context, settings being of particular interest to her as an anthropologist. When settings are very different (Barbara's experience of moving between supermarket and physiotherapy would be an example) she considers that transfer of skills rarely occurs, but looks instead at how the new environment allows and encourages specific ways of participating as well as how it may change identity.

Barbara is sensitive to potential tension with her superiors arising from her maturity. She noted the necessity of

.. not overstepping the mark because you are that little bit older .. not saying, "Well I know that because I'm 38." You still have to go down and be a student. You have to rein yourself in a little bit. (B1: 14)

It was important not to flaunt one's years of experience, but to be ready, with humility, to adapt as the occasion demanded. Yet Barbara has communication, and

possibly organisational, skills from her previous work that can be of good use in her new setting. As this becomes evident to her supervisors she may be offered more advanced opportunities for participation, so it could be that Barbara's transferable skills and the degree of participation allowed in the workplace are interdependent. It is this continual interaction between participation and the provision of affordances that Billett (2001b) discusses.

Greeno (1997) by contrast suggests looking for common patterns between settings, finding out what newcomers are bringing to the new environment and how they adapt to become engaged with the practice. Transfer will be facilitated, he thinks, if the newcomer is aware of the skills they have that can be made use of in both settings. Barbara is aware of her communication skills and Gwen of her teaching ability. But there may be other cross-over points, particularly between dance and physiotherapy, which share movement skills that have become almost automatic to the practitioner and so less noticed by them. Learning skills, for a professional, entails learning "new ways of using *kinds* of competences we already possess", according to Schön (1987, p 32). His emphasis on 'kinds' of competencies implies that opportunity, as well as actual physical ability and mental discernment, is needed to achieve successful new learning. In this Schön (1987) reinforces Lave and Wenger's (1991) emphasis on situated learning.

There is a question of whether the situation individuals are in opens to their degree of competence extra opportunities for some of their less developed skills to emerge and grow while other competencies they have may not be so favoured, or whether individuals carry around various skills and apply them in a knowing and rational manner. Mature newcomers are likely to have more competences to engage, or have more advanced adaptation skills from their years in other occupations, than the school leaver. However they may not always be aware of all that they have to offer. This will be discussed in greater depth in Chapter 9.

Barbara and Gwen are not alone in feeling they can offer more than the school-leaver. Cliff had worked as a Therapy Assistant before training as a physiotherapist.

I .. realise what's required in a workplace .. Like you know what it is and .. it's the little things you know .. knowing your limits, knowing what

you're good at .. being a professional is you're doing your job regardless of what you personally feel. So .. they could be wracking your head .. but your job is to find a way .. to get the job done .. to help them and to get them to see that this is what you're trying to do .. (C1:17/18)

Engagement in the field of healthcare seems to have taught Cliff not only about the kind of work expected in the workplace, and how things get done: it has also taught him about himself, his capabilities and his 'limits' and how he, as an individual, can best fit into this situation. This is reminiscent of the 'metacognitive monitoring of self' Eraut (2008) discusses as a major element of professional practice. It also indicates the value structure underlying practice. When Cliff goes on to define professionalism, he is speaking of a wider perspective than just practice. However low you are feeling, or however much the patient is irritating you, you have to find a way to inform and encourage them to show them what needs to be done and how they can best help themselves. This would appear to be basic to the generic qualities that help people like Cliff in a caring role belong in the working environment. It is a question of values as well as practice, of inward commitment as well as outward expertise (Beck & Young, 2005).

Cliff, although a newcomer to his chosen career, is no novice in the world of work then, and Lave and Wenger's (1991) assumption that the path towards full successful participation in a community of practice is always one from novice to expert must be questioned. Another newcomer with considerable experience of work is Eric, with a background including a varied selection of jobs such as activities instructor, fireman, sky-diving instructor and care worker. Such mature graduates may appear to their patients to be more experienced physiotherapists than they in fact are. His manipulation of this situation is interesting.

.. the patients put their trust in me a lot more, especially sort of the older ones or even the ones my age. They just don't question how long you've been doing it .. a lot of them . and they make remarks like, "Oh you've probably been doing this for years." And I sometimes say, "Well no. I haven't." But a lot of the time I let that ride because . they obviously think I've been doing it from school, and I'm confident with people in the way I speak, so generally they believe what I tell 'em, whether it's true or not. (E2: 13)

Eric knows that he gains the patient's trust, even without full practical competence. It is a question of being socially, professionally and vocationally acceptable. And when

people see him as more experienced, he sometimes fails to correct this false assumption. Writing of work with medical students, Beagan (2001) points out the importance of ‘training for uncertainty’, preparing the newcomer to the hospital environment for what to do when faced with the unknown. Students soon learnt that it was very unwise to give the impression that they were unsure of themselves. Some felt it resembled role-play. “They quickly learn to at least look competent” (Beagan, 2001, p 283). Eric seems to already know something of this from previous experience and his appearance of being older than the typical student helps. He can act the part and seems to have done so to good effect.

We have seen in the previous chapter how important trust in the healthcare worker is in the healing process (Goold, 2002), and this can be viewed in two ways. Firstly patients may well have more confidence in the older and more senior clinician. This has been acknowledged by authors like Beagan (2001) who writes of how important it can be to construct a professional appearance. There are status implications for the doctor, particularly the female doctor, whose normal clothes below the white coat project an idea of personality. This is not so in physiotherapy where full uniform is worn, so that the badge denoting seniority now has a similar effect to the absence of the white coat at medical consultant level. But it is not only the patient that gains confidence in this situation. Eric is mature enough already to be confident in talking to all types of people. But gaining patients’ confidence with ease at an early stage in his working life as a physiotherapist has assured him that he can get away with a certain lack of knowledge as long as he can talk his way through it. Goffman (1971) pointed out that it was not enough to possess the attributes of the professional. Social patterns of conduct appropriate to the professional group had to be sustained. Appearance of competence is basic to this, even if one does not feel it (Beagan, 2001). Gradually the newcomer’s perceptions of themselves change to fit the image they see is required of them.

Uneasy Transitions

So the atypical newcomer, and particularly people like Eric and Cliff, who have practiced as an assistant to, or in a capacity that overlaps with, their new profession, brings with them elements of past learning that considerably augment the formal

professional knowledge and skills requirement. Curiously it does not always make life easier for them. Crossing the boundary into the physiotherapy community of practice from the more marginal position they held before can produce destabilising perceptions of moving backwards, instead of progressing into the profession. During his first practice placement Eric noted that

as a care worker in the hospital .. a lot of the nurses see you as a physio even though you've got a different coloured T-shirt on. Walking around with the physios, you are a physio, and people would talk to you and treat you as if you were one. So in that respect, as a student, you're almost coming down a band, because people then see you as a student and don't think you know anything, whereas as an Assistant they saw me as a physiotherapist and thought I did know. (E1: 12)

So in a situation where Lave and Wenger (1991) might assume the peripheral participant to be moving towards full participation, rather than remaining in the marginal restricted position of the care worker, the participant themselves perceives a paradoxical accentuation of their peripherality.

But this is not a feeling Eric receives from his close fellow members of the community he is entering. It is the nurses' perception of his status that he is sensitive to here, and, despite being fellow health professionals, part of the MDT, these are not members of Eric's direct community. It might seem curious then that Eric should count the nurses' responses as so important in his learning to belong to this community. They are however crucial to the prevailing culture of the profession into which he is moving. As noted in Chapter 3, page 47, an individual's working relationship with colleagues, or that individual's perception of it, can influence how they engage in participation (Billett, 2001b). How members of allied professions react to working with him is one of the criteria by which Eric's success can be judged by his superiors and part of his acculturation.

Another newcomer with experience from a previous caring role was Fay, and she had found problems with past colleagues. She had worked in a Day Centre for adults with Cerebral Palsy before she commenced her physiotherapy training, and had continued this work part-time during the degree programme. This continued as she graduated, so that one week she worked as a Support Worker in the Day Centre and the next she was employed there as a Physiotherapist.

.. it was quite hard as well, because there were a lot of support workers who were like .. “You don’t need a physio degree to bend people” .. “or to do a bit of this.” [*indicating movement*] So I had that sort of comment, and especially coming, as a support worker and .. moving on. (F2: 8)

Fay’s boss had pointed out to her that this might be a difficult transition with her fellow workers, but Fay was finding it hard to attain other posts, so accepted the offer to work temporarily where she was known. Again this suggests that Lave and Wenger’s (1991) assumption that movement towards full participation follows a relatively unimpeded trajectory can be contested. Social relations in the workplace are not always easy for those moving ahead while others who were their equals remain at a more peripheral position.

Even more than Eric, Fay is feeling tensions arising across the boundaries of the community of practice. In her case too she is becoming affected by those who are not fellow members, but they are people she used to work closely with. The support workers belong to her past community and she has moved through the window of connection between two overlapping communities of practice (Wenger, 1998), leaving them behind. Fay has started the process of acculturation, of slowly changing status through legitimate peripheral participation in a new community, while her past colleagues remain marginalised from this community, restricted in their participation. They have difficulty seeing her in a new light, when she appears to be continuing the same work she did before, and their comments sound like negative feedback on her performance. It makes a difference to how Fay perceives her transition to becoming a physiotherapist. Wenger (1998) notes how a participant’s learning can set up boundaries and tensions in these circumstances. Remaining in this geographical area of overlapping communities of practice illustrates this, showing it to be an uncomfortable experience to be a ‘newcomer’ where one was once an ‘old-timer’.

Outside Influences

It is also important to remember that an individual’s smooth adjustment to a new workplace is dependent not only on the person themselves and the people around them at work, but on factors further afield. Hodkinson et al. (2008) criticise Wenger (1998) for tending to view people as having no lives outside the community of practice. My respondents frequently referred to other people and social situations

outside work that had an influence, positively or negatively, on their decision making and their progress. The women in Cliff's life were important influences. His mother cajoled him into working during his first experience of HE: his girlfriend spurred him on with his second.

.. now you're kinda wanting to get on with things. And my girlfriend wants me to get on with things .. (C1: 17)

Cliff is feeling the necessity to apply himself better than he did before, and the external influence of his partner endorses this.

For one of my interview sample acculturation to both HE and the workplace was a particular struggle, for her partner and friends made it clear that they questioned her career choice. Annabel had worked in fashion, managing her own shop at one point. She then trained as a fitness instructor and was in her mid thirties, making a good living for herself when she decided to train as a physiotherapist.

The most difficulty has been . I suppose like financially and ... I think as well because of my age, that difference then lights up between me and my friends and my partner .. that's been the hardest thing to sort of juggle, rather than actually adapting to learning or adapting to a new job. That's been OK; but I think the hardest thing has been sort of . getting your friends to understand what you're doing, really. (Q: 7)

Annabel herself argued that even if she didn't get a physiotherapy post her membership of the Chartered Society of Physiotherapy (MCSP) qualification would allow her to charge her clients more in the gym. Her partner wondered why she couldn't just open her own gym.

.. but I just wanted to get, for me, a deeper understanding. And I did want to work within health care rather than just fitness .. But I think the financial .. I think also the commitment of it, the fact that it was three years, and he [her partner]'s thinking, "You know, you're going to be 37 when you come out and that's ridiculous." And I was like, "Well .. that's what I want to do!" (Q: 8)

The path to Annabel's goal was anything but easy and those who cared for her found it hard to understand why she should challenge herself at her age. Hodkinson et al. (2008) see the early stages of acculturation in a career as a process of questioning, developing and confirming how suited an individual's disposition, stemming from their habitus (Bourdieu, 1985), is to the work. Annabel's challenge confirmed her

commitment, but this could be too much of an obstacle for others. Castles (2004), exploring mature students attitudes to learning, finds this, commenting that though “lack of support from close family may lead to withdrawal [from university] .. it may actually motivate the adult student (‘I’ll do it in spite of them’) ” (p 168). Be they obstructing or motivating or both, outside influences are not to be lightly dismissed.

Reconstruction of Identity

The social positioning of individuals can be seen as part of identity (Hodkinson et al., 2008), though referred to as ‘habitus’ by Bourdieu (1977). The term refers to dispositions that are partly “determined by .. past conditions” (p 72), past social structures and statuses. Dispositions, having developed historically, are more immutable, but others develop, often subconsciously, from fresh social environments encountered and continue to do so through life. On the occasion when the newcomer becomes aware that more specific adaptation of identity may be necessary, Hodkinson et al. (2008) suggest such orientation of habitus can facilitate some forms of learning and inhibit others. In changing career Pat found she had to learn a new manner of socialising and reflected upon this in an interesting way.

I think I’ve had to change ... spikier aspects of my .. personality. They’ve been sort of sanded down a bit .. you’re dealing with vulnerable patients and then you can get feedback that makes you quite clear that you might have done something wrong, or you did something very right .. and I think .. rather than in say other walks of life or in my previous job, I just feel that there are more intense sort of relationships than where I worked before (P2: 25)

The bike shop cooperative to which Pat had previously belonged had been one of the most similar to a community of practice in Lave and Wenger’s (1991) sense of any in my respondents’ experience. It had been an egalitarian group of like-minded people and had suited her very well until the team dynamics subtly altered. There were issues that were not being discussed openly among the members, something Pat thoroughly deplored. Moving to a new career had been a refreshing step, but personal relationships were again demanding her attention. More sensitivity was required in her new role. Dealing with vulnerable patients gave an extra intensity to the social interactions encountered, and she had become acutely aware of both negative and positive feedback.

How she was made aware is unclear. Perhaps she read non-verbal signs of pain or relief: maybe patients expressed their discomfort or gratitude more openly. Certainly she found herself reflecting more on her relationships with others: she even used reflective imagery.

So, more opportunities for .. holding a mirror up in front of you and seeing what you're doing. And teaching myself to hold that mirror up myself rather than someone doing for me as well. So I think it has taught me to be more effective .. And you know not just clinically but personally. So I'd say I'd changed .. In my previous job I could be brazenly political and lefty and I would be at home with most of the people who came to the shop and, you know, my colleagues. And here I can't .. (P2: 25)

Pat's use of the imagery of starting to 'hold a mirror up' for herself, rather than have others feedback to her, is perceptive. It equates for Pat with increased effectiveness, socially as well as clinically. In her previous occupation she had enjoyed speaking her mind without hesitation, but now she could not be sure that she was not going to offend someone by doing so, and it mattered more, not just with the patients, but with her colleagues too. There are echoes here of Hodges' (1998) difficulties in participating in primary school teaching (see Chapter 3, page 57), not least because Pat, like Hodges (1998), is a lesbian entering a career considered as traditionally female. Open criticism of some of the accepted conventions brought her trouble.

.. I find it quite amazing that a twenty three year old woman would get married straight away .. like quite a few in our department .. in the early days, I was a little bit too obvious with them: "Oh why on earth aren't you doing this, that and the other first ..?" And I've had some quite negative response .. And I've just thought, "OK, I'm just going to have to shut my mouth about this .. I think with colleagues it's the working environment. I have to be a bit more politic about how I go about things now .. also . it's a temporary job. I can't make myself too unpopular. (P2: 25/26)

Cliff knew that he had to amend his communication with patients even if they were irritating him (see page168). It had come with his experience of the world of work. Pat had worked in an atmosphere that had been at one with her inclinations, her habitus, and had not learnt this basic element of professionalism. Now she found she had to amend her communication with her colleagues as well as her patients. Their negative response to her 'too obvious' opinions effectively quietened her, for she realised the importance of maintaining a peaceful working environment. Boud and

Middleton (2003) note that an important area of learning for both those experienced and the novice is “negotiating the political” (p 198), getting on with everyone in the workplace and ensuring the possibility of career progression. This Pat felt to be of prime importance while in a fragile employment situation.

Thus through development of her awareness of the sensitivity of others and through pragmatic expediency, Pat was beginning to change elements of her habitus to fit her new professional identity. As Hodgkinson et al. (2008) suggest, her social learning has been facilitated and her assertiveness restrained. This does not mean that her opinions changed: in fact she felt uneasy about not expressing herself as frankly as before.

I realise I challenge people a lot less, and I’m not sure if that’s so good or not. (P2: 26)

It appears that she is protecting her position in this social group by using a degree of ‘deceptive discourse’ (Eraut, 2008), where patients are consulted and informed, but in such a way as “to keep them happy while asserting the professional role” and similarly good relations are maintained with colleagues “while preserving freedom from their influence” (p 5). Analogous to the ‘white lie’, deceptive communication can keep the peace and make for better tempered and smoother teamwork. Beckett and Hager (2000) suggest managing situations in the workplace is characterised by judgement-making ability, though they were exploring clinical decision-making in particular. But perhaps this holds for social judgement-making too. Pat’s judgement-making ability is being extended here, just as Cliff’s also had been in his previous career. It would appear that for at least some atypical, mature newcomers this ability has already been developed and will enhance their professional communication.

Two-way Learning

Lave and Wenger’s (1991) theory suggests that learning in the workplace only occurs in the individual peripheral participant. There are signs here though that dual adjustment is happening, both changes to the individual’s identity and methods of socialisation, and also subtle changes to the workplace, as colleagues react and adapt to others around them and to the constantly varying characteristics of the patients they have to treat. This demonstrates a degree of relational interdependences (Billett

et al., 2005), that “shape the participation, learning and remaking of work practices” (p 219). This happens at several levels. Firstly, some of my interviewees have positively looked in their chosen workplaces for an ethos of flexibility and willingness to change. We have already seen this with Cliff in the previous chapter (page 148), intolerant of those who ignored the possibility of change. He reasoned that it was because he was a mature newcomer that he was ready to question procedures that had become part of the workplace culture.

.. If I'd gone into that job when I was 22, I'd just be doing the job and it wouldn't occur to you to think, 'Oh I could do this' or 'Why couldn't we do that?' and maybe when you're a bit older and you've worked in different places you know what's important .. (C2: 19)

As someone fresh out of university the first time Cliff would not have had the experience of work that now enabled him to envisage how it could be just as effective in alternative ways. Mike too might have thought little of this at one point, in his early days in the army before studying physiotherapy. But now he too is intolerant of teams that do not consider change a viable option.

.. if perhaps at team meetings, lots of things just got said the same again and again and again and nothing got done about it, I'd get quite frustrated at that .. I do like being a service that isn't afraid to try a few different changes and move a little bit. (M2: 17)

It is interesting that Mike seems to see himself as 'the service' itself here. This is probably because he is working as the sole physiotherapist a lot of the time in a specialist MDT, although in a fairly junior capacity. This could result in increased levels of frustration as he negotiates with team members on behalf of patients, should they fail to move forward and make clear decisions as he hoped. For career changers like Cliff and Mike then, openness to change in the workplace is a definite expectation.

Two-way learning can also be discerned when, as Fuller et al. (2005) found, 'old-timers' in the workplace do their share of learning too when newcomers join their community, and Lave and Wenger (1991) agree that this can happen. Established colleagues will be stimulated as they encourage learning with junior colleagues and, if regularly used in teaching the new staff, go through a regular revision, reinforcement and extension of their own knowledge in the process. Fuller and

Unwin (2003) and Billett (2007) note how there may even be role reversal, citing how newcomers may contribute technological information to older colleagues. An example among my interview sample is Eric, who found himself teaching senior staff in his very first rotational post.

I actually did an in-service on reflective writing because everyone there .. hadn't been in Uni for God knows how long and they were expected to do this and they were sitting around chatting, going, "Well I haven't got a clue what to do. Have you got a clue what to do?" "No I haven't got a clue", so I put a presentation together from the stuff I'd done from Uni and gave that to them, and whether they're doing any I don't know, but they know how to do it now. (E2: 19)

Eric's recent studies in university made him, even as a newcomer to the team, the most up-to-date and knowledgeable regarding the process of reflective writing required to complete the more senior staff's CPD. The clinicians are thoroughly up-to-date with treatment, but they feel they lack the skills needed to deal effectively with the latest policy requirements. Eric has the 'cutting-edge' knowledge they require, and it will almost certainly have implications for his acculturation to the profession. One assumes that these 'old-timer' clinicians were grateful to Eric, but some might have felt themselves slightly on the defensive with a newly-qualified staff member teaching them new tricks. Such issues could create tensions. This will be further discussed in Chapter 9. Neither Lave and Wenger (1991) nor Wenger (1998) fully discuss such a reversal of influence.

Eric also showed initiative in creating a way of dealing with paperwork, which was now being used by other staff in his Trust. It is in small but significant ways like this that the culture and protocols of a workplace gradually change. Professionals can welcome the ideas that newcomers introduce. A fresh look at a problem, and especially from someone, like the atypical, mature graduate, who has seen what happens in a few other workplaces, can bring innovation.

Senior staff can show innovative methods of encouraging learning too. When asked who he would choose as a role model, Lionel spoke with warmth of one of his managers, and in doing so spoke of an attribute perhaps less expected of an 'old-timer', again suggesting that more established members continue to learn.

She's the best manager bar none .. She does some clinical work. She was extremely down to earth, so she's allowed me to supervise her before.
(L2: 12)

Two elements are noteworthy here. One is the manager who, perhaps knowing herself to be slightly out of date as regards patient care, opts for a role reversal with one of her junior staff, which must incidentally have informed her nicely about his own methods of clinical reasoning as they worked alongside each other. Far from feeling pressured in this situation, Lionel seems to have appreciated this unusual 'managerial' approach. One can read this as a good example of how learning can be promoted in the workplace, reinforcing Guile and Griffiths' (2001) comment that the ways of workplace learning may be alien to someone straight out of an educational institution, where knowledge is expected to be passed down from the expert to the novice. Though not specifically mentioned in Lave and Wenger's (1991) description of how newcomers are assimilated into a community of practice, this role reversal does underline the importance of situated learning, of those less experienced working closely with their superiors and thus sharing in the culture of a professional learning environment.

A final way in which change may come to the workplace, thanks to the atypical newcomer, is highlighted by the way several of these graduates value challenge and vigorous testing and guidance, as we saw with Cliff (see page 147). Guile and Griffiths (2001) noted the support needed by school-leavers: this seems to have intensified in the career-changer. Eric is married to a doctor and compares the career path in physiotherapy with that of medicine.

[Physiotherapy]'s not as structured. You're not going to get that same guidance, which I do find more difficult. And then depending on what you do and where you see yourself going you then have to find somebody and say, ".. What do I need to do to get to here?" And that's harder than you think as well. (E3: 23)

One learns to define oneself in terms of the community (Lave & Wenger 1991), but also of the profession. Thanks to his more horizontal learning, by dint of the series of rotations he has completed by now and the Band 6 post he has attained, Eric feels less peripheral in his working community. But he is not satisfied. From previous experience in the job market perhaps, he recognises the need to progress further, in a more vertical manner. He has definite goals of professional specialisation, and is

intensely interested in doing the right things to take him there quickly and surely. Perhaps the fact that he is older and has a young family to support makes him keener in this respect. But according to Bourdieu, the field of job opportunities can be compared to a game, “and it follows rules or, better, regularities, that are not explicit and codified” (Bourdieu, in Bourdieu & Wacquant, 1992, p 98). Eric, knowing there may be hurdles to overcome, is thoroughly frustrated at not knowing the rules of the game. It thwarts his plans to self-manage a chosen route to full participation, a notion that seems alien to the progression into a community of practice foreseen by Lave and Wenger (1991).

Among my respondents several seek that extra advantage. Indeed there seems to be a general feeling that one is heading for disaster if unprepared to be ultra-flexible. Collin and Young (2000) note that this section of the population, Generation X children (born between 1965 and 1981) tend to see things very differently to their predecessors the Baby-Boomers. The former show signs more consistent with portfolio-building than with building a traditional career, being less loyal to organisations than to team-mates, and searching for more independence and mobility (Summers, 1998). Students have been encouraged to develop portfolios of their achievements from an early stage in their training but past experience may have particularly emphasised the necessity for this in my graduate respondents. Eric (born in the middle of the Generation X period) is a case in point, for he tried to add a PGCE in science subjects to his physiotherapy qualification immediately on graduation. As he explained,

.. worrying about the job situation and not getting a job .. initially it was just a plan B, but the more I think about it, with having kids now, and the holidays .. the holiday period matching up with the period when they go to school, it's looking a bit more attractive to go into teaching .. (E1: 14)

When changing career Eric had had difficulty deciding between teaching and physiotherapy. He had taken a Peter Gordon Lawrence (PGL) course in teaching outdoor activities soon after leaving school and had found it useful in his work as a sky-diver. Now again he re-considered teaching, to some extent influenced by his family, for working as a teacher he could take his holidays at the same time as his children. But he was also doing this because he was worried he would not find a physiotherapy post. He felt the need to diversify.

There is also an innovative element of lateral thinking here. Eric saw the possibility of combining the two careers if he worked in special schools,

.. with children with learning and physical disabilities, so that I can utilise both the physiotherapy and teaching .. I done a paed's [paediatric] placement .. and .. I enjoyed that, but there was a bit of tension between the teachers and the physiotherapists, which I suppose is that battle between the physios wanting to do the physical stuff and the teachers wanting the kids to do the educational side of it. Neither I think understood exactly where the other one was coming from. But I think I'll .. have the advantage of both. Might be an interesting sort of career path.
(E1: 14)

Eric has noted how he might capitalise on his life experience, for he was brought up with a brother with learning difficulties and often went with him to the special school, so he knew this environment long before he worked there on placement. But it was in the professional situation that he noted the tensions between the physiotherapist, with a goal of encouraging and improving movement, and the educationalist, promoting stability and controlled movement so that learning is facilitated. Eric reasoned that linking the two careers could be to their mutual advantage. This too is a strategic position alien to Lave and Wenger's (1991) theory. Eric seems to be preparing to make an informed choice of which community of two to join on graduation, rather than become inducted into the one set out ready before him. He is actually electing to turn aside from the straight forward route to full participation, at the very moment when membership within his community has been confirmed, and is crossing the boundary to try out another community and start along a parallel route towards full participation there instead. Moving backwards in this way goes against all that Lave and Wenger (1991) suggest. He seems to be aiming for full participation in two communities of practice at once, a novel concept to the authors of Community of Practice Theory.

This way of thinking would probably be novel to most established physiotherapists too, but is a possible method of countering unemployment difficulties in today's world. To people in my graduate sample's position employability is a key consideration and moving from one project to another (or in Eric's case from one profession to another) may be the way to increase it (Boltanski & Chiapello, 2005). Rather than "becoming more and more embedded within a single community of practice across a lifetime", Jewson suggests, "identity may well lie in successfully

traversing many communities of practice without becoming immured in any one” (2007, p 79) and this it appears Eric means to do. Hutton (1995) writes of the ‘portfolio career’ as policy-speak for the *insecure* career, but there is at least the potential to offer more diversity in working practice in this manner.

However in doing this, people like Eric are impacting on the profession and may subtly introduce a change in the established professional career path. He is adding to his learning, not so much professional skills as strategic methods of seeking adaptability and ensuring his progression, accumulating a kind of promotional nous. But in which profession will he progress? This must remain uncertain, depending on his inclinations and resources. But not only Eric will change in the process. He may be said to exemplify the vocational newcomer with prior experience of the workplace who introduces change into their new professional environment and the practices there, as well as undergoing change themselves. This sets up some critical implications for the notion of a community of practice. In these circumstances the pathway into a community may vary considerably from the smooth induction process suggested by Lave and Wenger (1991). Career changers will not only experience deculturation from their past careers but also some reconstruction of their identity, in order to belong in first the academic situation and then that of the new career. They are anything but novices regarding the world of work, and indeed Eric shows how they may attempt to manipulate the field to their advantage.

Summary

In this chapter I have looked at the atypical newcomer to a profession, the mature career changer, noting their deculturation from previous occupations and their acculturation to the new one. The latter importantly includes acculturation to academic life for those who may not have studied for a lengthy period, and this may be more difficult for them than is acculturation to the new workplace. For these individuals can only questionably be labelled as novices, despite Lave and Wenger’s (1991) ideas. Nor can it be assumed that all paths into the community of practice are identically smooth and uneventful. Some with specific previous experience can feel it to be an uneasy and almost backward step, outside influences can impact and

potentially slow progress, and identity reconstruction may be more difficult than expected. On the other hand those with previous career experience have learning to offer as well as to receive and may inject innovation and subtle change into their new community, including the accepted ways of progressing towards full participation. In the next chapter I will show further how some are choosing to follow alternative routes into the new career, as a result of this previous experience and having already acquired useful knowledge and skills.

Chapter 7

Data and Analysis 3:

Non-Traditional Routes

The apprentice communities Lave and Wenger (1991) use as examples, such as the Gola tailors of Liberia and the Mayan midwives of Mexico, where local people are brought up and prepared from the outset to undertake particular occupations, are rarely seen in western society. The nearest equivalents, apprentices in modern Britain, must prepare for a very different trajectory. They have to persevere in a “dynamic and turbulent” environment, competing with “an ever-increasing number of university graduates ..” (Unwin, 2007, p 117) in a knowledge economy, rather than “becoming more and more embedded within a single community of practice across a lifetime” (Jewson, 2007, p 79). In the last chapter I likened Gwen, the professional dancer among my respondents, to Lave and Wenger’s (1991) indigenous examples because she was prepared from the first for her particular vocation. But she also knew she wouldn’t dance forever and she eventually used her experience of physical training to enter her second career, choosing to follow what I have termed the traditional route.

As explained in Chapter 5, this so-called traditional route is one of rotations that effectively continue the practice placements that are a mandatory part of training. It allows a few months experience in several specific professional areas, thus expanding the individual’s practical experience, knowledge and flexibility for future employment. It is only after two or three years that junior staff would normally decide to specialise in one of these areas. This has generally been the expectation of all entering the profession, but is now increasingly questioned as a viable option in a time of financial constraint (Limb, 2006). Several of my graduate respondents found themselves in permanent static posts or on short-term contracts which were non-rotational. Some in this situation were forced to contemplate innovative methods of employment when the traditional one was not available to them. The example given in Chapter 5 (page 134) was that of Susan who planned to formulate her own rotations from any short-term contracts she achieved. The contrast with Lave and Wenger’s (1991) concept of gradual assimilation into a single community of practice

could hardly be more stark. Susan aimed to move from community to community, fitting in as she could and hoping that a reasonable selection of specialities would present themselves in an appropriate order. This is too dependent on happenstance to be comfortable or thoroughly effective. She is not gaining the affordances Billett (2006) considers so important to workplace learning nor being allowed the continuous identity construction Lave and Wenger (1991) stress.

New Career Paths Born of Necessity

When permanent job opportunities are rare, or circumstances suddenly change, it is possible, and can be absolutely necessary, to be more innovative. One of my graduate respondents, Lionel, had had one temporary contract after another since graduation and felt he had to supplement his salary to ensure payment of his mortgage. He had done his Music degree locally and wondered if he could advertise in his old college. His knowledge of the specific physical ailments, like repetitive strain, from which musicians might suffer, gave him some capital in this instance. Being registered as a Chartered Physiotherapist also gave him social capital: those advertising help otherwise were mainly the college's third year music students.

Lionel also thought, reluctantly, of taking up private work.

.. it's almost like going the other way, because I was wanting job security, and doing something like that is the diametric opposite of that, but in some ways I can imagine seeing that as almost like a new challenge and something to look forward to. And I know .. somebody who's in book keeping .. And at the end of the day, you know, as long as it was properly managed, it might sound a little bit eccentric but I could theoretically put a plinth on a bike and do home visits .. (L2: 21)

It is not the situation Lionel had hoped for because he longed for more stability of tenure in his post⁹, and he saw this move as bringing him less support from older colleagues, the 'old-timer' support of Lave and Wenger's (1991) legitimate peripheral participation. He would no longer be within the security of the community of practice of the NHS physiotherapy department. Of necessity he was also considering the logistical difficulties of a private practice when he had no premises to work in. He would have to go out to people, rather than making appointments for

⁹ Lionel had suffered badly from work-related stress since graduation. See Appendix XIII for the transcript of his second interview telling of this.

them to come to him. He knew he needed some help from an accountant, and he had an appropriate contact, but he was deficient in transport, for he travelled by bicycle. However he had researched this and found it was possible to carry a folding plinth. That a firm provides these at all suggests that he is not the only person resorting to becoming a mobile practitioner. An unstable job market spawns these alternative routes to full participation, if working outside the accepted supportive environment of the micro-scale community of practice this early in the career can lead to full participation. This issue will be followed up in Chapter 9.

Attractive Alternatives

Others, though not driven by necessity, decided to try less usual routes as being more attractive to them, an example already encountered being Eric entering upon a PGCE on graduation with a view to combine teaching with physiotherapy (see page 179). This is anything but a normal route into the profession, but perhaps the chief element of surprise here is the timing. That Eric should consider trying out another profession just when he had succeeded in crossing the boundary into the first seems extraordinary. Far more common is the professional, like Lionel again, who decides to do a further degree or other qualification within the first few years of their career. Even here there are more accepted routes to take. Lionel aimed to do a day-release Masters in Manual Therapy, which gave him more knowledge about his work, and allowed him to practice alongside so that he did not become deskilled.

Eric had soon decided against teaching, but admitted that taking time out to try the teaching qualification made it more difficult to return to his initial career.

I think with musculoskeletal, it's about finding a pattern and getting into a routine .. If you've been out for ten months you just forget all that, and it takes .. two . four weeks to get back into it .. I actually knew two of the people that I worked with previously as an Assistant .. and .. they thought that I .. wasn't as vocal .. I had quite a serious head on for the first two weeks, where I was just constantly concentrating on exactly what I was doing and the things going through my mind. (E2: 12/13)

Eric had only had two five week placements doing musculoskeletal work during his training before starting the PGCE programme. The routines he had begun to acquaint himself with were not second nature to him. He had dropped back from being almost competent, having developed an awareness of the common situational patterns of

treatment, to being at the advanced beginner stage (Benner, 1984). As though he were continuously managing unusual cases, he had to practice Schön's (1987) 'reflection-in-action', and it made him appear very thoughtful and serious to colleagues who had known him previously.

