It Takes a Community to Make an Expert: Exploring Professional Expertise Amongst Allied Health Professionals

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Speech Science at the University of Auckland, 2020.

Abstract

This thesis explores the nature of professional expertise amongst allied health practitioners in New Zealand. Particularly focusing on highly-experienced allied health (therapy) practitioners, it identifies elements of expertise that are valued within workforce communities and that are exemplified by a collection of practitioners. The thesis offers a multidiscipline and multidimensional study of expertise and develops new understandings of highly-experienced allied health professionals and their relationships with work. Speech-language therapy is the initial practice context which later expands to include dietetics, physiotherapy, occupational therapy and other therapeutic professions. Participants were mostly female and did not identify as Māori or Pacific peoples.

First, an analysis of online survey data from speech-language therapists captures aspects of expertise that they value highly. The survey identifies a set of themes that characterise experts within the speech-language therapy community.

Second, a narrative review of the literature focuses on professional confidence as a key factor in expert performance for allied health professionals. The review discusses both internal and external factors that influence the development and maintenance of professional confidence and identifies current limitations of knowledge beyond the first few years of practice after qualifying.

Third, a typology of allied health practitioners' work orientation is constructed. Analysis of interview data from practitioners across more than six therapy professions suggested four conceptual types along two dimensions. The diversity of work orientation and its relationship to the development and maintenance of expert performance is discussed.

Fourth, a mixed method study explores critical incident narratives that highly-experienced practitioners told about their work. Affirming, challenging and otherwise

transformative incidents form a backdrop to detailed narrative study that highlights the practitioners' search for meaning and the role that meaning plays in the development and expression of expert performance.

From these four investigations, findings are brought together to inform what it might take to become known as an expert AHP. The findings highlight the value of experts and the roles they can play in their professional communities. A set of recommendations for practitioners and stakeholders including colleagues, managers and supervisors is identified. Overall, the thesis indicates that professional confidence and expertise are intrinsically linked and can be explicitly developed, through knowledge sharing, reflective practices and narrative reframing. Each professional community has an essential role in developing and encouraging experts to emerge. The significance of professional expertise is highlighted throughout the thesis, as are the possible causes and consequences of a shortage of professional experts.

For those that care and those that dare

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Certification by Co-Authors

The undersigned hereby certify that:

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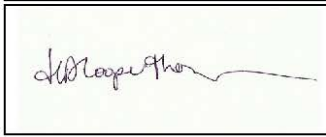
Prof. Helena Cooper-Thomas		06.04.20
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Extent of contribution by PhD candidate (%)	80%

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Certification by Co-Authors

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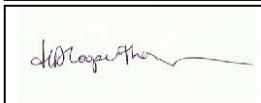
Prof. Helena Cooper-Thomas		06.04.20

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Table of Contents

Contents

List of Tables

List of Figures

Notes on Style

This doctoral thesis is presented as a thesis with publications, which includes published and unpublished research papers conducted under supervision for the degree of Doctor of Philosophy. Chapters follow the reference format and style required by APA 7th format, and New Zealand English spelling. Each manuscript, which is published or submitted to a journal, has been edited to provide a coherent structure and consistent style to the thesis. Headings have been added to Chapter 3 for a consistent style within the thesis, and do not appear in the published journal article.

In keeping with common usage in New Zealand, the terms *speech-language therapist* and *speech-language therapy* are used rather than speech-language pathologist or pathology. Throughout the thesis, I refer to *expert practice* and *expertise* interchangeably.

In Chapter 2, I refer to my supervisors and myself as 'the authors', consistent with the style required by the publishing journal. Through my research journey, I have developed my own voice and in later chapters, I refer to myself as 'I', and include my supervisory team in 'we', consistent with the qualitative and collaborative approaches used in this research.

Chapter 1

Introduction

I was in pain. I struggled to get out of bed. Eventually, I was dressed and ready, I tentatively lowered myself into the car. At the physiotherapist appointment, the vibrant young physio told me about her planned trip overseas for a year. She was excited about visiting Prague and London and Paris. She had not got her qualifications recognised for Europe, so she would not do any work there. She had not decided what to do when she gets back from her travels. She was counting down the weeks. I told her the pain in my back was not going away; she suggested I needed to keep doing my exercises.

I found the senior physiotherapist in the corridor. I talked to her and she suggested to the younger physiotherapist that they would have a talk about my case before the next appointment. When I returned, they saw me together, and took a different approach, with the senior demonstrating something new. In the same day, the pain and discomfort started to resolve.

About a year into this research, I had to visit the physiotherapist. The experience described above, captured for me, two perspectives. As a client, I wanted the best health care – the knowledgeable, skilled and experienced professional who could think creatively about my problem and work with me to find a solution that helped me recover my health. As a fellow health professional, I was shocked that the young physiotherapist confided in me that there was no professional development they were interested in doing, even though what they had been doing with me was not working.

Why is the highly-experienced physiotherapist still in her profession after 25 years of working and what inspires her to pass on her knowledge, skills, and experience to the recently qualified generation? Is she an expert? In addition, how does the young, vibrant physiotherapist become an expert, if they leave the profession after only two years of working? Why is the young physiotherapist not more motivated to pursue the professional path she has embarked on?

This chapter introduces my thesis on the expertise of allied health professionals, by outlining its rationale as well as my own motivation for pursuing this topic. I offer insights into different theories of professional expertise including challenges to, and supports for, those theories, which introduce the context for the research. The overall research project is then situated through a brief literature review. Finally, the chapter ends with overarching research aims, methodology and design.

Rationale and Significance of the Thesis

There are increasingly loud voices regarding experts and expertise. Whilst self-help and personal development media want to raise your status to that of an expert, with a huge following and great acclamation (Barker, 2016; Beuke, 2011; Denning, 2018), others will admonish you for claiming to be an expert, refuting your right to assert you know anything (Edwards-Levy, 2016; Eveleth, 2012; Satell, 2014). Society's rejection of experts is not new, but is an increasingly heard sentiment (Lewandowsky et al., 2013). Until the late 1960s, social analysts generally were supportive and positively promoted the success of the sciences. A scientific training gave a person with qualifications a position to speak with authority and decisiveness in their own field (Collins & Evans, 2002). Since the 1970s scientific method, experiments, observations, and theories have not been considered enough ground on which to base decisions: problems of regulatory process, generalisation and biases have become

challenges to the pursuit of truth and the status of experts. Within the politics of health, now in the 2020s, dissent about what experts provide surely predicts adverse consequences for society as a whole (Hornsey et al., 2018). As an example, amongst countries with high-immunisation levels, recent spikes in the outbreaks of measles are allegedly due to parents' rejection of vaccinations for their children, with "the spread of falsehoods" about the vaccine in Europe, USA and NZ reflecting an anti-science, anti-expert vibe (Chaib & Hasan, 2019; The Immunisation Advisory Centre, n.d.).

Does this rejection of experts and expertise affect allied health professionals (AHPs)? Not people on the front-line of vaccine delivery or the treatment of communicable diseases, but therapists and practitioners who are still very much involved in hands-on delivery of healthcare with members of the public. I tuned into anecdotes told by fellow AHPs about their professional successes and more often their failures. It seemed to me that the confidence of practitioners was shaken. This led me to ask, what is an expert? Do we need experts in health? What roles do experience and confidence play in expertise? What might it take to be known as an expert?

In this chapter, I offer a broad academic introduction to this doctoral research around expertise amongst highly-experienced AHPs, building an account of its theoretical, spatial and temporal contexts.

Relevant Contexts

Theoretical Context

In the conclusion of his book "Understanding Expertise", Gobet (2015) called for research to focus on bringing together multiple perspectives of expertise into a model or theory that encompasses elements from cognitive science, psychology, and sociology and that crosses domains of expertise from sports to music, chess to medicine, military fieldwork to

physics. AHPs have diverse expertise: physical manipulation of joints, using computers to test hearing, analysing video x-rays, fitting wheelchairs, supporting people through the end of their life and diagnosing swallowing disorders. This thesis focuses its efforts on multiple perspectives—those of the researcher, the allied health participants, a broad literature—and brings them together to deepen our understanding of expertise beyond classic thinking and domain-specific theorising.

Classic theories of expert performance being a result of innate talent, or a person practising more intensively than others have been the subject of discussion for decades. Recently, these are being replaced with more nuanced understanding of performance (Hambrick et al., 2014). For some activities, genetic factors would seem highly beneficial for example, height for basketball players, fast-twitch muscle fibres for sprinters, and working memory capacity for musicians. Strong evidence from studies of child prodigies supports innate factors, but a nurture component is essential, not least of which is the opportunity to fulfil the talent (Ruthsatz et al., 2014).

Turning to nurture, the intensive practice theory of expert performance has considerably more research support and is more compelling, suggesting that with practice, anyone can achieve anything. However, doing the same thing over and over is not enough: Deliberate practice is needed—a process of actively choosing what to repeat and gaining detailed and specific feedback on each attempt with the aim of improving the behaviours (Ericsson, 2008). Researchers including Ericsson (2008) have suggested that 10,000 hours of deliberate practice was a requirement for expertise. This claim has become prominent within the popular-science literature (Gladwell, 2008). Although the theory of deliberate practice is a useful addition in understanding expertise, many aspects of the theory are not consistent with the evidence. Evidence from the domains of music and chess indicates it is possible to attain expertise in fewer than 10,000 hours (Campitelli & Gobet, 2011; Hambrick et al., 2014).

Researchers have agreed that deliberate practice is necessary, but not sufficient by itself, for superior performance in fields such as playing chess (Campitelli & Gobet, 2011; Macnamara et al., 2014). Other factors such as general cognitive ability and the age of starting to play are important variables in the level of chess skill.

However, superior performance, as might be seen in an elite athlete or musician, is not comparable with the same definition of expert that might be applied to expert AHPs. Musical performance, chess and running are all highly predictable activities that can be practiced repetitively. Deliberate practice has been beneficial in the development of some specific clinical skills that are predictable, such as reading radiographs (Pusic et al., 2011), intubation and placing a central line (Wayne et al., 2006), but these skills can be attained to a high level with substantially fewer than 10,000 hours of deliberate practice.

Macnamara et al. (2014) found deliberate practice is minimally relevant in explaining expert performance for professionals such as pilots, as it counts for less than one percent of the variance in their performance. This is in contrast to 21% of musicians' performance and 18% of performance in individual sports. Macnamara et al. called for detailed research on the basic abilities and individual difference factors that could explain variance in performance across domains. The team nature of healthcare is an additional challenge in the study of deliberate practice of AHPs. It is considerably more difficult to analyse the individual performances of people working in a team, whether sports players or health professionals (Macnamara et al., 2014).

Theories of innate talent and deliberate practice do not adequately explain the expert performance of AHPs. Previous literature tends towards a managerial perspective of experts, within individual corporations. Publicly-funded organisations such as health services and schools are much less studied and particularly, AHPs have not been a focus of leadership, reputation or expertise research. Prior research has focused on organisational commitment,

where I will focus this thesis on professional commitment – commitment to the profession a person is trained for. Despite a limited literature, it is argued that knowing expert performance - what experts know, how they think, and how they perform in practise - is essential for entry-to-practice level training of the next generation of professionals, and the continued development of a profession (Jensen et al., 2000). This has been a driving factor in the study of the skills held by expert AHPs such as social workers (Fook et al., 1997) and physical therapists (Jensen et al., 2000). However, these studies have focused on describing clinical skills with the aim of increasing the status of each profession, resulting in increased entry-to-practice qualification standards and greater pay. They have started from a view that expert professionals exist and their skills are to be valued.

Within healthcare, researchers have investigated the specific expertise required for diagnostic decision-making (Ericsson, 2015), and also the broader scope of expertise held by professionals like physical therapists (PT) (Jensen et al., 2000), occupational therapists (OT) (Rassafiani et al., 2009; Robertson et al., 2015), nurses (Benner, 1982), and counsellors and psychotherapists (Jennings et al., 2003; Skovholt & Jennings, 2004). I will briefly outline these studies, as they are part of the background of the current research.

Beginning in the 1980s, Benner (1982, 1983) applied the expert model from Dreyfus et al. (1986). Dreyfus et al. took a phenomenological approach to the work of military pilots, which Benner applied to nursing (Benner, 1982, 2001; Benner et al., 2009). She caused a considerable stir amongst researchers in her assertion that intuition was a core part of the expert nurse, beyond competence and proficiency. Intuition is described as a non-conscious mode of reasoning resulting in rapid judgements. Benner's propositions were based on observations and in-depth interviews from the clinical workplace that supported theoretical arguments. The main counterargument to her work was that nurses at all levels of training may have intuitions and that intuitions can be wrong, but this objection was never quantified

amongst nurses (Cash, 1995). Intuition is a genuine phenomenon that can be observed amongst experts, but the latest theories ground intuition firmly in cognitive skills that are not as magical as was originally thought and therefore can be learnt, particularly through reflection (Gobet & Chassy, 2008). Its exact mechanism is still unclear but intuition could be a result of sophisticated pattern matching and heuristics (Kahneman & Klein, 2009) that can be refined through reflection on repeated experiences (Chaffey et al., 2012; Chassy & Gobet, 2011). Intuition is a present but not sufficient component of expertise: intuition without reflection is often flawed (Kahneman & Klein, 2009). Although nursing is not a focus in the current study, the history of expert thinking amongst AHPs cannot be told without including ideas of intuition, which several studies in allied health refer to (for example Chaffey et al., 2012; Cook, 2017; Yielder, 2006).

In the 1990s, Kamhi provided a model of expert practice crafted from interview and questionnaire data from experienced speech and language therapists (SLTs) (Kamhi, 1994, 1995). His four dimensions of knowledge base; 1) interpersonal skills; 2) attitudes such as adaptability, enthusiasm, confidence, interest, and innovativeness; 3) self-monitoring; and 4) procedural/ problem-solving skills, were developed through the consensus of practitioners but did not find great acclaim either in entry-to-practice courses or actual clinical practice.

With a desire to increase the status of PTs in North America, (known as physiotherapists in UK, Australia and New Zealand), Jensen et al. (2000) used grounded theory to develop a theoretical model of expert PT practice. Interpreting a huge amount of data about 12 peer-designated experts, they created a model with four dimensions:

1. Dynamic multi-dimensional knowledge base that is patient-centred and evolves with reflection;

2. Clinical reasoning that is embedded in a collaborative, problem-solving venture with the patient;

3. A central focus on movement assessment linked to patient function;

4. Consistent virtues seen in caring and commitment to patients (Jensen et al., 2000, p. 28).

Thus, the four themes of Jensen et al. (2000) are very similar themes to those of Kamhi (1994, 1995). With a focus on function rather than movement, the dimensions could also apply to other AHPs. For example, an SLT could substitute the word "movement" with "communication", an OT could substitute "occupation", and a social worker could substitute "social justice".

Researchers have developed some parameters for a theory of expertise in social work (SW) (Fook et al., 2000). Consistent with research findings from other professional groups, (Benner, 2001; Jennings et al., 2008; Jensen et al., 2000), the practice of expert SWs was substantially different from experienced SWs; it was not just a matter of more hours doing the job. From their longitudinal studies with socially-recognised experts, Fook et al. (2000) proposed that expert practice was characterised by the ability to work effectively with uncertainty. Jennings et al. (2008) similarly reported that comfort with ambiguity was a key aspect of expert performance for counsellors and psychotherapists. More recently Kamhi (2011) has written again about expertise and suggested that rational thinking is the critical skill that enables expert SLTs to work with uncertainty at a superior level, thus beginning to define more clearly what expert performance might look like. For these researchers, the theme of task predictability (or unpredictability, or uncertainty) is at the heart of what experts are able to work with. Consistent with this, Macnamara et al. (2014) theorised that comfort with uncertainty is a moderator for the impact of deliberate practice on performance.

The AHP who replicates previously successful practice with no modification is unlikely to be effective and, given the prevailing philosophy of client and family-centred practice, is unlikely to be considered even competent (New Zealand Psychologists Board, 2011). The nature of allied health work is so varied and complex that, other than manual and procedural skills, there seems little opportunity for specific repeated practice. Moreover, the components of the work that are most challenging are not the manual and procedural skills but the clinical decision-making (Rassafiani et al., 2009; Records & Tomblin, 1994). The activities of health professionals are not precisely defined domains that can be mastered through sufficient training and practice; instead the health professional must be creative and flexible in the face of uncertainty (Simonton, 2014).

Taking a different approach to the study of experts, but again observational, Rassafiani et al. (2009) considered critical thinking to be the essence of expert performance. Eighteen paediatric OTs, with more than 5 years' experience since their bachelor's degree, completed 110 case vignettes, with 20 of them being repeated cases. Their responses were examined for consistency (intrarater reliability) and discrimination (ability to differentiate between diagnoses). Experts were considered both consistent and discriminating. Only four OTs met the expert group requirements and there was no association with length of experience beyond the minimum five years that the whole cohort had. Robertson et al. (2015) writing a few years later, suggested that the understanding of what made an expert OT remained both unknown and important to know. More specifically, Robertson et al. raised the concern that people were still using years of experience to identify experts, rather than particular skills, knowledge, attitudes or behaviours. They reported that the criteria used to recognise expertise must be valid and concluded the "critical" occupational therapy practitioner, that is someone who is evidence informed, critically reflective and reflexive, has characteristics of expertise that are more valid than length of experience.

Although expertise is not a predictable consequence of years of experience, the skills, knowledge, attitudes and behaviours acquired through experience are important components of expertise (Collins & Evans, 2002; Rassafiani et al., 2009). Whilst researchers debate the relative contribution of experience towards expert performance, they do not dismiss it. Researchers agree that some substantial amount of training and practice is necessary to perform at a high level. The concept of experience is a guiding factor in the design of the current research regarding highly-experienced AHPS, and this discussion of experience is included in this Introduction to provide a broader picture of the context of the current research.

Allied Health in New Zealand

In New Zealand (NZ), the term *allied health* includes around 40 professional groups, and includes scientific and technical professions that are not client-facing (Health Workforce New Zealand, 2016). There is no single definition of allied health hence the uncertainty in specifying numbers. Around 27 different allied health professions in NZ are client-facing and within these, the therapy group form the focus of this thesis. The therapy group includes physiotherapy, occupational therapy, social work, speech-language therapy and psychology amongst others. This is the group herewith referred to as AHPs. Over 30,000 people make up this AHP workforce, with around 40% of these employed by District Health Boards (Allied Health Aotearoa New Zealand, 2016). Many AHPs are women – typically 80-90% of therapy staff, and 90% do not identify as Māori or Pacific. These AHPs, working directly with clients, are employed across health, justice, social welfare, and education providers, in private, public and non-profit sectors and work with people from birth to the end of life. Statutory government bodies regulate many but not all the professions for the protection of client safety; some are self-governing such as social work and speech-language therapy.

AHPs are the focus of this research to the exclusion of other healthcare practitioners; namely doctors and nurses. Doctors have substantial career structure support with lengthy on-going training, and supervision requirements that are considerably different from AHPs. For example, in NZ it takes at least 11 years to become a qualified general practitioner, compared to three or four years to qualify as an occupational therapist or speech-language therapist. Registered nurses have a more similar initial entry-to-practice route consisting of a three or four year degree, but after entering the workforce, opportunities for advancement and specialisation are notably greater. Registered nurses can have their current level of performance nationally recognised as well as take the opportunity to qualify as a nurse practitioner. These differences in training and workplace opportunity for recognition suggest that direct comparison with AHPs would be difficult, but this remains an opportunity for future research.

Interprofessional practice is challenging traditional role boundaries and professional responsibilities, and changing educational practices for those pursuing health professional qualifications (Engum & Jeffries, 2012; Margalit et al., 2009). The introduction of generic therapists, not specialized in speech or movement or tasks of daily living, but instead specialized in education access, dementia, stroke or cerebral palsy, challenges traditional ways of working and thinking (Gorman, 2015). Interprofessional practice in healthcare encourages cross-domain learning and practice (Margalit et al., 2009). Not all allied health professions are starting from the same literature-base on professional expertise for their practitioners. For example, psychologists, OTs, and social workers have considerable research literature on the nature of expertise in their profession; others such as SLTs and physiotherapists have much less research to draw on and there is opportunity to learn from each other. This study is across allied health professions because AHPs are often grouped together under a single manager, separate from doctors and nurses. They have a similar

qualification structure and career prospects in the NZ context. AHPs work in an increasingly mixed workplace, different professions have different values, philosophies and approaches but come together for the benefit of the clients. These factors will be expanded on in later chapters.

Is There a Lack of Expertise in Allied Health?

Workforce information from NZ is patchy. Allied Health Aotearoa New Zealand (AHANZ) is the advocacy body for many of the professional associations, but they do not provide specific data on the demographic profiles and distribution of professions across the country. Whilst available information provides some indication of the struggle to recruit and retain AHPs, it provides minimal data about experience and no data regarding the level of expertise of the workforce in NZ. These data and some of the issues will be discussed in Chapter 5.

Experienced AHPs provide supervision to less experienced recent graduates who learn on-the-job beyond entry-level. Researchers in Australia reported on a scoping exercise of 27 allied health and scientific professions, representing approximately 42,000 practitioners in the state of Victoria in 2015 (Nancarrow et al., 2017). In dietetics, occupational therapy and four other professions, at least 40% of the workforce was aged less than 30 years old. Professional bodies reported a lack of senior positions in the public sector and a concomitant lack of senior specialised staff available to support more junior staff. Like NZ, the research team reported a lack of workforce data in Australia preventing comparison.

The consequences of a trained but younger age workforce are not well researched or documented. Another Australian study, nearly 10 years earlier, across 12 allied health professions, showed a large drop in workforce numbers between 25-29- and 30-34-year age groups. For example, registered SLTs in these age groups fell from 81% being employed to

68% being employed over this time (Leach et al., 2010). Social workers and Dietitians had employment rates around 32-34% for the 30-34 years group. Given that AHPs might begin work after studying at 21 or 22 years old, this suggests a loss from the workforce of people with more than 8 years' experience. Participants in the study reported practical concerns such as challenges in maintaining high standards of care created by having proportionally fewer senior staff to supervise and support more junior staff (Leach et al., 2010). In addition, the loss of more senior members of the workforce was seen as a loss in capacity, and institutional and professional knowledge (Leach et al., 2010). An earlier study reported similarly that expertise was lost when supervision, mentoring and peer support was between staff of similar low levels of experience (Westbrook et al., 2006). Younger workforces run the risk that students have limited clinical placement opportunities with highly-experienced members of the profession. As professional expertise requires at least some experience, this loss of experienced practitioners is likely to impact on the availability of experts within the allied health workforce.

My Context as a Native Researcher

I am a highly-experienced speech-language therapist still in clinical practice and an academic in an entry-to-practice graduate SLT programme. Experiences from both these roles motivated me to engage in the research described in this thesis. There were a number of interrelated reasons that I was drawn to this research, rather than for example, measuring treatment outcomes, or designing a new assessment. Because of my own life experience as an AHP, I was seeking something more about people who experienced life similar to mine. More knowledge and more analysis offers more understanding. I was strongly influenced by a meeting I attended every 3 months amongst my SLT community. It became increasingly apparent, as the attendance numbers grew, that my colleagues were stressed and distressed

with a lack of knowing-what-to-do and these meetings offered a lifeline. As an allied health researcher I wanted to make a contribution to the knowledge and practice of my community.

The idea of the native researcher, an insider, stems from anthropology and *going native* is suggested as a way to become a participant rather than an observer of people (Kanuha, 2000). As an insider conducting research within a community where you are a member, there are both challenges and opportunities (Brannick & Coghlan, 2007; Chen, 2011). Often insider research is conducted with groups that are marginalised and it is my view that allied health is a marginalised group within NZ. It is common amongst native researchers to begin (at least) with narratives, life histories and interviews as research methodologies and my research here follows that tradition (Kanuha, 2000).

For me, experts and expertise are socially constructed within a given context. Expertise is relational: It exists within a relationship between the holder and the consumer (Selinger & Crease, 2006). Simplistically, at one end of the continuum are those who "have" expertise and at the other end are those that consume that expertise. It might be assumed that the highly-experienced allied health practitioner is the expert in a healthcare relationship between client and professional. However, clients (consumers) are not necessarily novices or uneducated, they may also be highly knowledgeable and skilled with considerable relevant experience themselves (Cordier, 2014; Ottewill et al., 2006; Towle & Godolphin, 2011). Similarly, the highly-experienced AHP is not necessarily an expert in the condition or difficulties the client presents them with.

Practically, AHPs have passed exams and proven their competency, usually multiple times, usually to other practitioners within the same profession. Taking a socially constructed worldview, we are AHPs because we say we are, and as professionals, we have created our own professional bodies to both represent us and hold us to account. We have created the hoops through which we have jumped in order to say we are qualified and ongoingly

competent. Conversely, we are not experts if we say we are not and if social structures such as our employing organisation support that stance, where might this lead us? My discomfort with my colleagues in some organisations having to downplay their expertise: “we are not the experts, the family are”, is a result of this. Can we not both be experts but in different, complementary domains?

As an insider, I have my own insights and experiences that are relevant, providing a recognisable connection with my fellow AHP participants. However, my story is not everyone’s story. I only have experience of being a SLT and of working with some other AHPs; I have never been a PT or SW, for example. Through reflexive journaling as well as robust conversations with my supervisors, I have taken great care as a researcher, to avoid transferring only my own views and experiences into the analysis of the data and interviews. In an interview, a world is constructed between the interviewer and interviewee and each brings with them their histories. As such, I believe that the interviewees and I worked together to create this work. I hope that the voices of the interviewees can be heard, as the choices I made in the interviews carry risk: vague statements not pursued, initiations not followed up, limited probing into taken-for-granted assumptions (Kanuha, 2000). This is the challenge of reflexivity in the moment—there is an ethical obligation to do the right thing by the interviewees (Finlay, 2002). A perspective is jointly constructed here, rather than capturing an already existing perspective, and clearly, there are numerous ways to do this, some more collaboratively than others. Ultimately, I have written this thesis. My supervisors, the participants, and I have co-constructed the research, but with my history and the influences of my physical and social environment clearly present.

Research Aims and Design

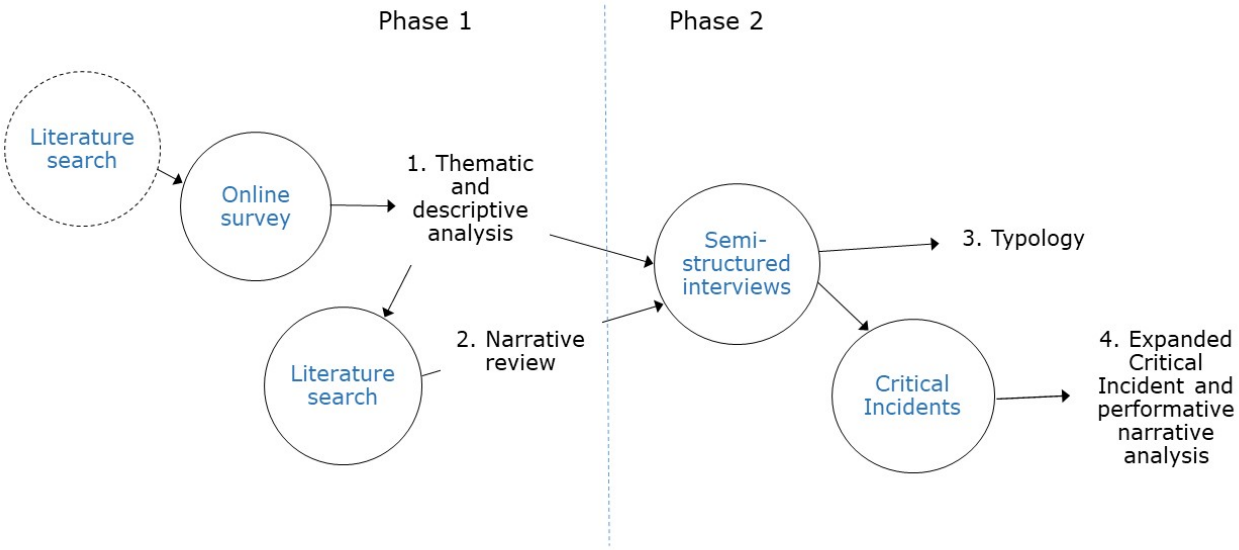
Existing theories of more experience, innate talent or deliberate practice do not fully explain the development and maintenance of professional expertise amongst AHPs. Given the call from Gobet (2015) to research expertise across domains and using the diversity of the available literature, this project features observations and perspectives from a diversity of AHPs. The overarching aim of this doctoral thesis is to explore the nature of professional expertise amongst the allied health (therapy) workforce in NZ. It brings together insights from across the workforce and the existing knowledge base to develop new understandings of professional expertise. The research begins by asking, "what is an expert?" and "what do they provide?" The concept of expertise is problematised and the knowledges that inform and shape it are discussed. Particularly focusing on highly-experienced AHPs, it identifies elements of expertise that are valued within the workforce community and that are exemplified by a collection of practitioners, thus deepening our understanding of expertise. It aims to pick apart the development and maintenance of expertise and to provide new ways of thinking about professional expertise that can be tested and refined in future research. The thesis aims to demonstrate how professional development might be clarified, advanced and sustained. Ultimately, I aim to provide practical resources that support allied health communities to prosper.

Methodology

I employed mixed methods to gather, analyse and interpret data in response to the research aim. In the methods involved, I took a firmly interpretivist stance with me as the researcher highly involved in the process of data capture, analysis, and interpretation. Predominantly, the work described in this thesis is qualitative in nature. The overall design of the research that makes up this thesis is shown in Figure 1.

Figure 1

Phases of the Research Process Showing Methods of Analysis for Each Study



Note: Circles indicate data sets. Number represent the four studies brought together in this thesis.

My thesis consists of four studies in two phases. The first phase began with scoping the broad literature regarding professional expertise, which informed development of an online survey (Study 1). Interpretation of survey results led to a detailed review of literature in relation to professional confidence (Study 2). This first phase informed the design of semi-structured interviews that provided data for the two studies in the second phase (Studies 3 and 4).

Informed by the literature, an online survey of SLTs gathered data about the SLTs' thoughts about experts and expertise within their own professional community. As an exemplar of a therapeutic allied health profession, speech-language therapy is the majority but not the only professional group for the research presented in this thesis. The quantitative

and thematic analysis of online survey data led to a narrative review of the literature on professional confidence. The findings from the survey and the review of literature influenced the questions that formed semi-structured interviews. Interviews with AHPs tapped into their own experiences of their work life and stories of critical incidents from their careers. Multiple analyses of interview data were combined with survey and narrative review findings to develop a conceptual model of the expert allied health practitioner.

Integrity and Trustworthiness

Various practices were used to ensure the integrity and trustworthiness of this body of research. This will be discussed further in Chapter 4 and at points throughout the thesis, but I briefly mention it here as an introduction to the various methods of data collection, types of data and analytic processes included in this thesis.

Pratt et al. (2019) describe two approaches to trustworthiness in qualitative research. One approach is for the writer to persuade the audience through means that are in some way similar to existing quantitative means. In this approach credibility, transferability, dependability, and confirmability are presented. An alternative approach, more aligned with the values of qualitative research, offers authenticity, credibility, and plausibility as being indicators of trustworthiness. Neither of these approaches has been reported to be better than the other and thus ambiguity persists (Rothman et al., 2017). Choosing between these approaches limits the researcher's ability to explain the method fully and present the complexity of qualitative findings, ultimately restricting the researcher's ability to theorise (Levitt et al., 2018). However, in choosing neither of these, what is lost in structure is gained in the ability to be creative (Pratt et al., 2019). This consideration has resulted in a *bricolage*, something created from a diverse range of available things. This thesis establishes itself as trustworthy by using diverse approaches taken from existing research methods consistent with the questions it aims to respond to (Pratt et al., 2019).

Structure of Thesis Chapters

This thesis is presented in accordance with the University of Auckland Guidelines for Including Publications in a Thesis (School of Graduate Studies, 2018), comprising a series of published and unpublished research papers. An introductory contextual framework and a concluding discussion are also provided. Specific details regarding publication status are provided at the beginning of each chapter where relevant. The small amount of literature that has emerged since publication has been incorporated into the body of the work. Given that chapters in the second phase reference the same data and all papers cover some overlapping thematic and analytic ground, a small degree of repetition across chapters is unavoidable, particularly in the article introductions and methods sections.

This introductory chapter has started by embedding the expert allied health practitioner within a context of the contemporary NZ workforce. It has reviewed existing theories of expert performance and highlighted ways in which these theories are insufficient for our purposes.

Chapter 2 addresses the question raised in this chapter as to "who are the experts?" It is an analysis and interpretation of online survey data from speech-language therapists who reported on aspects of expert speech-language therapists that they value highly. The survey identifies a set of themes forming an underlying construct of expert SLT and delineates avenues for further exploration.

One of these themes is explored in depth in Chapter 3. It offers a narrative review of the literature pertaining to professional confidence as a key component of professional expertise. The review discusses both internal and external factors that influence the development and maintenance of professional confidence and identifies the current limitations of knowledge beyond the first few years of practice after qualifying.

As an introduction to the second phase of the thesis, Chapter 4 provides a detailed discussion of conceptual and methodological issues relevant to the qualitative studies to come. Chapter 5 offers a detailed picture of the interviewees using their work history and résumés as data. These two chapters preface the following analytic chapters.

Chapter 6 is the result of the first analysis of interview data. It identifies a typology of the work orientation of highly-experienced AHPs. Analysis of interview data from AHPs across professional groups suggested four empirically grounded types of work orientation along two dimensions. This alternative view of work orientation highlights motivations and perspectives of AHPs that may lead to them identifying as an expert.

Chapters 7 and 8 explore the interview data through a combined critical incident and performative narrative analytic approach. I discuss the nature of incidents that contribute to AHPs' identities as experts. Affirming, challenging and otherwise transformative incidents are discussed in relation to confidence and the role confidence plays in the development and expression of identity as an expert.

The concluding discussion in Chapter 9 brings together the strands of this research project to illustrate how they meet the research aim. It includes discussion of both academic and practical contributions and areas for future development.

Following from the introduction in this first chapter to expertise in allied health, the next chapter begins with a discussion of our current understanding of expertise across domains of knowledge and domains of performance. In this thesis, knowledge is not limited to information gained from randomised controlled trials or equivalent scientific sources, but includes *episteme* (facts), *techne* (skills) and *phronesis* (a form of practical wisdom) (Greenhalgh & Wieringa, 2011).

The current healthcare environment provides several challenges to the existing roles of healthcare professionals and the value of the professional expert is under scrutiny. The study reported in Chapter 2 aimed to generate a construction of professional expertise amongst practitioners in the current healthcare environment. It used the speech-language therapy community in NZ as an example.

Chapter 2

This chapter is a lightly edited version of a published manuscript: Jackson, B. N., Purdy, S. C., & Cooper-Thomas, H. (2017). Professional expertise amongst speech-language therapists: "Willing to share". *Journal of Health Organization and Management,* 31(6), 614-629. https://doi.org/10.1108/JHOM-03-2017-0045.

Professional Expertise Amongst Speech-Language Therapists: "Willing to Share"

The study of professional expertise can cast light on performance beyond competency, that is, exceptional performance. The motivation for studying experts and expertise stems from trying to understand, and disseminate best practices to achieve, exceptional performance widely so it is more pervasive in services (Fulop & Campbell, 2011). The current healthcare environment places professionals in an awkward position. Managerial and organisational constraints challenge the authority of healthcare professions (Edwards, 2010). Greater accountability to clients, and the concept of the *expert patient* places the client in a position of expertise on par with that of the professional, and can even call into question the existence of the professional (Edgar, 2005). Given this climate, it is useful to consider the role and attributes of expertise from the perspective of the professionals themselves, in regards to their own profession and to what extent those roles and attributes are valued in the professional community. A construct of professional expertise, by professionals, in this climate, can enable professional bodies and healthcare organisations to develop clear expectations of what professional experts can provide. In turn, practitioners can identify clear pathways of development towards becoming a professional expert.

As long ago as Plato, expertise amongst doctors was thought best determined by considering their great knowledge and ability to teach others (Ericsson, 2008). Having

appropriate knowledge is essential in order to be able to teach, but the role of the expert then was in passing on this knowledge through teaching. This is less emphasized in recent views on expertise that focus on performance. Thus a traditional view of expertise summarized by Ericsson (2008) is one of "length of experience, reputation, and perceived mastery of knowledge and skill" (p. 988). Yet research since the 1980s has demonstrated convincingly that more knowledge, more training and more practice does not necessarily lead to better performance (Gobet, 2015). Numerous studies across different domains report that expertise is not a predictable consequence of years of experience, although experience is an important component of expertise (Collins & Evans, 2002; Rassafiani, 2009). Thus there has been a shift away from knowledge and skill as representing expertise, to instead view expertise as embodied in performance (Shanteau, 1992). This represents a shift from expertise being something that is held internally by an individual, towards a view that expertise can be seen in the outcomes of a person's behaviours.

Two approaches to identifying experts have arisen in research: by social recognition and by superior performance. Early studies on expertise relied on the identification of experts by reputation among colleagues. However, peer-nominated experts could not demonstrate a level of expertise that researchers felt was expected and recommended a redirection of research effort away from social-recognition and towards superior performance as a unique element that distinguished experts (Ericsson & Smith, 1991; Weiss & Shanteau, 2014).

Turning to the second approach, superior performance, a growing literature has identified a division in experts' performance related to task characteristics (Shanteau, 2015; Shanteau & Edwards, 2015). Studies of expertise have often focused on highly-defined professional tasks such as surgery (Alderson, 2010), or relatively technical jobs such as flying an aircraft (Schvaneveldt et al., 1985) or playing the piano (Duke et al., 2009). Shanteau and Edwards (2015) proposed that experts make effective and consistent decisions when faced

with highly-defined tasks; in contrast, for low (or ill)-defined tasks, experts provided inconsistent and poor decisions. Good performance was found when experts were presented with tasks characterized by unchanging, predictable problems, some allowance for errors, repetitive tasks, and with feedback available. Low-defined tasks include changeable (dynamic) stimuli, less predictable problems, limited or no feedback available, and minimal decision aids. The literature on decision-making has suggested that experts make flawed decisions with low-defined tasks, partly because of the biasing effects of judgmental heuristics (Shanteau, 2015). Notably, this research on decision-making for low-defined tasks has included samples of experienced healthcare personnel, such as clinical psychologists (Nystedt & Magnusson, 1975), nurses (Standing, 2008) and speech-language therapists (Records & Tomblin, 1994). This highlights the issue that many healthcare professions that deal with behaviour are largely involved in low-defined tasks.