Cathy, one of the established physiotherapists that I interviewed, decided on a degree programme that was questioned by almost everyone concerned. She had been qualified for ten years by this time, so it was not unreasonable to extend learning a stage further. However, she chose to study a Masters degree in First Contact Care,

an NHS initiative .. initially for nurses, nursing practitioners, to actually extend the scope of their practice so they could .. be competent to be a first point of contact for minor injuries .. (Expert C: 2)

She was told she would be offered a place in a GP practice on graduation and this really appealed to her for it seems that, rather as Eric had hoped to combine teaching with physiotherapy, she hoped to combine her physiotherapy and nursing skills effectively in such a situation. In the event she

struggled to get a GP practice because they couldn't understand why a physiotherapist would want to pursue this line of work. (Expert C: 3)

Cathy had stepped beyond the accepted bounds of her community: others did not share her rationale for attempting this merger. In fact the GP practice communities she approached were evidently strong enough to reject her, despite her extra qualifications. Thus this innovation failed and she resumed her previous post, only to find that this too raised tensions as staff had been 'acting up' in her absence and resented her return. Lave and Wenger (1991) fail to give due consideration to the potential in communities of practice for such lack of harmony and setting up of rivalries.

People can try new modes of practising then when they feel driven by circumstances, or may consider variations on the traditional route to full participation. There is also a third way that one of my respondents, Mike, has followed successfully. He came to the profession with such a store of particular experience from his previous life that he decided on graduation to specialise straight away. As will be seen this makes him a very unusual case and he has followed a singular route into his new profession.

Nevertheless he also has similarities with his peers, so his is an interesting case in this general argument. In this chapter I mean to spend some time looking at his situation in depth to show how rotations can be bypassed if an individual is able to enter a niche market from the first.

The Liberating Effects of Experience

As I argued in the last chapter, previous work experience is an influencing factor in the learning the atypical newcomer undergoes, but it is one of many elements that can be influential in this way. A person's ideas and preferences are individual to them, but they are set in the context of, and permeated by, "the objective social structures and cultural ... traditions in which that person lives" (Hodkinson et al. 1996, p 146). Several authors (Colley et al. 2007; Fuller et al., 2005; Hodkinson et al., 2008) feel that Lave and Wenger (1991) should take more note of the individual's life outside the community of practice in this respect. Not only people's previous experience of work, but also the influence of those around them, their social class, gender and culture can impact on their career decision-making and learning. An example in popular culture comes in the form of the film 'Billy Elliot', which portrays an individual whose lifestyle choice has strayed from that traditionally assigned him. It is still regarded as unusual for a boy from a northern working class family to choose to become a ballet dancer, yet Gwen, female and coming from the south of England, encountered no such difficulties when she showed a similar aptitude for dance. It is this restriction to choice of career that leads Hodkinson and Sparkes (1997) to write of limited 'horizons for action' and Bourdieu (1986) to discuss the 'choice of the necessary' (see Chapter 3, page 58).

But individual experience can sometimes open up opportunities rather than the reverse. This shows in the career path of Mike, who went into the army from school, but who was brought up alongside a brother who is a wheelchair user.

I did have a very close family life and .. it was quite an active life as a child really. And despite my brother being in a wheelchair, you know, it was still a normal, healthy upbringing. Anything I done, my brother done .. even to .. silly little things, climbing trees - we'd have the ropes out and the wheelchair was up the tree, that sort of stuff, you know. Probably quite . you'd look at it now and you'd think, 'Ooh, how did we get away with that?' But yeah .. it was probably why we are where we are today.
(M1: 2/3)

Mike's childhood had been full of activity, as it was for his physically disabled brother too. The family's positive attitude to disability must have given Mike a notion of the lifestyle possibilities for the wheelchair user that might influence the way he worked in the future, in physiotherapy. His brother was certainly influenced by his upbringing, to be a very active and independent person:

.. my brother .. runs two residential care homes, private independents for people who use communication aids and have physical disability .. (M1: 2)

This proved very useful to Mike on graduation, for he worked in one of these care homes while he sought his first physiotherapy post.

Nor was this the only involvement Mike had had with his brother's work. As had been the case with several of my graduate interview sample, Mike took an Access course to prepare for academic work, before applying for a place to train as a physiotherapist in university.

.. while I was doing my Access Course .. I did .. my level Two in Care as well, at one of my brother's residential care homes. And I thought, actually there's quite a lot of skills I have got that .. I could apply .. some of me communication skills with people with disabilities, or just the general people skills, have developed quite well over the years (M1: 9/10)

These are not the affordances Billett (2006) speaks of as crucial to good workplace learning: they far precede these. Having disabled friends and moving among them regularly had become part of Mike's lifestyle before ever he considered a change in career from the Forces to physiotherapy. Nor is it predestined that someone with this experience should take this path (Reay, 2004), but it does present Mike with unique possibilities, among them that of starting a career in physiotherapy at a higher level than his peers, specialising in work with disability.

Creating a Career

When asked if army training had been a good preparation for what he was doing in physiotherapy, Mike agreed, but his reasoning suggested a way of working that his peers might have rejected.

.. I'd maybe even say not the army training but what I've chose to do in life .. Yeah, really, because .. even in the army career, I chose what I

wanted to do. It wasn't like I was told I was going to do X, Y and Z. I always kind of engineered things how I wanted. (M2: 12/13)

There are similarities with Eric here and *his* wish to control his situation, both in choosing to attempt a PGCE straight after graduating (Chapter 6, page 179) and in manoeuvring his position according to the preferences of his managers (page 178). But Mike was ready to move away from pleasing others: he was adept at negotiating his case, as will be shown on page 199. It was not simply piecing work together as several of my graduate respondents had become adept at doing. Mike was happy to 'engineer' a new route for himself. He was extending Billett et al.'s (2005) ideas regarding the individual's manipulation of work practice at micro-level to alter the path of his whole career to his satisfaction. It is a reminder too of what Billett (2006) has to say about learners often being guided by their own interests, possibly deciding to work towards their specific goals rather than those of the organisation (see page 56). In many cases, he suggests, a balance must be struck between the individual's goals and the workplace's concerns, and this can resemble a subtle contest in its complexity. Then, as Hodkinson and Sparkes (1997) note, "... it is the more resourceful players who determine the rules of the game" (p 37). Mike appears to be such a player. He had particular knowledge to draw upon, derived from his brother's disability, and partly because of this, along with other experience, he had confidence, a confidence to question the traditional system. This was not newly acquired, but bred of many small issues in the past where he had negotiated successfully in his favour.

How Mike might actually go about using his well worn skills to negotiate in a new area appears to be quite complex. Eraut (2008) discusses such transfer of knowledge between different contexts and suggests the following takes place. First Mike needs to understand the new situation, this often being dependent on more informal social gathering of information, from potential or actual new colleagues. Next he would have to recognise the kinds of knowledge that might be relevant to that situation and then focus more precisely on those he had that would be particularly useful for decision-making in the new context. Finally he must interpret and maybe transform this knowledge or set of strategies to suit the new situation and context in which he now found himself.

A Choice of Specialities

Curiously he had not been so interested in following another path into the physiotherapy profession that was open to him, one that, to many, is of higher status. During his time in the army Mike reached an exceptionally high level in sport, and had many contacts in that field. Some might have assumed that he would continue along the path into sports physiotherapy. Early on he had dismissed the idea of doing a Sports Science degree however, on two counts.

One of my cousins had just finished Sports Science and was struggling to get a job and really needed to elaborate on his degree .. to get a job .. Also something else I thought was, I have had a life of sport; I don't want to go into Physiotherapy in the sports side, and I think I am going to apply some of my other life skills of disability and go into a disability type sector .. (M1: 9)

Mike was fortunate enough to have two possible routes to choose from. His cousin's experience was a useful reminder of the difficult job market, for Mike's cohort of students were becoming aware of the employment problems beginning to hit newly-qualified physiotherapists as they interviewed for university places. Asked about his preference Mike could have said he chose the disability route rather than sport because he felt he could have helped people like his brother by doing so. In actual fact, this was not his predominant reasoning. He had the feeling that,

Sport would be a bit .. I don't know. I think I would find it boring. (M1: 10)

He had thoroughly enjoyed an active life in sport, but continuing to work in this sector in a more passive role held less charm.

Rotations Questioned

While my other graduate respondents sought wherever they could for a rotational junior post in a reputable NHS hospital, what I have labelled the 'traditional route' into physiotherapy, Mike had other ideas. His viewpoint was

.. I would have time to, but I'm not particularly bothered about the rotational side of things. (M2: 4/5)

When asked about this, his first thought had been that he was rather old to do the rotations: but he immediately corrected himself. At 36 on graduation he did have time to work his way up to advanced practitioner level in physiotherapy, starting

with two or three years of rotations. However it was simply not what he wanted for himself.

It is worth comparing this attitude with Hilary's. The following was her response to hearing of Mike's decision to specialise straight away on graduation.

I'm quite happy I rotated, because I think you learn a lot by doing that and I think it's only by rotating that you know what you've learnt. So if you specialise in just one area, then how do you know what you've not learnt? (H3: 11)

Hilary is making the point that not only do you add gradually to your learning by practising in different areas in rotation, but you begin to see what you still need to learn. Concentrating on just one area means that you see only the needs for learning in that area. It is the generalist's main argument: their wider view sees when adaptation is required and they change with the times, while the specialist's methods can too soon become obsolete (McCollough, 2000). Contrary to the old adage, 'Jack of all trades, master of none', there is also the suggestion that until you have seen a little of everything you do not comprehend what is needed to make a truly rounded practitioner. The implication is that without the experience of 'all trades', you are not ready to be a 'master' of any one area either. I shall return to this point in the next chapter.

Mike would probably have answered this argument with the example he gave of why rotations were not ideal for some.

.. a friend of ours was a Physio Assistant and then studied . the same age as myself. He's .. four years ahead of me .. and he's still on rotations now [six years after graduation], but really wishing that he wouldn't have done the rotations because he's finding that he's getting a lot of skill fade. (M2: 14)

Mike's friend was interested in a particular set of physiotherapy skills. These happened to be in a speciality rarely rotated into, paediatric neurology. Where others considered that rotations gradually added more and better skills, he saw the ones he wanted to perfect fading. Mike told how his friend

.. actually dreads [another] rotation coming round. (M2: 14)

This story was to have a salutary effect on Mike.

What Mike has in Common with his Peers

Having recognised the peculiarities of Mike's case it should now be noted that in many respects Mike was no different to other atypical newcomers to physiotherapy. Along with his deculturation from his previous career, there was a shared problem of acculturation to the academy. Like Barbara and several others of the graduate respondents, Mike had not studied academically before.

I don't remember writing an essay first time round at school, so the second time it was just a world of, "Oh my word!" .. My computing skills were non-existent until the Access course. I couldn't even make a table and a letter, you know, a two paragraph letter would probably take about an hour to type. (M1: 8)

In this respect alone was Mike the novice Lave and Wenger (1991) expected in a newcomer to a profession. The Access course was essential in preparing him for academic work, and in common with his peers, finances were stretched at this point. Mike was working as a ski instructor on the dry ski slope locally, alongside the Health Professions Access course he had enrolled in. It probably also satisfied his need for practical work. When asked about his preferred way of learning he answered,

Learner by repetition; I'm a doer. (M1: 3)

Activity was important to him.

And in common with others of my graduate interview sample, Mike's skill at incorporating a range of activities into his daily life, his adaptability and flexibility of working, was clearly evident. He had successfully integrated seasonal high level sport with his army commitments: at the same time as doing his Access course, he managed to carry out some care work and studied for a City and Guild in carpentry and joinery, as well as teaching skiing. Several of his peers, Barbara and Gwen were examples, had similarly put together a patchwork of part-time work to cover financial demands. Some of my respondents showed a positive flare in this direction, and it was to be essential to Mike as he worked within a framework of short-term contracts following graduation.

My graduate respondents were often critical of the behaviour of younger students, while understanding their enjoyment of new liberty on going to university. Of them, Mike was perhaps the one that was most obvious in his condemnation of their habits. While still a student he spoke of the Access course and the university programme differing mainly in the fact that in the latter there were

.. lots of people straight from school and particularly in the first year, a lot of people just .. going out, having a good night out and .. coming in stinking. (M1: 10)

‘Stinking’ is a strong word, when many laugh off the binge drinking of the university student. I wondered if Mike really meant this. But as a professional soldier, he might have firm ideas of the importance of discipline. In this his values were similar to others of my interview sample. Kenneth too, who had been in the Air Force, criticised younger students;

.. at times .. I thought, “There’s a bit of immaturity here .. people not pitching up, people not seemingly that bothered about coming to lectures, and things like that .. (K: 9)

Gwen too spoke often of how important discipline was in her dance career. For some of these mature students it was also a driving force as they commenced their new learning, and they could have found lack of discipline in those around them something of a culture shock when first beginning at university.

It has already been shown that, along with graduates like Eric and Cliff, Mike appreciated the promotion of innovative change (Chapter 6, page 176). When asked who would be his role model, Mike praised the work of a therapy manager:

She was just very positive, thinking about ‘Why can’t we do this? This is what we need. Let’s make it happen’, sort of thing. ‘Let’s .. manipulate the services to get what we want for this person.’ (M2: 22)

Billett et al (2005) find that individuals may try to manipulate the regulatory practices of the workplace, but they mean that this could happen within the micro-level community of practice, where the newcomer decides to alter practice to suit their own situation. Here we see the idea being extended to the meso-level community, where AHP colleagues question traditional methods of practice in an attempt to gain advantage for the patient. Rather than being a possibly disruptive element affecting the power relations of the micro-community, standing up to

authority at meso-level, in an effort to improve outcomes, can enhance professional cultural capital if successful. It is this negotiating stance that Mike emulates in the workplace.

He also shared advantages, gleaned from his previous work, with the other mature students. Like Barbara and Eric, he felt he could talk to other professionals more easily than school-leavers could.

.. three of my placements I've been with other people from the university who .. definitely have found life a bit harder than myself .. on the first placement the young student I was with struggled with a lot of the nursing staff .. whereas I don't know whether it was because I was older or whatever, but as soon as I asked something people would .. not drop things, but then they wouldn't forget it as easily .. I don't know if it was respect or what .. (M1: 13)

This sort of thing, he commented, made the difference between being 'comfortable' on a placement or not. It seemed to be helping him move steadily on towards full participation in the placement community. Trying to analyse why he communicated better, Mike suggested that his experience as a sports coach, training everyone from children to high level athletes had helped him tremendously.

.. I think you've just got to adjust yourself to each situation, and I think having done that in a previous career has helped me a lot in physio . definitely .. in particular making it personal to each person. (M1: 14)

Mike has gradually acquired a spectrum of routines and methods of communication, a whole culture of practice (Arnseth, 2008), in his previous work, which he has found can easily be used in his new career too.

Finally, others, Cliff and Annabel for instance in their different ways (Chapter 6, page 172), pointed out that life outside work was important to them and that it could influence their learning. In Mike's case, health among the members of his family (not only was his brother disabled, but so also was a sister-in-law) and his disabled friends certainly influenced him. He had had to learn when to call a halt to study and concentrate on those around him.

.. there's . many influences that would have changed how I have studied. I've such a busy social life and personal life, my wife and I do, family-wise .. although I've been very keen and loving the physiotherapy, I've also made a point of cutting it off now and then, and saying, "Hold on,

enough's enough there. I need to mix this with my life" .. which probably I imagine a few younger people haven't probably got that, as much of an outside life or outside pressure .. (M1: 15)

Mike's distinction between the pressures, and possibly the release, of having family relationships to maintain as a mature student, and the lack of these in the school-leaver, echoes Cliff again to some extent (Chapter 6, page 165). But while Cliff feels the potential freedom of not having to make such an effort to socialise this time round at university, Mike tends to feel it is more of a juggling act. He loves his work and his social life and has to satisfy both needs. He senses that this tension between responsibilities is not an issue for the younger student. But he also seems to be saying that younger people may feel the lack of the social and family life he himself finds so supportive.

Mike's Turning Point

On graduation, Mike had a good idea of the area he wanted to specialise in, and with the example (mentioned on page 191) of his friend's experience of the traditional route before him (with a similar area of interest to Mike's too), he decided to go his own way. However, he emphasised that it wasn't all about what he personally wanted to do.

.. you kind of qualify generically but then, eventually, you choose which direction you're going in .. So .. are you just waiting to see what you do like or is it other things that help make your mind up, like perhaps the area you live in, the people you're working with, the client group that you're working with ..? (M2: 15)

On consideration, he saw rotations as often not particularly leading the professional to the speciality they ended up in. Other factors were influential. You might want to work near home or in a particular hospital or clinic; you might work really well with a particular group of people although the speciality was not what you had hoped; or you might prefer a particular group of patients and strive to stay with them despite other factors.

In viewing the situation like this, Mike agrees with Eric (see Chapter 6, page 178). But while Eric, also having a definite aim in view, felt he needed to control his progression in line with what his superiors considered correct in order to attain his

goal, Mike argues rather differently. He turns his back on the ‘correct’ path. To his eyes there seemed a degree of happenstance in this decision-making that he needed to counter as best he could: a lot depended on being in the right environment at the right time. Hodkinson and Sparkes (1997) write of ‘turning points’, moments of re-evaluation, and this seemed to be one for Mike. The expectations that training had built up, that rotations are a good entry route into the profession did not entirely accord with his situation at that time. As already mentioned, Mike’s family had a strong influence on his decision-making.

.. It’s where you happen to be in life .. and who’s around you at that time as well .. it’s not just about me . it’s about family circumstances or what family commitments you’ve got .. (M2: 15)

Mike was interested in following up work he knew of regarding wheelchair seating and postural management. His brother had had to have a spinal fusion, possibly stemming from years of poor seating: Mike took the opportunity of speaking to the physiotherapists working with his brother while he was an in-patient, and it spurred him to do his elective placement in this field. There he must have shown promise because his superiors paid for him to go on a course afterwards, on complex posture management. They had hoped to employ him as a Band 5, but local NHS restructuring prevented this. Instead he worked for his brother, gaining useful experience with cerebral palsy patients.

The problem was that his brother’s Care Home was over 150 miles from his own home.

I wanted to, obviously, get a bit closer to home. (M2: 1)

His wife was sympathetic however, as she did quite a bit of travelling at work too, as an OT employed by a health charity. Thus Mike started to work in a way his peers had rejected as impractical: he stayed near the Care Home during the week and returned to his wife at weekends. Other professionals have found this happening more as people sought work further and further afield. Some academics, for example, have been found to be commuting extraordinary distances, often seeing their spouses only weekly or fortnightly (Reisz, 2012). Mike is not alone in arranging to work in

this manner these days when appropriate employment opportunities are rarely come by.

The term ‘community’ suggests closeness and harmony, but, although he was working with people he knew in a micro-level community, right from the start of his career Mike had to contend with leading a double life of work and home, which could have raised some tensions. There was neither closeness nor real harmony in his situation. Wenger et al. (2002), discussing organisational learning (see Chapter 3), propose that people that are far apart geographically can work as a community of practice thanks to electronic communication, but these authors do not discuss the problems involved where distance needs to be covered physically. The expenditure of time and money, encroaching on family life and adding to possible financial burdens should not be overlooked. Once again one is reminded of the importance of not losing sight of the individual outside work (Hodkinson et al., 2008). Mike’s considerable commitment to his preferred speciality meant decisions that cannot have been easy for him nor for his immediate family.

Moving Forward

Nor did it get much easier as he began to find more stable employment in his chosen field. Mike registered with a few agencies and ended up working for a year as a Band 6 locum for Wheelchair Services, some 80 miles away, so a little nearer home, though still distant. Reinforcing Eraut’s (2008) ideas for the first steps in the transition process, Mike made sure he had

read around and kind of spoke to a lot of people. (M2: 2)

There had not been a physiotherapist in the Wheelchair Services MDT before, so it could have been difficult for Mike to be sure of what to expect. This is particularly striking when it becomes clear how he was used to working in his previous career.

I .. guess, in a way, it’s very similar [to the army] in the fact that there’s a lot of teamwork involved to getting to where you need to go .. you’d all get your heads together and .. create a plan .. and then work towards that .. But also be flexible enough to change that along the way .. (M2: 11/12)

Mike was very used to working in a team, but it would be a team of men he knew well. Now he had to find out quickly, not only the procedures commonly used in the

organisation, but how each member of the team expected to participate in patient management and what they might consider his newly-created role to be. This does not seem to be the legitimate peripheral participation envisaged by Lave and Wenger (1991), where the newcomer is afforded opportunities to engage at a basic level only, this being gradually extended to include greater responsibility. Mike was already working, the sole representative of his profession, in a more senior position. It was fortuitous that his past experience had also prepared him to be 'flexible enough to change' as necessary. This would alert him to the need for reflection-in-action (Schön, 1987) as he met unexpected situations, of which there were bound to be a few initially.

However he seems to have been well appreciated. The manager, who also happened to be the chair of a regional management group, put Mike in touch with another manager who gave him a Band 7 job for 7 months. This is a reminder of the importance of serendipity in career decision-making. Hodkinson found that an individual's decisions were "... strongly influenced by their position in the field, and the resources at their disposal" (2008, p 9). Mike's manager had seen his work and knew she could recommend him to others, and his position was strengthened by this social capital. It was fortuitous that she had the right contacts to enable him to find more work in this speciality area.

Vocational Manoeuvres

Mike had, as it were, parachuted into his new profession, quite confident that he needed no rotations. He had come to terms with the nature of the profession as a whole, and saw no reason to attempt to experience it all in depth. He wondered at his own progress.

.. it's only two years ago that I graduated. But then .. I do realise that I've got .. a lifetime of growing up with physical disability, which is a big difference . huge difference. (M2: 20)

It is to this, then, that Mike attributes his success. To this also must be attributed his single-mindedness. His life experience had certainly caused his career path to be very different to those of his peers.

Mike had gained promotion at a rate totally unexpected among the rest of my graduate interview sample. It came at a price however, for he was working part-time in two locations now, living during the week in rented accommodation in a town midway between them and returning home only at weekends still. That he goes to such trouble to follow his bent suggests a real sense of mission. His is indeed a vocation, a calling to work in a highly specific area. And he is coping: indeed he is managing well despite forgoing the traditional route. When the opportunity of a post nearer home arrived at last, his negotiating skills came to the fore again.

I was very open in the interview and said “I have got two supporting managers, one of which I’ve got on a Band 7 role, one on a Band 6 role: they’re both happy to do the KSF stuff” [knowledge and skills framework – necessary to decide AfC Banding]. “Would you be happy to at least take me in half-way on the Banding?” To which he said, “We’re not sure. We’ve never had anyone cheeky enough to ask, but can we get back to you on that one?” And they got back and they did; they managed to do it all OK. (M2: 28)

Taking every opportunity to further one’s progress in this way, even if it means changing the rules (Billett, 2006), requires confidence, professional nous and a real sense of purpose. Cliff and Eric showed similar kinds of talent in this respect, but had chosen to work in a more traditional manner and in a more expansive environment. It would appear that there are a variety of levels at which one can function in a profession.

Finding an Appropriate Category of Participation

Mike’s career path, his narrowed learning and development, and fast growing expertise, would appear to contradict Fuller and Unwin’s (2003) thoughts regarding the advantages of expansive learning. The environment in which Mike is using elements of his previous experience, and from which he is gaining still more, seems to accord more with these authors’ concept of restrictive learning. There is the fast integration into the MDT with, presumably, over-speedy attainment of full participation (in his peers’ eyes at least), and much of the time this is without the benefits of dedicated individual support from a supervising physiotherapist. An initial broader scale knowledge of physiotherapy might be preferred by the majority, but there are the opportunities afforded in expansive learning; a variety of both informal and formal learning experiences are available and Mike is managing to

learn a great deal in his particular speciality. It appears that the simple binary categorisation of expansive-restrictive learning has become less clearly defined. Mike is aiming for a broader than 'restrictive' learning, though in the narrow context one associates with the latter. It might be more accurate to describe his route as single-track compared to the multi-track traditional route of rotations.

Indeed it is hard to categorise Mike's participation accurately. It might be said to correspond not so much with Lave and Wenger's (1991) legitimate peripheral participation or Fuller and Unwin's (2003) restrictive learning, as with Handley et al.'s (2006) 'contingent' participation, the newcomer deciding to participate longer at a more marginal position in a community (see Chapter 3, page 75). And this 'community of practice' is the MDT - a group of people with a common purpose, but with few people of the same profession working closely together. This means that Mike is sometimes the only physiotherapist, a position which isolates him considerably at this early stage in his career development.

Yet he has not really chosen marginality: he aims to participate fully in a very specific niche of the professional community, influenced by his commitment to benefit disabled people like his brother. The situation does not entirely fit Handley et al.'s (2006) 'contingent' participation either then. Nor does it equate easily with Hodkinson et al.'s (2008) scales of practice. This is work at an individual level, below the micro-level that Hodkinson et al (2008) suggest is nearest to Lave and Wenger's (1991) community of practice: Mike is largely learning on his own or with those from other allied health professions, in a mixed form of community from a professional point of view. Perhaps the closest analogy to what is happening in Mike's case comes from Hodkinson et al.'s (2008) discourse regarding the possible permissive effect of disposition and background on learning. Mike's family upbringing gives him social capital which allows him more choice and widens his horizons of opportunity. His change of direction from the Forces and high level sport into physiotherapy has created circumstances that support a significant flowering of his learning, or his 'becoming' as Hodkinson et al. (2008) would term it. Here too are the interlocking dimensions of the decision-making process Hodkinson et al. (1996) discuss, the choice of lifestyle, influenced by social context and individual culture, the interests emanating from previous interests and family concerns. Despite what

appears as sustained marginality from physiotherapy colleagues Mike is progressing more rapidly than the other graduate respondents, and in fact it is clear that choosing this marginal position does not equate with marginalisation, as will be discussed more in the next chapter.

This does not seem to be foremost in his thoughts though. When asked if he expected to remain in his niche area or to broaden his field of practice before seeking promotion, Mike ruled neither out. Regarding the restrictive nature of his field, he reflected,

I think, for me to go narrow and high, I need to be doing it for a reason, ie. if the service wasn't being run very well and I thought I could do a better job .. then I'd probably try and step up to the mark. But I'd have to be very confident that I could do that. Other than that, I wouldn't see a reason why to do that .. (M2: 34)

Mike sees his position as potentially limited to an elite task, aiming 'narrow and high', though he would only push to be promoted in it if he was fully confident that he could do a better job than was otherwise being done. His inclination appears to be to broaden his scope a little more.

Pressures and Demands

He is quite definite about what constitutes a good working situation though, and he is clear that he would withdraw himself from anything less straight away.

If I wasn't happy .. if it wasn't a nice working environment .. One that works, one that's logical, one that's functional, one that provides a good service to people, and one that listens to the team .. I would certainly have the confidence to say, "No. I think I'm better fitted somewhere else. (M2: 17)

Mike values four attributes of the workplace in particular here. First and foremost he does not want to feel that he cannot understand the clinical reasoning that takes place there: there must be logic in how things run. It should also be 'functional', and this is rather less clear. It could be understood in two senses. Presumably, being a practical professional, he prefers that what happens improves patient function and enables them to live life more independently. But he could also be referring to the structure of the workplace and its utilitarian aspects. There should be constructive outcomes to the work being carried on there. In this regard it must also be seen to be giving good

service. And finally the professionals making up the MDT there and being consulted, should be listened to. Without these attributes and this kind of respect paid him, Mike is happy to move on and try to find something more to his liking. In this he is considerably more self-confident than the rest of my graduate respondents, for this is happening in times of an uncertain job market. Mike has high ideals and means to maintain them, however difficult this might prove.

Some of this confidence is explained as he gives his ideas of what will be required for him to progress in his career.

I know that Posture Management is an area that you always address and are always going to be addressing, with people who have long-term disabilities. So my way of thinking is, if I get that under my belt I'll be able to be a bit more diverse in what I do. (M2: 33)

Like Eric, Mike has considered strategies to make himself more useful to his employers. Eric though is feeling frustrated at not finding people to tell him what is needed (Chapter 6, pages 178/9), while Mike has made his plans independently. Reversing the traditional idea he is focusing on his main interest early, but means to broaden his scope to satisfy demand later. Being more adaptable could give him more variety of work options and also bring him nearer home. Eric never thought of moving away from home, for he has the extra responsibilities of a young family, which is bound to restrict his movements more. In this respect Mike has more liberty. Here again the world outside work impinges on workplace success. As James (2007) notes, "Lave and Wenger's (1991) understanding of communities of practice neglects the impact of external pressures .." (p 136). Eric's situation raises tensions for him which are not as dominant for Mike, thanks to their differently set social constraints.

The Established Physiotherapists' Viewpoint

When I told my established physiotherapist respondents of the route into the profession that Mike had chosen, they tended to admire his resourcefulness, but be uneasy about his complete competence.

.. I admire somebody who has that positiveness about where they want to work and what sort of practitioner they want to be .. but .. if I came across say a rheumatology patient [the area Cathy knows best] who also had respiratory problems, then I could draw on what I'd learnt from my respiratory rotation .. Even .. positioning of patients .. you'd bring other

stuff in from the fringes to help to deal with that particular patient.
(Expert C: 18)

Cathy practiced her rotations as a junior, spending longest in rheumatology, and now does freelance private work, where she could be categorised as a generalist, using several areas of physiotherapeutic work she had done earlier in her career while she was still working through rotations. Thus when she tries to imagine how Mike must work she envisages times when his practice will fall short because of his lack of general experience. She takes a realistic example from the area of speciality she knows best. Some rheumatology patients suffer from joint stiffness around the ribcage that can mean that their chest expansion is impaired, so they may be prone to respiratory problems. Junior physiotherapists in rotational posts normally deal with such patient care more fully in other rotations than rheumatology, usually specifically respiratory ward work or intensive care. Cathy therefore argues that Mike needs to draw on more than one speciality area of work to cover any deficiencies in his practice. Although a generalist, there are areas of speciality knowledge that she rarely uses, and these she labels 'fringe' activity. This even applies to positioning of the patient, Mike's own area of work, Cathy suggests, where many elements of 'fringe' care can be involved. The therapist must consider musculoskeletal issues, but also those of neurological and cardiorespiratory origin.

Beth, a cardiorespiratory specialist in a private hospital, thought along similar lines.

We're supposed to keep in touch with all aspects of what we do, even if we become specialised in one area or another, so I think it would be very difficult for him to retain a handle on all the other bits and actually have a working knowledge of them .. In a niche area I can't imagine that there wouldn't be other things involved. (Expert B: 28)

She seems to be thinking of the workplace annual appraisals and bi-annual HPC audits of physiotherapists to ensure they are up-to-date and fit to practice (HPC, 2006). Mike could have difficulty, she imagines, persuading his line manager or the HPC that he had enough all round experience. Like Cathy she envisages situations where more than one area of physiotherapeutic expertise is involved. There are flaws in this argument however. Firstly one tends to move away from generalist knowledge as one specialises anyway. Mike spoke of his friend's becoming 'deskilled' as he spent a number of months away from his preferred area on rotations. How much

more must a physiotherapist feel they have ‘deskilled’ in other areas when they have spent several years in a speciality as Beth has? It is impossible to maintain all skills at a high level once one has specialised to any depth. Secondly Mike’s line manager will very probably not be a physiotherapist, so they will be evaluating advance in techniques helpful to the MDT and their patients, and perhaps not so much evaluating specific physiotherapy skills as such. Mike could be seen as being at the boundary of his community in this respect (Wenger, 1998).

Diana, another established physiotherapist in a very exclusive niche position similar to Mike’s, is more pragmatic in her comments on physiotherapists in situations like his.

My only reservation about it is that they maintain the skill level and develop their own skill level in the niche market that they’re in. (Expert D: 25/26)

To her it is not just a question of maintaining skills; Mike will have to decide what skills he needs and develop his own skill bank. This will almost certainly also have to be adjusted over the years as practices change (Eraut et al., 2004). Whether Mike will be successful in this only time will tell, but he has begun this development. It formed the second half of the negotiating he did to get the correct pay level in his latest job (see page 199).

So then .. I said, “Now then, the other thing is, I really want to do this course.” So then . anyway, the outcome of it was they said, “It would really benefit our service and yeah, we’d be really pleased. We won’t be able to fund it, but we’ll give you the study leave.” .. And I phoned the CSP up and they said, “Well, if you apply in September for the charitable trust, we’ll give you £580” (M2: 28)

Off-the-job opportunities for learning, taking the newcomer “beyond the boundaries of the workplace”, can substantially augment the learning of junior members of a community (Fuller & Unwin, 2003, p 415). While others of my graduate respondents, realising this, have complained that they have to use annual leave and cannot get funding for necessary courses they feel would further their learning nowadays, Mike is negotiating both study leave and funding to his own satisfaction.