In fields with low-defined tasks, superior performance is more difficult to quantify and therefore measure, compared with fields with highly-defined tasks. For example, after cardiac surgery, the success of the procedure can be quantified in various ways relatively soon thereafter and expertise judged accordingly. Yet determining the likelihood of a stroke survivor aspirating if they drink water is less clear and a decision to continue with oral liquids may not have any immediate negative consequences. Given that low-defined tasks have less clear performance outcomes, social recognition may still be a valuable approach to the identification of experts, at least in the first instance (Joshi, 2014; Littlepage et al., 1997; Treem & Leonardi, 2015). This current study asked workers to describe experts within their own profession's community, with the aim of constructing a view of expertise, rather than aiming to identify accurately those who have measurable exceptional performance. Similar to Treem and Leonardi (2015), in an attempt to retain ecological validity around what the participants regarded to be expertise, the authors did not predetermine the type of expertise to

be considered. Given the multi-faceted nature of healthcare tasks, we asked participants to identify the salient and valued elements of expertise, using SLTs as our population of interest, but anticipating that findings will generalize across healthcare professions.

Theoretical Orientation

The purpose of this concurrent mixed methods study was to better understand notions of professional expertise by converging qualitative and quantitative data, as recommended for exploring aspects of health and education phenomena (Creswell et al., 2006; Curry & Nunez-Smith, 2015). This approach explored NZ SLTs' understanding of professional expertise in the domain of dysphagia. Dysphagia (eating, drinking and swallowing difficulties) was chosen because it is a field characterized by low-defined tasks: changeable and unpredictable client presentations, outcomes that are difficult to measure, limited decision aids such as clinical guidelines and limited feedback on performance. The SLT's role in the dysphagia team is central (Logemann, 1994). Anecdotal evidence suggests people do not embark on study to become an SLT aware that dysphagia exists or is within the SLT scope of practice. In this regard, it is an area that is unlikely to have been a focus of education or practice prior to embarking in tertiary level education.

Data from open-ended survey responses were analysed for themes and ranked categorical data were used to highlight elements of expertise that these health professionals considered important. Whilst the study was predominantly qualitative in nature, the addition of quantitative methods allowed the introduction of elements of expertise identified in past research that may not have otherwise been considered by the participants. These were intended as stimuli to elicit a more accurate picture of expertise. The qualitative and quantitative results were analysed separately and then merged into a narrative discussion (Curry & Nunez-Smith, 2015).

The current study asked SLT practitioners to identify professional experts and then consider their salient characteristics. The study generated a view of expertise that was at a moment in time and created within the community (Silverman, 2000). Participants were asked to identify experts in their own way. As noted by Kamhi (1995), practitioners may not know what makes an expert and answering a question on expertise may be the first time they have considered this. This qualitative approach is a useful beginning for further investigation into the nature of the expertise.

In analysing the qualitative responses, a critical realist view was adopted. Participants' responses were taken as real-for-them, and considered as stemming from socially available meanings, rather than showing some essentially true reality (Peters et al., 2013). A critical realist approach allowed for a practical reality that provides a basis for action. In this study, people – the researchers and the participants – were viewed as interdependent, within a complex web of social relations (Mauthner & Doucet, 2003). Consistent with a socially constructed view, the study did not try to capture existing perceptions; instead, through the questions, participant responses, and analysis and interpretation of the data, the study aimed to convey a possible construction of what an expert might be.

Method

Ethical approval was granted by the first author's university ethics committee (UOA 016535).

Participants

Participants were sought via advertisements e-mailed through professional networks and via the database of the New Zealand (NZ) SLT professional body (NZSTA). All SLTs currently practicing in NZ were invited to participate in this exploratory study (n=599),

regardless of their field of practice, their level of training, and experience working with people with dysphagia. This inclusion criterion was selected for the purpose of locating the study within a particular sociocultural context, as all invited participants were part of the SLT professional milieu.

Potential participants were sent an e-mail describing the study and provided a link to the online survey. An e-mail reminder was sent approximately 2 weeks later, followed by a final reminder approximately 2 weeks later. The website remained open to participate for 6 weeks. The online survey was completed by 119 SLTs (qualitative questions n=113, ranking questions n = 116).

Process

A mix of open-ended questions and ranking questions were asked using an online questionnaire created with Qualtrics software (www.qualtrics.com). Project information was provided on the front page of the survey and participants were able to give consent by clicking to continue, or to leave the survey at this point. Participants responded to three questions: “Think of speech-language therapists (pathologists)… that work with people with dysphagia, who you would consider to be an expert. Thinking about those people, what makes them an expert in your opinion?” The three questions asked about SLTs: a) overseas, b) in New Zealand, and c) locally. Open questions, with unlimited text fields, collected narrative data that were later analysed for themes and subthemes (Braun & Clarke, 2006).

For the quantitative questions, we gathered 18 possible elements that the literature suggested contributed to expertise. These elements were sourced from an extensive review of the broad spectrum of expertise literature (Gobet, 2015), described individually and put into a list in a random order. Participants were asked to choose seven from the list of 18 elements that describe an expert and then rank those seven elements in order of importance. Open-

ended questions were asked first to avoid a priming effect from the ranking questions. See Appendix A for all survey questions.

Participants provided demographic information. NZ has a small community of SLTs and therefore demographic information did not include gender, locality or job title as these would invalidate the anonymity of the survey. The online questionnaire was piloted with a group of six colleagues trained in psychology and their feedback led to four minor adjustments made to the types of acceptable responses, for example, only numerical responses were allowed in response to age or date questions. No changes were made to the wording of the questions.

Analysis

Descriptive statistics characterized the participant cohort in relation to age, workplace, education history and years of dysphagia experience. Descriptive statistics were also carried out on the ranking questions. The 18 items were weighted by rank and then ordered by count. Additionally the distribution of rankings for each of the 18 items was calculated in order to determine the relative importance of each item within the whole set of items.

All comments were analysed together using a method of inductive thematic analysis. This was data-driven, not aiming to confirm or expand upon existing theory in relation to the research question, but to identify patterned meanings, consistent with a critical realist approach. Broadly, latent meanings were identified, coded and organised to show patterns, then patterns of codes were put into themes.

All comments were read through once by the first author, with reflexive journaling completed immediately afterwards. Participants typically wrote short list-like responses. Following Braun and Clarke's step-by-step approach to thematic analysis, each response was systematically read and codes were developed inductively (Braun & Clarke, 2006). Early-

generated codes were looked for in the later readings, and later-generated codes were also looked for across the entire dataset. As more meanings were identified in the dataset, codes were added or refined until no new concepts emerged. During another reading of the entire dataset codes were compared and where they overlapped, were collapsed together – for example, “presents at conferences” and “speaks at special interest group meetings” were collapsed into “shares knowledge publicly”. Codes were grouped and patterns amongst them identified to create themes.

Candidate themes were developed from groupings of codes in relation to the research question of how the community constructs experts. Initially two overarching themes, four themes and two subthemes were generated. The dataset was re-read to confirm the presence of those themes as prevalent across the data. Themes and network connections between these were drawn into a thematic map with each theme given a name and then defined. After reviewing the data, the themes, subthemes and thematic map were revised to provide a better fit for the data. The significance of the themes and connections were then considered in relation to the existing literature on the topic. Themes are reported separately from quantitative findings and the discussion includes an integrated narrative of the results.

Results

Participant Characteristics

The response rate was 19.8% with participants broadly reflecting the diversity of the SLT membership of the NZSTA in relation to their workplace as shown in Table 1 (Johnson & Wislar, 2012). T-tests suggest no significant differences in the percentages of participants by workplace, compared to the NZSTA population they are drawn from.

Table 1

Summary of Demographic Details

	n	% of participants	% of NZSTA members
Current workplace n=112			
Ministry of Education	21	19	18.4
Ministry of Health – paediatrics	30	26	
Ministry of Health – adults	32	28	32.1 [a]
Trusts, charities, non-profit organisations, etc.	14	12	26.9
Special school	7	6	14.0
Private practice	16	14	14.3
University	6	4	10.0
Other	2	2	1.3
Multiple workplaces [b]	16	14	
Year of graduation n=109			
<1980	4	4	
1980-1989	11	10	
1990-1999	14	13	
2000-2009	44	40	
2010-2016	36	33	
Years of dysphagia experience n=110			
0 years	16	14	
1 to 2	21	19	
3 to 6	26	24	
7 to 9	15	14	
10 to 19	23	21	
20 or more	9	8	
Age n=112			
20-25	14	12	
26-30	20	18	
31-35	26	23	
36-40	12	11	
41-45	15	13	
46-50	10	9	
51-55	4	4	
56-60	7	6	
61+	4	4	
Foundational dysphagia training n=111			
Pre-qualifying course	77	69	
Professional development courses	16	14	
Workplace training	11	10	
Self-learning	3	3	
Other	4	4	

[a] Ministry of Health paediatric and adult workforce is combined, as it is not further broken down by NZSTA into adults and paediatrics. [b] Total workplaces = 128 due to some SLTs working in multiple workplaces

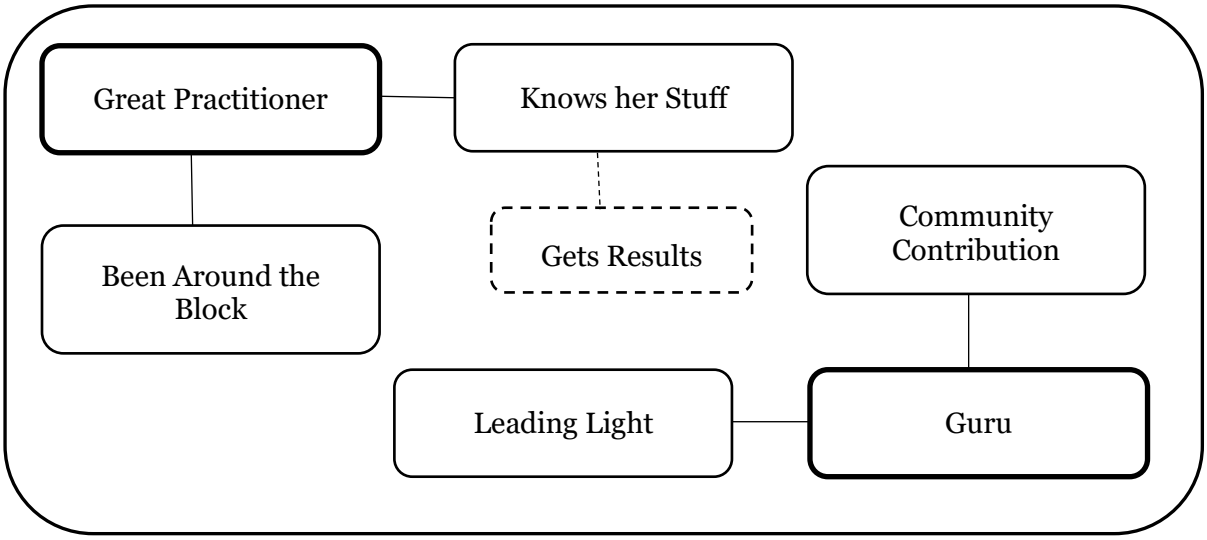
More than 60% of respondents had graduated since the year 2000, which was reflected in the years of post-qualifying experience they reported working with clients with dysphagia, with 27% of participants having 10 or more years of experience. Additionally 74% of participants gave their age as 45 years or less with a peak at 31-35 years of age. Participants had predominantly gained their foundational dysphagia knowledge during their qualifying SLT course (65%), with a smaller group learning this early knowledge whilst working and attending professional development courses (13%). Included in the "other" section here, are participants who reported having no foundational dysphagia knowledge (n = 1) as well as those who learnt in other ways, such as online post-graduate education (n = 3).

Thematic Analysis of Qualitative Data

From the qualitative responses (n = 113), two overarching themes were defined, each with two themes within for a total of four themes and a subtheme. These relationships between the themes and subthemes are shown in Figure 2. Overarching themes were Great Practitioner and Guru. Within these overarching themes, themes and subthemes will be briefly presented along with analysis focusing on more latent meanings, along with select verbatim illustrative quotes.

Figure 2

A Thematic Map of Professional Expertise Showing the Relationships Between the Overarching Themes (Thick Outline), Themes and Subtheme (Dashed Outline)



Overarching theme: Great Practitioner

This overarching theme constructs expert SLTs as those with experience, knowledge, skills and the "right" attitude, and who achieve great results with their clients. The theme is around their work as an SLT, typically with clients, doing the things that SLTs commonly do, and doing it well. There were two themes within this overarching theme: Been Around the Block and Knows Her Stuff with a subtheme Gets Results.

Theme: Been Around the Block. Participants highlighted the importance of extensive hands-on clinical experience in the construction of expertise. Experts have a broad experience gained over a considerable period of time. Experience was considered essential, for example, "If you don't have the knowledge and experience then you're not really an

expert" [P64]. Participants frequently described the expert as someone highly-experienced and various different measures of this were offered. For example: "…has extensive hands-on clinical practical experience" [P97], "experience they have gained through more years in the workforce" [P53] and "At least 10 years of working experience in a particular field" [P83]. Not only is the experience over a long time, but it is with clients. One participant wrote "I think of her as an expert based on the sheer experience she has had across time and aetiologies" [P33]. In this theme, time and experience are intertwined as the overriding aspects that identify the expert. For some respondents the experience needed to be broad as in "Someone who is very familiar with and knowledgeable on a wide range of presentations of dysphagia" [P93]. For others, the depth of experience was important, for example experts "have extensive clinical experience (10+ years experience) in specialised areas of dysphagia such as paediatric feeding" [P7].

Expertise was related to specific workplaces and geographical locations. Thus, a participant noted "I have yet to meet anyone who I would consider an expert in dysphagia who works outside of a hospital in New Zealand" [P48]. Specific workplaces potentially provide opportunities – both a greater volume of opportunities as well as opportunities to see more complex or difficult cases: "SLTs working in large hospitals have the most opportunities to develop these skills" [P61]. Hospitals were specifically noted by participants whereas other specialist workplaces were not, such as community child development teams or post-acute brain injury rehabilitation units.

The international context of the workforce and associated training and development options created different opportunities for expertise. There was a greater opportunity to become an expert if you were able to train or work overseas from NZ. International experience was related to opportunities for both professional development and to work with special populations, captured in comments such as, "Many have trained in the USA- seems to

have lots more opportunity for varied [professional development] at a lesser cost to us in NZ" [P37], and "it can be more difficult in NZ to develop expert skills in the more specialist populations such as tracheostomy, head and neck cancer etc, due to population size" [P61]. These perceived geographical, workplace and population constraints seemed to create disappointment and resignation for some.

Theme: Knows Her Stuff. The second theme within Great Practitioner was Knows Her Stuff. One characteristic of this theme was that expert SLTs can be constructed as those who are highly knowledgeable and skillful, even in complex situations. This construction holds that an expert SLT knows a lot about dysphagia as it relates to clinical work, as described in several comments about "wide scope of clinical knowledge" [P79] and "extensive clinical knowledge" [P7]. Due to their role or workplace setting, experts had access to specialists in other fields and had developed a knowledge wider than just SLT, often through multi-disciplinary work or an extended scope of practice. The expert had a solid foundation knowledge of assessment and management techniques, but also detailed specialist knowledge, for example "a great deal of knowledge about complex paediatric dysphagia cases, particularly around neonates and tracheostomies" [P39]. This was gained through a strong commitment to attending courses, and reading the literature to stay current.

A second element within Knows Her Stuff relates to ongoing learning which is applied in an expert's practice. Experts were up-to-date and kept on learning, either through reading research literature, further study or through reflecting on their practice and learning from their mistakes, for example: "She's also always learning and bringing up articles she has read or changes in the dysphagia world which she will critique and or find ways to implement in practice" [P33]. Humility was part of this construction with experts being SLTs who "never think that they know everything… and who learn from their mistakes and share that with others" [P67]. Experts were seen as knowledgeable but also honest about what they did

not know: “willing to share what she knew and didn’t know” [P97]. The admission of making mistakes was in contrast to the overwhelming sense from participants that experts knew what they were doing in their work with clients and their families.

A final characteristic within Knows Her Stuff was the broader communications skills of experts with families and clients. Thus, effective communication with families about their situation was seen as an essential component of expert professional practice, tightly related to professional knowledge. Experts were constructed as good communicators. One participant commented that being an expert involved “the subtleties of knowing your stuff and being able to explain to families” [P13]. Another said that experts “are able to "think outside the square" and explain multifactorial dysphagia and how to manage it” [P106]. Here, being able to communicate effectively with a variety of people about different aspects of assessment and management is an extension of the knowledge the practitioner has.

Subtheme: Gets Results. Within the theme of Knows Her Stuff, a subtheme of Gets Results was created. This focused on the importance of positive client outcomes in the construction of an expert. This is captured in comments about knowledge and the ability to “use it in their practice with positive results” [P105] as well as “being able to adapt to unusual presentations/ circumstances” [P64]. The experts’ ability to successfully manage complexity was highlighted: “They can manage complex caseloads as well as individual complex cases” [P7]. This subtheme is notable for both its client focus, and also for its surprisingly small overt mention by participants in this study. Whilst very few participants made any direct references to success or positive outcomes for clients, there was a latent sense that this was important. Successful outcomes for clients were implicit in the discussion about what experts are able to do.

Overarching theme: Guru

The overarching theme of Guru constructs expert practitioners as personal teachers and leaders. The guru theme constructed an expert as someone willing and available to provide professional input to other SLTs. SLTs sought expertise but also needed to make themselves visible in order to be seen as experts. Within this overarching theme are two linked themes, of Community Contribution and Leading Light.

Theme: Community Contribution. The theme Community Contribution situates experts as those that educate other practitioners. They explore, create and broadcast new approaches, ideas or research. The expert gives to the professional community as well as to their clients, for example, educating other professionals, participating on a professional body working party, or being involved in conducting research.

Experts contributed to the community by actively educating others about an aspect of their own practice, or the current research evidence which is summed up in "Individuals who present at courses and conferences, who publish and write textbooks" [P98]. Typically these SLTs were involved in lecturing or teaching and were seen as willing to present at conferences or provide other learning opportunities, such as "development of…online dysphagia training packages" [P6] and "presence in online Special Interest Groups" [P78]. A participant proposed "the SLTs who not only work with people with dysphagia but also who are published in this field" [P36], supporting the idea that it is not enough to be a great practitioner working with clients and families, but rather that experts also produce and share their knowledge with their professional community.

Advocacy was an important component of expertise for some, captured in this comment "[experts] participate in national projects that promote or develop the field of dysphagia within NZ" [P31]. Experts were involved in promoting or developing the field at a

national or international level, for example travelling to participate in working groups. Closer to home, they were involved in creating or contributing to policies, guidelines and protocols, for example, “they write guidelines for the country’s health sector or SLT association in their country” [P111].

The role of research in expertise was contended. Although participating in research was seen by many as an important component of expertise, it was not sufficient by itself and contributed to a sense of disappointment for some. Research (academic) experts were perceived as not “hands-on” and not necessarily realistic or practical. There was a view that such academic expertise was hard to translate into therapeutic work, compared with clinical expertise. Clinical work with clients was identified as most important and any research should have a client focus to be useful, valued and reflect expertise:

as I am a clinician I think it's important that this person works clinically at least part of the time to stay grounded in current practice and realities of clinical work (as opposed to just ideal lab-based research ways of working) [P40].

Not knowing what a researcher’s clinical skills were like was a source of concern “those heavily involved in research in this area are seen as expert [by others] - in knowledge, however, I wouldn't always view them as experts clinically” [P61] and there was an associated disappointment at a perceived lack of clinical expertise:

In NZ they are speech pathologists whose name is known for their contribution to dysphagia, though I would consider them in a research based way rather than their clinical skills in the first instance (as for overseas based experts). I look to them to provide strong robust theoretical underpinning for speech pathology and dysphagia in New Zealand, having an advocacy role for the profession. In my opinion I also need to be able to recognise and acknowledge their clinical knowledge [P106].

In contrast to this view, a handful of participants suggested that being involved in research did contribute to expertise, for example “consistent ongoing contribution to research” [P39] and “those that are conducting research into dysphagia” [P105]. This reflects the different contributions that experts were expected to provide – one being an academic focus on theory and evidence, the other being a practical understanding of working with a client.

Experts were constructed as willing and approachable: “willing to take on the responsibility of being an expert and as a result have extended their knowledge and contacts in their field” [P69]. They were also expected to be readily available for support, advice and talking through difficult cases with a sense of trust and respect for the practitioner: “willing to be contacted with really tricky cases and is willing to try to problem solve them with you” [P25]. This construction of the expert as a contributor puts high expectations on the expert to provide for the community, as a leader and teacher, not just individually but at a regional and national level. This aspect of contribution can be closely linked to reputation, which is captured in the next theme Leading Light.

Theme: Leading Light. A second theme under Guru was Leading Light which explores the importance of being visible. It discusses the way the expert can be seen and known for their contribution, through publications, training and supervision. The expert has a good reputation, or at least has a reputation – is known – amongst the community of SLTs. Having an expert reputation suggests a widespread belief that someone has a characteristic of being a “good” or expert practitioner. Some participants acknowledged those practitioners who are named as expert, such as being called an NZSTA Expert Advisor; thus a professional body or other appropriate organisation could bestow this title. More often, experts were constructed as the go-to person, even if not given an official title reflecting seniority or specialism. Experts were practitioners who were respected or admired within the community

as illustrated here: “They are the recommended go-to people for guidance or information regarding certain topics that other people with more experience than myself are unable to answer or suggest that I contact for further details” [P63].

Some experts were talked about in relation to others seeing them as experts, but not the participant themselves. In some sense, there was a reputation amongst the community that then needed personally verifying for the participant to also hold that view of a person as an expert. For example, “[Name] was THE name when I studied. She published a lot of research and was frequently cited by others, including our dysphagia lecturer, hence she appeared to be regarded as an expert” [P72]. What could be seen as a positive contribution to the community, such as speaking at a conference or publishing research, could also be viewed with doubt, perhaps based on a lack of visible contribution to the individual practitioner on the ground, and therefore skepticism about who is an expert.

For some participants, experts - whether researchers or clinicians - were mysterious, or at least problematic. There was a sense of wanting to know who the experts are, expecting expertise and that not being fulfilled, for example, “unfortunately, the people local to me who I would consider expert are not the people employed [in health]. The team locally that we are meant to liaise with are new graduate therapists with little support” [P13]. Another participant commented: “I struggle in [town] to know who is an expert” [P18]. One participant was more positive, identifying that perhaps there are many experts, but the wider community does not know who they are, as illustrated here; “There are many SLTs working in smaller hospitals and in the community who are experts, but perhaps aren’t well-known across NZ” [P61]. The importance of visibility amongst the community may put a demand on a practitioner to not only contribute to their community, but to do so in a highly visible way. However, the way in which the person contributes and makes that contribution known is important in gaining recognition as an expert with individuals in the community.

Quantitative Data Analysis

Of the 18 elements that SLT respondents (n = 116) were asked to select and rank, the two most frequently chosen were “has an in-depth understanding of the mechanics and science of swallowing and swallowing disorders” and “highly experienced”. “Has a PhD” and “a clear set of values” were chosen only rarely. Table 2 provides a summary of the expertise elements in the order of frequency chosen, including the highest (rank = 1), lowest (rank = 7) and modal ranks allocated per element.

Table 2

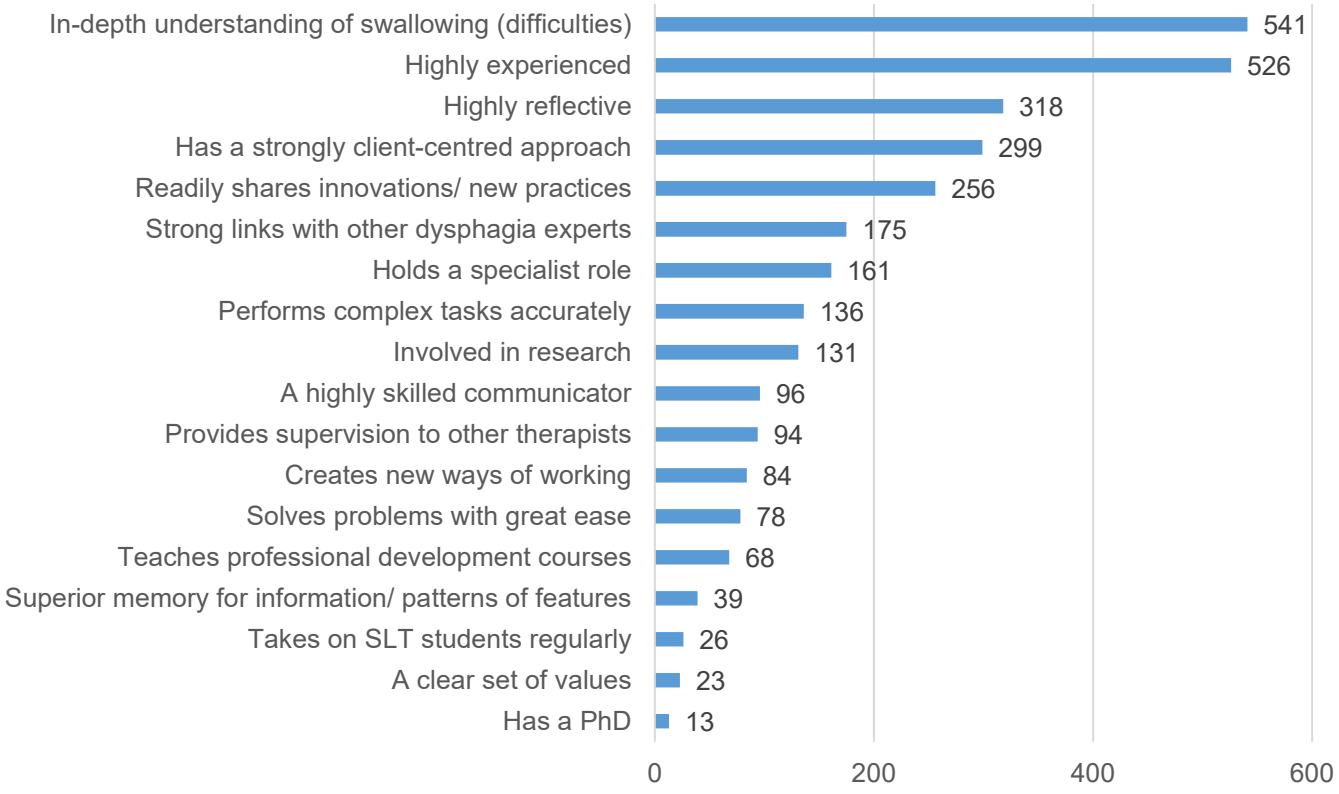
Summary of Elements of Expertise, in Order of Frequency (n = 119)

Element	Total count	Modal rank	Range
In-depth understanding of swallowing (difficulties)	94	1	1 – 7
Highly experienced	93	1	1 – 7
Readily shares innovations/ new practices	78	4	1 – 7
Highly reflective	72	3	1 – 6
Strong links with other dysphagia experts	64	7	1 – 7
Has a strongly client-centred approach	63	3	1 – 7
Involved in research	44	7	1 – 7
Holds a specialist role	40	5	1 – 7
Provides supervision to other therapists	40	7	2 – 7
Performs complex tasks accurately	33	3	1 – 7
A highly skilled communicator	30	4/ 6	1 – 7
Creates new ways of working	28	6	1 – 7
Teaches professional development courses	24	5	2 – 7
Solves problems with great ease	21	5	1 – 7
Superior memory for information/ patterns of features	12	3/ 7	2 – 7
Takes on SLT students regularly	12	7	3 – 7
A clear set of values	9	7	2 – 7
Has a PhD	4	7	2 - 7

Figure 3 provides the full list of elements in weighted rank order, for example “highly experienced” was ranked in first place by 37 participants and second by 28 participants. Six elements were not ranked in first place and “takes on SLT students regularly” achieved a highest rank of 3. One element “highly reflective”, was never ranked 7, but only 60% of participants ranked it at all, with 41 participants who did not include it as important for expertise. For further analysis, the distribution of each element’s ranks was determined. Two elements had a bimodal distribution, three were skewed to the left and three had a normal bell-shaped distribution. The remainder were skewed to the right.

Figure 3

Weighted, Ranked Order of 18 Elements of Expertise



Discussion

The findings of the qualitative and quantitative data analysis are complementary and provide credibility to each other in that they both support the view that experience and knowledge are important but not sufficient aspects of professional expertise. Experience and knowledge of dysphagia were ranked with the highest importance in the ranking questions and frequently mentioned in the qualitative responses describing an expert. The top two elements of professional expertise from the ranking evaluation, “Highly experienced” and “An in-depth understanding of swallowing” are consistent with the overarching theme of Great Practitioner and with the themes Been Around the Block and Knows Her Stuff respectively. Both results align with a traditional view of socially-recognised expertise that is founded in knowledge and experience (Ericsson, 2008). The elements “Has a strongly client-centred approach” and “Performs complex tasks accurately” also had left-skewed distribution, suggesting their high importance amongst those participants that did include it. These results are consistent with the subtheme Gets Results.

Additionally, the importance of teaching and learning was highlighted in items relating to teaching professional development courses, being highly reflective and readily sharing innovations. These were ranked as important, consistent with the overarching theme of Guru. Other elements were ranked less frequently and with a right-skewed distribution, suggesting their lower importance even amongst those participants that chose them. “Involved in research” was included by 37% and had a right-skewed distribution, whilst two participants ranked “Has a PhD” as highly important, but the vast majority of participants did not rank it at all. This could be considered consistent with the divergent views on participation in research found in the qualitative comments.

Professional experts are not solely constructed here as those that get exceptional clinical results, although there was a strong sense that having success with clients was

expected. Whilst SLTs did identify professional experts, there was also some skepticism of this expertise within the community. SLTs valued clinical expertise much more than research expertise, and this was supported in the quantitative data by the relatively lower rankings given to the elements of being research active, and having a PhD. Despite this, there was a sense that researchers were more known than clinical experts, even locally. This suggests that gaining recognition as a professional expert may need to occur at multiple levels, for example at the level of the individual, the local SLT workforce and the national SLT community.

The concept of reputation could be useful in developing our understanding of professional expertise, given its role in the traditional view of expertise. Reputation has been thought of as an organisational level construct in much of the past management literature but recently more interest has been on ideas of personal reputation, both within an organisation and across virtual communities (Emelo, 2012; Littlepage et al., 1997; Treem & Leonardi, 2015). This emergent work views personal reputation as a belief about someone, held across a community. This seems to fit well with the conceptualisation of expertise provided by SLTs. Thus, an SLT's reputation is perhaps more visible through publications and presentations; in contrast, doing great work with clients is confidential to the practitioner-client relationship and less visible, or only visible to the local SLT community. While successful work with individual clients is valued amongst the community, it will not be reported in the same way as larger more complex research studies of clients that are perceived as higher quality (Greenhalgh et al., 2014).

There is evidence elsewhere in the literature that SLTs have disengaged with the research base in some areas of practice (Beecham, 2004; Foster et al., 2015). This issue is not isolated to SLTs and has been discussed across a range of disciplines including social work (Epstein, 2011), teaching (Zeichner et al., 2015) and management (Anderson et al., 2017). This could be seen as consistent with a diminished recognition of research expertise found in

the current study. SLTs have in common with other health professions the claim that evidence-based practice is essential. The lack of recognition given to involvement in research brings into question whether those producing evidence are valued as experts. It was important for participants that researchers maintain strong links with clinical practice. A recent and ongoing approach to bridging this divide between research and clinical work is knowledge transfer and translation, from research academics to clinical staff, but this has had variable success. In nursing, questions have been raised around how to create effective partnerships between academia and clinical practice whilst considering differing worldviews around language, method and outcomes (Gerrish et al., 2016; Walsh et al., 2012).

A practical question then is, in workplaces such as government agencies and regional health services, how can information be shared across organisations, and between professionals? Emelo (2012) has suggested creating a "reputation system" within an organisation with a focus on encouraging knowledge sharing, and it would be interesting to consider how such a system can be set up across organisations such as through professional bodies, using digital technology. Whilst there are numerous websites dedicated to managing a physician's reputation online for example, a search on Google Scholar found no published academic papers about reputation either for physicians, or other healthcare professionals. An additional issue arises in that practitioners want to know who has practical rather than research expertise; moreover, practitioners may not want to take on the role of expert with its perceived responsibility. In a study of women physicians, the perceived costs of managerial roles outweighed the perceived benefits, dissuading the women from applying for managerial positions (Roth et al., 2016). Similarly, the perceived costs of being known as an expert, with the time and effort costs of contributing to the community outside of one's everyday job requirements, for example time in writing and maintaining a blog, or preparing for and

talking at professional meetings, may dissuade practitioners from taking actions that promote their knowledge and experience within their community.

Why would practitioners refrain from being more vocal about their successes and enabling others to learn from them? Whilst practitioners want access to shared knowledge, there may be a reluctance to do the sharing. Knowledge sharing requires trust, motivation and self-efficacy (Hsu et al., 2007). It requires both knowledge collectors, those seeking knowledge, as well as knowledge contributors, those providing the knowledge. The knowledge contributors are important in creating a safe place, a trusting community, but knowledge collectors have a more significant role in the promotion of the knowledge community, developing the reputation of the knowledge contributors (Chen & Hung, 2010).

Additionally, Treem and Leonardi (2015) reported that experts were more likely to actively seek advice relating to tasks, and specifically through communal communication channels. By asking for advice themselves, experts have an opportunity to display what they do know (Treem & Leonardi, 2015). This view is consistent with the findings from the current study where humility was an attribute valued in an expert. Thus, experts learn from their mistakes, recognise gaps in their knowledge and actively seek new information.

There may be cultural differences here between North American practitioners and NZ practitioners that lead overseas practitioners to be more forthcoming in offering advice (Kirkwood, 2007). This, along with the relatively small population of NZ may lead to a view that there are more opportunities overseas, which was highlighted in the qualitative responses. In this study, experts are both knowledge contributors and collectors. The balance between knowledge contribution and knowledge collection that is of mutual benefit to all in the community, is an aspect of expertise that requires further investigation.

Understanding how professional expertise is constructed within a community can provide healthcare professionals and leaders with new insights that may alter the ways in which expertise is developed and spread within services. Healthcare professionals across the world are often legally obliged to undergo continuous professional development, and will seek ways to achieve this. Professional experts in each healthcare profession are an important part of providing this ongoing professional development for their colleagues, but may be more or less willing, able, or available to take this role. In particular, our results raise questions about the role of reputation in the construction of experts which may have practical implications for the identification and promotion of both clinical and research expertise amongst the community.

Strengths and Limitations

This study of professional expertise using a mixed methods approach provided different types of data yielding complementary results. Open questions and ranked items were used to explore a perception of professional expertise in retrospect, rather than asking participants to create the ideal expert, or to describe the experts in a healthcare relationship which could have included managers (Fulop & Campbell, 2011), and the clients themselves (Edgar, 2005). The socially constructed nature of this research rests on a notion that individual perspectives are honoured. It is possible that other researchers may have generated alternative findings in response to the data; or that research with other healthcare professions would have yielded different findings. All the authors are health professionals, one an SLT with a clinical caseload and one an audiologist in a research management position, the third author having a background in organisational psychology. To counter expectations held by the team, the researchers ensured that analysis and interpretations were grounded in the data through the use of verbatim quotes.

The study surveyed SLTs within NZ, with respondents being representative of professionals nationally. The study design allowed for the data to be explored further by age or experience, but this line of analysis was not pursued at this time as the study aimed to create a construction from across the whole SLT community. Perceptions of different groups within the wider community could be investigated in the future, for example whether younger practitioners are more positive about the role of research in professional expertise as they are more recently graduated from university courses with an emphasis on the profession's evidence base.

The ranking questions did not include elements of social recognition that relate to reputational aspects of expertise, which came through in the qualitative analysis. While this shows the unique contribution of the qualitative data, it was a limitation of the quantitative part of the current study. The development and maintenance of reputation as part of expertise is an important area for future inquiry amongst health practitioners, and may be particularly relevant for those involved in research and in promoting evidence-based practice. The elements of professional expertise arising from the qualitative data such as reputation within the community and balance of research and clinical work, should be considered in future research around the topic of professional expertise.

Conclusion

This group of healthcare practitioners had a view of professional experts that was predominantly centred on a relationship of themselves vis a vis an expert, rather than between the professional expert and their clients, although the latter was acknowledged as an essential component of professional expertise. Many participants valued and commented explicitly on how a professional expert had helped them directly in their professional work. Professional expertise was constructed as highly developed knowledge and a wealth of experience that

needed to be seen by, and also shared amongst the community. Teaching and learning was integral to the identity of the professional expert. Practitioners valued the advice and support that professional experts provided and saw this critical. Practitioners valued hands-on experience as well as domain-specific knowledge, and in particular they revered clinical expertise over and above being research-active.

This study is novel in exploring a construction of professional expertise amongst practitioners in the SLT community in NZ. Within that professional community, experts could be viewed as highly-effective practitioners that visibly contribute to the community at international, national or local level. For those SLTs who are highly experienced, the opportunity to be known as an expert is available but clearly requires an investment of time and effort. The following chapter asks what it might take for a health professional to be willing to visibly contribute. It explores literature covering a wide diversity of allied health professionals and expands the scope of the research beyond SLT to multiple professions.

Chapter 3

This chapter is a lightly edited version of a published manuscript: Jackson, B. N., Purdy, S. C., & Cooper-Thomas, H. D. (2019). Role of professional confidence in the development of expert allied health professionals: A narrative review. *Journal of Allied Health*, 48(3), 226-232.

The Role of Professional Confidence in the Development of Expert Allied Health Professionals

Experts in each healthcare profession are important providers of ongoing professional development for their colleagues, with tangible benefits for patients. Aside from practitioners with a specific job and professional title, such as specialist therapist, expert advisor, consultant, studies have identified that expert practitioners, titled or not, are known as the go-to people for advice and support with professional challenges (Lunce et al., 1993; Pring et al., 2012). Given the importance of expert practitioners, beyond universal barriers due to scarce resources of time and money, what factors influence individuals' willingness, ability, or availability to take on this role? This narrative review of the literature considers both the evidence available and the gaps in our understanding (Dijkers, 2015).

For those practitioners with proven competence and substantial experience, willingness may be influenced by confidence, self-belief or self-efficacy as a basis for motivation (Bandura, 1997, 2001). The term *professional confidence* positions confidence specifically with being a professional, but not to a single task or situation (Holland et al., 2012a). In order to distinguish the concept of professional confidence from other constructs, a team of occupational therapists (OTs) conducted Rodgers's Evolutionary Concept Analysis using research literature as data (Holland et al., 2012a). This team analysed common usage of

the term professional confidence and generated a consensus opinion situated in the literature reviewed, rather than a definitive description of the concept. Hence, the quality of the concept analysis is dependent on the quality of the literature included. The Holland et al. concept analysis across 16 English-language research articles and five literature review and opinion pieces, covering at least 14 different healthcare professions between 2000 and 2010, defined professional confidence as:

> "a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice, and significance of the profession, and is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences." (Holland et al., 2012a, p. 214)

This definition of professional confidence forms the basis of the following review. The team called for further research to explore how the concept can be developed early in a healthcare professional's career, even during their qualifying study. Some new research has been forthcoming, particularly for pre-qualification healthcare students and those in their first year of practice. However, the importance of professional confidence across a person's career has not been explored comprehensively.