Frustration at the Professional Fringe

Mike seems to be on the fringe of his profession, in a situation where he sometimes almost sees himself as ‘the service’ itself (see Chapter 6, page 176) he has so little direct support from others of his profession. Indeed in many ways he has assumed the position Wenger (1998) terms a ‘broker’, one who tends to be at the edge rather than at the core of a community of practice, and that might prefer being so. Such individuals, Wenger comments, must “avoid two opposite tendencies: being pulled in to become full members and being rejected as intruders.” It is a fine line, “yielding enough distance to bring a different perspective, but also enough legitimacy to be listened to” (1998, p 110). The trouble is that Mike *is* a full member, at least of the macro-level professional membership, and although he feels he is being ‘listened to’ by his MDT colleagues he has the uncomfortable sense that fellow members of his professional body from within the ‘core’ of his community of practice are letting him down. When asked what obstacles he has encountered in his professional path to date, this is his first thought as he exclaims,

Lack of physios. Honestly . unbelievable! .. Typically, people are getting seen for 20 minutes every couple of weeks. It’s just a lack of physio intervention, generally .. And it’s soul-destroying, because .. you’ve agreed these common goals with a physio, but then are they doing their bit? We’re doing ours .. (M2: 29)

Mike’s work in correcting wheelchair posture needs to be maintained. Muscle imbalance and soft tissue contracture can result from poor positioning over time, and will require further rehabilitation after his front-line work is complete. Extremely frustrating to him is the fact that he spends considerable time with a complex patient, only to find that the follow-up care he organises from his fellows is minimal: the patient needs seeing more regularly than 20 minutes every two weeks, which is completely insufficient in Mike’s eyes. That his loyalties seem so firmly with the MDT rather than with his own profession reflects his boundary brokering position (Wenger, 1998). At the boundary of his own professional community, his immediate MDT colleagues are linked strongly to him as ‘we’, and are pulling their weight, while ‘they’, his fellow professionals, are letting not only him but the MDT, to which he is loyal, down. The corrections the MDT has helped the patient with are not being sufficiently maintained. Mike has the common goal with other physiotherapists of rehabilitating patients, but he is fussy about how that happens, that they uphold his

and the MDT's standard of care. His marginal position vis-à-vis the main stream of the profession is marked by the fact that he feels they do not support him or work to that standard.

Mike, a member of the national community of physiotherapy, is where he wants to be, but that is *not* with his fellow physiotherapists, or so it seems. He is on the way to a fuller participation, it is clear, but that this is the 'full participation' of Lave and Wenger (1991) is questionable. In one way Mike's dissatisfaction with a group of his professional community that are not delivering work of an appropriate standard shows a definite pride in the profession's work, a sense of belonging to the community that yields frustration with inferior practice and a longing to raise standards. The next chapter will give another case of an established physiotherapist, Diana, complaining of her colleagues' work in a similar manner. But such cases argue against the comfortable theorising of Lave and Wenger (1991).

It is worth remembering at this point that Lave and Wenger (1991) were carrying out different research to mine, namely anthropological observation. They were noting how people worked together. I have been talking to people about what they are doing and how they do it and collecting a different kind of data. If I had questioned one of the Vai or Gola tailors, they too might have voiced similar dissatisfactions to Mike's; they too could have told how they measured and cut out the cloth really well, while the tailor along the street did not follow this up with as neat sewing as they might. This demonstrates the tensions there can be in a community of practice, which perhaps Lave and Wenger (1991) did not particularly observe, but were there to note had the workers been questioned in some depth.

Might Different Routes Allow Innovation?

If he were to transfer into the main community of physiotherapists Mike might well be relegated to a more peripheral position to help him broaden his knowledge. But he has expertise to offer his profession, and this is best used at the moment in a different environment to the norm: it is a particularly specialised 'situated learning'. Could participation of this sort, one of a variety of alternative routes, produce practical change that might provide the profession with the possibility of innovation,

Arnseth's (2008) "temporal emergence" (p 300), new meanings emerging over time? Wenger (1998) agrees with this idea, suggesting that people at the periphery may facilitate change, their position allowing them to view things differently. Mike has moved to an expertise on the edge of, or even outside, the traditional community, and this is a twilight zone where there are tensions between specialisation and broader forms of practice, and issues of expertise get posed differently. One feels that he will openly question what is happening, and perhaps if enough people start to do this from their sometimes enforced peripherality, it will have an effect on professional issues and produce eventual change.

Summary

In this chapter I have used examples of non-traditional paths into a profession to show that necessity in a time of fragile employment and the attraction of what seem challenging alternatives to the traditional route are appearing. Among these, Mike's career path seems of particular interest for it shows how previous experience and individual upbringing allows some people the option of different routes into a new career. These can be narrow paths at the fringe of the profession and individuals may find themselves faced with lifestyle difficulties (having to live away from home for example) which are unacceptable to some. Taking such a route can facilitate more rapid promotion, but may also lead to frustrations that could promote professional innovation and change over time. There seems no doubt that external influences, and in particular family factors, can greatly influence the type of work chosen, as well as restricting or encouraging how career progression evolves.

However, there are questions posed about the meanings of full participation and expertise. There seem a variety of positions and levels at which newcomers can function in a professional community, to the extent that it is extremely difficult to categorise the form of participation occurring. Smooth progression to full participation does not seem to happen in some cases, with serendipity, frustrations and negotiation having a greater influence than Lave and Wenger (1991) allowed. How full participation and expertise are viewed by practitioners will be addressed in the next chapter.

Chapter 8

Data and Analysis 4:

Variations on Full Participation

In the last chapter we saw how Mike made use of past experience and brought outside knowledge to his workplace, but his was a professionally solitary position within a MDT, so could he be said to be moving towards full participation in his profession? He has made the transition into his new career, but his situation seems nearer the boundary of the community than the position of the traditional entrant. He was taking an independent, unconventional path compared to their trajectory surrounded and supported by professional colleagues.

Wenger (1998) suggests the newcomer's peripherality in a community of practice is part of an inbound trajectory towards full participation, while marginality is a restricted participation consistent with outward movement (see Chapter 3, page 73). Viewed from this perspective, Mike seems to be in a marginal position, as one of very few physiotherapists in a niche market, rather than a peripheral position, practising within the professional community. Such reasoning implies that Mike's vocational learning must be a stepping stone to a position other than the ultimate goal for which he was trained, yet he appears to be progressing up the ladder of seniority more rapidly than his peers. Perhaps if the perplexing term 'full participation' is explored in greater depth, it may be easier to comprehend whether Mike is aiming towards, or away from, it. Thus in this chapter I aim to explore the meaning, or meanings, of full participation as understood by those established members of the profession I interviewed, as well as the career-changing graduates. Other issues for discussion are those concerning marginality and exclusion, and how full participation might be different to expertise.

The Graduates' Initial View of Full Participation

It appears that the gradual integration into a community of practice through collaboration with more experienced practitioners suggested by Lave and Wenger (1991) is indeed how most of the mature graduates I interviewed viewed working to become a full participant. This is not surprising as they had been led to expect it; they

had experienced legitimate peripheral participation on placement as students and imagined it would continue to a lesser extent on graduation. Some were surprised that this did not happen more overtly. Once promoted to Band 6, Eric wanted to progress in a particular area of musculoskeletal practice and had asked a physiotherapist specialising in lower limb work to supervise him. When asked to clarify what he meant when he had said he hadn't had any supervision with her and (as something of a joke) whether he still expected to be watched treating patients, Eric noted,

That always amuses me as well actually. I think once you become . well even .. as a [Band] 5 being supervised, if you've got any problems you'll bring it up, and you'll be given ideas as to what you should and shouldn't do and you can ask specific things .. other than that, you're a 'fully fledged physio' so to speak and you get on with the job at hand. And then as a [Band] 6 it's even more so; you're sort of left more so to your own devices, and again just . you ask if you need to. (E3: 16)

The implication here is that the 'fully fledged physio' (perhaps equivalent to the full participant) is capable of working on their own with minimal support from others. They will require no direct supervision. Eric's impression is that this happens as early as Band 6 (for differences in job status between Bands 5 and 6, see Appendix XIV), and as far as he is concerned this is too early. He feels he needs to advance in skills before he can call himself a full member of the professional community in the way he wishes eventually to be.

Traditionally the Band 6 level of physiotherapist is regarded as the 'workhorse' of the profession. Having successfully completed a range of rotational posts, these practitioners' experience has gained them more senior status but is too limited to allow them managerial responsibilities as yet. Such a person could not be labelled as one of Lave and Wenger's (1991) 'old-timers'. As Eric appreciated in his request for more support, they could have difficulty improvising in the most complex treatment situations, and Handley et al. (2006) might well categorise them (see page 75) as the upper echelon of legitimate peripheral participants, on the brink of becoming the thoroughly proficient final category, full participants.

But the notion of full participation equating with complete knowledge is a perception contested by the interviewees in this study. They do not allow, as Boud and Solomon

(2003) suggest, that admitting ignorance has connotations of the novice and might be viewed negatively by the community. Cliff was emphatic that,

.. a real expert is never afraid to say when they don't know .. that's a mark of an expert, going, 'I don't know that yet.' (C3: 21)

As far as he was concerned, such humility was the first step in facing challenge.

The real skill as a professional is to work out the root cause of someone's problem, and that takes the ability to admit "Right. First off, I don't know", and then just trying to work through it .. (C3: 24)

Gwen made a similar point.

I don't think you ever really stop learning and I think things change and develop so that's also quite hard to ever think you really get to a point to think, 'Ah. Right. I know everything now.' (G3: 13)

Lionel too never expected to reach 'fully-fledged' status if this meant knowing everything there was to know.

.. when I look at the seniors for example .. plenty of them say "Well, we don't know how this works or how that works", and you don't realise .. how many unanswered questions there are .. until you keep on trying to answer them .. I don't think I would ever sense that for me 'arriving' and 'fully fledged' means you haven't got anything left to learn .. (L2: 9)

These graduates recognised very clearly that they would be expected to continue their learning and refine their skills to a high level throughout their career. For one thing, they had been educated to expect to provide evidence in their annual review with their line manager that they had advanced in professional development each year (as noted in the last chapter – page 203). More than this, as people who had already worked in other fields, they were aware of the necessity, particularly at a time of fragile employment, of proving their superiority to others also moving towards full participation in the community of practice. Fuller et al. (2005) suggest that thriving communities do not stand still but are constantly changing, and this change may well be accelerated when the membership feel threatened by altered organisational culture (as has been happening recently in the NHS) and the wider political climate. Eric's push to learn more could be seen as a sign of an individual attempting to control his career path in times of economic uncertainty.

The Perfect Role Model

In a bid to learn more about my interviewees' perceptions of full participation, I asked them to tell me what they admired in those more experienced in the profession. Responses often featured speedy efficiency and agility of clinical reasoning, but most of my graduate respondents suspected these skills only came over a number of years. Gwen's role model had gained proficiency in more than one area of physiotherapy:

.. she's really knowledgeable. She can treat patients on intensive care really competently .. I mean she has been in that area for many years but she has great knowledge of anatomy, so she's utilising all her musculoskeletal skills .. (G3: 15)

Gwen was impressed by a physiotherapist who is drawing on past experience in this way to enhance her work in her specialism of intensive care, but this is an area where several competencies are often called for in a wide variety of scenarios, and as time goes by such a specialist finds they are becoming adept at moving from one specialism to another, though always in acute care.

A few people impressed my graduate sample by seeming to have acquired similar expertise in quite a short time. Pat's role model was

.. very skilful .. incredibly knowledgeable. You can ask about anything and she just seems to know what to do or what you could try if something's not working .. she's probably been there for five or six years so she's not actually massively .. experienced in terms of longevity, but she's certainly got .. a fantastic flair .. (P2: 13)

The skills Pat pinpoints here are strategies to manage the unusual, when the patient is responding differently to the norm, as well as the everyday situation. Her role model reminds us of Beckett and Hager's (2000) ideas of an 'epistemology of practice', where judgement-making ability is crucial (see Chapter 3, pages 80/1). It implies an accurate analysis of the problem and a memory rich with stored possible methods of adjustment of practice to cope with each issue. Then a judgement may be made. It seems reasonable for Pat to be impressed with participation of this calibre that is not dependent on time spent in the community.

Something special was required of the full participant, Cliff opined, for this was

.. a high level physio .. working towards being frontline, I mean the first person that people see. (C3: 19/20)

This introduces the idea that full participation has links with how the patients, first arriving in a physiotherapy department, perceive the individual practitioner. It has implications for the solo worker in particular that I shall be returning to. This seems to be in Cliff's mind too, for while he agreed that it was preferable for such a person to have experienced several areas of physiotherapy, he felt that

.. a fully-fledged physio should .. be someone who probably has a very deep knowledge - one speciality, in one speciality and quite specific .. But in saying that, I think to become a really, really, really good specialist you have to have been an all-rounder .. to a certain extent (C3: 19)

This, as I have suggested, is the traditional way of thinking about full participation, that one has established a broad base of knowledge and climbs on towards a pinnacle of excellence (see Cathy's description – Chapter 5, page 131). But Lionel was not sure that thinking of the path into the profession as only one particular route was necessarily correct.

I think it totally depends on the person, because 'fully fledged' for one person might mean be a specialist in a certain thing and another might say a generalist .. (L2: 9)

His was something of a lone voice among my graduate sample, until I interviewed Mike. In his niche market his role models were not so much his relatively few physiotherapy superiors, but a Dutchman, known as a lecturer in the speciality throughout Europe, and an OT manager he had seen at work in the multidisciplinary team while on student placement. Once more this kind of experience put him in a separate category from his peers, and suggests that Lionel's reasoning had much in favour of it. The professional pathway seems indeed to be dependent on the practitioner, for Mike's route to full participation will be quite different to the rest of the graduates. His career route is marginal in relation to the main physiotherapy 'community', and his role models reflect this.

Though there might be various ideas of full participation and how to reach it, respondents tended to agree that attaining this goal was not an end to learning. Cliff exemplified this as he explained,

Nobody can be excellent at everything. There's just not enough time in life .. look at people who are really good at something .. they've learnt a

lot of skills and then they use those skills to make them better at a certain thing, and then you keep going and you keep going. (C3: 22)

It is a process that continues throughout the career, skills being both gradually honed by what is being learnt daily and subtly modified to the work situation, both because of change within the workplace and thanks to external influences affecting the pattern of work. This was the path my graduate interviewees saw stretching before them. But the established physiotherapists I interviewed might be regarded as full participants already, so how did they view the process and what did they consider 'full participation' to be?

More than Just a Job

I introduced the subject with my established practitioners by asking them when they first felt they had really become physiotherapists. None felt they could be said to be in that category on graduation. However Diana remembered that she had not been practicing very long when she started to notice that her presence counted for something with her patients.

I'd only been a physio for probably 18 months .. in the day hospital .. I worked with .. care of the elderly, and that was the happiest time ever, in that I really felt I made a difference. And I really felt I was a physiotherapist then .. It doesn't necessarily have to be a physical difference, but if .. it makes whatever the problem is for that person, if it makes it lessened or eased or better .. I developed a rapport with patients where I realised I was making a difference to people's lives. (Expert D: 19)

For such a physical occupation, it is interesting that Diana highlighted that it was not necessarily making a physical difference that counted, but perhaps making a psychological difference to her patients, people suffering chronic conditions, that made her feel most like a real professional. This accords well with what Eraut (2008) has to say about factors affecting learning in the workplace. Diana was encountering people at work whose feedback, giving her at least the impression that she was making a difference in their lives, increased her self-confidence and motivation, and this, Eraut (2008) suggests, could enhance her professional learning.

Of my experienced respondents Diana was the only one who, like the mature graduates I interviewed, was a career-changer. She had been a teacher, a situation in

which one might assume she was also ‘making a difference’ to plenty of lives. When I asked her how this differed from her feelings as a physiotherapist, she responded,

“Children didn’t run out of a lesson and say ‘Thank you very much.’ They .. were sponges and took. And patients, some are sponges, but for me the two greatest words that you can hear are ‘thank you.’ (Expert D: 20)

It appears that it was the obvious gratitude of some of her patients that inspired Diana to feel more useful and potentially adept at her work.

Andrea too appreciated being needed by her patients. At school she had initially been attracted to medicine but did not get high enough A level grades. Next she thought of osteopathy, which had helped her father when he had had back problems, but she couldn’t get a grant for that, so she chose physiotherapy instead. It took her some time to feel at home in the job.

I remember being .. in my job as a Senior I, and I was probably about seven years qualified. And .. I remember thinking, “Hmm, yes. That’s all right. I can do it” .. (Expert A: 10)

Perhaps it was because her career decision-making had been thwarted and that she had had to choose third best that it took her longer than Diana to feel established in her career. Diana had been confident and successful in a previous career, although she had come to dislike it; she came to her new career because she felt drawn to physiotherapy, and felt she could be even more successful there. It was her true vocation. Her decision was made with what Hodkinson et al. (1996) term ‘pragmatic rationality’, allowing for emotion and natural inclination, an instance of a decision being made for many reasons, not all of them necessarily fully conscious. Andrea’s decision Hodkinson et al. (1996) would term ‘technical rationality’, being based on rational reasoning: there were reasons why she could not follow her natural inclinations and she still had to learn to want to be a physiotherapist.

As she moved into her professional community, Andrea noted characteristics some of her colleagues displayed that made a real difference to treatment and could be part of being a full participant.

I think handling skills are the most important thing for me, and some people just .. when they hold you and put their hand on you .. you feel safe, and you think “That’s exactly how I want, you know.. your limb to

be held.” You know that you feel secure, you feel nice with it. (Expert A: 14)

Security and safety feature strongly here. This reminds us of Evetts’ (2006) comment (see page 145) that professionalism in any job can be defined by trust on the part of clients and behaviour which is worthy of that trust, and Andrea emphasises here the main way in which the good physiotherapy professional gains trust. Skilful handling allows the patient to have faith in what is being done, and to put their trust in the practitioner, with all the importance that has for healing (Goold, 2002). Andrea’s experience is first-hand, acting as model on some of the manipulation courses she attended and she has tried to emulate this practice.

Andrea has specialised in back care in private practice, and the other characteristics she counts as important, those of good communication together with clinical reasoning, link particularly with management in her speciality.

I think you’ve got to be able to listen. I think you’ve got to be able to have an enquiring mind. I think you’ve got to be able to see outside the box .. (Expert A: 14)

Back pain, and movement difficulties in this region, can arise because of problems elsewhere in the body, so Andrea must look out for such issues. Carefully listening to how patients describe their symptoms, together with well informed questioning, are essential skills to the full participant then.

Thus through the years Andrea honed these skills, performing routine care in her specialist field and coping with the occasional more problematic case. However, a moment of realisation came when her son, now attempting to choose a career for himself, questioned her initial career leanings.

.. he said, “Mum, why did you want to be a doctor?” and I said, “.. I wanted to make people better.” He said, “Mum, but that’s what you do.” And .. the penny dropped .. I thought, “Yeah, that’s me; that’s what I do.” And I do love it .. physio for me . it is more than just a job. (Expert A: 24)

Andrea had been forced to change direction in choosing a career. However her routine work had socialised her into being happy with her situation (Hodkinson et al., 1996), even to the extent that she felt so at home in it that the career had become ‘more than just a job’. The impact of such ‘epiphanies’ (Denzin, 1989) can cause

people to change career, as indeed had happened with some of my respondents (Barbara is an example). Here it had a confirmatory influence. Andrea realised that she had found her niche and was happy in it. To her mind this made her truly a full participant in the physiotherapy profession. But as a lone worker in her own private practice, the ‘community’ in which she was participating could only be the macro-level one of the professional body itself.

Between Communities

It is noteworthy that the newcomers to the profession that I interviewed showed less interest in the professional macro-level community to which they belonged and exploring closer ties with it than did the established physiotherapists. One might have thought that the novelty of membership of the larger organisation might have spurred them to make early use of some of the facilities afforded, such as regional and professional networks, and the opportunity to go to the professional Annual Congress, or to become more politically involved in Industrial Relations. Eric’s response, when asked if he had become involved in this way, was typical.

No. No, I’m not . at the moment I’m .. I’m just finding my feet in the profession, so in the future probably and I do read the interactive stuff [discussion pages on the CSP website] or I get emails from community bulletins or musculoskeletal or sports medicine bulletins. I go through them and read them .. (E2: 24)

While he is becoming established in his micro-level community Eric is setting the broader professional issues aside, though he is keeping an eye on website information and discussions that could further his knowledge. He seems to be consolidating his micro-level position before embarking on the macro-level.

Lionel is the only one of my graduate respondents who has tried to become more involved and, being on a short-term contract at the time, he immediately found he faced a barrier.

.. a CSP steward job came up for my current Trust. I was the only one who was interested. That again . I can’t do it because I’m temporary .. all the ways in which I want to expand myself and kind of develop into different areas of physiotherapy I’ve been unable to do, purely because of the temporary contract status, which I’ve found at times disheartening, frustrating .. (L2: 2/3)

In this way the fragile employment situation impinges on new members. Because of his temporary work status Lionel hadn't guaranteed access to patients for the full length of the Masters programme he wished to enrol on, and the further disappointment regarding the steward's post only added to his feelings of inability to progress.

There seems to be a chain reaction set up among the different levels of community in this situation. In Chapter 3 I introduced Hodkinson et al.'s (2008) scales of communities of practice, and told how I meant to use 'micro-level' for the workplace area or occupational community, meso-level when referring to the worksite within which the workplace is located, the organisational community, and macro-level for the overarching professional body. Applying this concept here shows how they can interrelate one to another. That the organisational, meso-level community has provided Lionel with a work contract and temporary status is helpful to him short-term, but has also resulted in the raising of barriers to his further progress in the micro-level occupational, or departmental community. This in turn affects Lionel's learning about and experience of the macro-level professional community. Such internal boundaries, set up because of external influences, the uncertainty of future employment in this case, impede progress to full participation in a way Lave and Wenger (1991) fail to discuss. The "broader historical and cultural contexts" of a community of practice are not sufficiently explained by them (Jewson, 2007, p 69), considering the impact they can have on members.

Six months later, once he had a permanent post, Lionel was able to achieve his frustrated goal of stewardship, but he was the only one of the graduate interviewees to attempt such a move, and gaining the permanent contract had been so stressful that he was loathe to do so at first.

I will not be doing any CSP rep/MSc stuff for a little while. I want to go to work, do the work, come home and focus on everything that is not physio for a while. (Email from Lionel: 3rd June 2011)

Perhaps newcomers need the tight-knit enveloping community, the security of micro-level support, and find maintaining their position within it quite sufficient at first, particularly in times of fragile employment.

Brown and Duguid (2001) suggest organisations like professional bodies should be viewed as networks of practice, where participants can share knowledge without necessarily ever meeting each other. This implies that it is the established more experienced members that are happier to involve themselves in working more closely with the macro-level organisation. This link with the professional community, the one Eric mentions above (page 216) of interactive website discussion or emailed bulletins on specialist topics, is the way in which more widely, and thinly, spread full participants can keep in touch and up to date with practice. Edwards (2005) too questions whether occupational, micro-level communities of practice are of the same importance to all practitioners. Their importance certainly seemed to fade in the case of my established physiotherapists, if not to become significantly undesirable in two cases, as will be seen. As these participants began to move into work with an MDT or in private practice, the professional body appeared to assume more importance than the occupational community.

This introduces a further complexity. It would appear that there are several variations on the theme of 'full participation', according to the prevailing form of organisational or meso-level community. There is practice with other disciplines (the MDT), within the wider organisation of the hospital, or in solitary private practice or sports work. Moving towards the centre of, or higher within, such a meso-level community signifies a degree of maturity, adding status or capital in professional terms, but the point at which people move away from their initial micro-level community does not necessarily equate with full participation. Intricacies of practice are often still being explored. Then there are some who never venture beyond the occupational community at all, specialising as an advanced practitioner in the Physiotherapy Department for instance, and some again, like Mike, bypass the micro-level community altogether.

Feelings of Difference

Lave and Wenger (1991) reminded readers not to expect full participation to be simply being at the centre of things, but they gave no firm indication of either location or boundaries for this position. I hoped to clarify such issues with my four well established physiotherapist interviewees. The private practitioners among them

could have set up their own community of practice from the working connections they had made, but few of these colleagues were physiotherapists. The exception, Beth, a respiratory senior physiotherapist, still worked in a MDT closely allied to a micro-level community of physiotherapists in a private hospital. She was also the first of these practitioners to give me the sense that she had not always felt entirely at home among her fellows during her career.

To gain a better idea of full participation I asked these respondents at what point in their career they had felt most embedded in physiotherapy. Colley et al. (2003a) question Lave and Wenger's (1991) perception of identity construction on approaching full participation as a relatively simple and passive acculturation of the newcomer to the workplace. They use the term 'becoming' and view it as "immersion in the social .. and emotional aspects of work" (Colley et al., 2003a, p 475). When I asked Beth to comment on this, it was clear that it had been her family, and particularly her three children, rather than her work, that had involved her socially and emotionally in the early years of her career. She had felt she belonged in the workplace most when she felt freest from family responsibilities.

.. unless you're completely happy with your child care, then you can't work properly because it's always in the back of your mind . what's going on at home. And I've been very lucky in that I always made absolutely certain that home is fine, so that I can just concentrate on work. And being able to get that balance has been key to me continuing in the profession. (Expert B: 11)

Here is an important external influence on participation. We have seen that starting a family has sometimes had to be put on hold (see Gwen's career decision-making in Chapter 6, page 160), but once there are children to be cared for, they can influence an individual's relationship with their occupation considerably. Beth needed to be assured that her children were well catered for before she could happily engage wholeheartedly in her profession. It was no surprise that she felt least embedded during her first three or four years of motherhood, when she gave up her professional membership for a time. She had returned to work two months after the birth of her first child and had meant to take only a few weeks extra when her second child was born, but all this changed because of an interview she had at this juncture.

She had applied to a specialist neurological unit, for a more senior post than she had had before. The reasoning behind this decision-making shows the way in which Beth felt her life being drawn in two directions. She considered a senior post to be suitable because of the years she had been in the profession and the experience she had gained to date, but

it would have to be a senior one because of the cost of child care. (Expert B: 13)

She was thus perhaps more sensitive about her role as a mother vying with the professional one, but she got the distinct impression that being a mother of small children was a disadvantage.

During my interview it was in the background. It isn't something you were allowed to talk about, family and that, but it was kind of unspoken but hanging in the air and I felt it quite strongly. (Expert B: 13)

She did not get the job and the atmosphere she had noted convinced her to become a full-time mother for the next seven years. This could be seen as another of the turning points Hodkinson and Sparkes discuss, where there could be a possible "mismatch between personal motivations and official structures" (1997, p 39). Thus the route to full participation may be challenged by social context, as Beth's inclinations to progress in her profession were challenged by her family needs and responsibilities.

Of the established physiotherapists, Cathy alone, although she had an area of particular interest, had remained more of a generalist. She was the only one of my interviewees to note a reaction among her colleagues that might be said to reinforce Boud and Solomon's (2003) idea that to be viewed as a 'learner' had associations with still being a novice.

.. I think I am at the level of an extended scope practitioner. It's just that I don't have the specialist knowledge of a particular area, and funnily enough when I did start to access lectures in the locality .. I was looked at by colleagues as if to say, "Well, why are you here?" and I thought that was a really odd . suggestion, so I haven't accessed anything for a while .. (Expert C: 9)

Cathy had attempted to enrich her learning by attending a meeting run by a Professional Network. These groups are run by members of the CSP who have a specific area of interest within the profession, but, although they have a registered

membership, they are open to all CSP members, not just the specialists in that subject. Hence although she is a generalist, Cathy should have felt welcome to attend those meetings which interested her most. However, it is clear that she felt her presence at a specialists' meeting was questioned. Wenger et al. (2002) mentioned the possibility of factionalism "derived from domain-related excesses and failures" (p 142) that can lead to feelings of discontent, and this appears to be an example. Zeal in raising standards in the speciality may have caused people to fail to accept the presence of those less specialised without question. It may be that Cathy was over-sensitive to the ambiance of expertise at the meeting, of the presence of people she knew as being advanced practitioners in the area. Whatever the reason, an enquiring look or two was enough to make Cathy feel marginalised and discourage her further learning.

How such specialist groups relate to the scales of communities of practice (Hodkinson et al. 2008) used up till now in this thesis is not uncomplicated. They stem from, and feed up-to-date practice information back to, the professional body, the macro-level community, but they are also a means of sharing knowledge and generating expertise in specialist skills to be used at organisational and occupational community level. There is a chance here to work collaboratively between communities, though this is done in a particular locality as well as in particular specialisms. Because of this it is possible that Cathy might have felt more comfortable attending a network meeting at some distance, where she would not have been known as a generalist. However, this sets such a grouping in a peculiar position as far as communities of practice are concerned. This seems a meso-level type of community, geographically outside, but informing, the organisational community, one of a number of sub-communities connecting with the professional body.

Several of my interview sample (see Gwen, chapter 5, page 136 and Eric, page 137) have supported Lave and Wenger's (1991) suggestion that clinicians with experience are a resource for one another and for those in more peripheral positions. It would thus seem to be important that those with some years of experience are encouraged in activities where they can compare notes and reach up-to-date consensus on patient management, so that further learning can be promoted. Benner (1984) notes that

except in intensive care, where they are working side by side ‘specialing’ acutely ill patients (managing just one patient each), expert nurses have less chance to “compare and develop consensus on their observations with other nurses” (p 35), and this would appear to be true of the lone practitioner generally. It highlights the negative aspects of Cathy’s decision to avoid specialist meetings. Not only does this affect her learning¹⁰, but it hampers the profession’s learning, for her voice, her observations and findings from clinical practice, are missing.

Cathy is a reflective clinician, the sharing of whose experience might help those less experienced move further along the path towards full participation in their community. She likes to spend time over her work, and indeed this is one of the reasons why she decided to move away from team work to a more solo career.

.. by going into the private sector but also working for myself, if I want to spend an hour and a half with a patient I can do that and I have nobody shouting at me, and no colleagues sort of muttering .. (Expert C: 10/11)

Lave and Wenger (1991) tend to write of the community of practice as a very friendly and positive entity, but newcomers are not all equally welcomed to their situation. Established members can feel pressured by the requirement to prioritise treatment, in areas where the NHS has a dearth of staff, who then have less time for their patients. Cathy has found it stressful to be hurried by her colleagues. They have not only ‘muttered’ about the time she has taken, but she suggests they have even ‘shouted’ at her, or, she feels, have been tempted to do so. The potential for such tensions in a community of practice is acknowledged by Wenger (1998), but he tends to diminish the impact of the idea by the over-optimistic view that, “as a form of participation, rebellion often reveals a greater commitment than does passive conformity” (p 77). This assumption that power relations can always be seen in a positive light negates the fact that feelings of difference and hostility can be disruptive and thoroughly disturbing for targeted individuals, who like Cathy can be driven from their micro-level community to a more lonely position.

¹⁰ If she has reached full participation, might there not be a risk of some kind of lessening of this position if Cathy’s skills are not kept up-to-date? Reification in the form of the HPC two-yearly audit implies as much.

Breakdowns in Community Relationships

Diana too has moved away to work more on her own, and she spoke of her previous awkward experiences while heading a team on care of the elderly wards.

I tried everything I possibly could to motivate, and it was exceedingly difficult with them .. they had .. their own agenda really, which was to work through whatever, bang bang bang bang . get through the day, and be gone. And .. I found that very, very difficult and I felt really isolated from that whole .. I really cared for those people [the patients]. That could be my mum: that could have been my dad. (Expert D: 14)

There is intense frustration and a sense of demoralization evident in what Diana says. Her junior staff and assistants showed little of her commitment to the patients. There was no feeling of 'joint enterprise'. Staff were performing at a low level, doing the bare essentials only. Something about the ethos of the organisation seems to have been intruding and interfering with the occupational work culture. Once more this would impact on professional learning as well. It pointed the need to feel part of a supportive, effective team, as Eraut et al. (2004) notes in the practice learning of nurses. These authors tell of the significance of working relationships, and how important it is for the early career professional to feel confidence in their superiors within the occupational community. Diana's experience suggests that it is just as important for the senior and middle-career staff to feel confidence in those below them.

When asked at what point in her career she had felt least embedded in the physiotherapy profession, she returned to this situation.

.. I probably felt least happy and most alienated when .. I had to work with colleagues who were less than enthusiastic .. And then .. I felt completely disassociated from physiotherapy. That's not strictly true. I felt disassociated from physio as a profession, but not from my patients. My patient rapport, my work, continued to be the same .. my work continued to have beneficial results, but other external factors certainly made it very difficult. (Expert D: 20)

Diana's feelings of disassociation highlight a curious dichotomy in her perception of her profession. On the one hand there is physiotherapy, the professional institution and all those connected with it; on the other there is physiotherapy, her vocational work with and for her patients. The implication is that if the former becomes difficult, in that staff are no longer negotiating towards common goals, then there

still remains the vocational calling, the patient care. As long as the patients are satisfied, then other difficulties in the workplace community can be endured more easily. This will be discussed more in the next chapter.

Diana felt marginalised from her community, but some find themselves right outside the established community, as acknowledged by their co-workers. Cathy was to find herself excluded in this way on one occasion. As a freelance practitioner she had worked on the Bank¹¹ for a small private hospital for ten years or more. Asked to deliver splints to a lady, she found a very angry patient, certain that splints would not help her, so Cathy quickly assessed her, agreed with the impression the patient had and advised her to try and have a particular form of treatment that Cathy used in her private practice, but was used more by specialists¹². She carefully documented that she had told the patient that she was unable to treat her.

I had to distance myself from her because I couldn't be seen to be getting a financial benefit from this lady. (Expert C: 21)

But the result was that

My manager finished me because I'd recommended a form of treatment which was outside what they offered in the hospital. (Expert C: 20/21)

Cathy felt slighted and under-valued. By giving her advice, she had implied criticism of elements of practice within the hospital and now found a boundary before her, the crossing of which removed her from the community (Colley et al., 2007).

She also had a suspicion that there were hidden financial implications.