Threats to Professional Confidence

The definition (Holland et al., 2012a) states confidence is relative to the understanding of and belief in the role that the practitioner takes on. Practitioners may take on a role that directly follows the training of their discipline, for example, physiotherapist, radiographer, nurse (Merton, 1957; Michalec & Hafferty, 2015). Roles tell us "how to be" in certain interactions and circumstances, and are associated with identities (Merton, 1957; Michalec & Hafferty, 2015). For example, a person who identifies as "nurse" may have numerous nurse-other roles such as nurse-patient, nurse-doctor, nurse-student which all

provide their own set of “how to be” in a variety of interactions. The person may use the identity “nurse” to define themselves and also to determine their ways of being. This role identity is central to the individual, and if their understanding and belief in the role of “nurse” is shaken, then their self-concept as a professional is in jeopardy (Alves & Gazzola, 2013; Duchscher, 2008).

Across the health workforce, ambiguity of roles and scopes of practice are cited as the most frequent organisational sources of conflict (Björklund & Svensson, 2006; Kim et al., 2017). Conflict also arises from differences in power between positions, expertise, and roles of different professionals. These have negative consequences for healthcare professionals' job satisfaction and intent to stay. Social-role theory suggests that if the practitioner themselves cannot clearly articulate their role-set, it is difficult for other professionals to relate to them, even if they are from the same professional background (Michalec & Hafferty, 2015). For example, the diversity of advanced and specialist roles amongst British nurses resulted in role ambiguity leading to confusion and animosity amongst fellow nurses and other health professionals (Lloyd Jones, 2005). Role ambiguity is a hindrance to acceptance and collegial support, and therefore likely to negatively impact a practitioner’s confidence (Harden & Crosby, 2000).

Patients are at the centre of healthcare, yet patients can cause practitioners to doubt their skills, knowledge and purpose. A study of 100 health practitioners in the UK explored perceptions towards expert patients, that is patients with long-term health needs who are able to self-manage to a significant degree (Wilson et al., 2006). Despite being experienced for three years or more, nurses talked about feelings of discomfort with expert patients. The knowledge and confidence of expert patients was seen as threatening. However, this was unique to registered nurses; nurse specialists, physiotherapists and doctors did not feel threatened. The registered nurses were seen to be threatened because of their inability to

clarify their role and specific medical knowledge and skills in relation to the expert patient, despite being competent to meet the emotional needs of their patients.

Additionally, there can be conflict between expectations regarding a professional role and the role the practitioner is actually able to fulfil, given organisation and service requirements and constraints. For example, a group of experienced speech-language pathologists (SLP) felt disempowered by the evidence-base for SLP practice with people with aphasia, as they were not able to live up to the expectations of the research literature within their current service provision (Foster et al., 2014; Foster et al., 2015).

Interprofessional Practice

The introduction of interprofessional working has provided a challenge for some practitioners in identifying the boundaries of their professional practice, and the overlaps with other professionals (Baker et al., 2011; Booth & Hewison, 2009). Interprofessional practice aims to increase patient care and wellbeing, and reduce errors, by breaking down barriers to communication, sharing resources and creating a joint approach. The process of renegotiating boundaries in a new context of interprofessional practice can put professional identities and sense of belonging under threat; it "risks undermining the values which hold professional communities together" (Pinder et al., 2005, p. 776). The unrest this might cause amongst the professional community can impact on quality of care. An example from the UK nursing literature highlights how the development stages of Clinical Care Pathways resulted in positive communication benefits between professionals, but the implementation of joint documentation threatened professional boundaries which in turn affected the quality of patient documentation, with professionals preferring to keep their own records "in order to retain their professional identity" (Atwal & Caldwell, 2002, p. 365).

Various power and control behaviours are used to maintain and define the boundaries of a profession's practice and to differentiate and elevate it from others (Baker et al., 2011; Witz, 1990). A qualitative study of 132 practitioners found that even after an extensive interprofessional practice initiative, there were views of elevated status of some professional groups, such as medical doctors, and a lack of engagement from others which were seen to perpetuate the separateness and dominance of those groups (Baker et al., 2011). The success, or not, of these power plays of exclusion, demarcation and usurping can significantly contribute to practitioners understanding and belief in their scope of practice, and therefore their confidence (Baker et al., 2011; Williams & Lawlis, 2014; Witz, 1990).

Bringing together professionals from different communities allows practitioners to explore the boundaries of their practice together and locate themselves within a professional landscape. For example, SLPs and physiotherapists have been collaborating with each other to develop new approaches to chronic cough, a scope previously covered by pharmacology (Birring et al., 2017; Chamberlain Mitchell et al., 2017). It remains to be seen how these three professions will negotiate their shared role boundaries within this shifting area of practice over time. Importantly, confidence with a scope of practice suggests a practitioner knows their scope and is comfortable and engaged in exploring what have been referred to as the murky edges (Williams & Lawlis, 2014), as is required for negotiating interprofessional practice.

The Status of the Professions

Several professional groups have undertaken extensive research to support lobbying to extend their professional boundaries, thus increasing the status of their profession, for example, social work (Fook et al., 2000) chiropractic (Weitz, 2017), physical therapy (Jensen et al., 2000), and medical radiation technicians (Coyler, 2004; Yielder et al., 2014). In the case of nursing, the profession has evolved from being considered an extension of a

"woman's duty" (Nightingale, 2010), to becoming an occupation, and then achieving professional status through specialist masters and PhD qualifications leading to advanced, specialist, and nurse practitioner roles that are encouraged throughout high-income countries such as Australia, Canada, New Zealand, UK, and the USA (Lloyd Jones, 2005; Weitz, 2017). Practitioners have pursued a higher level of professional status because they believed in the significance of the profession and used legitimised channels of recognition such as academic qualifications, to achieve this.

Challenges to professional status arise in situations where advancement or recognition is proposed but denied (Alves & Gazzola, 2013; Fook et al., 2000). Practitioners within a professional group who are denied enhanced recognition sought through higher level qualifications, or registration with a governing body, may become disempowered and lack confidence, as legislative organisations do not appear to share their beliefs in the significance of their profession (Weitz, 2017). Counsellors in Canada, as an example, have struggled to achieve recognition as unique providers of mental health services and their professional identity has been called into question due to a diversity of training and certification schemes (Alves & Gazzola, 2013), leading to insecurity amongst the community. In contrast, a strong professional identity can lead to a sense of pride and satisfaction amongst those that call themselves part of the profession (Canrinus et al., 2012).

A common finding reported in the literature is that if a profession is not valued within an organisation, the practitioner within that professional group may question their role within their organisational team and their ability to contribute (Holland et al., 2012a). This may cause them to question their professional identity. If this situation is not resolved, one possible outcome is this person leaves the profession (Björklund & Svensson, 2006; Canrinus et al., 2012). On the other hand, professional confidence grounded in the significance of their chosen profession, may contribute to a resilience to remain in their profession despite

constraints that limit their capacity to serve their patients and their communities (Pring et al., 2012). This happened for SLPs working in the UK who presented considerable concerns about their ability to provide a high quality service due to policy and resource changes, but these concerns were "balanced by a continuing loyalty to the profession and a commitment to the ideals that brought them into it" (Pring et al., 2012, p. 704).

With socially negotiated roles and scope of practice, and community recognition of the significance of the profession, professional confidence might blossom. It seems clear that professional confidence is substantially socially determined by professional bodies that deliver training and development, legislative organisations that provide registration, other healthcare practitioners and professional groups who are negotiators of role boundaries, and patients and their communities (Michalec & Hafferty, 2015; Williams & Lawlis, 2014).

Development of Professional Confidence

Given that professional confidence is a dynamic, maturing belief, a useful question to ask is how does it mature? Tertiary level training programmes for allied health practitioners, and the first year post-qualification when practitioners are new in the workplace, are important times for confidence to develop (Carpenter et al., 2013; Duchscher, 2008). A study of OT students concluded that professional confidence consists of three developing elements, "knowing", "believing" and "being" (Holland et al., 2013). Other studies of student health professionals similarly suggest that professional confidence is a developing feeling of becoming a practitioner during the first year of practice (Duchscher, 2008; McMullen et al., 2014). There is minimal research on the development of confidence after the first year in the workforce, yet this is necessary to understand how confidence matures over the career span of practitioners, and also, because confidence is a changeable belief that could fluctuate with changes in government policy, new technology, workplace, interprofessional, and personal factors such as stress and uncertainty (Carpenter et al., 2013; Ortiz, 2016).

Both affirming and disaffirming experiences have a role in the development of confidence, including building resilience to setbacks (McMullen et al., 2014). New graduate nurses reported both positive and negative workplace experiences contributed to the development of their professional confidence (Ortiz, 2016). Negative experiences included a difficult relationship with the supervisor, working with disgruntled families, a large caseload and making mistakes such as allowing a patient to fall. Given time and encouragement, reflecting upon these negative experiences promoted resilience and, along with positive affirming experiences, the nurses were able to move towards greater confidence. Similarly, practitioners with more years of experience in the workplace report that reflecting on negative experiences was useful in building confidence (Wilding et al., 2012). Opportunity to develop skills in critical reflection and allocated time to reflect on events, are valuable in building confidence (Carpenter et al., 2013; Wilding et al., 2012). Additionally, reflexivity is increasingly recognised as valuable. Self-awareness of cultural, political, social, linguistic and ideologic origins can increase confidence in one's own healthcare practices and those of other healthcare practitioners (Delany & Watkin, 2009).

Measuring Professional Confidence

Several researchers have attempted to measure levels of professional confidence. Studies have mostly used qualitative means, including semi-structured interviews, focus groups, recorded observations and reflective journals (Holland et al., 2012a). A number of studies have utilised Likert scale self-report responses (Canrinus et al., 2012; Carpenter et al., 2013; Minisini et al., 2010). This allows participants to declare their own confidence as defined by themselves, but makes generalisations difficult as few studies have used the same questions or type of analysis. Several studies have used previously published scales such as modified versions of the Generalised Self-Efficacy Scale (Luszczynska et al., 2005) or the Scale of Self-Efficacy (Sherer et al., 1982) but these have not been widely adopted. Despite

challenges with measurement, low confidence has been linked with withdrawal and avoidance of work tasks and workplace relationships, increased levels of stress leading to burn-out, and practitioners leaving their job, if not ultimately their profession (Hecimovich & Volet, 2011; Holland et al., 2012a).

Confidence and competence are strongly connected, with an ability to competently fulfil expectations needed in order to feel confident (Hecimovich et al., 2014; Holland et al., 2012a). Confidence is an internal feeling, contrasting with competence, which is an externally measured, acceptable level of skill. Both are changeable over time and can be aligned or misaligned with consequences for both the practitioner and the service, hence the interest in measuring both. Registration boards, professional bodies and academic institutions establish clear expectations of competence for attaining and retaining certification as a health professional, but the level of professional confidence expected is much less clear.

The Role of Training

It might seem logical that professional training would contribute to the development of confidence. Physiotherapists practising in rural and remote parts of Australia reported low levels of confidence working in specialist areas of practice. In urban centres, specialist physiotherapists took on roles in paediatrics, whilst in rural settings where specialists were not available, generalist physiotherapists included paediatrics in their role (Minisini et al., 2010). This work was not outside their professional scope of practice but was beyond the specific training the practitioners received, and combined with a lack of supervision, led to low levels of confidence. A similar finding arose with a multi-disciplinary group of health professionals working in rural New Zealand (Burgess et al., 2016).

An alarming study from the USA reported on self-confidence and training of 222 SLPs working in schools with children with eating and drinking problems (O'Donoghue &

Dean-Claytor, 2008). The study concluded that those with minimal or no professional development since qualifying felt more confident to work with this patient group than those SLPs who had met their registration requirements in relation to the number of courses and training hours they had attended. The authors suggested that those with recent professional development training had a greater awareness of the risks the children face, of their own limitations, and limitations of their workplace.

Training can increase both task specific confidence, for example surgical skills learnt via simulation training (Dagnan et al., 2015; Leopold et al., 2005), and confidence in a role, for example Intensive Care Unit nurses (McMullen et al., 2014). A longitudinal study of registered nurses enrolled in a year-long specialist course found all the nurses reported an increase in confidence that was not just related to specific skills but to their broader role and scope (McMullen et al., 2014). Experience also helps somewhat in building confidence, as many studies attest to, but is more effective if it is gained intentionally, for example, through guided-practice (Hecimovich & Volet, 2011), a preceptor year (Freiburger, 2002), or deliberate reflection (Wilding et al., 2012). Authors highlight the significance of time and encouragement for reflection and again emphasise that reflexivity is of substantial value. Awareness of the origins of personal values and beliefs is an essential component of understanding a health professional's place in their social and environmental context (Delany & Watkin, 2009; Patton, 2002).

The Relationship Between Professional Confidence and Expertise

This review asks how self-belief relates to professional expertise. The definition of an expert is debated but alongside superior knowledge and skills, experts learn from their mistakes, recognise gaps in their knowledge and actively seek new information (Alderson, 2010; Ericsson, 2008; Lunce et al., 1993). Practitioners can communicate what they know by asking about what they do not know (Treem & Leonardi, 2015). Experts, as well as novices,

share their knowledge with their community by asking for advice, which may expose gaps in their knowledge to others. A person must believe they have something useful to share, the ability to share, and have trust that the community is safe to share with. Differences in culture, of a workplace, of a professional group, of people of particular backgrounds, may also influence a practitioner's willingness to share (Kirkwood, 2007). Sharing is more likely when practitioners are willing to be vulnerable and to trust other professionals, who may be unknown (Chen & Hung, 2010; Hsu et al., 2007). Confidence increases the likelihood of sharing knowledge and skills (Hsu et al., 2007). Low confidence contributes to a reluctance to share knowledge, even though practitioners themselves and their patients would benefit (Wilding et al., 2012). The findings of this review suggest the relationship between professional confidence and expertise is influenced by diverse factors, and that reflexivity and knowledge sharing are actions that practitioners can take to develop both.

Lessons for Practice:

1. Professional confidence can be threatened from many directions. Table 3 provides questions to provoke reflexive thinking around these issues.
2. A lack of professional confidence negatively impacts on a practitioner's wellbeing and reduces their willingness to share knowledge and skills.
3. Practitioner-focused training and experiential learning opportunities should include time for reflection on events with the aim of changing future practice.
4. Practitioners should be enabled and encouraged to take time to reflect on workplace events, whether negative or positive, and their reactions because these can provide valuable inputs to building confidence.

5. It should be recognised that all members of a professional community are important in fostering a safe, supportive environment where practitioners are confident to seek help about what they do not know, as well as share knowledge and skills.

Table 3

Questions to Encourage Reflexive Thinking

Take time to consider the following questions. You may wish to make some notes on your responses and discuss the questions and your responses with a trusted supervisor or peer. Where your answers reflect potential threats to confidence, identify actions to take that address those areas - examples are provided, but you are encouraged to identify actions that fit your own specific needs and setting.

Theme	Questions to consider	Examples of actions to take in response to potential threats
	About my profession	
Understanding and belief in the professional role taken	What is my role, in the broadest sense? What training have I received that is unique to my profession? What is the focus or essence of my professional training? To what extent do I feel "one of us', one of my profession?	e.g. offer the opportunity to have a high school student shadow your work for a morning e.g. represent your profession at a recruitment event to attract people into the profession
Status of the profession amongst other professions and the public	What do other professionals think about my profession? How is my profession threatened by other people I work with, clients, and the general public? How is my profession celebrated or valued by other people I work with, clients, and the general public?	e.g. write a news article for another profession's professional body newsletter about some clinical work that was shared across professional groups

Theme	Questions to consider	Examples of actions to take in response to potential threats
	About my profession	
Value of the profession within the organisation	What do I add to my organisation that is specific to my profession? How is my profession threatened by the organisation I work for, including leaders and managers at different levels? How is my profession celebrated or valued by the organisation I work for, including leaders and managers at different levels?	e.g. attend a forum for staff with senior managers of your organisation and ask a question
Commitment to the ideals of the profession	What are the ideals of my profession and to what degree am I still committed to them?	e.g. review the mission statement, vision and ethical principles for your profession
Knowing where my profession belongs in interprofessional practice	Who do I work with from another profession? What is their role and their background? What is the nature of our relationship? How do I connect with people from my own professional background? Who are the people in my professional community? How do I keep in touch with my professional community?	e.g. attend a mixed health professions event and work to develop a network of colleagues within and outside your profession so that you can understand others' views of where professional boundaries lie

Theme	Questions to consider	Examples of actions to take in response to potential threats
	About me	
Clarity about the collection of roles that I have	What are all the roles I have that make up my current job? What unique information/skills do I bring to the team? What are the things I do and the outcomes I achieve that distinguish my role from others?	e.g. arrange a mutual feedback session (peer review) with a colleague of the same profession, and another with a colleague of a different profession
Clarity of my scope of practice	To what degree is there ambiguity in my scope of practice? Am I clear when I am acting out of my scope? What actions do I take when I am asked to do something out of my scope?	e.g. Review your CV/ Résumé and update your key professional development events e.g. review those occasions where your work is close to/ on/ beyond those boundaries and consider your practice relative to the code of ethics for your profession
Boundaries of my practice with other professionals	What overlap do I have with other professionals I work with? How do I negotiate roles when working closely with other professionals?	e.g. over a tea break with a colleague from a different profession, discuss the similarities and differences in the way you are approaching a joint case/ client
Opportunities for advancement and recognition are needed	What am I proud of accomplishing? Am I satisfied with what I accomplish? What opportunities are available for me to be acknowledged for my successes? Are there different ways for me to be acknowledged, by different people?	e.g. Talk with your manager/ leader about organisational opportunities to submit your work for an award

Theme	Questions to consider	Examples of actions to take in response to potential threats
	About me	
Clarity about my own skills, knowledge, and purpose	Am I doing a good job for my clients, for my team, for my profession? Do I have the opportunity to reflect on my work and to make changes to my practice? Do I have the skills to make good use of the time allocated for reflection?	e.g. set up a service evaluation with your manager to gather feedback from your clients e.g. write a reflection about the last client you worked with, and ask for feedback from a supervisor skilled in reflective practice
Organisation and service demands vs. individual/ team capacities	Do I have what I need to be able to do my job? Does my professional community support me to do my job well? What support, resources, skills or information are missing that limit my ability to do my job well?	e.g. post a question on a professional discussion board and acknowledge the responses e.g. create a peer or mentoring relationship with a professional in a different organisation or region

Conclusion

This review has drawn on literature from diverse fields in keeping with its interprofessional focus. In general, an expert practitioner has an enduring high level of professional confidence, gained over considerable time and events. They have an accurate judgement of their advanced knowledge and high level of skills they are able to use in working directly with their patients, which in turn provides them with considerable satisfaction and motivation to remain in their role, within their profession. Confident practitioners are more able to contribute knowledge and skills to their professional community. Training organisations and health workforce employers should consider how professional confidence can be developed and maintained across the careerspan, with subsequent benefits for development of expertise and knowledge sharing.