I think the manager had an agenda in the fact that I had negotiated my hourly rate of pay before she came into post and it was an enhanced rate of pay compared to the juniors that were coming in. And so by getting rid of me she could then use newly qualifieds .. on the wards, at weekends, unsupervised, at a lower rate of pay. (Expert C: 21)

While Cathy was distressed that she had lost a fair percentage of her weekly salary overnight by losing this job, she also foresaw serious repercussions for any newly qualified staff who might replace her. They would certainly be a cheaper option for the service, but their having to work antisocial hours, unsupervised by senior

¹¹ i.e. Working as short term supply staff. For a fuller explanation of this term see the Glossary.

¹² This form of treatment was taught not in basic training but at post-graduate level.

colleagues, was a cause for concern. There were times when Cathy had had to argue the case about treatment with medical or nursing staff.

It's not fair to put newly qualified members of staff into that environment, because you've got to be so confident .. you haven't got a clinician you can go to, who's thinking on your wavelength. (Expert C: 22)

In Lave and Wenger's (1991) community of practice such newcomers would be granted legitimate peripheral participation, including access to Billett's (2001) 'affordances', but here they would be allowed these opportunities without adequate support. They would be participating at a higher than peripheral level.

According to Benner (1984) the novice's performance is governed by rules (see Chapter 3, page 79) and even the advanced beginner has only enough experience to follow simple guidelines. These less experienced individuals need help to make decisions regarding clinical priorities. Success in dealing with this could greatly enhance their self-confidence (Eraut et al. 2004) and so motivate them, helping develop the belonging Colley et al. (2003a) suggest promotes progress towards full participation. Eraut et al. (2004) note how helpful senior staff are in this process when they support and encourage the newcomer, for it helps them become competent more quickly. Left to themselves there will be moments of indecision and stress which could demotivate them, and so slow, rather than assist, professional progress.

Crucial Features of Physiotherapy Professionalism

The one good thing to come out of Cathy's situation was that

.. despite the fact that I lost the work from there, this lady rang me up at home and said, "I really appreciated what you did for me", which was total vindication for me really. I behaved in a completely professional manner. (Expert C: 21)

Again it was the patient's acknowledgement of her help that meant most to Cathy from a professional point of view. As Easthope and Easthope (2000) find, investigating the intensification of teachers' work, it is not overwork that depresses professionals most, but the thought that they are unable to care as they would for those they are responsible for, that their professionalism should suffer. For both Cathy and Diana this is also true. Successful management of their patients is crucial

to their professionalism, with importantly, acknowledgement of this from the patients themselves.

Belonging, then, means feeling needed and knowing one is good at one's job and effective in the workplace. The professionals I interviewed had to feel reassured that they were meeting the needs of the patients first, and sometimes the service came second. They seemed to be judging their feeling of belonging and of their own competence, by their effect on their patients. Even if they felt detached, or perhaps alienated, from fellow staff, their care of their patients remained of primary importance. Diana, however, acknowledged this to be more difficult without the perception of a background supportive environment, that of sympathetic colleagues and management.

Physiotherapy doesn't work in isolation and can't. In all the areas that I've worked and trained and been .. I would liaise with [staff] and talk with them. And .. they helped me and I became a good deal more confident. In every situation you are part of a team, and I'm always respectful of whoever I'm working with .. (Expert D: 20)

Diana is now one of a team of a dozen or so self-employed physiotherapists overseen by and answerable to the Professional Jockeys' Association (PJA) travelling the country to attend race meetings and treat any jockey who is injured. The staff she speaks of liaising with directly are nurses and doctors: she rarely meets another physiotherapist, they are so thinly spread out geographically. When I questioned how she could feel at one with physiotherapists in these circumstances, she responded,

.. if I see jockey A [in the midlands] .. and he has say a problem with [his lumbar vertebrae] following a fall, I will work on him: I'll then liaise with a colleague in Scotland, because I know he's going to Perth .. and say, "Joe Bloggs is coming up .. and he will be riding at Perth in the 2.41. Can you feed back to me? I may be seeing him [down south] in so much time." So we have a network within the physiotherapists .. we coordinate and network between .. all of us. So yes, I do feel embedded in physiotherapy (Expert D: 21).

This is a good example of how a macro-level community of practice can work. Treatment continues from one physiotherapist to another as the patient travels around between them. There has to be good understanding between the clinicians of what each has done to help the patient and it must be communicated well. But all the

physiotherapists are well established in their profession: there is no place in this community for the beginner, for the legitimate peripheral participant. This is not the community of practice Lave and Wenger (1991) envisaged, though there must be at least full participation. Whether this equates with the expertise to be found in such a community is the next point to discuss here.

Intuition and Expertise

When my established practitioners spoke of full participation, the idea of intuition's being important sometimes appeared. For example, Diana felt she had soon been able to rely on a kind of intuitive balancing of confidence levels to evaluate her progress.

“.. the confidence from what you've gleaned both .. from what they [the patients] saw in you and what you felt in yourself. It was a two way intuitive thing really. (Expert D: 18)

She gained confidence from the way patients reacted to her and that, together with her own feelings of self worth, she suggested, naturally or intuitively helped her judge her success. As long as the patients improved appropriately and were grateful for her treatment, and she felt she had done the best she could for them, she was confident that she was working well. Presumably if one or both of these elements did not feel correct to her, she knew she had more to do.

Cathy felt that intuition came into play at a higher level than this. It might even denote the work of the expert, such as a physiotherapy consultant.

.. intuition .. comes with a wealth of experience .. It's more than a hunch that something needs to happen, or some input needs to happen, or you just look at a patient and you know there's something going on here and I can't .. I can't say why, but I know that there's something more going on for this person. You don't have it as a junior physio .. a consultant, yes .. It's the top of the pyramid really for our profession, isn't it? (Expert C: 19)

As a junior member of staff a lot of time is spent firstly remembering everything that needs to be assessed, and then working out what is happening and clinically reasoning the next step in management. Cathy implies that once this procedure becomes second nature, and normal expected progress for the condition being treated has been experienced many times, the seasoned professional will start to note the unusual as though by intuition, where it might have gone unobserved before. It has

already been mentioned in Chapter 3 (pages 79/80) that this was also the sign of an expert for Dreyfus and Dreyfus (1980) and Benner (1984), who quote the expert psychiatric nurse: “When I say to a doctor, ‘the patient is psychotic’, I don’t always know how to legitimize that statement. But I am never wrong” (p 32). This is a certainty that can be questioned (Gardner, 2012). Perhaps Benner (1984) gives a better idea of what may be happening when she likens the acquisition of this kind of ‘perceptual certainty’ to that of learning to recognise the finer points of the human face. After knowing a person for some time, it can be immediately obvious that something is not quite as usual in their life, even if they are trying to hide it, simply by reading their features. So, she suggests, it is with the expert professional, as they ‘read’ a patient’s condition.

Just as one has to learn to read new faces, however, so expertise in one area may not necessarily equip the individual for expertise in another (Benner, 1984). Those at ‘proficiency’ level can regress to ‘competency’ level if they have to work in an area new to them. The lone private practitioner among my established respondents, Andrea, was well aware of this.

My field has become narrower and narrower and narrower over the years and now my scope of practice is like this [*funnelling forward gesture to finally indicate a few inches in width*] and I am really only up to date in this scope of practice, and so if anything deviates from that, they [the patients] get whizzed elsewhere. (Expert A: 13)

Such refined high-level practice supports Eraut’s (2002, p 377) view that developing expertise in one area may be “at the expense of another aspect of practice” (see page 78), and it is as ‘expertise’ that this is likely to be regarded, rather than the full participation Lave and Wenger (1991) wrote about. In this respect Andrea might be said to be similar to Mike in his narrow field, though she has many years more experience. Mike’s career path would appear to be heading in this direction rather than in one of full participation in a micro-level community of practice.

For Dreyfus and Dreyfus (1977) the expert is one who no longer has to think about rules and guidelines. They can take shortcuts swiftly and safely. In Chapter 5 (page 140) an instance where deviation from professional rules of practice was shown to improve performance in expert pilots was discussed. But how can a point be reached

where the individual knows protocols are necessary to the procedural functioning of activities, and that they are useful guidelines for the beginner, and yet that individual feels confident that they can be circumvented in certain circumstances? If full participation is a matter of becoming a proficient member of a community of practice, the point where an individual can so ignore the guidelines seems a level further. Perhaps there are two distinct levels of competence here, the full participant, dealing with the ‘knowing-in-action’ of everyday, and the expert, adding to this more of the ‘reflection-in-action’ appropriate to dealing with the unexpected (Schön, 1987), plus an ability to safely bypass the protocols, potentially without reflection (Gardner 2012).

Is ‘Full Participation’ Meaningful?

In summary, the recently graduated practitioners in this study considered full participation to equate with the capability to work with minimal support, speedy efficiency and agile clinical reasoning, while having a knowledge of strategies to manage a variety of less usual situations. These are the elements Benner (1984) suggests positions the individual in the ‘proficient’ category, the one she places just below the ‘expert’ (p 27). Proficient professional nurses, according to Benner (1984), can judge what is most important in a scenario, unlike the beginner or less competent nurse who is more likely to have to work systematically through procedures. As the proficient practitioner is considering fewer options, their activity tends to speed up and, as they have a deeper holistic understanding of a situation, they are enabled to plan ahead, using maxims as guides.

According to Benner (1984), the expert no longer needs the use of maxims to help them. Doing the correct thing at the appropriate time seems to come without much thought, showing that they are working at a heightened level of informed judgement-making. Beckett and Hager (2000) would argue that these individuals have learnt to separate the need for judgement from the process of judgement itself, having mentally scanned any considerations necessary in the light of that separation. They have also learnt to separate themselves from the judgement to some extent, a kind of “de-centring” (Beckett & Hager, 2000, p 310) or moving into ‘automatic pilot’, that

can appear mystifying to the novice. But this must include continual looking and listening, as Andrea suggested, for the unexpected.

In their extremely narrowed fields of expertise she and Diana have moved from close-knit communities of practice to situations where there is little of a supportive network other than the CSP, the macro-level professional organisation. Wenger's (1998) 'mutual engagement' and 'joint enterprise' are present, but the 'repertoire of discourses, actions and tools' (p 73) is only shared with the professional membership in a very distant sense. They are working alone, or one of very few individuals working in their field. 'Full participation' in practice there may be, but the community of practice itself in which they are 'participating fully' is very thinly spread in the case of such lone workers. They may not be conscious of it at all at times, their practice extending or diminishing continually (see Chapter 5, page 146) depending on their occasional contact with their colleagues, their impulse to respond to a discussion topic on a specialist website, or their interest in an article relevant to their practice in the *Physiotherapy Journal*. The other established physiotherapists interviewed in this study worked as full participants in their workplaces, Beth in her MDT and Cathy in a variety of private practices, but even Cathy, because she moved between communities, could not be said to share entirely all the ideals and goals of those she worked with. As a freelance worker she must adapt to a different ethos and set of working patterns from time to time, and told of failing to do so in at least one case. This is 'full participation' in multiple communities of practice. Yet the perceived marginality of some of these practitioners is not a restricted participation consistent with outward movement from the profession as Wenger (1998) has suggested. The shared element that all these established practitioners agreed upon was that one feels confident that one is doing good and being effective, judged by the response of patients. A feeling of being at one with a community of physiotherapists was a secondary consideration.

Chapter 9

Discussion and Conclusions: Transitions and Situated Learning

Thus far in this thesis I have given the rationale for my study, with relevant background information; presented and discussed the literature concerning Lave and Wenger's (1991) community of practice theory and other literature concerning workplace learning; discussed methodology and research designs; and analysed and presented the resultant interview data. In this chapter it remains to discuss the extent to which my findings help me answer my research questions, how they may have advanced the theory discussed in Chapter 3 and what implications they might have for practice.

In compiling this final synthesis of the research material I shall look at the research questions one by one, discussing the extent to which I have managed to achieve what I set out to do and acknowledging the limitations there are to my research. I should immediately state that the work was restricted to but one BSc Honours programme at a single university; nevertheless this is a university noted for widening participation, so my research respondents came from a wide diversity of backgrounds and had many and varied experiences before beginning, and after completing, their professional training. This helped enrich the data gleaned in answer to my research questions.

Moving Across the Career Boundary

(Research Question 1)

My first research question was '*What are the experiences of physiotherapy graduates who have been members of a previous workplace culture as they seek to become members of the community of practice of physiotherapy?*' As stated in Chapter 4 (pages 97/8), I developed sub-questions from the main research questions, the first attached to the above question being 'How may previous experience impact on the paths mature students take into their new career?' This can be discussed from more than one viewpoint. Previous life experience may have an impact and so too may their previous work experience. There is also their acculturation to healthcare

and to the academy to be considered. All of these impact on the individual's expectations of, and progress into, the professional community.

Previous Life Experience

As far as previous life experience is concerned, a recurrent theme is that of illness or disability in the family home or injury to the participant themselves for which they received physiotherapy. Also four research respondents had mothers who were healthcare professionals. These were the ways in which they had become aware of physiotherapy as a profession. It is no surprise to find that people are made more aware of a healthcare profession when they or their near relations require its care. Greenwood and Bithell (2005) note that young people are much more likely to have heard of medicine and nursing as careers than of physiotherapy, and, although my research sample was older, there is no reason to expect them to have learnt a great deal more about the profession without some prompting. Very few of my respondents moved into physiotherapy apparently unmotivated in some way by family background or personal injury experience, and in none of those few cases had it been their first choice. For various reasons their original plans were thwarted and they followed other paths, sometimes only gradually returning to their original thoughts or readjusting them in the light of what they had discovered about physiotherapy in the meantime. It would appear that there is still a place for more knowledge, and better promotion, of physiotherapy as a career, in schools and elsewhere. Not only may working-class people like Fay, particularly as she is dyslexic, be told that such an educational route is less "accessible, worthwhile and desirable" to them (Archer & Leathwood, 2003, p 175), but also advisors might make assumptions about high-achieving middle-class people like Lionel that result in the perception that the same career is less appropriate for them too. My research confirms the findings of Archer and Leathwood (2003) that perceptions of individual identity and capability can strongly influence subsequent career pathway.

Those participants with mothers in healthcare occupations or who had siblings with disability have inherited a situation that might approximate to Lave and Wenger's (1991) route into a community of practice. Being brought up in proximity to that particular working culture yields social capital (see Chapter 3, page 59) and hence an

advantageous position in the vocational field of play (Bourdieu & Wacquant 1992). They can have inside knowledge of how healthcare professionals negotiate and manage treatments, and know who to contact if more information is required. It can also be easier for them to empathise with the patients' and carers' difficulties than it is for those without their background experience. Mike, for example, being brought up alongside his disabled brother, will have appreciated the life of someone in a wheelchair, having seen it at close quarters from childhood. Entering his new profession, after his army career, he was not just a "lay [person] with some scientific knowledge" (Beagan 2001, p 275). He had far more to offer. It is possible that he had more experience in the area of disability than some of his clinical supervisors. It caused him to be particularly suited to a niche area of the profession, the social relations built up in his original family situation opening opportunities to him that his peers lacked.

Having said this, the support my mature participants received in deciding to re-train and follow a new career was influenced more by the attitude to learning of partners and friends than by parents or siblings. The necessary adjustment of family and social life once training began resulted in altered relationships and responsibilities. The individual's career, in so far as they had any sort of career trajectory, had sometimes been suspended until this point, and HE offered self-fulfilment. In the case of the two mothers of children with special needs, there was also a sense in which they felt they were paying society for the help they had been given in bringing up their children.

Acculturation to the Academic System

However this came at a cost. Reay (2002) suggests that for mature students returning to education there is always "a negotiation of the balance between safety and challenge" (p 412). Though they were eventually safe in securing a university place to study for their vocation, the situation presented a challenge on several levels. In many cases the balancing act between the two impinged upon other family members' lives. For a couple of them it meant taking longer than anticipated to complete their training. Family roles, their own and those living around them, had to alter in order to accommodate to the transition period leading to their new career (Bozick 2007). As a single parent Susan suffered emotional strain as the, sometimes ailing, older

members of her family attempted to shoulder some of the responsibility of caring for her children: Tim and his wife, whose two children were born during this period, found the economic strain of the situation too much for them for a while. These are the extreme examples among my participants, but such issues were mentioned by several. It certainly seems to endorse Bozick's (2007) contention that less affluent students often have to negotiate external factors that can affect academic attainment. It also pinpoints a major difference between the more typical newcomer to the profession, the school-leaver, and the older student, often burdened by extra responsibilities.

The mature respondents in this study had not only taken the risky decision to change career, but to do so by undertaking a degree course. Half these people belonged to families where they were the first, or one of the first, to attend university, those I had tended to label as being working class because of their families' lower expectations of them academically (see Chapter 2). Those from middle-class homes tended to have a previous degree and knew much more what was expected of them in an HE institution. There was particular pressure on the pioneer however, who could feel they were being required to do better than those before them and were not sure if they could. Beck (1992) suggests that should individuals attempting change of this sort in their lives not succeed, quite possibly because of family setbacks rather than for academic reasons, they increasingly view it as 'personal failure' (p 136), and Dhillon (2004) cites fear of failure as a major barrier for the adult learner. It becomes particularly important, then, to enhance the chances of success by preparing for the transition to academic life. Extra experience could be gained and existing qualifications upgraded. Many got what work experience they could as Care Workers or Healthcare Assistants, and nearly half of them took an Access Course.

Career Expectations

The second sub-question to address was 'What are mature students' expectations of their future career in physiotherapy?' For two participants this was dependent on their perceptions of their first career. Both Gwen, when thinking of her life in the theatre, and Kenneth, describing his life in the armed forces, talked of living in a 'bubble', protected from the real world (see Chapter 6, page 159). As has already

been pointed out, Lave & Wenger's (1991) concept of the close-knit community of practice can appear more like the 'bubble' situations, almost too stable and cohesive (Fuller et al. 2005), possibly even a little out of touch with the frenetic and fragmented reality of today's everyday working life (Bauman 2000). The graduate respondents in this study were in something of a similar 'bubble' as they practised on placement during their training. They were not yet committed to the profession and so had fewer responsibilities. There was no rivalry for posts, so fewer external pressures. They were, however, integrating with a greater diversity of people than before, who had varied experience and might view goals in different ways. They were hopefully gaining a useful impression of the 'real life' culture of the community which they might aim to imitate and inhabit in their future career.

There were those among my respondents, however, who felt they had been more in contact with 'real life' in their previous occupations. Tim, for example, felt he had faced far more sensitive and complex social situations in his job as a police officer. Jean could have shared this feeling, having experienced a couple of robberies when she worked as a cashier in a Bookmaker's, but her main attitude to her previous occupation was that it was a job, not a career. This was a common theme in my respondents' comments. Both graduate and established practitioner respondents talked of the physiotherapy profession as "more than just a job" (Expert A: 24). All seem to be differentiating between the 'job' as a means of earning money, perhaps not demanding full commitment, and their present career which appeared to incorporate something more, the values and attitudes that give form to the nature of a profession (Lawrence, 1992).

There is a change in value position here, as they make their transition. The idea of 'practice' is being extended to include estimates of worth and value. In this we see an extension of the idea of a community of practice to become a community of thought and values. 'Practice' now implies a body of activities which have antecedents and purpose, and in which novices can see a role for themselves in the future, as well as in the immediate practical present. This is akin to "the historical production, transformation, and change of persons" that Lave and Wenger (1991, p 51) suggest is linked to learning. There is a noticeable evolution of the individual to conform to the culture of the work environment (Lave 1996), one part of the two-way change Lave

(1996) suggests occurs in the newcomer, the second half being passive adjustment of the individual so that their persona fits into the workplace. She would view the entire process as the transformation into a member of a community of practice, with a newly shaped identity and a perception of belonging to a distinct culture, with all the values and loyalties that entails.

But the findings of this study suggest that being a member of a profession yields something beyond Lave's (1996) ideas of identity evolution. There is a perception among my respondents, moving from one occupation to another, that they are now attaining their natural vocation; they feel more at home in their new career and see becoming a physiotherapist as a fulfilment of their rightful destiny. The strongest affirmation of this was voiced in the pilot interview that I had with my career-changing friend (see page 115): "Being a physiotherapist was who I am" (Pilot: 15). This is a rather different engagement with a community of practice than the more physically embodied training model, though incorporating identity change, described by Lave and Wenger (1991). There is less sense of a necessity to conform and adapt to the workplace, and a certain confidence in these mature respondents that they can effect change in their new environment. The majority of them already have the perception that they belong as they make their transition.

Literature mainly considers the school leaver's transition from education into the workplace, discussing 'planners' and 'avoiders' of settling into work (Ball et al.2000, p 18) in a different way to what happens in the case of the career-changer. Despite feeling more at home in the workplace, the mature newcomer moves from their previous work culture into a community of learning in their teaching group, where it is the school-leaver who might be expected to feel more at ease, being an extension of their academic education. Yet the older individual can sometimes find themselves allotted an advanced place as mature students in the hierarchy here. They have already worked and are seen as people of experience. They may have expectations of this in the workplace, but in the Academy it seems mistaken, for many of them have more difficulty accustoming themselves to university than to the workplace. One has only to think of those whose computer skills were almost non-existent and who saw themselves as active learners rather than essay writers. Yet Mike, as one of these, achieved a higher status in the profession than any of the others within two years of

graduation. Difficulty acculturating to the academic system need not preclude professional success.

The Difficulties of Pyramid Building

(Research Question 2)

The second research question to answer is *'What is the nature of these graduates' movement from legitimate peripheral participation onwards?'* As noted in Chapters 5 and 8 (pages 131 and 227 respectively), one of the respondents talked about building a career in terms of erecting a pyramid, starting from a solid knowledge base. Rotational posts gave a variety of learning experiences, the building blocks from which the 'pyramid' of a professional career could gradually be raised. One drew on previous experience and honed specific skills, narrowing the focus of practice towards the 'pinnacle' (Expert C: 19) of consultant status.

In this respect mature graduates might be thought of as being advantaged compared to other newly-qualified staff. The graduate respondents in this study, moving from one workplace to another, possessed previously developed skills that could be utilised in the new situation. It might well be supposed that those trained in sport to a high level, for example, would expect to make use of coaching and other exercise skills, once they were legitimate participants in physiotherapy. This is Greeno's (1997) contention, that individuals, aware of these advantages, will do their best to see they are used. It appears that there is a repeated, interactive process occurring here. It is evident in Mike's narrative that his extra knowledge of wheelchair seating gave him more opportunity for negotiation, when funding was scarce to send staff on a useful course (see Chapter 7, page 204). That a newcomer can negotiate such affordances to some extent counters Rainbird et al.'s (2004b) and Billett's (2001a) claims that those more advanced in the hierarchy of the workplace are usually given more opportunities to progress than the newcomer.

There are several points to note here however. Firstly, this kind of negotiating interaction could cause tensions by bringing some participants into rivalry with others (Billett 2001a), though one could argue that the paucity of permanent posts at present has created a more competitive environment anyway and that such contention

would only be an extension of this. Secondly, career changers are not always aware of the skills they have that might fit the new situation, whereupon they would be reliant on the encouragement of the perceptive 'old-timer', senior staff that can bring it to their attention. Then, it is possible too that they are aware of a capability developed previously but need guidance to allow it to be modified to suit the new position (see Chapter 6, page 166). Such proficiencies and skills are not carried around as the property of an individual in this way, to be mechanistically called upon in a methodical and rational way. They become evident to the onlooker (a supervisor perhaps) and are used best when the situation allows. If the ex-sportsperson is known to have coaching skills, supporting senior staff may open up appropriate opportunities, as Billett (2001b) suggests, where they may be used to an extent, but it will not be in the same way that the ex-sportsperson experienced using them in the world of sport. The nature of their skill usage will necessarily alter to conform to the exigencies of the moment. Thus some of the skills' use may be allowed while other aspects are restricted.

Hodkinson's (2008) comment that movement into a new career is not necessarily smoothly onward is confirmed by the findings of this study, transition being shown to be strongly influenced by situation and circumstances. Thus the linear trajectory from novice to full participant suggested by Lave and Wenger (1991) is not supported. The mature graduates' very change of professional direction militates against it. For one reason or another, they are people whose occupational experience to date has not been that of building the 'pyramid' (page 131), but rather one of coping with and then dismantling it.

Some had thought these issues were behind them when they started afresh, only to be confronted with difficulties finding employment. Relationships between the individual's emotional subjectivities and their learning can be neglected by Lave and Wenger (1991). Owen-Pugh (2007), investigating the use of community of practice theory in elite sport, questions the idea that there is always co-engagement in gradually supporting newcomers' learning towards full participation. She notes that in competitive sport, attainment of mastery results in the failure of others. So it can feel in the situation of a fragile job market. Newcomers become rivals for the next full-time post. Some had made considerable efforts to gain extra skills on graduation,

only to find it made little difference in the acquisition of a permanent post. Failing in this respect was ‘disheartening’ and ‘frustrating’ (L2: 3), probably contributing, in Lionel’s case, to his later problem of ‘burnout’ (see Appendix XIII). This is not the smooth entry to the community that Lave and Wenger (1991) imply, but rather the prolongation of a troubled process.

Boundary Difficulties

Although acknowledging the possibility of conflict in communities of practice, Lave and Wenger (1991) avoid consideration of boundary disputes in any depth (Owen-Pugh 2007). Marginalisation and exclusion were evidenced by a minority of established physiotherapists and graduate respondents alike in this study. Examples are Cathy, who experienced exclusion from the hospital where she did ‘Bank’ work (temporary locum-style work: see Chapter 8, page 224), and David, who voiced his frustration at his marginalisation on returning to try and find work in his home area (Chapter 6, page 153). Up against local graduates half his age, he felt more peripheral than he had done as a student. Then he had been supported and encouraged in his participation. Now he felt himself becoming deskilled and demotivated, legitimised by graduation yet unable to find work. David has been awarded membership of the CSP and has crossed the boundary meant to prevent outsiders from encroaching any further into the profession, but he has found a further barrier for the insider beyond it, that of finding a position in which to practice.

Such an instance makes a case for arguing that the professional body awarding MCSP registration cannot count as a community of practice if crossing its boundary affords *less* legitimate peripheral participation than before. Wenger (1998) saw peripherality in a community of practice, the situation in this study of the student on practice placement, as an uncomfortable position, allowing access in a limited fashion. David’s position as a legitimised member attempting to gain employment is even more uncomfortable. This is less than peripherality, amounting to exclusion if he is unsuccessful, access to the expected support of the professional ‘community’ now anything but certain. If the CSP fails in this respect it cannot amount to a community of practice in Lave and Wenger’s (1991) terms at all.

Two points arise from this. The first concerns those professionals providing formal training in the university, termed ‘brokers’ between communities by Wenger (1998). He notes that they can become isolated from the workplace practices with which they are supposed to be connecting, becoming totally immersed in education. Now they may need to become more active in helping prevent the deskilling of graduates like David. This indeed has been happening, universities providing practice revision sessions when possible, but this too can be threatened by financial constraints.

The second point concerns the role of the CSP and the importance it holds for members. Wenger (1998) suggests that those more experienced in a community, and this certainly holds for the professional body, “represent the history of the practice as a way of life” (p 156). Each generation of newcomers enters the profession with a new historical perspective. When they first arrive, Wenger (1998) suggests, they take an interest in the history of their profession. “Newcomers .. have an investment in continuity because it connects them to a history of which they are not a part” (p 157). Later, as established practitioners “.. with less future, there is less urgency to reconsider history ..” (p 157). If this implies an interest not only in the culture and history of the professional body but in participating in its activities, this study suggests the reverse is now true. Newcomers can be less interested in what the CSP stands for or has to offer them, quite possibly because there is more than the initial graduation barrier to negotiate before progress can be made. Once established and on a permanent contract, the perception that one has crossed the boundary may result in more interest and involvement in the professional body’s activities (see page 246).

Ways to Progress

The experiences, expectations and assumptions of many established members of the profession as to the best path onward post-graduation are not necessarily those of the newly-qualified. The expectation that newcomers should follow the ‘traditional’ rotational route into the career, as ‘old timers’ once did themselves, still lingers, maintained over time despite the fractured and variable routes that actually take place in practice. The ideological idea of this route is reproduced over and above the empirical experience of actual managers and graduates. The imaginary diverges from the real in this.

The ideal of gaining broad experience at first, of experiencing a variety of professional specialities at first hand before settling down in a more senior post, seeing what is good local practice and what is not so good, is a common goal for newcomers in many occupations (Campion et al., 1994). There is a general expectation that this is how one progresses in a career, be it medicine, teaching, the police, or a large business. Perforce this means a slowing of progress towards promotion, which can be seen as undesirable by those, like Eric, who know where they want to go and are keen to arrive there soon. The move from horizontal to vertical learning occurs over time, and it is time several graduate respondents were unwilling to spend gaining a variety of experience rather than concentrating on the learning they considered pertinent to their intended career pathway. Eric was doing his best to customise his own career trajectory, just as some students made sure they got a First on graduation, or as Susan was willing to arrange her own rotations from short-term posts (Chapter 5, page 134).

It is interesting to compare Susan with Eric in this respect, for both see the necessity of doing rotations, the argument being that senior staff are looking for this all-round flexibility in juniors they employ. However, while Susan feels she can profit from extending her experience, Eric wants to do nothing superfluous. He is becoming frustrated in his efforts because no-one seems willing or able to tell him the best way to accomplish this. It appears that he believes there to be tacit rules on this, that some additional experiences he might aim for are less acceptable than others. This idea is similar to the process of sponsored social mobility described by Turner (1960), where promotion is based on the possession of attributes considered necessary by superiors. Not every opportunity gained works to the individual's advantage: some may be superfluous. For example, Cathy's Masters degree (Chapter 7, page 186) brought no additional capital and could actually count against her progression. It is a feature of these mature graduates' progress into the profession that they are driven to gain extra leverage towards their promotion, which has become a much more competitive affair in the NHS over the last few years. It has also become important to further one's career in an appropriate way. As the 'traditional' rotational route breaks down, new ones are being invented, but some seem more effective than others.

Current economic circumstances in Britain have caused difficulties in the job market generally, not only in the NHS. With fewer jobs available, applicants need to evidence their specific adaptability and resourcefulness compared to others. Employers stress this in graduate publications.

Now, more than ever, we need to ensure that we are recruiting and developing graduates with the appropriate skills of flexibility, resilience and proactiveness to maximise their impact on the organisation's achievements (Village 2010, p 19)

This could bode ill for the vocational graduate, looking at one career only, and there are suggestions that with fewer prospects of enhanced job opportunities post-university, people like my mature research respondents will be wary of the self-investment of training for a new career in the future (Boden & Nedeva 2010). Those graduating already tend to be particularly anxious about gaining employment, and this is heightened among those with the added responsibilities of a mortgage to pay and dependents to support. It is understandable that they feel driven to gain promotion as quickly as possible to a status that might be viewed as more secure.

In the light of this, Mike's choice of an alternative career path appears a risky venture, for he is designing a career to suit his own personal objectives, not those of his superiors, and he is willing to negotiate resolutely to maintain it as a viable option. While newly-qualified staff complain at being obliged to accept static posts too early in their careers (Trueland 2009), Mike searches for innovation, a pathway to suit his particular experience and skills. Bourdieu (1986, p 142) suggests that a knowledge of how to invest in oneself, and of when to pull out of devalued work and move to what is more appropriate, is very valuable cultural capital. But the 'rules of the game' (Bourdieu & Wacquant, 1992) are changing and the possession of such cultural capital is not an unchanging and static attribute. It seems evident that Mike and indeed a number of the graduate respondents in this study are succeeding in learning the new rules, while someone like David is not. Once more the balance of risk, which Reay (2002) says accompanies return to study of the older student, is evident.

Faced with the uncertainties and contradictions of modern society, and the "socially produced existential insecurity" (Beck & Beck-Gernsheim 2002, p 48) induced, it

can be difficult for the individual to make rational decisions and be sure of the outcome. Individual perception of the situation is important here. When seeking employment, those like Mike or Eric, with what Beck and Beck-Gernsheim (2002, p 48) term a 'risk biography', think they still have some degree of control or at least can calculate for the best, but to David the situation appears to be one where he does not have control, the so-called 'danger biography' (Beck & Beck-Gernsheim 2002, p 48). The boundary between the risk and the danger biography is dependent not only on subjective opinion but also on hopes and expectations stemming from past experience, as well as on others' (family, friends and advisors) prophecy and warnings. Where failure used to be seen as a class experience, it is now viewed as the individual's own fault. Deranty (2008) writes of the many seeking individual salvation, while the few that fail to adapt "will have to be sacrificed .. for the economic order to maintain itself" (p 461). The neoliberal 'utopian vision' of the fully autonomous practitioner, Deranty (2008) suggests, now goes hand in hand with the fear of failure if one is not able to adapt sufficiently. In forging ahead on his specifically individual path, Mike's is seen as a success story, while David's failure to gain physiotherapy employment is likely to be viewed as his own personal fault.

Change in Practice?

My sub-question relating to the second research question on entry into the profession was 'What happens when people move into communities of practice where their characteristics are considered atypical?' Mature, and therefore atypical, newcomers have been in previous workplaces and can be quick to accustom themselves to new situations. The majority of my respondents moved forward with some confidence, prepared to face change. Indeed some graduates expect and look for it, perhaps because of their previous career experiences.

It has been noted that people who cope well with change tend to possess a positive self-concept, "an internal locus of control [and] high self-esteem .." (Cunningham 2006, p 42), and there were instances in this study, notably when Eric confidently offered to help his seniors with their reflective writing, thus reversing learning roles. It could be that clinicians, though they know themselves to be more up-to-date clinically than those fresh from university, see students and newly-qualified staff as assets in that they bring fresh ideas with them from the academy. Their questioning

of existing norms may promote learning in the supervising staff (Fuller et al. 2005). Though Lave and Wenger (1991) acknowledged that established practitioners might review and refresh their practice in such circumstances, they seemed to see the community of practice as an unchanging entity, yielding the same learning through practice from ‘old-timer’ to ‘novice’ through the generations. It appears in this study to be far more dynamic a concept, and the learning two-way.

One might speculate that some clinicians could become defensive if newcomers tried to persuade them to update and change the way they performed. It is perhaps to their advantage that some of the research respondents looked more mature, for it could be seen as easier to learn from someone older. None of the mature career-changers found the relationship with their, often younger, supervisors particularly difficult, though a few noted that clinical educators often commented on their welcome acceptance of feedback, which could suggest that the educators were a little nervous when correcting them, perhaps expecting to be challenged more. A degree of tension made some respondents aware that they must not overuse their age to their advantage (see Barbara’s comment, page 166). Given a less tactful newcomer this might have influenced their acculturation negatively.

Such adjustment to the sensitivities of others is essential in the workplace. As commented upon in Chapter 6 (pages 174/5), it is not simply physical practice that is learnt but a more ephemeral professional commitment and socialisation. Values, amongst others integrity and loyalty, are inculcated. In other words there is “the creation of a professional habitus” (Beck & Young, 2005, p 188). This is the sense of identity that Lave and Wenger (1991) suggest is inseparable from situated learning. In the case of these mature graduates, however, this can amount to reconstruction of identity. Some have reassessed their values since they changed career and adapted willingly to such change, but there is evidence that others have had to reconfigure some of their traits, or give the impression that they have done so, in order to ‘belong’ to the workplace culture. Their knowledge of social interaction from past experience and the fact that this is not the first time they have undergone this process can lead to what Eraut (2008) terms ‘deceptive discourse’. Colleagues are kept happy and the individual feels they have control over the situation, but integration has not wholly occurred. People are restricted in what they feel they can choose to say and it

“prevents any discourse that might trigger reflection or enable a productive discussion that leads to a deeper conceptualisation of practice” (Eraut 2008, p 5).

Because they have not referred to the possibility of older people as newcomers to the community of practice, Lave and Wenger (1991) do not discuss the difficulties someone might undergo in forging a new identity, nor how this might impact longer term on practice. They tend to assume that incomers will fit in with the demands of the community, “internalize the values and beliefs .. of that profession” (Clouder 2003, p 220) and have their identities moulded to the system of relations in which they find themselves. Clouder (2003) questions if this process means newcomers gradually “become subject to social control at a largely unconscious level” (p 220), for her study, as well as this one, showed instances where practitioners had reservations about the system they were in. Mature newcomers can make a show of conformity while still seeking change.

Advanced Tactics

Some of the mature graduates had learnt survival strategies in their previous careers. They could organise their lives, prioritising what was most important to them, or at least attempting to. The ‘nomads’ amongst them, Eric and Cliff, moving from job to job had experienced the impossibility of doing everything they wanted all of the time, but they had learnt Eraut’s (2008, p 5) “deceptive discourse”. They knew how to maintain good relations with those around them, while keeping free to carry out their work in their own way. They realised that it was important to “tell managers what they want to hear while keeping them off your back” (Eraut 2008, p 5). It seemed to be the fact that he did not know for sure what they most wanted to hear that frustrated Eric as he aimed for promotion. Eraut (2008) thinks it an advantage of deceptive discourse that one preserves one’s “personal autonomy of action” (p 5) and this is indeed important to Eric, as it is to many of my graduate respondents. They gained confidence from feeling in control of their future and were unsettled when they were not, as when piecing a career together from short-term contracts.

Perceptions of Full Participation

(Research Question 3)

'How do respondents conceive of full participation and what factors enable or constrain their movement towards this?' was the third research question to discuss. Throughout this study an attempt has been made to reach some acceptable definition of what Lave and Wenger (1991) might have meant by 'full participation', for they purposely left the term vague. That it is "what partial participation is not" (p 37) is perhaps their firmest approximation, and in some ways this is very reasonable, for it seems from this study that full participation can mean different things to different people.

Of my respondents, the ones that can be assumed to have experienced full participation are the established physiotherapists, so how did they know if they had reached this stage? The response was often very simple. There was a realisation at some point, often several years post-graduation, that they had confidence to carry out most of the work well. They tell of noting others' work, reflecting on why what they did made a difference and then honing their skills to try and do the same, very much the image of learning conjured up by Lave and Wenger (1991). Handling skills in particular made a difference. This was reinforced by several of the graduate respondents. A few commented that, although interested in professional matters, they would only take part in Chartered Society of Physiotherapy activities once they were confident in their basic, and particularly handling, skills. As noted on page 240, it is as though becoming a local CSP representative or 'steward' (see Chapters 2, page 23 and 8, pages 216/7) or attending CSP network meetings, might be a sign for these people that full participation had been reached.

Similarly reaching a more isolated role, where there is less immediate support from those more experienced, can suggest full professional integration. As noted on pages 141-143, community physiotherapists, working with patients at home, have generally been regarded as more advanced practitioners, and the same applies to those in the private sector, where insurance depends on years of full-time experience. Until recently being accepted into these roles could be said to act as a signifier that full participation has been reached. Now however the field is gradually opening up to

more newly-qualified staff, as one of my graduate respondents confirmed, though he was not at ease in the role (see pages 141/2).

Recognising Full Participation

Full participation was defined by established practitioners as the state of being confident of the basic skills, so that the knowledge of what is being done can be passed on, not only to patients but, to other members of staff, both professional colleagues and those in allied occupations. The graduate respondents, a year into their professional career, agreed. They felt that being able to communicate knowledge was of prime importance, that a good practitioner should be able to explain what they did to anyone. Wenger (1998) notes that “.. it is more important to know how to give and receive help than to try to know everything yourself” (p 76), and perhaps it should be seen as the ultimate quality of the full participant that they can pass skills on to the newcomer effectively. Lave and Wenger’s (1991) example of what happened when these affordances for learning were withdrawn was the case of the supermarket butcher apprentices. They were given no chance to watch and question certain aspects of their job and lost their peripheral rights to learning, thereby finding their progress impeded. ‘Old-timers’ have the dual responsibility of providing the learner with an exemplar of good practice as they work alongside them, and of answering their questions satisfactorily. Thus will high standards of practice be perpetuated.

Another constant theme regarding full participation to come from this study is the perception of research respondents that one was needed and was making a difference to patients. This varied in magnitude from feeling trusted and respected by patients, as Eric noted when he knew he appeared older, and so more experienced, than his fellow junior staff; and the perception Diana had that, even if not making a physical difference to people, she was having a psychological effect for the better. It is clear that in both cases this had an equally positive psychological effect on the practitioner, helping Eric to gain confidence and assuring Diana that she was being effective. These perceptions of being useful need to be accompanied by a confidence that the patients’ trust is not misplaced, however. Eric knew that the patients were wrong to think him so experienced. He was willing to use the misconception to his

advantage, but was well aware that he had more to learn before becoming a proficient practitioner.

For of Benner's (1984) five-stage model (see page 79) it is the stage of proficiency that seems to equate most closely to full participation. No longer having to follow guidelines of practice, the proficient professional is one who is functioning fully in the clinical field, can take a holistic view of the task in hand and can be relied upon as a member of the team. Within this last element they can also 'negotiate the political' (Boud & Middleton 2003, p 198), getting on with everyone in the workplace and ensuring the possibility of career progression. Interviewed three years post-graduation, the graduate sample in this study appeared to have reached a competent standard as they described it, but still referred to more experienced colleagues when faced with the occasional difficult case. I would argue that the latter, proficient 'old-timers' are the full participants, or even perhaps a stage beyond that. Lave and Wenger (1991) refer to "the centripetal development of full participants" (p 57), implying both a continual gradual replacement of 'old-timers' with new practitioners and a movement beyond full participation, equating to Benner's (1984) final stage of expertise.

The sub-question I had added under this section was 'If full participation is recognisable, will it be recognised by the participant, or by others?' It appears that it must be recognised by the participant and by their colleagues. Patients may believe in an individual's proficiency, but, as in Eric's case, the practitioner may know better. Experienced colleagues working alongside the newcomer are likely to be better judges than the patients as to their level of competence.

Tensions in the Workplace

There are instances when patients' recognition of quality treatment can seem to matter more than colleagues' however. As a Senior I physiotherapist leading a team of disinterested staff, Diana had felt 'disassociated' from her profession, but not from her patients (Chapter 8, page 223). Her feeling was that staff problems could be endured if patients felt her work to be of a high standard, but the fact remains that the cultures of the organisational and occupational communities can eventually impact on the individual's professional work with patients. Such complexities suggest that

Lave and Wenger's (1991) theorising is over-simplistic and support Hodgkinson et al. (2008) in maintaining that if the learning culture is unsupportive and tensions exist in the working environment, it is likely that learning will be less effective. One suspects that it is a reason why some professionals, like Diana, move to more solitary practice.

This is reminiscent of the situation reported by Colley et al. (2007) of the teacher, Ruth, whose sense of responsibility for her learners distanced her from the difficult micro-politics of the FE campus where she taught. For Ruth the questionable notion of the 'community of practice' is "more dynamic and variable" (Colley et al., 2007, p184) than just being a member of a particular FE staff section. Her 'clients', the students, were equally important. So it is for Diana: her patients form part of her community as much, if not more so, than her fellow physiotherapists. With the exception of the Mayan midwives, the groups in Lave and Wenger's (1991) exemplar case studies dealt with inert material, the tailors' cloth and the butchers' meat. People, as students or patients, add another dynamic to the 'community' situation. If full participation means belonging to a coherent community of practice, and that community is conceived to involve both physiotherapists and their patients, it seems strange to think of being a full participant as far as the patients are concerned but marginalised as regards one's colleagues. Diana's perceptions suggest further research could be undertaken to investigate the extent to which professionals regard their clients as part of their 'community of practice', and with what consequences for the development of practice.

Two years post-graduation, Mike also showed real unhappiness with his fellow physiotherapists' standard of work in continuing his patients' care. A sense of loyalty generally builds between newcomers and established professional members, "a pattern of appropriate conduct, coherent, embellished, and well articulated" (Goffman 1971, p 75). Beagan (2001) notes how mature medical students worried when they saw things done which they would not do themselves as doctors, but that they kept quiet as long as the patient was coming to no direct harm. This "sense of alliance" with members of the profession rather than with lay people is "a key to professional socialization" (Beagan 2001, p 281), part of belonging to a united community. In the light of this, the complaints of individual practitioners like Diana and Mike become all the more noteworthy. The concept of full participation in these

circumstances is more complicated than Lave and Wenger (1991) allow, if in fact it can be said to exist here in the form they imagined at all.

Diana and Mike's loyalty to patients, rather than to both patients *and* colleagues, in the community suggests higher level connections are being invoked than simply those of the occupational micro-level community. It is at professional macro-level that one must negotiate if relations among staff at micro- or meso-level break down. Similarly the professional level community must become more involved if the individual member finds themselves being sued by a patient. Professional breakdown of relations in either direction, with colleagues or patients, tends to sharpen focus on the overarching macro-level professional community. My participants had no issues with their patients, but community membership relations failed them more than once.

Factors Influencing the Route to Full Participation

The third sub-question under the research question on full participation is 'what sources of influence impact on the path towards 'full participation'?' A key factor to consider here is that of unstable employment. Lave and Wenger (1991) stress the importance of learning in the workplace, and undergraduates practice their new skills on specially organised placements. But continuing the process post-graduation has been shown to be much more of a problem.

Improving job prospects by gaining academic knowledge in university has been presented as a means of self-empowerment, a way in which the individual can control their destiny (Levitas 1998) by being able to gain the best jobs. Physiotherapists, as members of one of those professions that made the transition from diploma to degree qualification in recent years, were assured that raising the profile of a profession led to no deterioration in job prospects (Purcell and Elias 2004). Graduates might now agree more with Brown and Hesketh (2004) that, "A university degree is not enough to make one employable as credentials do no more than permit entry into the competition for tough-entry jobs rather than entry into the winner's enclosure" (p 2).

Nor are people taking a vocational degree usually aiming for better paid jobs, or indeed expecting to access any occupation save the healthcare profession for which

they are training. A few of my participants have indeed taken a *cut* in salary in changing career. So this is a different category of HE programme from the purely academic one, what Purcell and Elias (2004) term a 'new graduate occupation' (p 7), and although one of those of my participants who failed to find physiotherapy work has been able to successfully move into an associated career as an OT Assistant, the others have returned to their previous work. The conclusion to be drawn is that the current employment situation in the vocation is extremely important to these people, for despite their success in crossing the initial barrier of graduation and membership of the professional body they may be denied the opportunity of aspiring to the full participation that was their goal.

Necessity gives rise to innovation, and with increased competition for any available posts people have begun to think laterally in an effort to make themselves more employable. In Chapter 7 some of the unusual ideas the graduate research participants had thought of were discussed, Lionel carrying a folding plinth around on his bicycle, Eric attempting a PGCE, and Mike entering the niche speciality of wheelchair postural management. The last of these is the only one to be fully tested and has proved very successful, but all three ideas move away from the concept of supported development from legitimate peripheral participation to full participation in a micro-level community of practice (Lave & Wenger 1991). Lionel was contemplating solo work very early in his career, and Eric and Mike's notions depend on holding a position on the edge of or between occupational communities. All three have membership of the macro-level professional body, but this is no guarantee that full participation, such as has been discussed above, can be attained, owing to the existence of fragile employment. The highly specialised full participation Mike is aiming for so early in his career seems outside the realm of Lave and Wenger's (1991) ideas of integration into a community of practice.

Nor do these examples of innovative career path planning support the reasoning Thomas (2001) suggests some widening participation policy makers had, if they imagined that educating social groups that did not traditionally participate in HE might 'normalise' and control their integration into the dominant culture (see page 30). As atypical entrants to physiotherapy it is perhaps unsurprising that Lionel, Eric and Mike have considered or chosen to explore non-traditional routes towards

attaining their goals. In a time of fragile employment, widening participation policies have tended to introduce change and innovation rather than ‘normality’ and controlled progress.

Full Participation and Expertise

So far, the terms that have seemed to equate with full participation are proficiency in a team or community of practice, including good communication skills; a perception of belonging and of being of use (to clients if not to colleagues); seeing what one does as amounting to a vocation rather than a job; and having security of tenure (as voiced by Cliff and Pat, pages 148/9). Benner’s (1984) suggestion that a proficient nurse moving to a new area reverts to being a novice for a while has also been noted (see page 79), so it may be that full participation can be lost temporarily in some circumstances. It seems more likely that this would be the case with expertise, which, a stage ahead of proficiency in Benner’s (1984) model, is almost by definition concentrated on a narrow field of work.

Despite an initial inclination to do so, I have not equated full participation with expertise. There is a troubling tendency to describe expertise as almost impossible to articulate. Benner’s (1984) unfailingly right expert “[does not] always know how to legitimize” her statements of clinical knowledge (p 32); Dreyfus and Dreyfus (1986) write of experts acting “in a manner that defies explanation” (p 36), and that they know how and when to deviate from the rules (see Chapter 5, page 140); Schön (1987) describes expertise as artistry, “of problem framing, .. implementation, and .. improvisation” (p 13); and my research respondents often referred to experts’ intuitive powers. These seem descriptive of the unusual clinician who shows themselves to be more talented than the norm, an outstanding professional and excellent communicator, often an inspiration to others, but not necessarily one with greater knowledge (Schön 1987). A full participant in the workplace need not be at this level to function well and most never attain it.

Key Elements of a Successful Transition

Considering the answers to my first three research questions, I have found that my graduate respondents’ pathway towards full participation comprises two overlapping

sections. First there is the transition from one career to another, including deculturation from the previous career and acculturation to the new profession. Following this there is the transition from peripheral participation to full participation in the new career. I shall begin by summarising what is entailed in the first of these if the individual is to progress satisfactorily.

The journey commences with an increased awareness of the potential new profession. In the case of physiotherapy, individuals are attracted to its ethos of care and commitment. They like the idea of working with people in a practical hands-on way, and are often attracted to the career's connections with the physical, how the body works, sometimes linking this to their own aptitude for sport. A degree of serendipity is often involved at this initial stage, and the individual needs to be prepared to gain from this. The influence of position and field is crucial, for life outside work has to be attuned to the move from one career to another. Atypical newcomers such as my respondents can be burdened with familial and financial responsibilities which can restrict progress. People's own agency is now a key element. They have thought about possible change; now action is needed.

For all my respondents there was an evaluation of their life at this point. Transition meant moving away from, or onward from, values held in the previous career. It could be a small and fairly obvious transition for some, but for the majority it meant at the very least a change in attitudes and values. It was positively life-changing for several. It is not an overstatement to speak of a transformation of personality during acculturation. The successful transition usually incorporates preparation in the form of a part-time healthcare assistant role of some kind, a check of true aptitude and liking for the work involved. Newcomers are changing to embody a different set of values, or at least an additional set of values compared to those they had before, when they move to work in healthcare. The desire to 'belong' encourages identity change in order to fit in with the new work culture.

The following stage, the move from legitimate peripheral participation to full participation, commences with successful acceptance onto a training programme. The initial placements then experienced, as well as the preparation work before beginning the training programme and any appropriate skills and knowledge carried

across from previous careers, act as the foundation for professional practice leading to full participation. The competition to get employment is aided not so much by novel extra experience as by more mundane work to strengthen existing advantage. Examples are working as an assistant at weekends during training, in the Trust preferred for future employment if possible, and continuing work there during the elective placement. Getting a reputation as a reliable member of the team is positively advantageous. This, and any knowledge gained of requirements for promotion in the field, 'the rules of the game' (Bourdieu and Wacquant 1992), are key elements that will aid social mobility towards full participation.

The time for innovation comes when this pathway fails to bring employment, but tenacity and demonstrating adaptability and resourcefulness compared to others can result in a greater degree of personal autonomy in the end. Strengthening self-confidence through accepting and overcoming challenge, and nurturing a feeling of 'belonging' in the profession by so doing, are important because of their motivational value. Possessing a positive outlook and an internal locus of control can make a real difference to progress. Career-changers have useful previous experience of the workplace, and may be able to negotiate extra affordances which help them move further along the route to full participation. This particularly happens if the extra knowledge and skills fit a particular area of work. Once more serendipity can intervene, and not everyone is aware of these opportunities or has the imagination and confidence to negotiate appropriately. Again personal situation and the overarching social and political fields need to allow such action.

Progression in the career seems best achieved in one of two ways, depending largely on personal requirements. Either the individual can aim for speedy promotion to gain a secure position in a preferred speciality, or a steady, slower progression can be followed by means of any rotations that are available. The latter situation, if a permanent posting, has the advantage for mature female graduates of allowing maternity leave without losing position, and of ensuring greater range and adaptability of practice, which will be helpful, not only in guaranteeing continuity of employment, but also in supporting future newcomers, an important element in the sustaining of good professional practice.

There is a noticeable discrepancy in thinking between how relatively new entrants and long-established practitioners view the transition from peripheral to full participation. The new entrants see their experience with patients as leading to growing knowledge and confidence, and expertise in skills, with quicker and easier recognition of patterns of symptoms. Strategies are sought to cope with more unusual situations. A few years after graduation newcomers have developed the feeling that they belong in their new workplace, or do once they gain a permanent post, and are mostly confident enough to argue for change when they feel things might be bettered in their workplace.

While established practitioners agree that confidence with basic skills is fundamental to progress and that the individual must be able to communicate these to others well, they also thought in terms of organisation, how people worked together, what rules governed practice and what norms must be upheld. They had a set of values and commitments that they were now comfortable with and generally adhered to, in the face of institutional friction in two cases. A learning culture that supported these norms and a lack of tension in the working environment provided the best background for progression to full participation. Failing this situation, moving away to work alone, where one could hold to the values one wished to adhere to, seemed the answer.

It was noteworthy that established practitioners showed a developed sense of vocation, a feeling that they were meant to do this work, that it suited their habitus and was where they had to be. Being effectively useful to their patients was of first importance. Full participation for them referred to their work with patients, while maintaining adequate contact with colleagues to smooth patient management. These issues were expressed less by the newcomers and may be characteristic of true full participation.

A Largely Redundant Concept?

(Research Question 4)

'Is the concept of a 'community of practice' a useful way of making sense of transitions from one career to another?' was my final research question. Lave and

Wenger's (1991) theory can be viewed as both an empirical model of transition from novice to full participant, a theory of "the production and reproduction of social order" within a community of practice (Lave & Wenger 1991, p 47), and as a theoretical model of interactive social learning. In answering my first research questions I have explored the first of these and questioned Lave and Wenger's (1991) ideal concerning the following points. Firstly it was rare for my respondents to feel immersed in a community from their earliest days, as Lave and Wenger's (1991) case study apprentices had been. Next, as mature trainees, they came from different workplace cultures, were not novices regarding the world of work, nor even complete novices in some aspects of their new career, in one or two cases. They did not share a typical vocational identity, as Lave and Wenger (1991) suggest might be the case, previous experience having coloured their work expectations. They often saw their last working situation as 'just a job', while the new career was perceived as something more, a whole overlay of cultural values being added to practice. Then their transition into the community of practice was not a smooth path from legitimate peripheral participation to full participation (Lave & Wenger 1991), since many external influences impinged on the process. Nor was the forging of a new professional identity without difficulties, marginalisation and exclusion being distinct possibilities.

Similarly Lave and Wenger's (1991) theoretical model of situated learning cannot be accepted without question. Essentially a social model, the claim is that learning is constructed through interaction with others in the working environment rather than acquired solely by individual cognitive means. Lave and Wenger (1991) represent the transforming of the newcomer, or the process of 'becoming' (Colley et al. 2003a), as a relatively passive absorption and induction into the culture of the workplace, practice being refined and perfected by working alongside the 'old-timers'. It can appear a one-way process in theory, but, as has been seen from the experience of several of my respondents, it is in reality more of a two-way process of learning, particularly if the newcomers have specific skills from their previous work experience, or from up-to-date academic training, that can be of use to 'old-timers'. Thus, owing to their situation, working closely alongside each other, both the newcomers and more experienced practitioners will learn.

'Belonging' and the Short-term Contract

This supports Owen-Pugh's (2007) account of the more complex interactions between novice and old-timer, with their apparent contradictions. Allowed legitimate peripheral practice by those supervising them, student newcomers knew they were being offered essential affordances and that they could often negotiate useful learning on top of more everyday practice, but they also recognised that simultaneously the supervisor was watching and grading their progress and was empowered to fail aspects of their work if it did not reach the level expected. This continues into professional life, line managers and the HPC acting as gatekeepers when it comes to assessment for progression to the next level of salary on the AfC scale or the bi-annual professional audit (see page 27). For the majority of respondents at the start of their career paths, in short-term contractual work, both the extra opportunities for learning and these elements of reification can be missing (see page 149). That opportunities should be restricted is frustrating, but the controlling influence of the progression milestones is replaced by the necessity to impress superiors in order to gain a helpful reference for future employment. It is necessary to build up a good reputation locally (of particular importance in a relatively small profession) for those whose family and financial responsibilities preclude working at a distance. Until they were employed on a permanent contract, the respondents in this study found their progress towards full participation in the life of the workplace was slowed and they did not feel as though they truly belonged in the team of practitioners around them.

Lave and Wenger (1991) see belonging to a community of practice as the most significant feature of situated learning. There is a paradoxical relationship here that is well described by Colley et al. (2003b): "we cannot learn without belonging (to something) and we cannot belong without learning the practices, norms, values, identities and understandings of the community to which we belong" (p 14). This pertains for the macro-level, professional community: the mature graduates all learnt what was expected of CSP membership and felt they belonged in this respect, though it did not ensure legitimate, let alone full, participation, on graduation. It is true that my graduate respondents on short-term contracts were learning plenty about the culture of the workplace; they were involved in everyday practice and usually had

support and encouragement from the more experienced members of the community they were in. Yet they could be afforded fewer opportunities for learning and were unable to feel thoroughly integrated into the workforce. They sometimes felt there were unacceptable inequalities between themselves and their permanent colleagues. Once again this is reminiscent of the instance given by Lave and Wenger (1991) of failure of legitimate peripheral participation, the supermarket butchers, who were not given full access to available affordances and so failed to be peripheral members of the community, though their participation was legitimated (see Chapter 3, page 72).

There is also an element of misrecognition of position here. To have gained a temporary post in a fragile employment market is portrayed as an advantage, when actually these newcomers can find themselves in a less than adequate situation. Colley (2006) gives the example of nursery nurses being taught how grateful they should be to have gained this employment, especially as they were viewed as having failed at school. Part of the 'doxa' (Bourdieu 1986) is then that complaints should not be made about poor pay or working conditions. This has to be misrecognised, or at least accepted, as an advantageous position, when it is really a subordinate one. In this study mature respondents, again some of them with a background of having failed at school, feel coerced into being grateful for such jobs as they can get, despite finding they are not allowed all the affordances expected of legitimate peripheral participation.

Learning Despite the Odds

All my respondents noticed a difference when they gained security of tenure. They were likely to be given more challenging work, and more supervision sessions were built into their routine. Eraut et al. (2004) note how overcoming challenge can increase newcomers' confidence and this would indeed seem to be the case in this study. Several respondents recognised the way their eventual permanency, and the added responsibilities often entailed, motivated them. One or two noted that responsibility gave them some pride in their work. They were beginning to feel they belonged. Presumably Lave and Wenger (1991) would suggest that participatory learning might now take place properly. It remains curious then that a fair amount of learning has already occurred without that feeling of real belonging.

Despite the fact that they have not followed a seamless transition of the kind advocated by Lave and Wenger (1991), the majority of my respondents seem to have become perfectly adequate physiotherapists. Not only have they learnt to utilise their skills appropriately and to become habituated to the values and customs of their new workplaces, but they have become confident enough to consider practice in a variety of ways that may be at variance with the practice of the ‘old-timers’, those who never suffered the transience of a temporary contract. Examples include those who, within the first year of their practice, thought of linking physiotherapy with another career to the benefit of both; contemplated offering unusual clinic services and domiciliary physiotherapy; actually maintained a private practice while its owner was on holiday; and entered into a niche speciality as the first physiotherapist to be involved in the team. All this has happened in a time of rivalry for employment, and indeed there would appear to be instances where “personally meaningful learning can emerge from competitive relations” (Owen-Pugh 2007, p 83). Frustrating it most certainly sometimes is, but by negotiation, imagination, the seizing of every opportunity that seems feasible, and a continuation of habits born of necessity while in University, the mature respondents in this study have pieced together work, so that the majority have been enabled to progress in their career. People are certainly experiencing situated learning, but not always within a community of practice as Lave and Wenger (1991) suggest, nor entirely according to their theoretical model.

Sometimes it is almost as though the community of practice concept had become an imaginary trajectory into the profession in these times of fragmented employment. Not all people are working side by side with more experienced staff in a stable environment. Yet despite this there is still a definite idea of what it means to be a physiotherapist, inculcated during training and on practice placements, even if the path progresses no further. Just as Lave and Wenger (1991) write that the goal of full participation is a motivator to peripheral workers, so this mirage of the ideal professional community leads newcomers forward, and those who do achieve progression know whether or not they are being successful. The image they have sustains and motivates them, even when it does not exist in any describable sense.

Workplace Reconstruction

All this suggests that Lave and Wenger's (1991) concept gave too stable and dependable an image of workplace culture. The sociological construction of the workplace is in constant flux, extending or diminishing practice for the newcomer (Hodkinson et al. 2008), depending on the varied proficiencies of the established practitioners around, the different opportunities on offer, local needs and other external pressures influencing work levels. It must not be forgotten, however, that there is equally input from the newcomer and this study supports Billett et al. (2005) that alongside the reconstruction of the newcomer's identity and learning, the cultural practice of work will have subtly changed too.

In fact there are elements in the data from this study that suggest this could be more radical change if some of the dissatisfactions voiced were to result in action. Some of the graduate respondents would certainly argue in favour of innovation were it opportune; other respondents have been instrumental in activities productive of change, Mike, for example, having forged non-traditional contacts in his niche MDT setting which could modify patient management considerably. All this is set against the background of professional reconstruction that is continually on-going, both work that would normally be taking place and that involved in adjusting to the employment difficulties. Lave and Wenger's (1991) concept of the community of practice gives an impression of permanence and inflexibility that aligns poorly with these expectations of flux, reconstruction and innovation.

The Multidisciplinary Team as a Model of Situated Learning

Although he moved between part-time and short-term jobs, Mike seems, sooner than most, to have felt he belonged to the MDTs he worked with. In Chapter 3 (page 52) the professional body as an example of Knorr-Cetina's (1999) 'epistemic culture' was contrasted with the MDT, where members of different professional cultures worked towards a common goal from a variety of outlooks and via a variety of practices. Mike had hardly had the chance to develop a professional identity in practice other than that developed during student placements. Yet he quickly became integrated into the MDT, having learnt so much through initial legitimate peripheral participation that he was confident to act almost alone in the team only two years

post-graduation. His route into his new career confounds Lave and Wenger's (1991) model of transition into a community of practice, but his is an interesting example of their theoretical model of situated learning. Through his social interactions with the team, he has constructed not only the necessary skills but the negotiating ability and the self-confidence he needs to work even on his own in this milieu. He is working towards a very definite individual ideal. Admittedly much of this comes from his previous knowledge of disability, his drive to prevent surgery such as his brother had undergone (page 196), and the kind of teamwork he was used to in his previous career. As Wacquant (1989) puts it, "habitus contributes to constituting the field as a meaningful world .. in which it is worth investing one's practice" (p 44). It is still noteworthy that Mike is prepared so soon to take part in these teams that have opened up, have indeed in one case actually created space, to accept him.

Again Bourdieu's metaphor (Bourdieu & Wacquant, 1992), comparing the field of job opportunities to a game (see page 242 and Chapter 6, page 179) is apt. My respondents were all doing their best to find a job, but they are taking part in a game, and the game has rules which they do not set. In order to play the game at all they must abide by the rules, and these, in a period of change, appear to be constantly being modified. In these circumstances it becomes important to gain an advantage over the other players. To fit in well with the MDT Mike had to understand the values and working cultures of more than his own profession. Here was the advantage he needed to put him 'ahead of the game' (Bourdieu & Wacquant, 1992). He is married to an Occupational Therapist and had often discussed wheelchair postural management with her. He could therefore imagine how some of these other professions might position themselves and, in the case of the leading members, how they might argue to socially position and negotiate with others in the MDT.

In socio-cultural theory such as that of Lave and Wenger's (1991) community of practice, practice does not refer to what people do as individuals. People like Mike inevitably have to fit in with a whole set of practices, traditions and social relations that, at different periods, more or less shape what individual practice is. However, contrary to Lave and Wenger's (1991) theory, Mike is doing some of the shaping. While he is fitting in with the 'doxa' of the MDT (Bourdieu 1986) he is also introducing new ideas, and questioning how his fellow physiotherapists are

performing if they fail to fit in with MDT ideals. This could be seen as almost subversive behaviour as far as a community of practice is concerned, if such a concept can be employed in this situation.

The Impact of the Overarching Field of Power

At this point it is worth considering the overarching field of power (Bourdieu 1996) to see where the action is happening that affects a particular field at a lower level, like healthcare or education. An example from FE illustrates this. A number of FE tutors Colley et al. (2007) were working with had been quite subversive and had managed to retain a space within their institution as the recession hit. However, a repeated series of policy decisions and their implementation by the college, threatened by closure for financial reasons, meant that the skilfully subversive could not continue so. Their activities were restricted and their funding sometimes removed. A similar situation pertains in the NHS where funding has been cut. Policy makers agree to the continuation of public services, but with less money to run them, and with staff who are less qualified and therefore cheaper to employ (Technical Assistant Physiotherapists (TAPs) replacing physiotherapists, as classroom assistants often replace teachers, and community support officers the police). Activity is perforce restricted and adequate services supplant the good.

Very possibly because of the lack of local resources, Mike's colleagues are unable to follow up his work as well as might be expected. Such situations can lead to low self-esteem among staff trying to implement good work in an impossible situation. There can be a mismatch between their actual principles and beliefs and what they end up doing. In this study this was seen among the cases of the established physiotherapists. External factors, predominantly financial in nature, could be seen to be impacting on the learning of effective practice. Instead these respondents perceived the threat of learning to over-prioritise work and to create shortcuts in practice, to the detriment of patients. This appeared to have led to a few of the established respondents leaving the NHS to work more on their own terms in private practice. They felt that continued involvement in a meso-level institutional community of practice was actually detrimental to their practice and continued learning. Contrary to Lave and Wenger's (1991) theory, they were happier working

as individuals, their community now determined by the macro-level reifications of the CSP and centred on their patients.

Solo Practitioners

At the core of Lave and Wenger's (1991) theory of situated learning is collective practice with co-participants. Newcomers actively participate alongside those more experienced to learn the community 'curriculum' of practice in context. In so doing they absorb the customs, routines and regulations of the workplace milieu, gradually being socialised into a particular professional identity, the process Colley et al. (2003a) term 'becoming'. The social relationship with fellow members is all-important to Lave and Wenger's (1991) theory and works best in the micro-level, close-knit occupational community. However this study found a great variety of groupings that might be called 'communities of practice' (see Appendix I), several of which bear little resemblance to Lave and Wenger's (1991) original concept.