This narrative review of the literature was prompted by the Study 1 survey finding that experts have a willingness to share what they know and thus expose what they might not know. Being vulnerable within a professional community takes trust and confidence. The finding that SLTs value other SLTs that are willing to share knowledge and skills (Study 1) combined with an enhanced understanding of professional confidence as it relates to AHPs (Study 2) is the foundation for Phase 2 of this research. In response to the findings of these first two studies, Phase 2 offers an in-depth exploration of the narratives and perspectives of highly-experienced AHPs themselves, with a view to understanding more deeply the nature of expert practitioners.

Chapter 4

Methodology of Phase 2

This chapter outlines the philosophical approach, methodology and methods of the second phase of my thesis. Phase 2 is a multiple analysis of data that dives deeply into the nature of expert AHPs. In this chapter, I introduce the flexible, open nature of this exploratory research, particularly focusing on a critical pragmatic approach. Consistent with an iterative exploratory approach, the details of my methodology emerged over time, as did the methods. First, I will discuss the underpinnings of the research including the ontology, epistemology and axiology. In the second part of the chapter, I will broadly outline the methods used in Phase 2. The information reported here is consistent with the qualitative method standards of the American Psychological Association (American Psychological Association, 2020).

In brief, Phase 2 involved me collecting semi-structured interview data and curriculum vitae (CV) from 45 AHPs, using an iterative process over the course of a year. The data were analysed in multiple ways and findings are reported in subsequent chapters including content analysis of CVs (Chapter 5), typological analysis grounded in the data (Chapter 6), expanded critical incident analysis and performative narrative analysis (Chapters 7 and 8).

Philosophical Underpinnings

This chapter begins with a discussion of the theories and philosophies that scaffold my thesis. Within psychology and organisational behaviour, the place of theory in forming the central argument in research is unavoidable (Adams & Buetow, 2014; Ashkanasy, 2016;

Corley & Gioia, 2011). I have developed this research from a series of interests and commitments common to critical qualitative researchers within and outside of psychology. Research methodologies are underpinned by a philosophical approach. There are many different approaches that are marked by differences in ontology (the nature of the world and its people), epistemology (what we can know about the world), axiology (the values of the research), and methodology (the ways of research) (Nightingale & Neilands, 1997). I will discuss how consideration of these four aspects leads to the methods used in Phase 2 of my research. Discussion of methodology leads to a brief discussion of the specific methods and analyses. Detailed discussion of methods and analyses is included in chapters to come.

Foundational theories shape the process, but not the topic, of doing research (Adams & Buetow, 2014). There are a handful of foundational theories including meta-narratives of *progress* through empirical knowledge and reason, and *emancipation* through self-determination and empowerment towards a free and just society. The *critical* meta-narrative "draws on assumptions regarding the complex, layered, and interactional nature of understanding and truth" (Adams & Buetow, 2014, p. 100). Critical theories fall under a broad umbrella of post-structuralism.

In general terms, a post-structuralist stance is underpinned by theories of discourse, power and subjectivity (Grant & Giddings, 2002). Post-structuralists position people as creators and products of various discourses (ways of thinking and talking) of power and control that can be written on our bodies (appearances) and our actions (behaviours) (Cunliffe, 2010). Post-structuralism is a theory that language is not a transparent medium that connects directly to reality, but that meaning is derived between speakers. Phase 2 of my thesis takes a post-structural stance, in that it focuses in the main, on the identities constructed during conversations between the researcher and interviewees.

Critical qualitative research provides a way of hearing the voices of those who are not front and centre stage – in this project, it is about hearing the voices of AHPs. It is about noticing the unnoticed and paying attention to that dismissed as irrelevant (Schostak, 2006). As an AHP myself, I feel the voices of AHPs in hospitals and education facilities are crowded out by those of nurses and doctors, teachers and students, parents and whānau (family).

What is Real, What can be Known, and What is Valued, in Critical Theories

Within critical research there are different critical theories and two are considered here: critical realism and pragmatism.

Critical Realism

Bhaskar's theory of critical realism proposes that what is real (ontology) is not reducible to what we know about reality (epistemology) (Bhaskar & Danermark, 2006). He gives an example of the time when people thought the earth was flat, they feared going to the edges, so strong was their belief that they could fall off the edge. This was socially constructed knowledge, that influenced their behaviour and understanding of the world, and yet all scientific knowledge points to the earth being round, and having always been pretty much round. There was a conflict between "what is" and "what is known". Critical realism focuses on understanding reality (ontology). Critical realism, with its emancipatory values (axiology) and its embrace of the real (ontology), seeks to identify causal mechanisms that can be (or even should be) manipulated (Bhaskar & Danermark, 2006). In Study 1, I adopted a critical realist view, but on reading more deeply into philosophical and methodological approaches, I have interpreted my approach as being one of critical pragmatism.

Pragmatism

An alternative critical theory – pragmatism - similarly takes a realist, tentative ontology but in contrast, does not value inquiry into the nature of physical reality that does not have any consequences for human life (DeForge & Shaw, 2012). Although we can discuss and debate in the world of relativism (where no practices or actions are valued above any other), we must live and act in the world as if it is real, as if there is foundational truth to its ethical demands (Stainton Rogers & Stainton Rogers, 1997). Pragmatism focuses less on ontology and instead considers it useful to work with a practical reality. A pragmatist approach considers that constructions are real-enough, it is not useful to question the reality of them in regards to their ontology (DeForge & Shaw, 2012).

Pragmatism takes a subjective, critical epistemology, focused on knowledge as our learned response to our environments. Although the constructions created through discourse are real-enough, other ones are also available and can be created. As mentioned in the introduction, people have sought out expertise historically, seeking doctors for the benefit of their health, teachers for the benefit of their education, and financial advisors for the benefit of their monetary wealth. Yet some people historically, and currently, find the notion of expertise problematic (Berlyn et al., 2008; Hardey, 1999; Satell, 2014). Distrust of experts is strong amongst some groups such as those opposed to the employment of professionals as civil servants, and those who are anti-vaccination (Edwards-Levy, 2016; Lamberts, 2017). The sociologist Fuller (2017), suggests that anti-expertism was at the leading edge of Brexit. Although he is a self-declared anti-expert in some regards, he also recognises that more knowledge per se is not a bad thing. Given that expertise is socially constructed and not a truth, the construction of expert is malleable, as Fuller also suggests.

Where a critical realist view is fundamentally emancipatory at its core, pragmatism is ethical (Clandinin & Rosiek, 2007). If suffering or wrongdoing is found, critical realism

would view it as inherently in need of fixing. However, pragmatism takes the view that it is not "really" wrong, and instead sees a moral responsibility: by putting the language, actions, and circumstances that bring about suffering into context, the rhetoric on which the suffering is based can be identified, and a new rhetoric considered (Butt 2000). Pragmatism would not seek to find any "real" causes of suffering as such, but to contextualise the experiences that arise (Clandinin & Rosiek, 2007; DeForge & Shaw, 2012).

Taking a Pragmatist View

Given these two critical but differing worldviews, this thesis overall takes a pragmatic research approach. It is not inherently emancipatory, nor does it question the physical reality of the constructions at play – the participants, their colleagues, their organisational environments – but it values experiences and aims to provide new insights that can provide alternative effective and persuasive text (Butt, 2000). Critical research is not about uncovering things about other people, but about interpreting data, turning it over and exploring it to see how sense can be made of it. By exploring interview data with AHPs, the experiences they share can be contextualised. The question of "what is an expert AHP?" can be put into a relevant context. Butt (2000) calls us to "stand in the other's shoes" (p. 94). Exploration and interpretation could lead to identification and understanding of problems, but problems are not assumed in advance of the research. Similarly, the researcher can recommend solutions or actions relevant to that new understanding, rather than the researcher anticipating solutions before a deeper understanding is gained.

The idea of standing in another's shoes does come with dangers (MacKenzie & Scully, 2007). Although I can imagine being in another's shoes, I cannot experience it as they experience it. There is a need for empathy in the research relationship, but I cannot know how the other feels, no matter how much I might try to merge with them (Smith et al., 2009). This reinforces my position that in dialogue, we create and explore together, not as one. If I

respond to them as “other” there is less likelihood of me projecting my own perspective on to them, less chance of them being subsumed by me (MacKenzie & Scully, 2007). Cultivating a deep level of self-awareness through reflexivity does not negate this projection, but reduces the strength of judgements in particular directions. I will discuss reflexivity in more depth later.

Determining the Research Direction

The Research Question

A critical moment for me, in the development of this research, was in response to a comment from a survey-respondent in the first study. The person wrote:

> New grad [*sic*] can have expert knowledge but as mentioned before the application to practice is key for me. The subtleties of knowing your stuff and being able to explain to families. I feel there we have under-utilised skills in others in this regard. In answer*, I don't know where are* [*sic*] *experts are* [emphasis added].

This person was not alone in wondering where the experts were. Other respondents commented similarly and this was consistent with my own anecdotal experiences that my colleagues were looking for guidance and support from experts but could not find it. The comment highlighted the power of visibly contributing to the community, or not, as an indicator of expertise. As I mentioned in the first study, the way in which a person contributes to their community is important in them gaining recognition as an expert within that community. This concern expanded my research question from simply “what is an expert AHP?” to a more nuanced question of what it might take to become known as an expert.

Responding to the Research Question Required a Qualitative Approach

Two factors strongly influenced the decision to take a critical qualitative approach to answer the questions "what is an expert AHP?" and "what might it take to become known as an expert?" Firstly, I was influenced by the work of Fook et al. (2000) who completed a substantial piece of research with social workers, that changed the structure of the social work workforce and its training in Australia. Their work used critical incident technique to elicit narratives from social workers, from which they were able to determine parameters of novice, intermediate and expert practitioners. A narrative approach describes human experience as it occurs through time. Fook et al. (2000) carried out their study to forward the status of social work as a profession, and so their approach was emancipatory rather than pragmatic. However, narratives are an in-this-moment event and this approach also fits well within a pragmatist viewpoint that is not attempting to identify a reality of what happened, but to make sense of experience (Clandinin & Rosiek, 2007).

Secondly, the findings of my initial study clearly indicated to me that experts were created amongst their community; they were sought out by their community and therefore talking to the community seemed important. Using the findings from my initial survey, expert AHPs are role models and leaders in their profession: they are go-to people. They have knowledge, skills and deep and broad experience but, very importantly, they are able to share this with their colleagues and community. If I met highly-experienced people within the community, what would they share with me?

Exploratory Research

This research project is very much exploratory. Stebbins (2001) argues that exploratory research is broad but purposive, designed to maximise the discovery of generalisations leading to description and understanding of human beings and the social

world. He goes on to distinguish exploration from qualitative research, the latter being a tool for the former. Exploration is primarily inductive, but not exclusively.

In keeping with exploratory research, theory is emergent in this thesis through inductive reasoning, although existing literature is incorporated at all stages of the project. The introductory chapter of this thesis used the research literature to set out a background landscape for the research to follow. Despite the considerable literature about some aspects of expertise, many questions remain and the broad nature of the research question "what makes an expert AHP?" requires an inductive response. It is important to discover if any new ideas could come from open-ended study – a case of "when in doubt explore" (Stebbins, 2001, p. 88). Additionally, given the iterative nature of the project, further literature from different fields of knowledge became relevant and additional fields of knowledge were explored as the project progressed. As a result, my findings are many and varied and include descriptions of concepts, beliefs, processes and structures.

Stebbins (2001) highlights the dangers of exploratory research, where a lack of vigilance may allow confirmatory practices and procedures to creep in. Effective exploration requires flexibility and open-mindedness in preference to confirmatory practices involving sampling, validity and generalizability. My use of critical qualitative approaches focuses the research methods, analyses and interpretation on exploring facets of people in their social worlds, and addresses concerns about trustworthiness, rather than validity and generalizability. Confirmatory practices such as data saturation are addressed later in this chapter. Once exploratory aims are accomplished, confirmatory ones can be pursued.

Interpretivist Research Methodology

Broadly speaking, interpretivism and positivism are the two general research methodologies in the social sciences (Grant & Giddings, 2002). On one hand, a positivist

approach to psychology seeks to discover truths (epistemology) that can be generalised to reality (ontology), in order to explain human behaviour. The use of the scientific method, particularly through observing and then manipulating patterns, would provide certainty in knowledge leading to accurate reflections of reality (Cruikshank, 2012). Interpretivist approaches, on the other hand, seek to understand human behaviour in its context of the social world. The interpretivist work of Foucault (1926-1984) is an important tool for the critical analysis of health and healthcare, interpreted here:

> We cannot know the truth about ourselves because there is no truth to know simply a series of practices that make up the self. Nor can we escape the regulatory institutions and discourses in which we are produced. But we can identify them (or at least some of them), and identify our own practices of the self, and from this basis of knowledge, formulate tactics by which we can live in the world. (Danaher et al., 2000, p. 131)

The research discussed in this thesis has an interpretivist methodology as its underlying basis, which aligns with its foundational critical theory. Foucault (and the work of his interpreters) never formulated a set of guidelines for how to do interpretivist research (Fadyl et al., 2013). Methods are not fixed, nor are methodologies. Instead, Foucault suggested the focus of inquiry should determine the instruments used, even creating instruments during the course of the research. Consistent with this approach, the details of my research methodology were not determined wholly in advance, but were iterative, responding to prior findings and data.

Responding to the Research Questions Using Interviews

My initial survey asked a community about others who might be experts. I was then interested to know what I could learn about expertise from what highly-experienced AHPs told me about themselves, in a manner similar to that of Fook et al. (2000). This could have

been achieved with further detailed surveys, but the limitations of survey research pointed me in the direction of semi-structured interviews. Whereas surveys have the benefit of capturing the opinions of a large group of people, they are also distant from respondents and do not attract in-depth responses, nor are they conducive to producing rich robust insights (LaDonna et al., 2017; Rowley, 2012). The challenges of survey question interpretation and poor responding were not appealing and instead I took an approach that allowed me to interact directly with people (Meade & Craig, 2012; Schwarz & Oyserman, 2016). I wanted to do research alongside AHPs, acknowledging their experiences rather than doing research "on" them, testing whether theories from elsewhere fitted also for them. Through conversations with AHPs I could ask for clarification, provide clarification and probe deeper into their experiences and thoughts for the future (Holstein & Gubrium, 2004; Mann, 2016; Schostak, 2006).

If we want to deeply know someone, then hearing their authentic voice is a great start (Mann, 2016). In-depth interviews can be designed to give the interviewee space to explore more deeply their self, rather than following a predetermined fixed set of questions developed by the researcher, which may or may not gather the required data. In-depth semi-structured interviews are reflexive and the interviewee makes choices about what to say about their life and how they live it (Mann, 2016; Schostak, 2006). Interviews are a valuable method to develop further understanding of AHPs and what it might take to be known as an expert.

Interviews have a long history as a data collection tool and are a frequently used method in qualitative research (Holstein & Gubrium, 2004; Mann, 2016). This is despite the challenges inherent in qualitative interviewing, particularly in relation to time: high demand on the participants' time before and during the interview, and high demand on the researchers' time in meeting the participants, and then transcription and analysis (Braun & Clarke, 2013; McCracken, 1988; Rowley, 2012). Nonetheless, well-designed interviews and

appropriately selected interviewees have the potential to generate valuable insights that might be useful to various stakeholders. Additionally, similar to many health researchers, as a health practitioner myself, I have training in history taking and interview techniques that were of benefit to this methodology (McGrath et al., 2018).

In relation to qualitative methods, Silverman (2000) suggested to avoid thinking that the data are whole and complete representation of the big picture: they are not and never will be. The interviews did not attempt to completely capture a moment that has passed (Taylor, 2001). In an interview, a world is constructed between the interviewer and interviewee and each bring with them their histories. This is what Mauthner and Doucet (2003) termed *selves-in-relation* where people are viewed as interdependent, part of a complex web of social relations, as opposed to independent and separate. When there are opposing views between researcher and researched, reflexivity is a way of managing that conflict (Finlay, 2002). Whilst I was ongoingly concerned about my own position, the use of reflexivity in the final narrative analysis was instrumental in transforming my understanding of how I positioned myself and the interviewees during the interviews and afterwards.

Reflexivity – Knowing Myself

Reflexivity is not optional (Finlay, 2017). Humour is helpful to provide lightness in the sometimes murky swamps of my thinking about these topics:

> For instance, on the planet Earth, man had always assumed that he was more intelligent than dolphins because he had achieved so much — the wheel, New York, wars and so on — whilst all the dolphins had ever done was muck about in the water having a good time. But conversely, the dolphins had always believed that they were far more intelligent than man — for precisely the same reasons (Adams, 1983, p. 119).

This quote highlights how we can be blind to different perspectives of the same thing. I use reflexivity as a device to help me see, and then declare, my position in relation to the process of this research – meeting interviewees, working with my supervisors and with my own reflexive journaling (Berger, 2013). Using disciplined self-awareness, examining what is taken-for-granted or assumed, the researcher (I, me) develops not only greater insight into themselves, but also into the way in which the (my) research creates knowledge (Berger, 2013; Finlay, 2017). As a researcher it is often advisable to determine the demographic information of the individuals being studied. As a researcher participating in my own research alongside others, it is essential to also know this information about myself. However, it is more than my age and gender that are relevant here. I also have a backstory that I carry with me. My cultural, social and personal politics are also brought to the project (Creswell et al., 2006).

Identifying my Position in the Research

Positions are dynamic, not static, and reflexive thinking allowed me to discover, and create identities that contributed to my position (Deppermann, 2015). Riessman (2015) refers to embarking on reflexivity as entering "the hall of mirrors". Reflexivity firmly places me within the research: I have responsibilities to take. Analysis of my reflexive journaling of the past years highlighted feelings from confused and sceptical, to melancholic, amused, excited and reassured. At the beginning of the PhD journey, I was concerned with practicalities related to being reflexive and keeping a journal. I did regularly write in my journal, every few days. There were times of many questions and times of seeming to have answers and then not, there were many conflicts and ambiguities. My life is not made up of independent parts that can be usefully studied separately, even if it would be neater that way (Willig, 1999).

This thesis was crafted with the knowledge that as an AHP myself, with more than 20 years of clinical practice, I could be considered a native researcher – someone who researches

their "own people" (Brannick & Coghlan, 2007; Chen, 2011; Finlay, 2002; Kanuha, 2000). This brings benefits and risks. At times during this project, I felt that I was a native, researching my homeland. At other times, I was very much feeling like an outsider. It was a relief to read Kirkman's article around gender (Kirkman, 2001) and to hear from someone else that being a woman does not mean I can automatically represent or be represented by other women. If I am a native to the same land as the interviewees, even if I can stand in another's shoes, I cannot experience their experience in the same way (Butt, 2000; Smith et al., 2009). Experiences and the stories of those experiences are the result of numerous social influences coming together, from their inner life, their environment, and their unique personal history (Clandinin & Rosiek, 2007).

My Geographic Story

Being a highly-experienced speech-language therapist, does not mean I can automatically represent other SLTs, and particularly so, not other AHPs. I am now in my mid-forties, born in the UK and grew up in various small towns and villages of the Midlands. I have white parents and grandparents, and a brother – our family history is very much based in England. I studied SLT in the UK a year after leaving school. Initially I studied biochemistry in Sheffield but that was not for me. I was married after graduating. I worked for the NHS for several years in schools and early childhood centres, spent a couple of years in a residential school then returned to the NHS in a different town, working with adults. On moving to NZ in 2005, I worked in child development and a special care baby unit for a year before becoming a clinical educator at the University of Auckland, where I am still working now – some clinical work with children's communication and swallowing, and some classroom teaching. I am no longer married and have no children but do have a lovely cat. This is my geographic story, a brief tale of the characters and locations of my life, particularly in relation to being an SLT, and it is relatively easy to recount. I shared a brief

version of my story with the interviewees. I asked the interviewees to tell me their geographic story too, and the level of detail provided was similar to that presented here. Our stories are unique to us as individuals but there are also similarities with the stories of others and these particular stories provided the data reported in the next chapter, which describes the interviewees.