For established practitioner respondents, who left the hospital environment for private practice or work with sports organisations, the community of practice concept could sometimes be carried little further than the professional body. They saw themselves as proficient and confident in their practice and yet questioned that they belonged to any close-knit, single profession community. When they had 'belonged' in such a way it had entailed learning more than the practice and culture of the community. It entailed learning to develop survival tactics when those around them were not as interested in 'negotiating a joint enterprise', shared little of their expected 'mutual engagement' (Wenger, 1998, p 73), and failed to support them in moments of difficulty. This had sometimes led to their marginalisation within, or actual exclusion from, the workplace, situations far removed from Lave and Wenger's (1991) ideal socially interactive learning. Their 'community' was now much more widely spread, around the immediate locality or even further afield, as well as in the overarching professional body. Integration into a community of practice was not seen as a goal and they affirmed that they were better off where they were.

Beck and Beck-Gernsheim (2002) write of criticism of the collective bias of the social sciences in the modern world in favour of individualisation, of people moving away from organisations where they might be expected to have a more passive role and becoming “active shapers of their own lives” (p 24). These solo practitioners, along with a number of the graduate respondents, could be said to be questioning and defying tradition and some core community values in order to satisfy their own standards and goals. It is becoming increasingly difficult to “simultaneously be individualistic and merge with the group” (Beck & Beck-Gernsheim 2002, p 158). These modern self-challenging individuals are organising themselves and are prepared to take responsibility. In going their own way, and by doing so calling into question theories of learning by social interaction like Lave and Wenger’s (1991), they are considering the unusual career paths seen in this study and possibly beginning to introduce innovative forms of practice into the profession.

Within the group of established practitioners in this situation there was a range of social interaction with others however. All were self-employed, but Cathy mixed with the physiotherapy staff of several practices, though not strictly aligned to any particular one. In these small groups she might occasionally share experience and discuss practice alternatives. Diana did not have this option, though she liaised with distant physiotherapists and worked in a MDT for the more serious accidents she encountered. Only Andrea worked totally alone, but even she had useful contacts in the profession with whom she was in regular communication. The term ‘solo’ was thus relative. The range of their practice was similarly varied. Having her own private practice for some years had meant that Andrea was gradually narrowing her field to a very specific expertise. Cathy’s work was wider ranging, though mostly working with musculoskeletal conditions, while Diana described herself as a ‘fire-fighter’ (Expert D: 3), tackling everything from ankle sprains to head injuries. All felt embedded in their profession, counting their experience with patients and relatives as important opportunities for learning.

There were criticisms of the hospital system in both the private and public sectors, echoing similar complaints from a few of the graduate respondents, though it was acknowledged that staff these days were under pressure and doing the best they could in the time allowed them. The established respondents themselves had left the NHS

because of such frustrations and restraints in attempting to reach personal goals. They perceived financial difficulties as affecting staff morale and hence motivation, and this, they felt, was happening in the private sector now too. The graduate respondents had reported similar financial restraints, particularly when they had tried to have external courses funded.

Continued Learning

If, as Lave and Wenger (1991) suggest, learning is constructed through interaction with others in the working environment, how is it that learning can continue in these more solo working situations? In interviewing the established practitioner respondents one theme to appear was that of how to keep up-to-date in learning. In their first years after graduation specific interest groups and in-service training had augmented what had been learnt in practice. Courses had also been funded more readily than they are nowadays. Working alone generally meant a change from this approach, though private practitioner evening meetings were mentioned. As these physiotherapists were self-employed, they also had to self-fund all CPD they embarked on. It was clear that they made efforts to attend the occasional course to update their skills and kept in touch with private practitioner and sports specialists. This learning is not experienced in the place of work however and Lave and Wenger (1991) focus on learning through participation in the work context, to the exclusion of the acquisition of knowledge and skills that formal teaching from external courses provide. Once more the conclusion must be that the majority of situated learning such practitioners do, aiming now for expertise rather than full participation, derives from practical and social interaction with patients and their carers, not fellow professionals, a concept not discussed by Lave and Wenger (1991).

Also tending to counter the community of practice theory is the established members' isolation from newcomers to the profession. By this point in their careers Lave and Wenger (1991) might have expected established practitioners to be encouraging and advising others new to the profession, to support perpetuation of best practice. This was restricted in all their cases. The PJA in particular, that oversees Diana's work (see Chapter 8, pages 226/7), allowed no unauthorised (student) admissions to the treatment areas at race courses because of betting

regulations and the risk of 'race fixing'. This makes Diana's situation vis-à-vis newcomers to the profession dually problematic. Firstly, her work takes her around the country, from race meeting to race meeting, so that she is never in one place long enough to form relationships with HE practice placement organisers who might wish to make use of her as a supervisor of students on a regular basis. Secondly, she is answerable to a particular agency, the PJA, that has specific security issues. No students or junior staff can profit directly from her valuable expertise.

Of the three established solo practitioners only Andrea had once allowed a student to assess patients in her practice during part of their elective placement. The supervision required determined her only to employ a younger practitioner when they had had at least five years practical experience in the profession. Thus newcomers enter these areas but rarely and will not be entering into socially interactive learning in context with such practitioners until they are well on their path to full participation. Specific learning of a considerable range, learnt from interaction with patients and carers is not passed on to newcomers in the hospital system, very possibly to their detriment. It can therefore be argued that as far as these practitioners working more on their own are concerned, the concept of a community of practice from both their angle and that of the newcomer to the profession, appears to be largely redundant.

Critical Reflection

Focused qualitative studies are illuminative and illustrative rather than definitive, but some important themes have been aired and may well resonate both with physiotherapists and healthcare workers, and with those in other professions. It must be taken into consideration however, as I mentioned in the opening chapter, that I was a newcomer to qualitative research at the start of this research and had not carried out a study on this scale before, nor carried out much semi-structured interviewing. There was plenty to learn, but as I did so I recognised that I was following a path similar to my graduate respondents as I accustomed myself to new practices. It made me more appreciative of their difficulties, as I forged interactive relationships with those more experienced in the field, acculturating myself to the

social sciences, alongside carrying on my everyday profession. My respondents too were often dealing with both home life and other part-time occupations.

As already stated at the opening of this chapter, this study has been restricted to a small number of graduates in one university and an even smaller number of middle managers and other established members of just one healthcare profession, physiotherapy. Their narratives have provided richly complex data. In this, priority was given to those of my mature graduates, and given as far as possible in their own words, it being of importance to me as author to render their perceptions in their voice and not mine. I provided a brief corresponding narrative of my own career path in the early chapters to throw theirs into relief in the later ones.

My main respondents were all mature students. I chose to restrict the study to them for several reasons. Firstly they had made the extra commitment to leave a previous career and I was interested in investigating both their experience of transition from one career to another and how this might impact on their participation in their new profession. I was also keen to find out how they coped with the responsibilities older students might have in a time of employment difficulties. However, I did not interview any of the school-leavers studying alongside them, who might be termed the typical newcomers to physiotherapy, so I cannot make a direct comparison between them and the atypical newcomers featured in this study. It was therefore tempting at times to assume differences that may not actually exist.

Recommendations

As noted above, the path of school-leavers, the ‘typical’ newcomers could be investigated to compare and contrast the findings with those of this study, though it would have to be borne in mind that researching at a different time, be it only a difference of a few years, will mean that key variables may have altered. Healthcare has changed considerably during the time of my study and is likely to undergo still further change. External influences on what is happening in the workplace are varying constantly.

As regards training itself, more could be made of the useful skills my graduate respondents gleaned from their previous occupations. Well over half of them had particular experience in communication, having had to deal with awkward social situations, from the complaints fielded at the Customer Services desk of the supermarket to occasional serious aggression faced by those in the army and police. Negotiating with, and managing, people were often particular accomplishments, and similarly teamwork was well known to them. They realised something of “what’s required in a workplace” (C1:17), the little things that made life run more smoothly. There were some too who had more specialist skills, understanding more about exercise, while others had experienced high level sport in their everyday work. They had teaching and coaching skills and could empathise with the injured sportsperson.

An increased “focus on individual responsibility for ‘employability’ within an increasingly ‘flexible’ labour market” (Johnston 2003, p 7) in many academic university courses has led to more emphasis on the teaching of specific employment-driven skills. To a large extent in vocational courses those are the skills that are already taught, so this is nothing new. But how the individual with previous experience is led to gain the best opportunities for learning to specifically suit them might be improved upon. Johnston (2003) advocates different approaches to those with different types of knowledge – “disciplinary, vocational and experiential” (p 4), allied to greater reflexivity on the part of the students, starting to forge new identities in a new career. While such reflexivity might tend to turn the student inward, to concentrate on self and personal needs, negotiation with placement organisers and clinical supervisors would help remind individuals that they are part of a community working together, a helpful way to use Lave and Wenger’s (1991) theory. It presents an idea of the community which again extends the original concept however, for both university and placement personnel would be involved in this negotiation. It could be seen both as an instance of brokering (Wenger 1998), a connection between people who are introducing elements of one practice into another, negotiating across boundaries, and of the ‘fast’ community mentioned by Roberts (2006).

This process could begin with a series of discussions between mature students and their personal tutors to decide what particular skills they brought from previous occupations and lifestyle opportunities that might be channelled usefully into their

new career learning. Their findings could then inform the decisions of placement coordinators in the university, so that over the duration of a few weeks, the identity-forming work of practice placement might be improved and augmented or challenged on successive placements, according to what the mature students and their personal tutors felt might be most helpful. In certain respects these individuals are not novices learning skills for the first time, but are re-working practice they have already learnt in a past workplace to fit the new situation, part of the deculturation and acculturation of their transition from one occupation to another. As suggested in Chapter 3, supervisors learning of such extra experience might be able to provide specific opportunities that can advance skill still further to the benefit of both the individual and the placement, the interdependence remarked on by Billett (2001b). There needs to be more individualisation, shaping the progress of particular students through their specific transition.

The training period, including as it does secure experience in placements in selected areas under the supervision of able practitioners, is now of particular importance. It is the time of true legitimate peripheral participation in line with Lave and Wenger's (1991) theory of situated learning. It seems to yield the opportunity to develop an ideal of the professional culture that is now sustaining graduates in the more difficult times ahead. The ideal of situated learning which used to continue on graduation is not so easily available today. Employers can be made aware of any extra experience the individual feels they have to offer, by mentioning it on their personal statement on application for a job. The difficulty is that many first posts are short-term contracts or Bank work, where the graduate may be filling in in times of staff shortage and opportunities to use specific skills may not be afforded.

Also in a time when it is difficult to gain funding or time to go on practical courses, it is all the more important to support junior staff in their practice. Sharing of expertise across Trusts might be a possibility, as it already is in some areas where Trusts with differing specialities are joined into one larger organisation. "Unlike the academic, the practising professionals are in a 'what ought to be done' environment. The aim is not knowledge but action" (Eraut 1994, p 52). New staff need to watch good work and then practice under supervision, as Lave and Wenger (1991) advocated, but it is something more rarely attained nowadays. Where the professional body helps

provide formal education, this might be supported by more practical workshops, furthering what opportunities are afforded in the workplace, with a view to augmenting skills and moving newcomers onward towards full participation.

Conclusion

In my research I have followed the progress of career-changing graduates over a three year period and it is possible to see there are various ways of coping with the exigencies of uncertain employment. They have not always achieved what they originally hoped for, though one at least got further than they expected. Being atypical entrants to the career, several have drawn successfully on previous experience. What was already learnt in other working communities and factors such as upbringing and habitus were particularly influential in their progress. Their past experience, knowledge and skills can enrich and affect the work of communities of practice, and it seems possible that innovation might result.

Lave and Wenger's (1991) theory has been deployed but also challenged, the empirical model of transition into the workplace shown to fall short of their ideal in several respects. Early immersion in a community of practice rarely happens, and mature trainees come from a variety of work cultures and so cannot be termed 'novices'. These people do not share a similar outlook as they begin training, not having the typical characteristics Lave and Wenger (1991) suggest. They do not move smoothly from legitimate peripheral participation to full participation, external factors often impacting on the process. During their training they are secure in their position of peripheral legitimate participation, but once training is complete, the individual can find that registration as a member of the professional community can prove a barrier that removes protection of access to practice. Neither is the construction of a new identity uncomplicated, there being evidence to support the findings of Colley et al. (2007), Colley et al. (2003a) and Hodkinson and Hodkinson (2004b) regarding the marginalisation and exclusion of some people. Wenger's (1998) suggestion that communities are sometimes unhappy environments is thus also supported.

The theoretical model of situated learning can similarly be challenged. For example, learning has been shown to be two-way, newcomers informing 'old-timers' as well as the reverse. In this way it is possible that they can impact on the culture of the workplace. Then, modern fragmented practice can be at variance with the ways of the 'old-timer', and learning can occur without the individual's 'belonging' to a community. Indeed competition and personal rivalry seem to promote personal learning at times, rather than the comfortable support of the community of practice in moving towards full participation. There is a broad range of social interaction going on, not just that of the close-knit single profession community. Incoming practitioners are soon called upon to work in MDTs and this entails an understanding of, and adaptation to, the professional cultures of other professions. This sometimes also means that fellow professionals can be viewed in a critical light, if they do not maintain the MDT's ideals of practice.

Having said all this, it is nevertheless the case that Lave and Wenger's (1991) emphasis on social context has broadly been validated by my data. Their paradigm changing view of the process of learning (Hughes et al. 2007) is directly relevant to career transition. Lave and Wenger's (1991) work has indeed proved a major intervention in the understanding of learning despite my study's findings of various difficulties not accounted for in their original analysis.

One of these is that full participation has been found to be a difficult concept to define, findings suggesting that it equates with proficiency rather than expertise. Stability of tenure of employment was generally helpful in giving both an added confidence, and the motivation and commitment for further learning towards attaining the goal of reaching full participation. However, before this was achieved, today's altered forms of employment could lead to changes in what might have been thought of as the traditional way of working, for being on a short-term contract, when both extra opportunities for learning and reification symbolising progression can be lacking for such a newcomer, can interfere with the ideals of community practice. Piecing together such short-term jobs seems almost bound to slow progress, but people have an image of the ideal professional community, developed and shaped during their training and on student placement, and are aiming for it, even if it no longer always exists. Contrary to the majority of respondents, however, there was an

instance in this study where progression and learning were speeded up by the individual's single-minded attention to finding specific niche work. It seems that in modern society individuals may be beginning to self-manage their careers more in this way, a practice very much at variance with Lave and Wenger's (1991) theory.

Amongst established practitioners inadequate provision of services has led some to leave communities and go their individual ways. Two particular elements of their practice then militated against community of practice theory. Firstly it was with patients and their carers that social interaction leading to learning occurred most in solo practice, and it was to this client group that practitioners felt loyalty and a sense of belonging, rather than to any community of fellow professionals. Also solo workers are often isolated from the newcomer and cannot pass on their learning as Lave and Wenger (1991) suggest.

My work, then, shows what is happening to a group of career-changing newcomers moving into a healthcare profession, demonstrating a selection of innovative methods of using capital of various forms to ensure continuous employment. I have made a contribution to the understanding of community of practice theory (Lave & Wenger 1991) in a specific field, questioning its usefulness in explaining how newcomers learn in today's workplace. The thesis as a whole gives some indication of the way in which a profession's traditions may be changing in a context of widening participation and the problems of a fractured and uncertain employment.

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Appendix I

Levels of Community of Practice

Sub-Micro-level

(Individual)

Individual workplace learning/practise

Solo work in own Private Practice

Freelance Practitioner (slotting into several micro-levels)

Micro-level

(Occupational)

University teaching group (although not in the workplace)

Physiotherapy Department

Group Private Practice

MDT (slow or fast [Roberts 2006]/ stable or transient)

Own Private Practice (with ancillary staff)

Meso-level

(Institutional)

Hospital Trust

Primary Care Trust

Charity Organisation

National Sports Organisations

Large firms (employing occupational physiotherapists)

Professional/Regional Networks

Macro-level

(Professional/National)

The Chartered Society of Physiotherapy

Super-Macro-level

(Worldwide)

World Congress of Physical Therapy

Appendix II

Semi-structured Interview Schedule 1 (Managers)

Contact by phone, asking if they would be willing to receive an information pack. If so, send information sheet with a covering letter, the bottom section of which is a tear-off slip indicating interest. Formally state reasons for research and that the interview will be recorded. Once agreement is reached and an interview time and place decided, briefly explain research, and ensure permission to record is given.

Explanation

Over the past three years increasing numbers of our students have found it difficult to gain employment as physiotherapists following graduation, due to a reduction in advertised posts. The main focus of my investigation is to explore, in this situation, the experiences of mature students who have left previous full-time employment in order to train as physiotherapists, and thus might be seen as particularly vulnerable in the present climate, and to trace their career paths after graduation. But I need your help to fully understand the background context to their situation. I'd like to know how you perceive the situation and what the implications might be for you in physiotherapy management ... how you view the current employment situation for the profession, especially for newly-qualified graduates. Your perspective is going to be very important to my study.

Introduction

Thank for being willing to participate in my study and be interviewed.

Assure regarding confidentiality of material and anonymity of person and place.

Having read the information sheet, do they have any more questions about the research and how it will be used?

Make sure again that permission to record is given and the consent form signed.

Assure that if any subjects arise that they wish to mention but do not wish recorded, this will be respected and the recording instrument stopped immediately.

Reiterate my need to find out about management issues.

For each theme ask for:

description with personalised, detailed, concrete examples

explanation (why? how? by whom? in response to what drivers?)

evaluation (values/attitudes in relation to what happened, what it felt like)

Participant background:

- What is your key role/position at present and how long have you been in it?

Staff Recruitment:

- What are your responsibilities regarding recruitment?
What is your role in the process?
- What are the key issues regarding staffing here at present?
How are your staffing needs determined locally?
What about other external influences – for example, what regional or national issues influence staffing needs?
Have your staffing needs changed in recent years? What has led to these changes?
What is the relationship between staffing needs and recruitment levels in your department? And what issues influence this?
- What process do you follow to recruit staff here (written/online application; interview/first apply-first picked) and has this changed recently at all?
What is your opinion of the process?
- Over the past three years increasing numbers of our students have found it difficult to gain employment as physiotherapists following graduation.
Why do you think this seems to be the case?
What are your thoughts about recruiting mature graduates here?
Do you know what employment physio graduates are going into if they can't get posts as physiotherapists in the NHS?
Does this have implications for your future recruitment needs?
- What do you see as the implications of the current recruitment situation?
What is your opinion of your staffing levels?
Are there long-term implications for your department? For the NHS nationally?
For the physiotherapy profession?
Are there any wider implications – locally/nationally/professionally?

Closure:

- Have you any further comments/questions?

Thank you very much.

Semi-structured Interview Schedule (Graduates)

To be contacted by email, attaching an information sheet and asking if they're willing to be interviewed in a quiet room in university.

Briefly explain research and tell them the interview will be recorded.

Give meeting time options.

Explanation

Over the past three years increasing numbers of our students have found it difficult to gain employment as physiotherapists on graduation. But we don't have any clear evidence about what they go on to do, and how this affects their long-term career development. I mean to investigate this situation by interviewing a cohort of mature students who have left previous full-time employment in order to train as physiotherapists. I am focusing on mature students because any difficulties in the labour market may affect you in different ways than they would younger students. I therefore need your help. I hope to interview you now, before graduation, and also in one and two years time, to see what path your career takes. This graduate view could be extremely helpful in informing those involved in healthcare policy making, and to those providing education, guidance and employment in physiotherapy and in higher education more generally. Stories like yours will be crucial to this research.

Once they email back in agreement, back up with a confirmatory letter, formally stating the reasons for the research and giving the agreed arrangements for the meeting. Book a small tutorial room and prepare a notice to put on the door, warning that an interview is in progress.

Introduction

Thank for being willing to participate in my study and be interviewed.

Assure regarding confidentiality of material and anonymity of person and place.

Assure that they are free to withdraw from the research at any time in the future if they do not want to continue.

Having read the information sheet, do they have any more questions about the research and how it will be used?

Make sure again that permission to record is given, and ensure the consent form is signed.

Reiterate my need to find out about their particular career paths, that I am interested in anything they feel is relevant to this, as long as they are happy to talk about it.

For each theme ask for:

description with personalised, concrete examples

explanation (why? how? by whom? in response to what drivers?)

evaluation (values/attitudes in relation to what happened, what it felt like)

Participant background:

- Tell me about your previous career before you decided to study physiotherapy.
[Possible prompts, if absolutely necessary:
Why did you choose ... as your work?
How was your career developing in ... ? What were your future prospects in it?
What influenced your decision to change career?
Were there things about your previous life and work that you regretted leaving behind?
Many people think that the sort of career change you have made must be difficult.
How have you found it?]

Career transition:

- Tell me how you came to think of physiotherapy as a career:
How did you find out about a career in physiotherapy?
What sort of information did you need in order to make your decision about changing career? Were you able to get all the information you needed? Where did you get it from? Did anyone else help you with this, or with making the decision to go for it?
What was it like becoming a student again?
Are there skills, knowledge or experience from your past job that you have found useful in physiotherapy training?
What has it been like working in physio departments on placement? How does it compare with your previous experiences of work?
Do you feel you have 'become a physiotherapist' through following this course, or is that something you feel will happen only when you have graduated and get a job as a physio?
- As far as career moves are concerned, are there any things that you would do differently now, in the light of your experiences or with hindsight?

Expectations of the future:

- What are your current thoughts about what you will do after graduation?
- What employment opportunities do you see as being open to you on graduation?
How will you go about finding a job?
What sources of information have been most useful to you?
What do you see as being the main things influencing your chance of getting a job?
How have the job prospects affected your studies?
How do the job prospects make you think now about your decision to make this career move into physio?
How does the job situation impact on you, yourself?
Is it having any impact on your studies?
How does the job situation impact on significant others in your life?
- Tell me how you see your career progressing in the next few years.

Closure:

- Have you any further comments/questions?
Thank you very much.

From Legitimate Peripheral Participation to Full Participation?**Investigating the career paths of mature physiotherapy students in a context of changing NHS employment opportunities**

I am a PhD student, currently working on the above research, and I am approaching you in the hope that you may be willing to be one of my participants. Detailed below are answers to a series of commonly asked questions.

What are the aims of the study?

The main aims of the study are:

1. To provide evidence of what is happening to the career paths of mature students, who have changed careers to take up physiotherapy, in a context of changing NHS employment opportunities
2. To understand the impact of current healthcare policies on the dynamics of graduate participation in the physiotherapy profession, particularly any impact on recruitment, retention and the destinations of the newly qualified

What is the purpose of the study?

Physiotherapy students are no longer assured of an NHS post as a physiotherapist on graduating and there is no robust evidence about what physiotherapy graduates do if they find themselves unemployed or about their longer-term prospects of entering the profession. It is my intention in this study to explore the situation as it impacts on mature students who have changed careers in order to train as physiotherapists, thus showing a particular degree of vocational commitment. I hope the study's findings will inform healthcare policy makers, and those providing education, guidance and employment in the field of physiotherapy in ways that should benefit both future physiotherapy graduates and NHS users.

Why have I been chosen?

You have elected to change career to study physiotherapy and are currently in your third or final year on a pre-registration physiotherapy programme in the North West of England. Your experiences and views would provide important evidence for meeting the aims of the study.

What would participants be asked to do?

If you agree to participate, I will arrange to interview you about your career up to the present and your expectations of the future. It will be a semi-structured style interview, ie. while we will need to cover certain topics in the interview, it is designed to allow you the opportunity to discuss what you view as the most relevant issues. I expect the interview to last between one and one-and-a-half hours. With your permission, it will be recorded, so that I can really listen to what you have to say. You have the right to stop the interview being recorded at any time, should you wish to tell me anything 'off the record' and I shall ensure that anything thus told me is not reported unless I have your express permission to do so. If you do not give your permission, I may use the material to inform my understanding, but will not refer directly to it in any way. The transcription will be shown you to check that you are happy with what has been recorded.

If all goes well I hope to interview you again in one year's time and again in two years to trace your career path and experiences during that period.

Do I have to take part?

It is up to you to decide whether or not you take part in this study. If you decide to take part, you will be asked to sign two consent forms prior to being interviewed. I shall keep one and the other is your personal copy. You will still be free to withdraw at any time, without giving a reason. On withdrawing from the study you will have the right to withdraw any data that you have given as part of the study. Be assured that if you decide not to take part in this research, this will in no way jeopardise your physiotherapy studies.

What are the possible disadvantages of taking part?

There may be emotional implications for you as an individual, if, during the interview, I were to ask you to discuss any issues that you might find upsetting. Should you experience this, either during the interview or at any time thereafter, the following will be useful.

Student support services:

Counselling Service

Northtown University

Telephone

Email counselling@.....ac.uk

I will be as flexible as I can be in arranging a time for the interview. I envisage interviewing you the first time in a quiet room in the University.

I foresee no disadvantages in your participation for any of your fellow students or colleagues. All information you give me will be kept anonymous and identified solely by a code. You and any place of work will not be identifiable at any point.

What is your position as a researcher?

I qualified as a physiotherapist in 1969, worked mainly in the NHS till 1988, and since 1988 have taught Physiotherapy Studies in Higher Education. In this study I am completing a postgraduate qualification.

Will my taking part in this study be kept confidential?

All information that is collected during the course of the research will be kept strictly confidential and stored in a locked filing cabinet (to which I alone have the key) at Northtown University, and electronic back-up will be password protected. Any information about you that leaves the security of my office will have your name and contact details removed so that you and any institution for which you worked, or currently work, cannot be recognised. The key to the identifying codes replacing your personal details will be kept separately from other research material in a locked file at my home address.

What will happen to the results of the research study?

The results of this study will be used in the completion of a PhD dissertation with the Institute of Education at the university. A copy of the study will be available from the university library and the British Library. I mean to submit the results of this study further for publication in an appropriate physiotherapy and/or educational journal and disseminate the results at an appropriate conference. Although, as interviews are recorded, use may be made in published material of direct quotations of what you had to say, neither you, nor any past or current place of work, will be identified in any report, publication or presentation.

Who is organising and funding the research?

There is no external sponsorship of this study. It is part of my PhD project, which is funded by the university. The project is supervised by two university staff experienced in research and graduate student supervision, from the Department of Physiotherapy and the Institute of Education.

Contact information:

Daphne Dawson

PhD student, Institute of Education

Northtown University

Telephone:

[Email](#) address:

Should you agree to take part in this study, I should like to take this opportunity to thank you.

I wish to inform you of a research project which you might be interested in that is happening in the Department of Physiotherapy over the next few weeks. Daphne Dawson is the researcher and the title of the study is:

From Legitimate Peripheral Participation to Full Participation?

Investigating the career paths of mature physiotherapy students in a context of changing NHS employment opportunities

Daphne is keen to interview any students who had another full-time occupation before starting their training in physiotherapy. She aims to interview anyone interested three times: now (before graduation), next year, and the year after. Each interview will last no longer than 90 minutes.

Attached find copies of the more detailed Information Sheet about the project and the Consent Form that participants will be asked to sign before interviews are undertaken.

If you are interested in taking part in her study, please email Daphne at:

d.dawson@.....ac.uk

She will be happy to answer any queries you may have regarding the project before you make a final decision about participating.

Appendix V

Consent Form

Doctoral Study: From legitimate peripheral participation to full participation?
Investigating the career paths of mature physiotherapy students in a context of
changing NHS employment opportunities.

Please initial box if appropriate

- I confirm that I have read and understand the Information Sheet (dated April 2008) for the above study.
- I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.
- I confirm that I understand my role in the above research.
- I understand that my participation is voluntary and that I am free to withdraw myself and my data at any time, without giving reason, and without any adverse consequences for myself.
- I confirm that I am happy for the interview to be audio taped.
- I agree to take part in the above study.

Printed Name of Participant

Date

Signature

Printed Name of Researcher

Date

Signature

Appendix VI

Transcription Codes

Legend for understanding marks used in transcription:

- to . a** Gap with one dot between words is a brief pause in speech.
- to .. a** Gap used in quotation, denoting word(s) missing from the original transcribed speech, often opening or closing a quotation, to show that words quoted are not at the beginning or ending of a sentence.
- to ... a** Anything more than three dots shows a longer pause in conversation.
- to a** Underlining denotes emphasis.
- (frenetic excitement – gesturing ‘What ME!’)* Italicised words denote the interviewer’s words, but occasionally also describe movement rather than speech in transcriptions.
- I’m confident ..** Blue denotes words that cannot be heard well, and show that a guess has been made at meaning.
- [his]** Bracketed words add to the original, either to make more grammatical sense or for clarification.
- []** Red brackets separate text the interviewee wishes not to be used in quotation.

Appendix VII

Database

Code

Date

Date of Birth	
Gender	
Ethnicity	
Parents' occupations: Father	
Mother	
Type of Schooling	
Marital status	
Dependents	
Disabilities	
Main hobbies	
Educational level	
Previous occupation(s)	
Perceived successes	
Perceived failures/mistakes	

Email address (not Uni):

Appendix VIII

Thumbnail Sketches of the Interviewees' Career Paths

Graduates (2005-2008 .. 2010)

Barbara (B) – interviewed twice. (38 at first interview, pre-graduation)

A single parent with two sons, the first born when she was 17. Eldest of a large working class family, her longest spell of work was in a supermarket. Prepared for university with an Access course.

Cliff (C) – interviewed three times. (30)

Irish, from a middle class professional background. First degree was a four year BEng in Electronic and Software Engineering. Worked briefly, but then travelled extensively taking short-term labouring jobs. Finally settled in a Rehabilitation Assistant post, prior to commencing training.

David (D) - interviewed twice. (43)

Brought up on a farm in Northern Ireland, the youngest of the family. Did a part-time BA in Business and Management and joined the Civil Service. Move to physiotherapy is a last ditch attempt to escape from this. His elderly parents died close to his graduation and he is responsible for the family home. He has not found physiotherapy work and has returned to his previous job.

Eric (E) – interviewed three times. (34)

Working class background, a brother having learning difficulties. Married to a trainee GP and has two little girls. Nomadic career path including Care Worker, Fireman and Sky-Diving Instructor. Admitted 'adrenaline junkie'. Attempted a PGCE on graduation. Plans to work in the Antipodes.

Fay (F) – interviewed twice. (32)

Working class Jehovah's Witness background (more importance given to religion than education). Discovered to be dyslexic only on preparing for university. Worked as a labourer for her father, a builder, at first. Eventually took a GNVQ in Health and Social Care. She then cared for people with learning difficulties and challenging behaviour. Prepared for university with an Access course.

Gwen (G) – interviewed three times. (35)

Vocational dance school from 11 – 19. She worked as a professional dancer in musical theatre and on cruise liners till her late twenties. She then had several temporary jobs, including office work, cosmetic retail and air stewardess, before preparing for university with an Access course.

Hilary (H) – interviewed three times. (29)

Irish, her background being professional middle class. She did a four year BSc in Plant and Microbial Biotechnology when she left school and got a short term contract for a pharmaceutical firm. Then she dislocated her shoulder kayaking and had to have physiotherapy, which decided her to change direction.

Susan (S) – interviewed once. (39)

Working class background. A divorcee with two children, the second being a high functioning autistic girl. Her previous ‘community of practice’ was a group of mothers of autistic children. Took 4 years to graduate instead of 3, thanks to family circumstances. Not employed as a physiotherapist, but eventually achieved OT Assistant (in Paediatrics) status.

Tim (T) – interviewed once. (37)

Took an Economics degree after school. Then joined the police force for 8 years, specialising in domestic violence and child protection. Married with 2 children, both born during his physiotherapy training. Took 5 years to graduate instead of 3, due to financial constraints.

Graduates (2006-2009)

Jean (J) – interviewed once. (38)

Working class background. Married with two sons, one having Aspergers Syndrome. Her job was Assistant Manager in a Bookmaker’s and she continued as their Cashier during training. Prepared for university with an Access course. She has not found physiotherapy work and has returned to her previous job.

Kenneth (K) - interviewed once. (26)

Initially attracted to PE teaching, but joined the RAF from school and became an Assistant Air Traffic Controller which included work in the Middle East. He studied Human Biology with the Open University rather than an Access course (difficult when in the Forces). Now working in Australia.

Lionel (L) - interviewed twice. (26)

Middle class background and a high-flyer at school, though had not chosen science subjects. He took a BA Music degree and got a First, but was not keen to be a performer. He then worked in a Call Centre for a year. Next he worked in a Care Home, while studying A level Biology and also working part-time for the Samaritans. Suffered work-related stress while working in short-term physiotherapy posts.

Mike (M) - interviewed twice. (35)

Middle class background, brought up with a physically disabled brother. He joined the Army from school and stayed in the Forces for 13 years, ending up as one of their chief instructors for mountaineering and skiing. Prepared for university with an Access course. Got married during training, to an OT whose sister has learning difficulties.

Nancy (N) - interviewed once. (29)

Worked in the Customer Services department of a bank, to finance her football which she played at a very high level. She also did some part-time work as a Care Assistant in a hospital. She then moved to the United States to take football up professionally and studied there for a Bachelor’s degree in Exercise Science immediately before starting physiotherapy back in the UK.

Oliver (O) - interviewed once. (32)

Didn't get good enough grades to do physiotherapy from school, so did a Sports Studies degree instead and then worked in odd jobs in sports shops and warehouses, finally ending up in an IT job, programming for a large retail company. He did similar work for two companies over seven years, suffering redundancy from the first firm.

Pat (P) - interviewed twice. (47)

Middle class background. Did a 4-year degree in German Studies, including a year in Germany, and taught English (TEFAL). She returned from Germany to do a PGCE, but then saw an advert for a job in a Biking Workers' Co-operative that combined her passion for cycling with her interest in leftwing politics. She spent 13 years here, but suffered back problems. Prepared for physiotherapy by taking a Foundation course. Lives with a same sex partner.

Annabel (Q) - interviewed once. (36)

Worked in a clothes shop, became a buyer and had her own fashion business for some years. She then travelled and found her interest in sport growing, so became a fitness instructor. Lives with her boyfriend, who can't understand why she should want to train as a physiotherapist when she can just have her own gym. Prepared by taking OU Human Biology and other units.

Ruth (R) - interviewed once. (26)

White British Caribbean, where she did her initial schooling, before going to boarding school in Canada. Studied Psychology for two years in USA, but then her parents split up and there were financial issues. Worked in the tourist industry back home in various capacities. Finally she was able to follow her healthcare inclinations and do physiotherapy. Now working in New Zealand.

Managers (at time of interview in 2008)

Shirley (Manager Z)

Qualified over 30 years ago. She's been Professional lead for Physiotherapy (in a multiprofessional team) since 2006. She retains her clinical role, for half her time is spent as Clinical Specialist for Amputee Rehabilitation.

Ian (Manager Y)

Qualified in 1996, an ex-student of the researcher. Did some ESP work in Orthopaedics, listing people for surgery and working with Consultants, before taking a Team Leader role in his large NHS teaching hospital.

Ted (Manager X)

Graduated in the early 1990s from a 4 year honours degree programme. He had been in a Senior I post on a Stroke Unit for a few years, and had worked abroad for a while, but had now moved into the community. He now manages physiotherapists in a PCT.

Wanda (Manager W)

Qualifying some 30 years ago, she has worked in some well known hospitals abroad and in London. She is now the Physiotherapy Manager of the Acute Services in a large NHS teaching hospital.

Virginia (Manager V)

From Senior I level she was promoted to junior management in 1998. Now she is a Therapy Service Manager and also the Professional Lead for Physiotherapy. Eventually she will manage all the AHPs in one particular clinical area in her NHS Foundation Trust. She has also coordinated the Band 5 physiotherapy rotations for the last eight years.

Una (Manager U)

She has been 20 years in her current Trust, specialising in musculoskeletal work and originally Superintendent III in the physiotherapy department. She is now Out-Patient MSK and Community Site Lead. Married to a private practitioner.

Established Practitioners (at time of interview in 2011)**Andrea (Expert A)** – Qualified in 1984.

Originally interested in Medicine. Did her rotations in a couple of NHS hospitals. Started work for a Rugby Club when at Senior II level, joined the Private Practitioners association for insurance purposes, and then went into private practice. Now she works full-time, and alone, in her own practice.

Beth (Expert B) – Qualified in 1979.

Traditional route till 1984 when she moved with her husband and took a 7 year career break to raise her 3 children. In 1991 she returned to a part-time junior post in the NHS and then a Senior post in surgery and respiratory work. Now she has a senior respiratory post in a private hospital. She has avoided management responsibilities.

Cathy (Expert C) – Graduated in 1994.

An ex-student of the researcher. Rose to Senior I level in the NHS and then in 2004 took an MSc in First Contact Care. This programme folded and she was unhappy on her return to the NHS, so began to work in small private hospitals and for private practitioners. She now works free-lance in the latter capacity only.

Diana (Expert D) – Graduated in 1993.

An ex-student of the researcher. Originally taught PE for 14 years, and played cricket and hockey at national and olympic levels respectively. Rose to Superintendent level in the NHS, but became disillusioned by her colleagues' poor attitude. She left to work for a Football Club for 2 years. Having been made redundant, she then acted as a carer for a stroke patient abroad, followed by 2 years working in an independent hospital. Now she works for the Professional Jockeys Association, travelling to race meetings around the country.

Appendix IX Second Graduate Interviews

Semi-structured interview schedule 2

Introduction

Thank for being willing to continue participating in my study, following up on the first interview.

Assure regarding confidentiality of material and anonymity of person and place.

Assure that they are free to withdraw from the research at any time in the future if they do not want to continue.

Do they have any more questions about the research and how it will be used?

Make sure again that permission to record is given, and ensure the consent form is signed.

Reiterate my need to find out about their particular career paths, that I am interested in anything they feel is relevant to this, as long as they are happy to talk about it.

For each theme ask for:

description with personalised, concrete examples

explanation (why? how? by whom? in response to what drivers?)

evaluation (values/attitudes in relation to what happened, what it felt like)

Your situation as you graduated:

Your expectations of the future last year:

Career path during their first year post-graduation:

- Perhaps we could start by you telling me how you've got on in Physiotherapy since last we met.

[Possible prompts, if absolutely necessary:

What applications did you make?

What interviews have you had? Did you feel adequately prepared?

Where did you consider working?

If you didn't get work straight away, what did you do to make ends meet/fill the time?

How did you find the job hunting experience?]

Transition from Uni to work:

- If you found a job:

How does it compare with being on placement as a student?

Was it strange now having younger Band 6s & 7s supporting you?

Did you know enough about where you were going to work? Any surprises?

Did anyone else help you in finding/acquiring this post?

What did it feel like working again?

- As far as this/these career move(s) are concerned, are there any things that you would do differently now, in the light of your experiences or with hindsight?
- If you haven't found a job/have done something different from physiotherapy:
 - Have things been a disappointment, or gone according to your plans?
 - What's been your experience of work?

Expectations of the future:

- What employment opportunities do you see ahead?
 - How long might you continue in your present situation?
 - Upon what factors does this depend?
 - How does your work experience make you feel now about your decision to make the career move into physio?
 - How has the job situation impacted on significant others in your life?
- Tell me how you see your career progressing in the next few years.

Closure:

- Have you any further comments/questions?

Thank you very much.

Appendix X

Interview Schedule 3: for the 2008 cohort 3rd and 2009 cohort 2nd Interviews

Introduction

Thank for being willing to continue participating in my study.

Assure regarding confidentiality of material and anonymity of person and place.

Assure that they are free to withdraw from the research at any time in the future if they do not want to continue.

Do they have any more questions about the research and how it will be used?

Make sure again that permission to record is given, and ensure the consent form is signed.

Reiterate my need to find out about their particular career paths, that I am interested in anything they feel is relevant to this, as long as they are happy to talk about it.

For each theme ask for:

Description with personalised, detailed, concrete examples

Explanation (Who? What? Where? When? Why? How? By whom? How come? In response to what drivers?)

Evaluation (values/attitudes in relation to what happened, what it felt like: What are your opinions about that? Do you think things could be different? Do you think this is how it should be? Is it like this everywhere? How does it feel to you?)

A useful clarifying prompt:

*I think I know what you mean, but I don't want to assume something wrongly.
Can you just explain that a little more for me?*

Career path during the first years post-graduation:

- Perhaps you could start by telling me what you've been doing since we last met.

[Possible prompts, if absolutely necessary re-:

Type & attractions of various posts

New levels of responsibility

Restrictions to getting work

Any ways of making ends meet/filling time – previous job?]

Moving to full membership of the physiotherapy profession:

- Take me through a typical day at work
[Possible prompts, if absolutely necessary:
Give me an example of you learning something recently
What are your feelings about work where you are at the moment?
Do you think this is how it should be?
Is it like this everywhere?
How does physio work compare with other jobs you've had?
Why do you think that is?]
- How would you describe to someone else what it would mean to be a fully-fledged physio?
- Tell me about the people you mainly work with.
[Possible prompts, if absolutely necessary:
What teams are you part of?
Can you describe the ways that you work together? Give me other examples.
Can you think of instances when that *didn't* happen?
How has that, do you think, affected your development as a physio?
How does that make you see yourself?
How do you think other people see you?
How do your fellow workers now compare with the ones in your previous job(s)?]
- Tell me about someone you think is a really good physiotherapist – one you'd like to be like when you've become experienced in the job.
- We've talked before about how you're not the typical entrant to physiotherapy ('18-year-old girl whose aunt's a physio'). What's that been like?
How is it now you're out in the workplace full-time?
What's it been like to fit in?
- What do you see going on in Physiotherapy at the moment?
What does that mean for people coming into the profession?
What are the challenges everyone, including you, has to face?
What are people you work with having to get to grips with?
What can you offer? What do you see as your role in this?
- In your path into physiotherapy so far:
Have there been any obstacles that you've encountered?
What kind? What goals were hindered, if any?
What do you consider hampers your progress most?
Have there been any key moments or processes that have developed you as a physio?
What aims have been/are being facilitated?
What would you consider has been most supportive of your progress?
- As far as this/these career move(s) are concerned, are there any things that you would do differently now, in the light of your experiences or with hindsight?
What do you wish had been different (if you do)?

- In what ways do you see yourself as having changed during your move into the new career?

Expectations of the future:

- What employment opportunities do you see ahead?
How does your work experience make you feel now about your decision to make the career move into physio?
- How do you see your career developing in the future?
What are going to be the key issues supporting that?

Closure:

- Have you any further comments/questions?

Thank you very much.

Appendix XI

Working through Hollway and Jefferson's (2000) Questions

A helpful set of questions to ask oneself as a beginning to the analytical process.

- *What have I noticed?*
- *Why did I notice what I noticed?*
- *How can I interpret what I noticed?* (Hollway & Jefferson 2000, p 55)

From the example of Gwen, the ex-dancer:

What have I noticed?

- The intense, single-minded discipline of the first profession
- Expectations of an insecure future – dance wasn't for ever
- Speaking of occupation as being in a 'bubble'
- Being used to short-term and temporary contracts
- The worry of knowing when to start a family

Why did I notice what I noticed?

The intense, single-minded discipline of the first profession

- My two participants who had been in the forces talked in a similar way.
How important was this to someone changing profession?
What difference did having this outlook make to progress towards full participation?

Expectations of an insecure future

- This graduate might be more ready for uncertainties than some.
She's already been through her 'crisis'. She prepared for it ever since school.
She looked forward to the stability of her new profession

Speaking of occupation as being in a 'bubble'

- Again the two participants who had been in the forces talked of their previous occupation in a similar way.
Gwen doesn't feel she's had to face 'real life' .. routine 9-5 work?
Routine stability is now more attractive to her.

Being used to short-term and temporary contracts

- This is what is needed to cope with the fragile employment market now.
Would it make a difference to Gwen that she had been used to this before?

The worry of knowing when to start a family

- Only voiced at third interview. When on a temporary contract, dare you start a family? And if so, when's best? Being in her late thirties, the clock is ticking for Gwen.
A new issue – something to explore with other female participants??

How can I interpret what I noticed?

- From what I noticed I suspected that to have become accustomed to discipline in her previous work experience was helpful to Gwen now. It seemed to have made her more single-minded and determined to achieve her goals .. and the same might be said of Kenneth and Mike, the ex-forces respondents.
- Of my respondents Gwen is perhaps most used to uncertainty in her previous occupation. Others like Lionel had become very stressed by having to piece together short-term contracts: Gwen possibly less so?
- It's interesting that while Gwen suffered uncertainty in her previous profession she also felt protected from the real world, in her 'bubble'. Is this protective, thoroughly situated, close-knit community what Lave and Wenger were describing? Is it then a little out of touch with reality?
- Gwen might cope better with work uncertainty, but the problem of when to start a family was new to her and crucial at this stage in her life. Her repeated mentioning of a longing for stability might be linked with it.

Appendix XII

Two Respondents' Narratives

Cliff (interviewed three times)

At the first interview, approaching graduation, Cliff was 30 years old. His hobbies were all sports related, running, swimming and football. He's a wiry little man and speaks fast and with passion. His perceived successes are having kept in touch over the years with close friends, having stayed with his long-term partner (who lives in Ireland, where Cliff comes from), having seen some of the world, and having changed career successfully. He's tried all sorts of work in his nomadic past, and has certainly travelled extensively.

Cliff's background is middle class professional. His father is a Maths lecturer and his mother a pharmacist. He did well at school, particularly liking English, Maths and History. He hadn't been sure what to study further, though he knew he wanted to do something at university, and initially he'd thought of Law. But he didn't get in at the first try, and then it didn't seem to matter to him what he did. If his mother hadn't remonstrated with him, he might have ended up doing Media Studies. His mother's attitude was that if Cliff went to university, he should enjoy himself as much as he wanted, as long as he got his exams and a job at the end of it. He followed a four year BEng in Electronic and Software Engineering degree programme in the end, which included a year's work experience.

On completing this degree in 1999 he spent six months with a sister in the USA doing odd manual labouring work, before settling down in a mobile phone company back home. After working there for a year he took leave of absence and travelled to Australia. It was perhaps inevitable that when Cliff returned to his previous job, he found his heart was not really in it. In 2002 he took one of the voluntary redundancies that were being offered at that time (there was an IT down-turn), so did not suffer at all financially in the process.

It so happened that a good friend of Cliff's was planning a caravan trip in the south of Ireland, so they joined forces and spent six months there. He also started doing Yoga for the first time. From this point on he did it regularly and loved it. He did

consider teaching Yoga, but it wasn't all he wanted. He wanted a professional qualification.

Meanwhile Cliff's lifestyle led to more adventurous ideas, trying to get to New Zealand without flying being the main project. After crossing Europe, Russia, Mongolia and South-East Asia using only local transport, Cliff and his friend used their work visas in New Zealand to gain employment as painters and as apple harvesters, as well as helping in a winery. But it was while doing these odd jobs that he began to question what he really wanted to do full-time. Following an idea of his uncle's, Cliff went into an internet cafe and fed the skills he felt he had into a programme to choose a career. One suggestion in response was physiotherapy, so he researched it off and on, learning where physiotherapists worked and what they studied. He found a job as a healthcare assistant in a physiotherapy department back in the UK, but it didn't last long for he was feeling quite homesick, not having lived at home for three years. Moving back there, he set about searching for the ideal Assistant post. After several abortive attempts Cliff interviewed for a post near home as a Rehabilitation Assistant and was delighted to be successful. He would have loved to have progressed up the tree in such a job, but it was a short-term (one year), static post.

However, when it came to actually starting training, places for mature physiotherapy students in Ireland were very rare, or very costly in private establishments. So he applied in the UK and attained a place on the undergraduate physio programme. Now Cliff worked very hard, far harder than he had done for his first degree. It was a definite help to be among several mature students, but he'd not made any close friends. Every effort went into doing well on the course. Having been to university before was a help, for he knew what was expected of level 3 work right from the start, and he liked the way he was expected to study. It was also helpful that he knew his way around the internet well.

In his last year at university Cliff interviewed at home for a panel. (All hiring for jobs at this time was done by the Health Service Executive (HSE) in Ireland and posts allocated following central interviews.) He'd put a lot of effort into it: everything else was put on hold. It paid off, for he was put in the top 10 for two areas, though

there were no jobs available. Although the job situation was better in England, he wanted to return to his girlfriend and settle down a bit. He hadn't lived anywhere longer than 12 months in the last 14 years. Apart from returning to his girlfriend and his wish to be back with his family, there were financial incentives for physiotherapists are paid a lot more in Ireland.

He decided to do his elective placement in the same hospital he had worked in as a Rehab Assistant, and at the start of this Cliff was offered a job there (as summer cover for staff holidays). He'd got validation to work as soon as he returned home – an expensive business – but he was ready to go. His temporary contract began the day he got his results. It was rather uncertain how long it would last and what would be happening next, and there was a high staff turnover at that time. Physically too the job was something of a strain. Cliff was working on Orthopaedics and also cycling in to work from outside town.

After working there for 6 months, a couple of permanent posts came up and were advertised among the 18 people on temporary contracts. Cliff managed to come first in these interviews, so he was extremely pleased. But then the Irish government put a moratorium on permanent contracts, so his was nearly shelved. That it wasn't was just as well, for Cliff's girlfriend had come to join him from another town and got a new job, and the thought of their both starting again somewhere else was not pleasant.

His interviews for the Irish panel produced several offers of jobs during his first year back home, but the hospital where he was working was well known and he felt comfortable staying there. So he turned down some four jobs elsewhere and trusted that he would be made permanent. Though he'd had rumours of permanency it wasn't certain. He and his girlfriend rented a house and waited. Finally after a year's worth of temporary rotations, Cliff was told he had his permanent post. His loyalty and single-mindedness had been rewarded.

At the third interview, three years post-graduation, 33 year old Cliff was still doing rotations as a junior physio in the same Irish hospital, though he had a permanent slot twice a week in the hospital's Hand Clinic. He had interviewed for a more senior

position but failed to get it, something that obviously rankled. The news at home was that he was to marry his partner within the month.

A nomadic lifestyle and serendipity are important in this narrative, linked closely to a particular habitus. How Cliff begins to think as he lives his 'carefree existence' shows the influence of his background upbringing and his reaction to his position and field (Hodkinson & Sparkes, 1997). He is not a drifter per se, but seemed to have only gradually developed a vocational habitus.

David (interviewed twice)

At the first interview approaching graduation, David was 43 years old and the only member of his family (he has at least four siblings) to be unmarried. His background is rural, his father a farmer and his mother a housewife. It's a close family and his parents older than the norm: his father was nearing 50 when David was born. He enjoyed walking, folk dancing and watching sport, and his perceived successes are being the champion folk dancer in his region of Ireland at one time and that he is about to qualify as a physiotherapist.

David hated his time at secondary school, but he had no inclination whatever to join the family farming business, so he had no idea what else he might do. He left school at 18 with six O levels, and briefly tried a course in Computer Studies, a popular subject in the early 80s. However he thoroughly disliked this too. This was followed by an abortive effort to gain some A levels, Art Technical Drawing and English Literature. Art had been one of his best subjects at school. However the teacher now, in college, had been so critical of David's work that he was completely put off the subject.

Over the next couple of years he was either unemployed (he admits to getting pretty depressed at this point) or had odd clerical work, the latter leading eventually to a permanent post. It was at this point that he realised he needed some sort of

qualification. A Social Sciences Access course led to a part-time BA in Business and Management. It yielded results and he was promoted to a junior management position in the Civil Service, dealing with non-payment of Council Tax. He disliked the strain of court appearances and the fact that the job made him unpopular with most people he dealt with. However, the skills he'd gained there were transferable - team building, communication and motivation.

David did have a vague leaning towards physiotherapy, as he was interested in sport, although he didn't play competitively. Also as his parents got older and his mother started to suffer with arthritis, he felt how good it would be to be able to do something practical about it. However, having studied on and off over seven years he was loath to start more training. He then saw an advert in the local paper and enrolled for a Level 2 Diploma in Sports and Fitness Therapy which he really enjoyed. It also gave him an opportunity to speak to a physiotherapist who taught on the course, and ask him how he would train as a physiotherapist. He began the application process, but all along, because he didn't have the biology background normally required, he was sure he wouldn't succeed. David was also very aware of the possible financial difficulties such a university course represented. He was reluctant to leave behind the regular pay of a full-time job, however unfulfilling it might seem.

Another issue was his parents' health. His father was nearing 90 and his mother had had more than one stroke and didn't always recognise him. However his two brothers had both built houses very near the family home, and so when he was in fact offered a university place, he felt their support. At this point he had to face the situation squarely. He'd lacked confidence about going to university, but now he felt more ready. However becoming a student again had been quite difficult. For one thing, being on a student loan meant building up debt, a situation alien to him.

David enjoyed being on placement most. He was a practical learner he explained, so books were less helpful to him. He found it a nuisance always having to find an evidence base for treatments too, though he saw the sense of doing it. He aimed ultimately to open his own practice, though for that he imagined he would need at least two years experience. He had already applied for two jobs, though without success. He recognised that his interview technique was going to matter, and was

unsure about his life experience being in his favour. He preferred the idea of a job back home nearer his parents. If there weren't many jobs going straight away, he might find work part-time at the local sports clubs in the area.

At the second interview, a year later, David was working as a Civil Servant back in the job he had before commencing training as a physiotherapist. Both his parents had died. His father's death had been very sudden, just a week before graduation and his mother died only three months later. He'd felt a twinge of guilt that he might have done more for them, but had gone away to train instead. Now he had inherited the family home, where his 92-year old uncle still remained. David had taken a career break from his previous job so that he could return if the worst came to the worst, and he was now able to avail himself of this backup arrangement. His costs had gone up though, for he was lodging at a place in the city where he worked, as well as keeping the family home going in the country.

As far as physiotherapy posts were concerned, David had had five or six interviews in all, for permanent or Bank work in five Trusts, but he'd not felt thoroughly prepared. In the last three or four months he'd had two interviews and they'd gone somewhat better, but he had still not got the jobs. He'd applied to an agency many of his peers had been using, and eventually he had been offered a post through them, but there were problems. Firstly, it was with immediate effect, and he needed to give two weeks' notice. Then the post was a little uncertain. David wasn't prepared to go further with this.

He also felt unsure about how the job market worked back home. Posts seemed to be being frozen, and jobs advertised Trust by Trust, rather than centrally. There was little sign of support for people like himself. He also wondered what the effect was of having a local physiotherapy programme at the university back home. Were those students preferred to people like himself? They were certainly better known by local physiotherapy managers. He sensed himself panicking about getting a job, knowing he was becoming deskilled, and yet not having done enough preparation. Courses to update himself were expensive. It needed courage to return to where he trained and try to find physiotherapy work there, but it might be his only chance. He couldn't afford to go back and forth between the two regions. His ideal job would be a full-

time post back home and he was still wondering about the Sports Club possibility at home.

There are several examples of serendipity along David's career path, reminiscent of Hodkinson and Sparkes's (1997) theory of careership. That he has noted them and agreed to try what's offered is quite amazing, coming from the seemingly restrictive background that he does. But the world's changed since his youth: it's possible to get out of a 'rut' mid-career now. He has seen his opportunities in a generally negative light though, feeling he has consistently failed thanks to the controlling influence of outside forces, reminiscent of the 'blows of fate' in Hardy novels (and sometimes viewed as dramatically). His habitus displays a lack of self-confidence that links with this external locus of control. But Beck's (1992) 'risk biography' idea also has to be borne in mind. David has gradually moved from a safe old-fashioned society at home, perhaps to escape its restrictive elements, to a changing, responsibility-laden one. It is sadly clear that he is failing so far to attain anything like full membership of his community of practice. In fact he is an example of the so-called full member (post-graduation) who is now more peripheral than he was as a student.

Appendix XIII

Interview with L2

8.4.11 (1hour 1min 14secs)

Mins. Transcript

0 **DD:** *Right, well to start off with then, can you tell me what you've been doing since . March 2009 I think it was, when I saw you last?*

Lionel: March 2009. Goodness! Right, so by then I must have been getting stressed about dissertation and applying for jobs . I'm guessing it was about then. So . had a lovely relaxed summer; it was nice not to work for a while. And .. yes . I wouldn't have spoken about interviews or anything like that. So I went to five interviews. The . I got onto .. In summary I ended up getting one job, which was a temporary 12 month contract, and I got put onto two reserve lists and got a 'no' from two other places. So I was put onto two places where I was put on reserve lists. One of them was quite frustrating in fact because they had a second wave of interviews using the same questions and the people who got more points in that second wave got put above me on the reserve list which I thought was really totally unfair basically . to one where I actually contacted the CSP, like . you know like a legal advice line or something, and the woman basically said, "Well, you know . welcome to the real world; unfortunately there's nothing you can do", which was . a concise response which I appreciated. Anyway, got the job at V., PCT, 12 month fixed term, MSK out-patients, was supposed to be 8 month's there and then rotating onto some other rotations. But ... I don't know if it's relevant . any issues which I came up with, any work place issues which I came up with during the time I was working – is that relevant, or ..?

You could mention those at this point, yes, if they had an effect on you.

So I was going to work for eight months and then do community for the last four months. At interview I'd mentioned that I cycled, and they said, "Oh yes, people have cycled in the past. It's absolutely no problem." Anyway, six weeks before I was supposed to go onto that rotation, the community manager caught wind of it and wasn't best pleased, and rang up and was really quite forceful to be honest, and, you

know, inappropriate with the way she spoke to me about it, to the point where I ended up having to speak to my current team manager . at the time, and go through an informal resolution, if you like.

So I ended up doing 12 months of MSK. Got stressed out about obviously not having a job to go to a few months before the end of the contract, but then managed to secure a job with a start date to be September 2010. So I'd served 11 months of my first contract before starting my next one. I ended up giving up some annual leave because they gave me a start date before I could organise and take some annual leave. So when I say 'giving up', I got the money for it, but still .. at the time I needed some time off. So I took some time off early on into my second contract. In the meantime as well .. Well, I started that contract and I was .. Again I'd done a round of interviews to go to that second . before going to that second job and I'd got (I can't remember now) oh, a couple of 'no's. In fact I've just remembered another little one.

Oh dear.

I was given a temporary contract at E. Hospital . and .. but obviously I was still going for interviews, because it was just a temporary contract, and they were offering a couple of permanent posts at S. The day that I was supposed to ring up and get a start date for E., I heard from S. and they offered me nine months, so because they offered the longer contract time, I decided to go with them. So E. weren't best pleased when I rang them and that was .. that was again quite difficult, because obviously . because again the woman made it quite clear that she was really unhappy with the way which I'd gone through things .. and that's been a real difficulty. But there are some managers out there . I don't know if it's like a cultural backlog thing . but kind of expecting loyalty but not offering it. So you know you offer someone a job for six months .. well, if they find a job for longer somewhere else, they're gonna take it, you know, and . you know, you get what you're offering basically. So that was awkward. So now I wouldn't apply for E.

So . the contracts that were on offer were MSK out-patients, static orthopaedic and two rotational . all temporary, at S. And they put me onto the MSK one basically because they had a huge waiting list . 18 weeks or something I think it was.

5 And they, you know, because I had the relevant experience, they put me there. So . both teams where I've been have been absolutely fantastic and I mean really, really excellent. Learnt absolute loads, felt really supported, always . had kind of regular supervisions and trainings, things like that. So now I'm due to finish my contract at the end of May. And now I suppose is where my biggest challenge so far lies, if you like . because I applied to . well, I got successful to start on a Master's course here at NKO. But I didn't start last September, because due to the temporary contract I didn't have guaranteed access to patients, and I couldn't really ask for annual leave because they'd got me to sort out my backlog, and I didn't want to give up more annual leave because I needed it just for . mental health really . just for a work-life balance.

So . that's in the pipeline, but it's something which I want to do but I've kind of been stopped, if you like, due to the temporary status. Also a couple of months ago a CSP steward job came up for my current Trust. I was the only one who was interested. That again I can't do it because I'm temporary.

So . all the ways in which I want to expand myself and kind of develop into different areas of physiotherapy I've been unable to do, purely because of the temporary contract status, which I've found at times disheartening, frustrating; all the gamut of emotions. Things came to a head, I don't know, maybe two . three weeks ago .. where I'd just had some time off and then . oh, on Tuesday afternoon at work things went OK. I mean I didn't sleep all night and I rang in sick for the Wednesday, basically quoting, we still don't know what really, either stress or burnout or low mood or whatever, just some problem to do with work. Every other area of my life is fine. My health, relationships, you know, flatmates, friends, everything else is OK.

.. I agreed to go on reduced hours at the start of .. from the start of this week, and we agreed with R., the manager, and went to a couple of counselling sessions, but I managed up till about eleven o'clock on the Monday morning and got to a point where I physically couldn't work. I was looking at my notes, and . you know, I'm used to MSK by now; I know what I'm doing; it's not .. a tax on the brain any more than any other busy job now, and it got to a point where I couldn't even read the letters on the page or write notes. So I spoke to a senior, the most senior person around at the time, and said "I'm sorry but I'm going to have to go." My manager has been extremely supportive and fantastic. She said .. she's liaised with Occupational Health and they've mentioned . discussed that a phasing back to work

needs . shouldn't be done too soon, so I've got the rest of this week off. I'm seeing my GP again on Monday. I'm not taking anything at the moment, and I don't want to; however I do need to listen to the opinion of professionals in that area. So maybe looking to go in doing part-time hours, very part-time I'd imagine, doing non-patient-facing stuff. One of my big concerns, of course, was that .. I've become unable to work at the position where I'm going to be applying for jobs and don't want my sickness absence to be affected. Though my manager's reassured me that, at least as far as S. goes, that that will be for Occupational Health to deal with, and it shouldn't . provided people are playing correctly with interviews . that it shouldn't affect future job appl ... you know .. the likelihood of being given a job, it shouldn't adversely affect me. So that's where I am.

Right. So . have I got it right? You had a contract at V. and you almost worked it completely out ..

Yes.

So about 11 months MSK there?

Yeah.

And .. was it a six month rotation then?

It was four month rotations with a double rotation in MSK to begin with, so I should have done eight months MSK and four months at community, but another girl didn't mind going onto community and to please . to make it easier for everyone concerned, I was quite happy to stay on MSK.

What other options were there in the rotations?

So it was MSK out-patients, community, community respiratory with a little bit of clinic work and exercise class work, and Neuro . community again.

Right. And then you had a go at E. but that was shorter term than S. so you ended up at...?

Yes I was accepted at E. but never worked there.

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There's one or two questions here really. First of all, this is a bit of an uncertain business I suppose and this burn-out – how did that happen do you think? How do you ..?

I think . I'm quite confident that I know what it is that's going on, and if anything I think I've made the GP and my counsellor's jobs fairly easy, because they both said . they both said I've got a lot of insight and I'm very self aware, and that .. the fact there's no other confounding factors, that everything else is fine .. I just know it's work-related because I've felt OK when I'm not working, more or less . because obviously the career insecurity affects you outside of your office hours.

But I think it's because I came into this profession at 23 and it's .. One of the main reasons I came into Physio was for job security and pensions and all of that kind of strong organisation behind you that it offers. So, you know, I worked for a few months in a nursing home, I volunteered at Samaritans, got on the course, was the CSP rep. for three years, and . There were two of us but I did - between you and I - I did a lot more of the work. You know . went on two extra placements, one of which was in India, and that I funded myself through part-time work. So I did absolutely everything possible to make myself as employable as possible, to really make sure I got that rotational post or that permanent post, and .. so the reason why I think I've ended up feeling like this is firstly that I've done everything I can to put a hell of a lot of effort in without the reward and . so that mismatch is definitely a source of frustration and loss of motivation. Another sense being almost like a sense of randomness at which . where people get desirable posts. I've spoken to many colleagues about how you get some people who kind of coasted along, and some people who are a bit rubbish really, who have got their permanent posts, and others . and then people who were really good students and who, although I never saw practice I can imagine would be excellent Physios . fantastic people, who are now out of work. So .. you know it's . if you take these last one and a half years of being qualified and the three years of study and before that, so that's almost five years, and

at 28 that's still a decent chunk of my life, and where I'm at now I don't feel like there's nowhere to go, but I'm having to drastically change my plans. I can discuss plans later on I'm guessing?

Yeah yeah, sure.

So I think that .. you know, I'm nowhere ... where I need to go with my life and the options that I have, they're completely different to what I've expected, and despite my best efforts to stay on track, external circumstances which I haven't been able to affect have pushed me off. And I think the reason why I'm off work with this, whatever it is – stress, low mood, burn-out - I mean the GP and counsellor have both said that they agreed with me that they're labels and everyone has .. you know, similar to physio, you don't get two anterior knee pains the same, and you don't necessarily get two depressions or burn-outs that are exactly the same. So I feel like I understand what it is and my brain is just trying to adapt to a new situation and as a result it does have things like effects on mood, motivation, energy.

It sounds like the stress of the situation is a little bit much for you.

Oh yeah. Chronic stress as well.

But have you always avoided stress up to now? Because I remember from the last interview a little bit you had.

Some stress?

Well yeah, but I think you talked about how you'd avoided it, if anything? You'd got some fair ideas about what stresses you.

I think stress at work for example . Again MSK out-patients, obviously it's very busy. I thought I was fine at managing stress at work, so for reasons why people tend to have problems with on the job, the actual job itself, were things like not keeping to time with appointments. But I was fine with that, I was happy to say, “Well I'm not going to do this today with this patient, because the system hasn't given me time.”

You know the employ .. So I knew my place within a system, I knew what I could do and not try to change the world, which I think a lot of newly qualified people try to do. So that, I didn't do that. I made sure I didn't do my Master's because I didn't have enough annual leave to take. So I think .. on a day to day job, purely job basis, I've been OK at managing it. In my last year of Uni, I stopped working for Pizza Express for pretty much all of the third year because I wanted to concentrate on my studies. So I've always been motivated and driven and making sure I'm putting lots of stuff on .. but I think I'm better at allowing myself that free time, and with the work stuff it was ..

- 15** .. I chatted to my manager very early on about how I was feeling, and explained to her, so she knows that it's to do with chronic job insecurity. When I didn't even manage three hours at work, to be honest, that was a shock to me because I didn't expect to manage so little. So . and you know, the feelings of that and not being able to work due to the situation, it was kind of a .. it was an interesting sensation. It's something which I think I'll learn from, you know, because I think I'll .. I'll know not to feel like it again, and, you know, I'll hope to see warning signs and also to see the warning signs in others, so I don't think it's going to be a bad thing in the long, long term.

No. No. What I was going to ask you next might be a wee bit difficult for you. I don't know, but .. I was going to ask you to take me through a typical day at work.

I can do. I can do. Yeah, that's fine.

So can you just tell me what your work entails at the moment? What do you do, when do you arrive and all the rest of it?

Well, my most typical day would be arrive at half eight, leave at half four, with half an hour lunch in between. My clinics would probably vary between . if I go from say a fortnight ago, before all this interruption . my clinics would vary between 75 and 100 per cent full. Forty .. I can't even think now . forty minutes for a new patient, twenty minutes for a follow up; between two and four maybe new patients every day, if you have lots of gaps in your follow ups they might be filled in with new patients.

Every day . new patients?