Stating my Position and Managing it

It became clear over time that my own position in the research relationship was not and is not fixed and that, in the same way that I interpret the position of the interviewees in light of their words and actions, I also have a position that changes (Deppermann, 2015). Firstly, I conducted my research as a highly-experienced SLT. With interviewees that I already knew through working together, we had a shared history. Our status as professionals was already somewhat known to each other. However, the interview was an opportunity for curiosity on my part that allowed the interviewee to clarify, correct and challenge my assumed knowledge of them, as well as expand my knowledge as we discussed topics that we had never discussed before. With interviewees I did not know, but who were also SLTs, we had shared professional knowledge and with those who were not SLTs we had shared ground in the values that brought us into the allied health professions. With some interviewees, we had a common background in being born overseas, or specifically in the UK, and adjusting to living in NZ.

These various similarities bring the challenge of reflexivity in the moment – there is an ethical obligation to do the right thing by the interviewees (Finlay, 2002). My positioning changed in a dance with the interviewee, although broadly I was clear to announce myself as an SLT of more than 20 years, from the UK but now living in NZ for more than 10 years. Secondly, I narrated myself as a researcher, interested in the experiences of experienced AHPs. This provided an opportunity for distance between myself and the interviewee that

allowed me to ask for more information or an expansion on a comment or topic. On the one hand, I had insider knowledge of working in the health and education workforce, and on the other hand I was a researcher, wanting to hear the interviewees' stories. On one hand, I was able to use language and listening skills that created trust and empathy allowing interviewees to share on a deep level (Kanuha, 2000). On the other hand, my experiences as an AHP are only my own perspective and I do not have intimate knowledge of all the members of the group, or their experiences. In each meeting with an interviewee I was careful to acknowledge my position as an SLT and a researcher.

Research Methods

The remainder of the chapter outlines details of the research methods used in regards to recruitment of interviewees, and data collection, including issues of sampling and data saturation. The different analyses are introduced here, with more detail provided in subsequent chapters to avoid repetition.

Ethics

Ethical approval for the interview phase of this project was provided by the University of Auckland (019482).

Recruitment

Practitioners were invited to be involved in this project through their various channels. I initially sent the advert electronically to the appropriate person within the national SLT organisation, New Zealand Speech-language Therapists' Association (NZSTA), who agreed to disseminate it to their database of approximately 800 SLTs. I also distributed the advert via email through my own professional network, which reached around 120 people working across allied health in NZ. Because of this, I was later invited by an operations

manager to her non-government organisation's staff meeting, to advertise my project with all their staff. I spoke for five minutes about my project to the whole staff group. Paper copies of the advert and participant information sheet were available from the operations manager, who also acted as a contact person if people wanted to participate. At a similar time, locality approval was granted for further distribution of the advert throughout the staff of Southern DHB.

Inclusion Criteria

Practitioners with more than seven years of experience working as an allied health professional, in a profession that they had an entry-to-practice qualification for, were invited to join the study. Seven years of experience was chosen to demarcate highly-experienced AHPs from experienced ones. Despite popular claims, Hambrick et al. (2014) and Gobet and Campitelli (2007) have both shown that 10,000 hours of deliberate practice is not necessarily needed to achieve expert-level performance, but research does not suggest a specific lower limit of time required. Instead, we decided on a lower limit of work experience as an inclusion criteria to ensure that interviewees did have a substantial amount of experience, beyond entry level as a new graduate. The mean length of employment for an AHP within a DHB in NZ was 6.5 years (McLean et al., 2017; Valentine et al., 2017). Seven years was chosen as the lower limit to include the workforce who more likely to have had a breadth and depth of experience across different jobs.

To be included in the project, AHPs needed to be working or on temporary leave, for example maternity leave, in an allied health profession that is client-facing, in other words, not a solely managerial, scientific or technical role. In theory, AHPs would have been declined if they had contacted me to participate but then subsequently were not working in their profession at the time of the interview. In the first study using the online survey, I had specifically targeted SLTs and asked them to tell me about experts in relation to a specific

field of practice, dysphagia, but for Phase 2, I was keen to expand the range of professions included. The SLT profession is relatively small at only around 900 practitioners, and those with knowledge of dysphagia would be a small proportion of that. The close-knit community of SLT may expect practitioners to contribute to their community whereas in other professional groups such as social work, who are large in comparison at well over 6000 practitioners, there may be less expectation. To bypass this assumption, interviewees from several professional groups were sought.

Determining how Many People to Interview

As mentioned earlier, sampling practices are more consistent with confirmatory than exploratory research. However, for the purpose of the initial ethics application, there was a need to identify a potential number of participants, and at the time 15 people was considered a lower limit. This was a provisional anticipated lower number of interviewees that would potentially generate adequate data (Braun & Clarke, 2019b). Consistent with exploratory research approaches, a sample size was not calculated (Braun & Clarke, 2019b; Stebbins, 2001). The richness and complexity of the data collected determined the final sample size, as the research progressed: an approach described by (Braun & Clarke, 2019b).

Initially, I interviewed people on a convenience basis, interviewing everyone who volunteered. I had little difficulty recruiting interviewees. Once analysis had begun, after the first nine interviews, I subtly changed my strategy to seek greater participation from AHPs who were not SLTs, to gather a more diverse sample (Morse, 2015). For example, at the staff meeting I was invited to, I specifically acknowledged the non-SLT staff and declared I would value their participation. Non-SLTs were also keen to participate in the research and I had no shortage of volunteers.

Nine people who contacted me to participate did not get included in the study (five OTs, one PT, one SW, two SLTs). One did not respond to further communication. Two people did not attend their agreed appointments and did not respond to follow-up communication. One cancelled at short notice because she was overwhelmed with workload and did not want to reschedule. Five people were declined as they had contacted me outside the time I had available to interview them.

The Researcher-Interviewee Relationship

The researcher-interviewee relationship typically began when potential participants contacted me via email to express interest and I responded with the participant information sheet. If the person was still interested and met my criteria of seven years or more of working as an AHP, then I asked for their consent via a signed consent form and we arranged a mutually agreeable time and place to meet. The only exceptions to this were people at the NGO where I visited personally and people approached me in person to participate, or informed the contact person that they wanted to make an appointment with me. In all cases, the PIS and consent forms were sent to the participants by email as well as on paper if they requested that as well. No material incentives or compensation for participation were provided.

Riessman (2008) particularly, and other critical researchers also, highlight the importance of context in locating research (Cohen & Duberley, 2013). The nature of this project prompted me to meet at a place of the participant's choice and whilst it was preferable to meet at their workplace, in order to gather a fuller picture of the context in which they worked, I did not insist on that if it was not their preference. I chose to assume that all the participants were busy people and that it was important I meet them face-to-face if at all possible (Rowley, 2012). Hence, I travelled around NZ in order to meet people in their own locale (27 different locations). Only two people were unable to meet me face-to-face and both

were due to unforeseen circumstances on the day, which meant that they were not able to get to the agreed location and because it was difficult to reschedule, we agreed to speak over the phone.

AHPs were very receptive and willing to be involved. Particularly, SLTs expressed to me their pleasure in participating in research about them, for them and with them. The focus on highly-experienced practitioners was also celebrated by them. Not all the interviewees were strangers to me. I had worked alongside two of them for approximately two years and had met 11 others at various work events such as professional conferences, courses or meetings. This is unsurprising given the relatively small population of the face-to-face allied health workforce and my employment at the university, where a substantial component of my job is community service, including interprofessional practice. Despite this there were more people included that I had not met before. This was something of a surprise, particularly amongst the SLTs and reflecting on this, established it as one of the reasons for interviewing the number of people I did – 45.

Decision to Halt Recruitment of Interviewees

I continued interviewing beyond the provisional fifteen interviewees, as I was still hearing new stories and because of my concern of familiarity with some of the participants. Initially, in the planning stages, I had aimed for two interviews each with a purposive subset of interviewees, a year apart. However, after starting to interview, this decision was changed in preference for gathering data from a larger group of people. I attempted to include a diverse workforce and although there is a predominance of SLTs, in some regards I have achieved this diversity (see Chapter 5 for details). Disappointingly, the diversity does not include any practitioners who identify as Māori or Pacific Islander. I stopped interviewing because I made a decision that pragmatically, I had collected a valuable amount of data, had

sufficient diversity and that I did not have more time or funding to collect more data at that time.

Some qualitative researchers and journal reporting standards state explicitly (Tong et al., 2007) or implicitly (Levitt et al., 2018), that data saturation is important; that information redundancy is to be achieved. This is the idea that more data does not provide more information. For other researchers, ideas of data saturation and sample size are not consistent with their approach, their research is situated within a paradigm that considers issues of validity from within and finds trustworthiness in other methodological factors related to ontology and epistemology (Braun & Clarke, 2019b; Stebbins, 2001). For example, narrative researchers would generally view a narrative as a partial telling from one point of view and verifying its facts would have limited use (Riessman, 2008). McCracken (1988) describes the potential for a single qualitative interview to generate endlessly various and abundant data.

I took a view of data saturation consistent with interpretivist critical qualitative researchers such as Braun and Clarke (2019b) and Riessman (2008). Data saturation suggests that there is no new information to be gleaned from a certain point, but a critical pragmatist view suggests that there is no end to the interpretation, similarly with narrative approaches there is a commitment to *unfinalisability* (Frank, 2012). With new eyes and new constructs, the same data could produce different conclusions with similar methodological integrity (Levitt et al., 2018; Smith et al., 2009). Any ending of data collection and of interpretation is provisional, given a commitment to unfinalisability and therefore I did not pursue data saturation.

Career History Data Collection

Once written consent was gained, interviewees were invited to submit their most recent long-form CV detailing their work and training history. It became obvious that some

interviewees did not have a CV and some provided me, without asking, a written history of their work and courses. Others provided a relatively recent CV from when they applied for their most recent job. Thirty interviewees provided a resume or CV and all interviewees were asked about their career path in semi-structured interviews. I asked for the CV in advance of interview to avoid asking the interviewee to repeat information they had written down. I read the CV in advance of the interview and was able to ask clarifying or extension questions about the person's work history. For example:

> B: yep. Okay. And you've got, like looking at your CV you were backwards and forwards and backwards and forwards
>
> I: yep, yeah. I went for the proverbial two years…….

The advantage of collecting CVs is they are typically written with care and attention to the details rather than reliant on memory searching in the moment of conversation (Dietz et al., 2000). CVs provide a personal expression of how a practitioner wants their career to be viewed (Cohen & Duberley, 2013). Cohen & Duberley provide some of the numerous ways in which we perform our careers. We frame our career experiences during interviews, promotion processes, marketing, grant applications and our CV, in particular ways to highlight or diminish aspects that we want to promote or downplay to others. Whilst the written CV and narrated career history of the interviewees in this project are also performances, they provide detailed information about the pathways of a group of AHPs about whom little is written.

For highly-experienced practitioners, CVs may get condensed or truncated, for example listing only recent jobs and skipping over locum positions for the sake of succinctness in telling of a long career (Dietz et al., 2000). Information that seemed important in the early stages of a career such as clinical placements before qualifying or every

workplace training, may become less important later and may disappear entirely from the CV. Alternatively, CVs may become lengthy with every career detail having similar importance (Dietz et al., 2000). Similar to other studies of workers' careers, CVs are used here as a supplemental source of information that serves to fill in gaps left from other research modalities (Cañibano & Bozeman, 2009; Sandstrom, 2009). They are not utilized as the primary or only data source, but do provide further detail about career history, that may not have been discussed during the interviews (Dietz et al., 2000).

These two sources of data, CV and interview, were analysed for content such as demographics, employment history and geographical mobility. Simple categorisation and counts describe the details presented. Whilst I realised that the performance of a career could be analysed using a performative approach, my intention in gathering career history was in setting a scene. The career histories demonstrate the diversity and mobility of the interviewees and, consistent with other aspects of this project, I have not attempted to verify any truths, instead analysing the data that was presented using descriptive statistics and highlighting aspects that seemed to me, on reflection, to be relevant in creating the context.

Semi-structured Interviews

Interviews took place over a period from December 2017 to September 2018 due to scheduling travel around the country, but also due to the iterative nature of the process and needing time in between interviews to analyse and reflect on the data collected to date. Because the interviews were only partially structured, in the sense that there was an interview guide but not fixed questions, the data are "messy" (Braun & Clarke, 2013, 2019b). The interview followed the lead of the interviewee and questions were not worded the same for each interviewee, nor asked in the same order. Some questions were not asked at all if the interviewee spoke about a relevant topic without being prompted. The interviews were fluid

and open as much as possible, although I was careful to ask only questions that were within the scope of the project, suggested by the interview guide shown in Table 4.

Typically, interviews were at the interviewees' workplace, often in a bookable multi-use space as most did not have their own private space at work. Of the remaining interviews, these took place either in cafés, at the interviewee's home, by phone, or at the researcher's office, according to interviewees' preferences. I was the interviewer for all interviewees, mindful of the notion that "the interpretive process begins during conversation" (Riessman, 2008, p. 26). Interviews took between 40 to 115 min, with an average interview time of 60 min. Interviewees were verbally reminded about being audio recorded. To begin each interview, after initially meeting the person and introducing myself, and sitting down, I introduced the topic of the discussion and began with a broad question about their current job. Questions about the nature of their present job are a good opener for an interview as the interviewee is likely very able to answer the question given the context (Holstein & Gubrium, 2004; Hunt et al., 2011; Mann, 2016; McGrath et al., 2018). For example:

> B: Yeah, so I'm interested to learn about experienced, learn from experienced professionals and to hear I guess, words of wisdom (laugh), and new experiences in terms of what might have changed about you and your practice, and your approach to your profession now compared to back when you started. And if you've got examples that would be great, and yeah, can you start with telling me about what your current role is?

I reviewed and adjusted my approach across each interview. For the first two or three interviews, I was less flexible in following my interview guide, which resulted in a more interview-style dialogue than later on when my approach was much more conversational. At the end of the interview I asked if there was anything more the interviewee wanted to say, or ask of me, as recommended by (McGrath et al., 2018).

Interview and Topic Guides

The interview guide provided me with a list of topics to discuss, with example questions (McGrath et al., 2018). The topic guide was sent out to prepare interviewees (see Figure 4). Table 4 shows the possible interview questions, broad purpose for each question and the literature source each question was drawn from. There was no fixed wording or ordering of questions used. The interview consisted of questions about interviewees' work history and experiences at work recently, and also specifically asked for *critical incidents* (which will be discussed below). The interview guide was trialled on a peer who is a radiographer. This allowed me to try out the questions for clarity and to consider the kinds of responses I might get, as well as the time the interview might take.

The questions arose from detailed reading of the literature in relation to expertise and to professional confidence. Specific sources are detailed in Table 4. The interview guide was slightly modified, iteratively, as interviews occurred and were reflected on (McGrath et al., 2018). For example, an additional question was asked about the use of social media, as a way of discussing the practitioner's views about the nature of their professional community.

Table 4

Literature Sources for Questions from the Interview Guide

Question	Purpose	Literature source
Tell me about your work with people in the place where you work now	Starting with an easily answered here-and-now question	Mann (2016); McGrath et al. (2018)
Tell me how you came to be an AHP and how you came to be in this job	Work history is often easy to report. Introduces the topic of the interview	Mann (2016); McGrath et al. (2018)
Is anyone else in your family an HP?	Family history of health work may have influenced career choice	Ackerman (2014); Ruthsatz et al. (2014)
Do you think what you do is pretty much the same for everyone on your caseload, or are there differences?	Probing into complexity and uncertainty of the work	Collins and Evans (2002); Fook et al. (2000)
What do you love about your work?	Probing into meaningful work	Oelberger (2018)
What do you think is the importance/ significance of your profession?	Aspects of professional confidence	Holland et al. (2012a)
What do you think are the challenges to your role and scope of practice? Is your profession under any threat?	Aspects of professional confidence	Holland et al. (2012a)
Has evidence-based practice influenced your own work in any way? If so, how? Tell me about the things you read in relation to work. What literature, philosophies or practices do you keep coming back to?	Keeping up to date and having a meta-view of the work	Ferriss (2017); Foster et al. (2015)
Have you ever been involved in any research? Tell me about what you did	Aspect of expert practice	Jackson et al. (2017)

Question	Purpose	Literature source
Do you reflect on your work? Tell me more about reflection	Aspects of professional confidence	Holland et al. (2012a); Kamhi (1995)
Tell me about recent PD you have done as a teacher	Aspects of knowledge sharing	Jackson et al. (2017)
Do you ever take students? Tell me more	Aspects of knowledge sharing	Jackson et al. (2017)
Do you use social media in your professional capacity?	Aspects of knowledge sharing	Edwards (2010); Pfister (2011)
What does expertise mean to you?		Jackson et al. (2017)
Is there an AHP that you admire?	Aspect of expert practice - Guru	Jackson et al. (2017)
What's different about you as an AHP now, compared to when you started working?	Probing into identity changes over time	Hecimovich and Volet (2011)
What do you think you'll be doing professionally in ten years' time?	Consideration of the future remaining in the work or leaving it	Ericsson (2008)

In order to help the participants prepare for the interview, they were provided with a topic guide five to seven days in advance of the interview (see Figure 4). The topic guide was a modified version of the interview guide, with a smaller number of questions including two critical incident questions (questions 4 and 5). Sending questions out in advance is good practice where critical incidents are sought (Flanagan, 1954).

Figure 4

Questions from the Topic Guide Provided to Interviewees

1. Tell me about your work, in the place where you work now.
2. Tell me how you came to be a Dietitian/ Social Worker/ OT/ SLT/ PT…
3. What's different about you as a professional now, compared to when you started working?
4. Tell me about a recent case that you found affirming in some way
5. Tell me about a recent case that you found challenging in some way

Expanded Critical Incident Approach

Critical incident narratives are stories of events that might change the way a person is, that is, the event is transformative. The events are critical because they are significant, rather than specifically a crisis (Fook et al., 2000; Fridlund et al., 2017). Flanagan (1954) is considered the founder of critical incident technique. He described his technique as a set of procedures, mainly specifically worded questions, for collecting recounts of directly observed human behaviour. In other words, first person narratives. The technique has evolved in different ways. It is now used as a reflective practice technique in clinical supervision (Alpers et al., 2013; Lister & Crisp, 2007; McAllister et al., 2006; Ross, 2010), as an incident reporting tool (Guhde, 2014; Westbrook et al., 2007) and as a research tool for gathering

narratives (Ferguson et al., 2010; Fook et al., 2000; Hughes, 2012; Savaya et al., 2011). The method used here is based on the later set of literature, specifically the expanded critical incident approach of Hughes (2012). The questions are asked in such a way as to gather useful data for solving practical problems and developing broader psychological principles.

The method described by Hughes (2012) outlines critical incidents as being not necessarily a crisis or emergency, but any type of situation that was significant to the narrator. Incidents could be unusual or mundane but resulted in a transformation in thinking or being. The narrator was encouraged to decide on their own story to tell, which fitted the parameters of the question, in their opinion. The questions were provided in advance in order to facilitate a detailed description of the incident, as recommended by Flanagan (1954). I followed these recommendations for the purpose of the research described in this thesis.