Yeah, every day. Yeah, at least two, and maximum four .. unless someone has a really quiet clinic and they've specifically requested to fill them up with new patients. When I have gaps or people who didn't attend or something like that I might be writing discharge letters, and sometimes just stealing a moment for a cup of coffee and chatting with a colleague because, as much as .. you may not say that sort of .. you know, that's optimum productivity, I think those little moments are good for all concerned . and discussion of awkward patients as well, complicated cases. It's worth to take a small part of the working day as well popping out to chat to a senior colleague about that. Thankfully it's curtains, not closed doors, so it's easy to find someone. When I first started that would be . that would happen more, whereas now .. chatting about an awkward patient is less and less . becomes less and less common, and when I do ask about it more commonly the senior will just agree with what I've said, which is nice.

Oh, that's lovely. Yeah.

Is there a sort of tier system where you can only ask certain people such things?

I've got a supervisor and ideally would chat to him. Recently they implemented something where, near the end of a morning, there will be one senior who's got a slot free so that if you've got a burning question you can save it till the end of the morning and that's something which is kind of just being trialled at the moment. I don't think there's too much of a need for a tier system, at the moment particularly, because most of the band . I would be the least experienced Band 5 and I've been doing it for a year and a half, and only . and just that. So it's not like I've just been rotational and come onto it, so everyone kind of knows what they're doing; no one really needs significant support and there's enough physios for there to be always, almost always somebody free. And the culture is, if there isn't, people will open their curtain and speak to you if you need help.

And when you say 'clinic', just to be absolutely clear, you are all working in one department? It's not as though you're ..

Yeah, yeah.

Or are you following a particular doctor's clinic or something?

No. We have a . there's an office and a kind of row of desks, if you like, and then the curtains, you know, just everyone all in one big room if you like, yeah.

That's good. OK. What about the people that you're working with? Do you work in teams as such? You said you'd got a supervisor.

Yes. So where I am, there's let's say, I don't know . three Band 5s, a few Band 6s and a few Band 7s. And then every week I would meet with my . like a clinical supervisor, if you like, who sorts out yer . who will talk, who will teach you something or talk through complicated cases. There's a policy in my department where if you've been seeing . if you're seeing someone about – I can't remember now – about four times . three or four times and they're not improving, to automatically discuss it, which is good because it brings up answers where you wouldn't have initially asked the question. So that's lead in to more case studies being discussed. His role is also to go through your key skills stuff and those sorts of things. So that's structured on that level I guess.

- 20** The admin staff book in the patients for you, things like that. We have a technical structure, a guy who did a degree in sports science and is re-training as a physio. So he gets passed patients like ankle sprains and things which are easy to rehabilitate but could do with one to one exercise. Most people are involved in an exercise class at some point, so I'm involved in shoulder class on a Monday afternoon; lower limb, we have one on Thursday afternoon. Is that enough?

Yes, that's nice.

Yes. Aside from that it's fairly . not self-sufficient as such . We don't have a lot of contact with other MDT members. It's just, you know ..

Do you see any students?

We've had a couple of students come in and I've asked for them to come in on my clinics to . so I can put it in my CPD file basically, which has been nice. It's nice to see them look completely flummoxed. It reminds you of how far you've come. [Laughs] So that's happened maybe twice. I think it's nice to have students around, but the main limitation is physical space, because there's not enough desk space even for physios. Physios end up writing on a plinth in the cupboard where the skeleton is kept and things like that, so ..

Oh. Yeah. Not so good.

Now .. if somebody said to you "What would you say a fully fledged Physiotherapist was?" what would you say?

I think it totally depends on the person, because 'fully fledged' for one person might mean be a specialist in a certain thing and another might say a generalist if you like, so .. I mean, I don't know if I would ever consider myself fully fledged anyway really because . what is it, 'you stop learning when you die', or whatever that famous phrase is. So . you know, I would consider fully fledged . I'd want to be spreading my wings a bit more by doing . by looking into the academic work or the CSP steward/personal relations sort of work. ... So .. I personally will just want to continue fledglingly. [Laughs]

So you don't think you'll ever arrive? That's interesting.

Well, when I look at the seniors for example they're probably the best idea, and when I chat to the .. them at work, plenty of them say "Well, we don't know how this works or how that works", and you don't realise how grey and how many unanswered questions there are until you . until you keep on trying to answer them. One of them at work is considering retiring because he feels like he's forgotten more than he knows, and he thinks that's a bad sign. So I don't think I would ever sense that, for me arriving and fully fledged means you haven't got anything left to learn .. if you like.

Right, and that's worrying as far as you're concerned?

Yes, but I don't think that's . I think tha . I don't find that upsetting if I'm invigorating and exciting and motivating, so ..

What is quite interesting is that unlike one or two of your peers you consider that you're expanding yourself and becoming a bit more fully fledged, at least that's what I understand so you might correct me, by becoming a steward?

Oh yeah absolutely.

What's the attraction there?

Ooof!

How do you think it expands you?

.. Oh dear, I haven't had to verbalise . I know in my head, but to actually translate it into words .. I had a chat with a lady who does it, so I think the first, the one thing is the .. well obviously, I was CSP rep. so that kind of helps a bit. I think having an idea of physiotherapy within the wider spectrum is great. I mean I'm not really too political so I'm not that bothered about rallying and all that kind of stuff, although I think it's very interesting, and at least to be able to facilitate people into doing it, should they wish, would be fantastic. I like how it's . it would take . it's .. Provided you're with an organisation who will give you the time to do that as well, which S. is, you're .. it means you're not just seeing patients all the time, so it's a way of giving your role more variety. I think the whole interpersonal communication and discretion and all of that . so taking part in, as a third party for disciplinaries and for grievances, I think would be absolutely fascinating, and that, not negotiation but mediation rather . I've been told at many kind of interviews or, you know, professional feedback that I'm articulate, and from the kind of experience from things like the stewarding and mentoring, and from the Samaritans, I feel like I'd be able to apply those skills more and working, you know, a professional for professionals, again is a different thing again so I feel those are all different things which I could expand on, and I would just genuinely find it really interesting I think.

That's interesting because I think quite a few people seem to think that, you know, being a physiotherapist is enough, that contact with patients and getting to see more and more patients is enough, but you're suggesting that you're wanting to negotiate with your workmates and things as well.

Oh yeah. I think it's a real . because it gives you .. an extra role or an extra ... an extra string in your bow if you like, so I guess it can be good for employability to some levels. For example, if a job comes up and I'm interviewing for S., I'm going to bang on about wanting to be a steward, because they need one and no one wants to be one. So that would definitely help. So of course there's that, but . that actually wouldn't be the primary reason for doing it; it would be just for the enjoyment of having something else, so .. No, a physiotherapist is not just about seeing patients. Those who just want to see more patients . and I mean .. There's one person I can think of where I'm working now, who . I don't think their interpersonal skills are that great, and when you're in the staff room I don't think their views are that well formed and they can sometimes come across as very short sighted sort of opinions .. well, not short sighted, but ill-considered opinions. She's only young, but still. And it's surprising how, when you work with a population that can be so diverse with such a multitude of opinions of patients, that you can still get physios who haven't quite . whose eyes aren't quite that open. And I think being something like a CSP steward widens your eyes even more, and I think that can only, you know, I don't know exactly how, but there are intangible ways in which that would bleed through into patient contact as well.

Right. Ah . that's an interesting thought, isn't it?

OK. Tell me, you've talked about one member of staff there – what about a role model? Is there somebody that you consider is the kind of physiotherapist you would like to be?

... My .. Clinically, or ..?

Whatever.

OK. I'll kind of split it in fact, because clinically . clinically I think my supervisor . I do think is excellent in fact, because he hasn't pushed himself towards any sort of discipline if you like. So yes, he does acupuncture but .. you do get people who acupuncture everybody and he doesn't do; but he only does it when he really feels it's necessary. He's very heavily exercise-based which I think is fantastic, but in lots of different ways, so it could be kinetic chain or it could be just pure exercises or it could be your protocols or there'll just be . or it can be functional and ... But his. his reasoning is obviously sophisticated and all of that, but it's extremely consistent as well. And note writing if legally probably . they .. other colleagues say they can't understand what he's written down, because he'll use abbreviations which aren't that common. However, he is extremely consistent and concise, and you know exactly what he's done. And he just takes out all the crap basically when, you know, he can really, really focus in, but still cover everything as well. His time management is terrible, but he knows that and he tells me [laughs] that mine's better than his, but he's happy to do that, and so you know I let him carry on with that.

But then professionally, it would be my old team manager. My current one is excellent as well but my one at V. she was absolutely fantastic. She's the best manager bar none, and I've been working since I was 13 in all disciplines. She does some clinical work. She was extremely down to earth, so she's allowed me to supervise her before. She would explain where the organisation lay . where I stood. So she would try and help us and support us as much as possible, for example when it looked like I was going to have a grievance with a prospective manager who I hadn't met yet. Extremely supportive, but you could approach her at any point with any questions. I think when someone's really stressed out, myself included, if someone comes at the wrong moment you might just go, [heavily exhales] as if to say, "What now?" She never, ever, ever did that and that's .. Another thing which she said, when I was having problems and discussing it with her about the potential grievance, she said the way in which she operates as a manager is that . she was told to repeat anything which she'd liked about previous managers and not do anything which she disliked and that's what she went by.

- 30** And I've remembered that and should I have been in that sort of . should my career take me to that sort of thing, where I do something managerial or even something like a steward thing, where you're dealing with people in a specific role, then . I

think that's something which you can remember and use. It's almost like somewhere to guide you if you like. You can never stop repeating that to yourself, so ..

Right. Yes, that's really helpful. So you wouldn't be averse to taking a managerial role, if you had a chance to?

At this current point in time I think not averse as such, but I think there's plenty of other things which I would like to do. Obviously it's too early to consider something like that, but there's other ways in which I want to .. go in the short to medium term before something like that.

Is it important to you that this manager actually still had contact with patients?

.. I don't know. I'd be interested to know if it was important to her really. I think because they often say it's very important; they say it's useful to keep in touch basically and keep abreast clinically, and when I did observe her clinically it was highly useful. I think if a manager isn't .. Where I'm currently working my team manager's clinical but the manager above her is not clinical, and she knows that she can't be clinical any more, but she's kind of, you know . she's out of touch now; she's not up to date, let's say. So because she's always in an office I guess it gives maybe an extra level of removal, but I don't know if that's because she's not clinical, or just because of kind of your status, or because of how she is as a person. She's fine but she's not ultra warm or anything like that, so ..

Now . you said you went into physiotherapy at 23. I seem to remember from last time that you hadn't thought of doing it from school and said that you would take the same route if given the chance again. So it wouldn't have been the right thing to go into physiotherapy from school as far as you were concerned?

. Well, because I hadn't .. No actually, because when I did music, I really enjoyed it and if anything it's something I've noticed myself going back to a little bit, especially while I've been off. It's just which I seek .. not 'seek solace in'. That sounds a bit dramatic . but that sort of thing.

Well, something comforting.

Yeah exactly. And I'm not just a physiotherapist. I don't want to be a physiotherapist for more than 37.5 hours a week, you know; that and when friends ask me questions and that's it; that's enough. And also when I was 18, I was quite happy to spend my money badly and get drunk and things like that. And you don't really want to be doing that when you're dealing with people's health, so .. And you know you see some students doing it . as physios, which I frown upon. And I think a big thing with me is my people skills as well. I've never . since qualifying I haven't had any colleagues say anything other than complimentary about how I deal with patients, people-skills wise. Is it something like 30 per cent of .? There was a study to say that over 30 percent of people's improvement is due to communication, and you hear about placebos. So I think one of my skills as a physio is just the way I chat to people, and I would never have been able to . I would never have done that in the same way at twenty . coming straight out of Uni. No way. So I think I'm better for it, for having waited.

But that of course makes you what I label an atypical entrant.

Yes.

Because you're not an 18 year old girl whose aunt's a physio.

That sounds about right, yeah.

So how has it been for you? Are you glad that you went about that way? It almost sounds as if you are.

That I did physio ..?

That you are unusual to physiotherapy?

.. I think when I was studying, it meant that I naturally gravitated towards a smaller group of .. I ended up hanging around people who were in their 30s and 40s rather

than people who were just a few years younger. Having .. Once I started working . it can be a little bit .. It's very difficult when you start because obviously you're so new . you're still new and you're .. I've always been, everywhere where I've been, I've been the least experienced person, aside from maybe the Technical Instructor where I'm working now. And because of that it can . it does ... when you think of like a life path or something that it, it can knock your confidence a little bit, if you like, to feel like you're at the start, when you're with other people of a similar age, who are .. you know, or even just one or two years older, who are a couple of bands above and they've got a house and they've been able to get all the other things which I would want. However, you know, in doing that obviously they don't have a Music degree, you know. They don't know classical music as well as I do, and obviously they don't want to but I did, and I'm glad I do. So yeah I'm broadly happy with it. I consider my choices well and so I wouldn't regret them as a result.

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No. Right. OK.

Has it been at all difficult to fit in with these people? I mean, it sounds a tiny bit as if there's a certain amount of, oh I wish I'd got that far by now, because things have changed a bit in the time that you were training. Unfortunately things changed and the people that did go straight out of school perhaps had an easier time than you.

Yes they did, but .. I wouldn't .. that was something which was unpredictable. I could never have predicted that, so that's just tough luck, you know. Plenty of people have problems in a recession. I know loads of people whose jobs are insecure inside and outside of Physio, or out of work, again inside and outside of physio. So for that I don't blame my timing or the physio profession. That's just the economy. So .. yeah.

Are there things that, because of the economical changes though, are there things that your colleagues are having to get to grips with? What sort of things are causing problems in physiotherapy as a profession . that you've seen?

Well, the waiting list obviously ... because you get . you see more chronic conditions and people coming in who've waited ages, and they've either healed or got a whole lot worse, or just want to . who are just a bit pissed off and want to rant at you at the first appointment. But that's only minor. Most people are just happy to see you, and

.. At least that's my experiences. So, the economy .. Well, my peers, the ones who went to P.N. (that's the place which had the jumping people ahead on the reserve list) ... those people, funnily enough, those who got the temporary contracts are now out of work. Of the three that I know, two of them went back to Ireland, so they've kind of moved as a result of it. So there you go; that's a drain on UK physio. Two of them have gone. I think there's one girl who I saw via her Facebook and on the website that she's gone into private practice. I don't know if that was an economical thing or not and frankly when I look at the website, I'm pretty disgusted, because she seems to be offering Interferential and TENS. And as part of advertising herself, she's put something like, "Oh, NHS waiting lists are really large, so come to me", basically . in a nutshell, which I think is quite unprofessional, to be honest. So amongst my peers I suppose that's that.

Amongst my colleagues, well there's all the restructuring of different NHS places so you know S.'s going to be mixed . turned into . and become part of some giant Q. Trust. There was a perceived .. job insecurity with all the mixing of Trusts, but we've been assured the front line aren't affected, although I have known a couple of managers who have been a bit concerned about their posts. Where I'm working now, they feel for me and my colleagues from our temporary posts. They say they don't know how we're doing it; it must be awful. And I've spoken to people at Band 5 who had the same thing a couple of years ago, said it was a really stressful time so . obviously not just me. And for Band 7s at work now . they believe that . the word is on the street that their job description's going to change, and then they're going to be brought down to Band 6. Now obviously there's loads of people . there's a kind of block at Band 6 at the moment, because there's not many Band 6 jobs and therefore all the Band 5s . there's not many Band 5 jobs going, because everyone's stuck there. And they're even less likely to move aren't they, because if they re-band Band 7s down to Band 6, there's just going to be an absolute choke . a sort of asphyxiation, if you like, on progress. So that's the main thing, not so much job security but less remuneration and not feeling so worthwhile I think. I'd say that's the main concern of most clinicians.

And its effect on you, do you think that's part of the burn-out situation?

No, because that's above. I'm not too worried about making more money. I want to just, the way in which I would see myself progressing is for example the Master's and the stewarding role and just doing the same thing for longer. So staying at Band 5 wouldn't fuss .. at least not in the short term. You know, I wouldn't want to do it for 10 years, but it doesn't fuss me now because there's plenty of others ways in which I can grow.

40 So no it doesn't affect me, shortly.

That's fine. OK. So what particular things in your path into physiotherapy so far, may have been an obstacle to you, that you've either countered and got over, or that is still looming?

Well, perceived obstacles I suppose were interviews, in that I really expect .. I didn't expect to be carried through with all my extra stuff and .. sometimes I think I'm a bit unfair to it because all that extra stuff on the form quite possibly got me to interview stage. However when it got to interview .. and this is no offence to you and academic staff, but when I was working . when I was studying here, we had the impression that doing all the extra things would help me at interview. To be frank, when it got to interview, it didn't. They asked a certain set of questions and you had to answer those questions a certain way, and if you got them .. you know it's tick boxes, and I think that's something which is really sad at the interview process because there isn't .. I've done 10 interviews over two years, five each year, and only one place did they say "Is there anything you'd like to add in support of your application?", or, you know . was there any room for me to say what extra stuff I've done. And I'd say less than half . yes, only three or four Trusts looked at my CPD file. So obviously if you don't look at the CPD, and you don't ask in questioning, it's not going to make any difference. So that is ..

Do you think they've maybe assumed, because they'd read your statement though, that they knew about those things?

I guess so, but I think just because they have to have the process so rigid, and they have to treat everyone so fairly . I mean the NHS is so big on that, the whole equality and all of that, that they ask you a set of questions, there's a tick box and answers

from which, you know, the more boxes you tick the more points you get, and they're not going to have things like CSP rep., and 'did a placement in India', because they're not boxes which are going to apply to the population I suppose.

Right. So too much systematic approach at interview then was a bit of an obstacle?

.. Yeah. I don't know if it was an obstacle as such, but it was I thought I was going to be able to . not 'stream ahead', but that sort of thing. I thought I was going to have the upper hand in it, so it wasn't so much an obstacle as such, but it was an opportunity which I thought would be there which kind of wasn't. So that I kind of sense as an obstacle, because I expected to be ahead of the pack. So I didn't . I was just put back in the pack with everybody else, which is why probably I got acceptances – acceptances, reserve lists and 'no's because I ended up going backwards.

Do you know of other people who've had the same sort of experience, or anything different for that matter?

Not those who .. I don't know of other people who've kind of done lots of other stuff and they didn't count for much at interview. I would say that there has been that sense definitely of interviews not ... You know, if they ask you the right questions you get the job basically; you know, it just has to fall well for you. And if they ask you the right questions then great and if they ask you a couple of questions where you don't know, then tough. There were definitely a couple of interviews which I thought were just very poorly done, but I think that's the same with any profession. Some people are just rubbish at compiling interview questions, you know . really just languid questions or irrelevant stuff, you know. And the other obstacle really which I would put down is just the unemployment, well the availability of jobs; that's the obstacle to me. That is really the big . the big thing.

Yes, that's not too good is it? On the other hand, have there been any key moments, or key processes I suppose really, where you've felt you're really developing as a physiotherapist?

.. Well, with clinical work, the fact that I've only done one thing means I have a really good timeline if you like, because it's just so narrowed down onto that band of physio. So that has just been a slow continual thing with, when you get a complex patient, and initially when you knew you were overwhelmed and so on, sort of hold your hand and explained you through it. And then you get more and more of those patients and you consolidate. So that's something which is just very ongoing; no particular event . but as an entity, if you like, it's definitely extremely relevant. When I started on my new post I pretty much revamped on exercise class which I think ruffled a few feathers because there was a girl there that had been doing her exercise class for years .

45 which basically wasn't very good, and my manager gave me free rein to kind of sort things out. And I did get a little bit of feedback of, "Well, maybe you could have included more people in here, and in there", but you know it was a bit difficult because you're trying to fit in. But that's just being a newly qualified professional in a workplace, so that helped me develop.

... So again, being in the exercise classes, so really .. the other separate little roles, I've done a few exercise .. I'm really proactive so when I've had some down time I've worked out something, so my last place, for example, we didn't have any upper limb tension test exercise sheets, so when I had DNAs, or anything like that, or had some time off . we didn't even block time off, just said, "Well what we'll do, as and when, I'll sort out some exercise sheets." And I did that, and printed them off, and now we've got exercise sheets. And it's just little things like that, so .. I think it's quite easy in MSK because it's so busy you could easily just keep your head below the radar and just go along, treat your patients and that's it, but if you've got the gaps and you've got a little bit of imagination then you can find ways of developing it yourself, so .. Some of it was suggested to me and other ones, it's just been rubberstamped. It's been supported by the managers as opposed to pushed.

Do you think people have given you enough suggestions and opportunities to do different things?

.. Yes. In my current post I would say to my manager, "Well, would this be useful to the service? Because at the end of the day I'm employed to improve the service. So, "Would this be useful to the service?" "Yes." "Can I block time off for it?" "Yes."

And I'd say if ever I felt as if I had too much on my plate, that would have been where I haven't blocked enough time off and I'd . you know, because it's always a balancing act; we're always learning how to balance our time. And I wouldn't have got it right 100 per cent of the time, so that would have just been me learning differently to block time off then. I've approached my manager and he's allowed me to do that.

Great. Do they send you on courses, go on in-service training, anything like that?

The in-service training is there in my current trust but several times, I don't know, someone's forgotten to do it or something like that so it hasn't been that great. I don't mind too much to be honest, because I get plenty of learning, just loads from informal discussion. Regular in-service training at my last trust as well. There was a course which came up called Leadership Challenge which was at a hotel in V. and this was when I was at my first Trust. And I asked if I could go on it, even though I was, you know, the most newly qualified, and she said "Yeah, by all means." That was great. It was two days with a night in a hotel, so it was a bit of a change. And it was kind of, this very . giving you scenarios about some sort of .. Imagine you're the manager of a Trust and, I don't know .. wild animals have roamed into the Trust and, you know, just things like that and then a more serious one on day two, and so that was kind of all about discussing and team work and all those sorts of things. So yeah, that has happened .. but .. what I would say I've been limited by would be economics and funding . the fact, for example, that I haven't been given study leave to do a Master's and therefore I haven't been able to do it. If you go on courses now I mean you basically have to pay yourself, so I've booked myself to go onto a Pilates course at the end of June, your mat work number one if you like .. but, you know, that's at a weekend and I'm paying for it myself. It's not so much a financial thing but not being able to take the time off, I think, does limit people, because I think study leave is useful and I'd say it's, given that .. they've been so supportive in every sense in both places where I've worked, yet study leave is something which they haven't been able to provide. I think it's money, at the end of the day, that's stopped that.

Have you heard of anywhere that is providing courses OK for those staff? Is there anyone that you know?

These days not really, no. I mean it happens but it has to be pretty exceptional in order to do that and, you know, they might let one person go or something or... So no I've heard of very little.

In what ways do you see yourself as having changed since you moved into physiotherapy, to this new career role?

..... As myself, as having changed?

Yeah, if you think you have. Maybe you haven't.

More recently where I planned to go with my life goals and things like that are changing.

Ah. That's coming up next, so you can do more on that if you want to.

- 50** Yes. So I don't know if I have changed. I think I'm just more of the same really. So you know I've developed my people skills, I've developed my clinical skills, etc. etc. etc. I just feel like it's kind of I'm just digging in with more roots as to where I wanted to be. So ..

Good, good.

Which is fine. So yeah my aspirations and goals and ideas are .. I'm having to revisit those. And very recently I think I'm very much in the middle of a process of changing those at the moment.

Right. Well, tell me a little bit about it then?

Yeah. So, it leads on quite beautifully then. Basically I've been wondering where to go with work, because I think it's quite realistic now that I could potentially be given a permanent contract, I could be given a temporary one, I could be given nothing. So it's .. I think part of this whole me being off work and getting stressed out is, you know, letting things settle in my head and knowing where I want to be. Because I've

been . clinging on to this permanent work thing for so long, and it just becomes less and less and less .. As time goes on, and you've got more experience, less and less jobs come up. And you hear more on the TV about, you know, the NHS shake up, which in my personal opinion sounds like a disaster waiting to happen. And I've lost faith in the NHS; I really have. Well, not so much lost faith in it – I think it's a fantastic idea, a brilliant institution – but the way in which it's . I feel like it's going to be dismantled before our eyes. Whether it will be or not I don't know, but on that level at least, I'm not . I can be positive in some ways and very cynical in others, but because of my personal experience has been nothing but insecure.

So if I can a permanent job, great. That's the ideal I guess, because it gives me job security and it means I can just do my nine to five, potentially do the other stuff, and then maybe, you know, in a year or two's time, I'll be able to get a house and a mortgage and something like that. Because I drive but I don't own a car, and I live . and I've got extremely, extremely cheap rent . as a result I can save on my wages. So the job security is more important than my wages themselves. If I got a temporary contract, I don't know if that would be very good for my mental health to be honest, because it would just feed into that insecurity again. So I'm wondering if it would be better not to go for that, because I'd probably be better off out of work. I'd probably be more productive doing that than . I'd feel like I'm flogging a dead horse if I'm in a temporary contract, although at least I'd have my foot in the door somewhere.

The other option is agency work, and the other option is finding my own patients. And frankly I would have wanted a few months more experience or to have done more courses before doing something like that, because clinically I'm ambivalent because, so .. and by 'ambivalent' I don't . you know, I mean in me, in the 'torn between two' sense rather than the 'impartial ambivalent'. Because I've had experienced staff say to me, "Well, you've done nothing but MSK for 18 months; you could theoretically apply for a Band 6 post." So clinically I might match for job descriptions for that, so I'd be OK for my own working and that sort of thing. However it's 18 months, but it's only 18 months. When you check the CSP, which I have done because I've made some research into it, the CSP suggests 5 years experience, 2 years minimum, so I would be going lower than the minimum recommended by my trade union/professional body. However I've got to earn a living ..

The bottom line I guess.

Exactly. But I do trust myself with regards to things like scope of practice, integrity, my limitations, knowing when .. you know, those sorts of things. And I would be responsible with that and I would not save face at the expense of clinical judgement. I'm heartened by the fact that when I do chat to colleagues about something .. sometimes it's someone who's very complicated and I just want to go to him just because I'm a Band 5, because of my job role rather than because of my limitations. And they go, "Yeah, that's absolutely fine", so I feel confident in all of that. Organisation and legally and book keeping and all of that, I feel like I could, you know, I am very much, much more organised with all those sorts of things than I used to be.

So the idea of fun and .. but it's almost like going the other way, because I was wanting job security, and doing something like that is the diametric opposite of that, but in some ways I can imagine seeing that as almost like a new challenge and something to look forward to.

55 And I know people who, you know . I know somebody who's in book keeping, I know someone who's in business and you know those sorts of things. And at the end of the day, you know, as long as it was properly managed, it might sound a little bit eccentric but I could theoretically put a plinth on a bike and do home visits, you know, and that would be . I think it would very much appeal to all the lefties in Z. and .. [Laughs] or even just getting a little car and doing home visits and things like that. I think it'd be a really interesting venture. But I would rather do that. I would rather have done that six months down the line; however I may not have a choice. The other thing being as well is, you know, the expectations that people have, and there are a few other courses which I'd like to do. So for example, Pilates . you know you need your mat work II on top of your mat work I to be the instructor in Pilates, so exercise classes would be a way to go to try and set up one somewhere.

I go climbing and there's a couple of empty rooms in climbing centres so that's a .. to me, that's an untapped market of middle class, high earning, middle aged people who are just waiting to get fit, and also something like sports massage. It's a level down from physio in the responsibilities wise. However it's a nice little earner, and I would be quite happy to do something like that and working for myself means I've only got

.. 'I've only got myself to blame' sounds really kind of accusatory, but that sort of thing, that sense of being your own boss ..

So I feel . there's mixed emotions about doing something like that. I think there's risks and pitfalls which I would have to be careful with. And .. there are definitely people who have gone private earlier than I, who are doing it already and frankly I think they're either foolhardy or irresponsible or a mixture of the two, because when you go and you work, you know, if they haven't got any NHS experience I mean that's really foolhardy to be honest. I think if you go into the NHS as a newly qualified you realise how little you know.

The other thing about working for myself, or something like that, is I wouldn't put any pressure on myself financially. All I would have to do is not even sustain like subsistence if you like. It would mean I could do my Master's and I would love to do that. So it would be . the insecurity would be there, but if insecurity's . omnipresent then it would be liberating, to work for myself and do the Master's, because I'd be . everything would be of my own doing.

So who knows, in the next eight weeks or so, because it's the start of the financial year, jobs are going to start to come up. I'm just going to apply for the jobs and see what happens, so I do expect a stressful time ahead but to be honest I think whether I be in permanent employment or unemployed I think I'm going to be happier. I think I'll be happier unemployed, or at least once I get to that stage. .. I mean I've been in perpetual flux and transition and not knowing where .. And once I'm somewhere, I know where I'm going then. Then I think I'm going to feel a whole lot better, for better or for worse. I think I'll be better in my own head.

Right. Jolly good. Yes, you need something stable for a while, don't you really? That's the feeling.

Yeah. And even if it's stable unemployment and stable trying to find some customers of my own, that's still . it's still a path. At the moment I don't know what path I'm taking and that's what's doing my head in.

So ideally what would you want to be doing in ten years' time?

Ten years time? Ooof.

Awful long way ahead! Sorry. Any ideas at all? I mean if you haven't, don't worry. It is a bit of a vague future isn't it?

'Blue skies thinking' are we going for here? Yeah?

Yes we are.

I think 'blue skies thinking' . I will give you a realistic one as well. 'Blue skies thinking' .. nice sort of environment, stable, NHS still intact and still the same NHS as what I see it as today, working at a level where I am Band 6 or 7 clinical. I suppose at ten years . should be ambitious; let's go for Band 7. I think I would like to have seen some students and still be observing students. CSP steward. And potenti .. I'd like to have a Master's, and potentially be doing some academic work; I don't know. I'd only find out once I'd done the Master's but I haven't ruled out academia, at least in part.

- 60** I think you probably get the idea from me that variety is the spice of life. But I think you can, in physio you can do those things. There are people who are part clinical, part stewardly, part academic, so that is for 'blue skies' scenario. And if the NHS goes to pot, then still academic and potentially doing some private work. I don't know. If I did do the private work, the other thing that I didn't mention is that I would look to do it quite organically. Some people can be very competitive; "I'll business plan. I'll do this, that and that." I think what appeals to me, the idea of doing that sort of thing is working at your own pace and at your own terms, and .. given that I have been stressed out at different points and I've done the whole hard and fast paced thing, I think that would be .. possibly good anyway. It's an interesting . it would be an interesting door to open and have a look at what's inside.

Very good. Anything else you want to comment about that we haven't covered?

I don't think so, no.

That's really good. Thank you very much indeed then.

It's alright.

Diary Notes

Environment:

In my office. We sat at the desk by the window (Lionel admired the view) with the recording machine between us. I checked with Lionel about this last, as he was the only person to ask to have the recording machine moved out of his line of vision last time. When I told him that he laughed heartily, but maybe a shade self-consciously. Perhaps I shouldn't have mentioned it.

Position:

It was a sunny day and I had my back to the window, eventually finding myself over-hot. I soon became aware that Lionel, facing the window more, had bright light in his eyes. But he didn't complain, and in fact had said it couldn't be too warm for him.

Sound changes/interruptions:

Late in the interview, Lionel crossed his legs in such a way that his knee could tap under the desk where the recording machine lay. This happened a couple of times. As the window was open, there was some traffic noise.

Interviewer:

Reasonably at ease.

Interviewee:

Lionel came across as being slightly nervous. His hand was at his face for two-thirds of the interview, covering his mouth and tugging at his chin. At about 40 minutes into the interview, he crossed his legs in a more relaxed way, leaned back and his arms fell away from his face.

After the interview:

Lionel cleared up a couple of points I'd forgotten. He definitely means to stay where he is. So travelling's an issue, particularly as he gets around on a bike at the moment. He has a driving licence – just no car at present. (This had stopped him getting a rotation in the community.)

Also, he's not tempted to work abroad. I suggested France, where his mother is. The idea made him laugh. Clearly out of the question.

He did wonder if the fact that he had a music degree could be put to use. Perhaps he could offer physio to people at his college? There were notices on the board there – third year students offering massage etc.. for instrumental-caused physical problems.

We discussed his plans to cycle round local patients and what might be entailed. It's a somewhat risky venture, which only Lionel could have dreamt up – but one that excites him, I feel. I told him to get really good testimonials. I'd be worried if he went for this in a big way and the project failed, with this suggestion he has now of a slightly depressive personality.

I told him I wanted to hear how he got on – a progress report on the scheme. This he promised to send me. Interesting how this employment problem and the recession are forcing people to innovation ... but will it be successful?

Appendix XIV

Band 5 and 6 Characteristics

Job Evaluation Factors	Band 5	Band 6
Knowledge Training & Experience	Degree qualified. No post-graduate experiential learning	Some specialism; in-depth; post-grad practical & theoretical demonstrated /rotational achievements.
Analytical & judgemental skills	Undertake initial assessments; set & adapt treatment programmes; choose from range of treatment programmes; can access advice on treatment plans and choices.	Undertake initial assessments on patients with complex conditions; set & adapt treatment programmes where there is a range of options and multi-pathologies; choose from range of treatment programmes /where choice may be challenged; access to advice or support available, but not frequent access.
Patient care	Sets relatively straight forward care programmes; case load not complex /managed by senior staff	Specialist programmes of care: complex caseload /multipathology /patient condition /environment /patient type (children/older people). See as a source of advice to other staff on specialist areas.
Freedom to act	Case load managed, supervision given either directly or in regular meetings/expected to seek advice & guidance on a regular basis.	Work not directly supervised; no direction unless requested on day to day basis; audit and assess and adapt own practice without permission/no supervision but review of outcomes/peer review.

from CSP (2005b). *Guidance for the Band 5 to 6 Run Through – ERUS Information Paper 38*. London: Chartered Society of Physiotherapy