The critical incident questions are shown in Figure 5. Only the first two questions were sent to the interviewees in advance as part of the topic guide, to minimise the perceived amount of work the interviewees thought they might need to do in advance (Fook et al., 2000). In response to reflecting on the first three interviews, I added a third critical incident question about changing practice, as the incidents told appeared to result in business as usual rather than events that were transformational in some way. After hearing the recount of an incident, I asked extension questions about the incident based on the question guide provided by Ferguson et al. (2010). The extension questions (Figure 5) were only asked if they related to information that I thought was missing from the initial recount, or seemed relevant to explore in more detail. Typically, the critical incident questions were asked later into the interview, once I felt the interviewee might be comfortable to discuss them, and some interviewees provided additional narratives akin to critical incidents throughout our conversation, which was fine.

Figure 5

Critical Incident Questions and Extension Prompts

Critical Incident Questions

1. Tell me about a recent client or situation that you found affirming in some way
2. Tell me about a recent client or situation that you found challenging in some way
3. Tell me about a client or situation that changed something about your practice

Extension to critical incident questions (Adapted from Ferguson et al. (2010))

Can you tell me what happened?

Interviewer prompts (to be used as needed):

- How did that fit with your scope of practice?
- What role(s) were you being asked to play?
- How long did this episode take (days, weeks, months)?
- To what extent was the patient and whānau involved?
- What other types of professionals and what members of the family were involved?
- What data did you need to seek?
- Was there data that was needed but unavailable?
- What resources did you consult (people, information)?
- What resources did you need, but were not available (equipment, supervision etc.)?
- What aspects of your previous training and experience did you bring to bear on the issues?

Recording and Interview Data Transformation

All the interviews were audio-recorded on two devices in case of technology breakdown and written notes were taken during the interview as prompts for my later analysis. As soon as possible after each interview, a summary of the interview was written from memory, which included the location and mood of the meeting as well as my reflections on the conversation. An example of an interview summary note is included in Appendix B.

I transcribed 30% of the recordings myself and a third-party transcription company converted the remainder of the audio recordings to written transcriptions, after signing a confidentiality agreement. The transcriptions they provided were broadly verbatim, however, I reviewed every transcript against the original recordings myself, listening and re-listening in order to construct a written record of each conversation that I felt represented what had been communicated. Both my own speech and that of the interviewee were transcribed, consistent with a dialogic approach described by Riessman (2008). I included details of overlaps in talking, pauses, non-verbal communication such as laughter, sighing and fillers such as "umm", "hm", "ok". I paid particular attention to the words that were used, and attempted to reproduce them in the transcript, rather than cleaning up the language in some way.

Reflexive Journal Data

I kept a reflexive journal that also formed part of the data for this project. As mentioned previously reflexivity is an essential component of qualitative research, particularly critical research, and a reflexive journal is a recognised way to carry out that work (Braun & Clarke, 2019a; Riessman, 2015). Morse (2015) highlights that data in qualitative research always include information beyond the number of participants. After reading articles, meeting interviewees, transcribing and checking transcription of interviews and moments of data analysis, I took time to write comments in my journal that captured decisions I had made, and my thoughts about what I saw and heard. Over 120 journal entries were made and formed part of the data set. Examples of journal entries are included in Appendix B.

Member Checking

Member checking, or informant feedback, is a process used in some qualitative methods to increase credibility of results (Birt et al., 2016; Morse, 2015). One version of

member checking involves giving the transcribed interview back to the interviewee to comment or correct data (Lincoln et al., 2011; Morse, 2015). In the ethics application relevant to this project I said I would offer interviewees the opportunity to review their transcripts. As this was included in the participant information sheet, there was an ethical obligation to do as I said I would. Once transcripts had been reviewed to the point of being complete for the purpose of analysis, I sent a copy, by email to those who had requested a copy of their own transcript. Interviewees sent back various comments in reply, mainly identifying spelling mistakes, but otherwise only one person requested a change to their information. In the interview they had said that around 40% of their professional development was self-funded but they requested this was changed to 70%.

Arguments against member checking consider the reasons why researchers would offer people the opportunity to change their mind about what they said (Morse, 2015). This is not an approach that would be taken in more empirical methods such as behavioural testing, nor in survey research. Similarly, the theory underpinning my project and research methods I have used contribute to an understanding of all the interviews, in combination, and the individual interviewee is in a difficult position to judge that interpretation. In hindsight, member checking gave something back to the interviewees that they may have enjoyed reflecting upon. According to current thinking around member checking, merely sending back the transcript and asking for comments is not a useful strategy (Birt et al., 2016; Morse, 2015; Thomas, 2016).

An alternative method of member checking is to check data between participants, during interviews. Some analysis was completed during and between every interview and in later interviews I asked questions about what others had said – by changing the interview guide and by following up using a question similar to “other people have said […], what do you think about that?” For example, confidence was reported by many people to have

changed over the years, and so I specifically asked for examples of how confidence had changed, or situations that showed how it might have grown. Morse (2015) suggests this type of member checking is valuable in achieving credibility.

Analyses

The following two chapters of this thesis contain details of the analyses and findings relevant to the next steps of the project and are reported separately. For the benefit of the reader a brief introduction is given here but the analyses will be described in depth in each relevant chapter to provide clarity and avoid repetition.

Grounded Theoretical Typology

Using a grounded theoretical research design, dimensions of AHP types and properties of those types were used to construct a typology. This involved an iterative process of analysis of both collected data and theoretical knowledge consistent with the approach described by Kluge (2000). The analysis of all 45 semi-structured interview transcripts alongside existing literature resulted in the development of a typology of the work orientation of highly-experienced AHPs in relation to expert-level performance previously defined in this thesis.

Individual people were not deconstructed in the typology, only their work orientation. The types represent extreme points of a continuum and act as initial exemplars. This reductionist view can help people to start thinking about how different dimensions can combine to support a positive work orientation (Collins & Evans, 2002; Kluge, 2000). In creating a typology there is an inherent danger to people because categories propose ways in which individuals can feel constrained to identify themselves (Ostlund et al., 2002). However, the contribution that the typology can make towards understanding expertise and highly-experienced AHP's orientation to work mediates that risk. Also, administrations can

like the finality of categorising people, but although there are risks they do not preclude us engaging in creating a typology with due care (Frank, 2012). The proposed typology is abstract and conceptual, not concrete even though it is grounded in data. The use of categorical or nominal measurements (as opposed to interval or ratio data) is useful in the early stage of concept formation (Collier et al., 2012). The types proposed are empirically grounded rather than real (Kluge, 2000), and the fuzzy boundaries between them have been firmed up for the time being in order to develop a starting point for thinking about work orientation in a different way (Cornelissen, 2017). Details of this analysis and the findings are reported in Chapter 6. The relationship between the types and expert-level performance is discussed.

Combined Critical Incident and Performative Narrative Analysis

Further in-depth analysis of the critical incident narratives told by the interviewees combined two approaches to analysis. Firstly, for both analyses the critical incidents were identified and extracted from the interviews. Critical incident narratives were both prompted for and arose naturally during the interviews and further detail of extracting the critical incidents from the complete interview transcripts is in Chapter 7.

An expanded critical incident analysis was combined with performative narrative analysis in a method akin to that described by Shukla et al. (2014). Each analysis alone can provide insight, but by combining the two, I could situate individuals in the broader context.

The expanded critical incident approach to analysis described by Hughes (2012) includes a quantitative (binary) analysis and a thematic analysis. First, the incidents are categorised by features that are present or not present. I looked at the surface of the narratives for categories, chosen a priori from the literature relating to professional confidence and expertise. The thematic analysis looked at the semantic level for themes that were not

developed a priori, but rather arose from the incident narratives. The quantitative and thematic findings were combined to develop themes that provide the broad context for the deeper, richer performative narrative analysis.

Performative narrative analysis, with its focus on how narratives are interactively produced and performed between speakers is a tool to address the more ontological questions of "who" is speaking and what are they trying to achieve: in this case, the "who" of an expert AHP. I developed a nuanced, case-based understanding of individuals, which in combination with the expanded critical incident analysis, offers a detailed exploration of four highly-experienced AHPs and considers their narratives in relation to being an expert. This narrative approach was strongly influenced by the work of Riessman (2008, 2015) and Frank (2012). The detailed methods of analyses and of combining the findings are reported in Chapters 7 and 8.

Decision to Halt Data Analysis and Interpretation

Although qualitative interviews can potentially provide endless data, and interpretation is not finalised, there still needs to be a point at which the researcher draws a line in the sand and presents their interpretation (Frank, 2012). Three things, proposed by Riessman (2008), were acknowledged in deciding to stop analysis in time to present my interpretation in this thesis. I acknowledge the storytellers allowing me to interpret their stories. I acknowledge the readers of this thesis and their listening of my interpretations, and I recognise that my interpretations can affect people. My decisions have consequences, including the decision to stop analysis based in part on a deadline. Frank (2012) reminded me that it is okay that stories (and their tellers) are selected and neglected in narrative analysis: that is the skill of interpretation.

Additionally, recalling the commitment to unfinalisability, ending the interpretation because there is nothing more to be said suggests that the *other* will not change, they (the stories, the interviewees) will always be that way (Frank, 2012; Smith et al., 2009). Finalisation can silence other voices and interfere with people's rights to tell their own stories and with them making choices to tell their stories differently or to live differently (Smith et al., 2009). That is not my commitment and so the end of this interpretation provided in this thesis is not the end of all interpretation of the data that could occur.

Conclusion

In summary this chapter presents my rationale for the approaches I have taken in Phase 2 of this project, as a result of reflection on Phase 1. This second phase is grounded in the ideology of interpretivism, the critical meta-narrative and a pragmatic approach. These considerations led to the use of interviews as the main source of data, alongside CVs and reflexive journaling. Consistent with these ways of thinking and specific methods, procedures that support methodological integrity have been included throughout the thesis and some, such as member checking and reflexivity, have been specifically included in this chapter. In the following chapter I provide details of the 45 interviewees that participated in Phase 2. Their description provides a snapshot of the AHPs and the context of Phase 2 analyses. In the next chapters, I will describe different specific forms of analysis and report on my findings. The particular analyses suit the particular theoretical aims in moving forward our understanding of what might it take to be known as an expert AHP.

Chapter 5

Study Interviewees in the Context of the New Zealand Allied Health Workforce

To put the interviewees into the context of their work, facets of NZ society are important to mention, particularly the structures of organisations that AHPs might work in and the nature of the allied health professions in NZ. The health service in NZ is a socialised, comprehensive health system, comparable in many ways to that of Norway or Great Britain (Katuu, 2018). In NZ, 20 District Health Boards (DHB) provide and fund around 75% of healthcare services in their region (Ministry of Health, 2017). They directly pay providers and own most of the facilities. In 1938, the New Zealand Government passed its Social Security Act, which included goals of creating a universally accessible national health service, along with other services such as education and social support (Gauld et al., 2019). The series of values and principles which underpinned this included that healthcare access should be a universal right, with equal access to treatment and no barriers for patients to receive needed care. These goals were not achieved as a result of the initial negotiation process that saw patients having to pay a fee to see a General Practitioner (which still exists today), although all outpatient and walk-in emergency services are free of charge. The government sought to place all health professionals on the government payroll, similar to teachers and police in New Zealand, but again this was not achieved, with many healthcare services being in private or voluntary ownership (Ministry of Health, 2017).

Similarly, the Health and Disability Commissioner, who oversees consumer rights in regards to health and disability services, also does not have sole jurisdiction across all situations where allied health practitioners work, as employees of the Ministries of Children and Education fall under the jurisdiction of the State Services Commissioner. This results in a

fractionated collection of allied health services that are not equally available to the members of the public across the country. Professions are not consistently and equitably regulated, and professionals are not equally held to account. These potential downsides are a counter to the upsides of a freer market and less regulation that allows for greater diversity and choice for some professionals, some organisations and some of the public. The diversity of funding, regulation and accountability is consistent with the diverse types of professions that make up allied health. Some of these factors will be expanded upon further in this chapter, which aims to describe the allied health interviewees that participated in Phase 2 of this research.

Purpose

In-depth workforce data is vital to help understand the existing workforce, support future workforce planning, and help determine if training, education and research adequately reflect the needs of the present and future allied health workforce. Detailed workforce data also provides a basis for considering the current and potential roles of AHPs within NZ. This chapter provides an in-depth examination of the subset of AHPs from the self-selecting sample that agreed to participate in the interviews. Although sampling was not purposive or stratified, nonetheless the findings add to the limited literature on the allied health workforce and the professional development of AHPs. Information on qualifications, employment background and geographical mobility is presented in order to understand the structure and dynamics of the AHP interviewees' career pathways (Lepori & Probst, 2009). Workforce information is limited but, where possible, comparisons are made with the New Zealand workforce. This chapter is mostly descriptive. Participant data presented here were either directly available from interviewees' CVs, or were derived from discussions about work histories as described in Chapter 4 (for example, supervision).

Who are the Allied Health Workforce?

In NZ, the allied health professions include over 30,000 health professionals that work directly with patients/clients but are not nurses or doctors (Allied Health Aotearoa New Zealand, 2018). For comparison, there were around 14,600 medical doctors registered in 2015 and approximately 52,700 nurses with annual practicing certificates in that year. AHPs have a relevant tertiary education, a professional association, an appropriate code of ethics and standards of practice, and a recognised system for monitoring ongoing competence (Allied Health Aotearoa New Zealand, 2018). This includes practitioners from a multitude of professions that work face-to-face with the public, such as dental assistants, osteopaths, speech-language therapists and social workers. The nature of NZ's health system, geography and the relatively small population contributes to a low number of AHPs being employed in senior or advanced practice roles.

There is no central collection of workforce information for the allied health professions even though they are typically grouped together by employing organisations. From the large number of professions included in allied health, a small number are the more commonly known, mainly due to their face-to-face patient contact, the number of people practicing and their longevity as professions. Details of the professions included in this research are shown in Table 5. Some professions such as dietetics are regulated by the Health Practitioners Competence Assurance (HPCA) Act (2003), a small number are regulated under a government ministry, for example social work, and increasingly some are self-regulated, for instance SLT. An additional factor in describing the diversity of AHPs, is that amongst those working outside of health organisations, some practitioners do not identify themselves as *health* professionals. For example, speech-language therapists employed by the Ministry of Education do not align with being called health professionals (New Zealand Speech-language Therapists' Association, 2018).

Table 5

Overview of Selected Patient-facing Allied Health Professions

Profession	Number of members [a] (year)	Registering body	Principal employment	Information source
Clinical psychology	2757 (2017)	HPCA	Unknown	HealthCentral.nz (2018)
Dietetics	787 (2019)	HPCA	Unknown	Pelvin and Domanski (2019)
Music therapy	~60 (2018)	Non-regulated	Private practice	Music Therapy New Zealand (n.d.)
Occupational therapy	2435 (2017)	HPCA	Ministry of Health	Occupational Therapy Board of New Zealand (2018)
Physiotherapy	4040 (2014)	HPCA	Private practice	Stokes et al. (2014)
Social work	6472 (2017)	Ministry of Social Development	Ministry of Health, Oranga Tamariki-Ministry for Children	Tertiary Education Commission (2019)
Speech-language therapy	822 (2019)	Self-regulating	Ministry of Education, Ministry of Health	New Zealand Speech-language Therapists' Association (2019)

[a] total number of members may include student, associate and other unspecified categories of membership.

The Ministry of Health reports that women comprise over 80% of the allied health workforce within the DHBs (Health Workforce New Zealand, 2016). The DHB workforce sector with the largest number of unfilled vacancies is allied health, which was 465 full-time equivalent staff down on budgeted staff numbers across 2017-18 (Allied Health Aotearoa New Zealand, 2018). In order to improve health workforce flexibility and sustainability, changes to legislation were made in 2016 to allow appropriately trained health practitioners, such as physiotherapists and prescribing pharmacists, to perform designated tasks that previously only a medical practitioner could do, such as certifying proof of injury and completing assessments under the mental health act (Ministry of Health, 2018). These changes suggest a willingness within the Ministry of Health to respond to the need for a workforce that can work differently from the past – and that sees value in professions other than medicine. The Ministry recognises that a "lack of career development frameworks contributes to difficulties retaining [allied health] staff and building depth of expertise" (Health Workforce New Zealand, 2016, p. 17). There is acknowledgement that the future health workforce cannot continue in the manner it has been in the past and that services need to take advantage of the skills and knowledge that their whole workforce has in order to meet the demand of an ageing and growing population and limited resources (Ministry of Health, 2018). However, there is also a call for changing scope of practice and evolving flexible roles for workers, that can "fill the need for more general health care workers, such as rehabilitation practitioners, rather than specific roles, such as physiotherapy, occupational therapy, and speech language therapy" (Gorman, 2015, p. 402).

The Ministry of Health is not the only government employer of AHPs; the Department of Corrections, Ministry of Social Development and Ministry of Education also provide relevant services and employ AHPs (Ministry of Health, 2018). The Ministry of Education employs physiotherapists, occupational therapists, psychologists and speech-

language therapists (Erin Whitton, personal communication, 29 January 2020). Although the ministry employs around 35% of registered speech-language therapists and considerably fewer of the registered psychologists (8%), physiotherapists (<1%) and occupational therapists (2%), the Education Workforce Strategy Governance Group does not have representation from AHP bodies (New Zealand Government, n.d.). In addition to government ministries, many AHPs work in privately funded services and for non-health organisations in non-clinical contexts, such as early childhood centres and people's homes. For example, DHBs employ 23% of registered social workers and Oranga Tamariki–Ministry for Children directly employs another 22%, leaving a considerable number of practitioners not in government employment (Tertiary Education Commission, 2019). Physiotherapists work principally in private practice (54%) (Stokes et al., 2014). This non-government workforce is more challenging to track as practitioners tend to work for small organisations with no centralised data collection.

Descriptive statistics are used to give a portrait of the 45 AHPs who participated in this research. In order to preserve their anonymity, some details are not expanded upon. Three interviewees identified as being Asian and the remainder were pākehā (NZ European, European and Canadian). Table 6 shows basic demographic information. Twenty-seven people were born in NZ and three moved to NZ as children and completed at least their secondary schooling there. Two New Zealand born interviewees moved to the UK as children and completed their schooling and qualifications there. Whilst SLTs were the dominant professional group, seven other professions were also represented: physiotherapy (PT), occupational therapy (OT), social work (SW), dietetics (DT), music therapy, play therapy and psychology.

Table 6

Basic Demographic Information about Interviewees

Variable	Count	Percentage
Gender (Female)	41	91
Age at interview		
20-29	1	2
30-39	8	18
40-49	17	38
50-59	7	16
60-69	9	20
70+	3	7
First language(s)		
English	40	89
Other	5	11
Place of secondary schooling		
NZ	30	67
Other	15	33
Allied Health Profession		
PT	5	11
OT	5	11
SLT	25	56
SW	5	11
Other	5	11

Qualifications

Half the interviewees completed a Bachelors degree in order to enter their profession. Details are shown in Table 7. Four interviewees had higher degrees as their entry-to-practice qualification. Some professions such as dietetics and psychology require a higher degree for entry-to-practice. For professions such as speech-language therapy, a higher degree is

optional and provides the same entry-to-practice entitlement as a Bachelor's qualification. A majority of interviewees took their qualifications for entry into their profession in New Zealand. Whilst most interviewees were in their twenties on qualifying, six were in their forties when they completed their qualifications.

Table 7

Entry-to-Practice and Additional Qualifications of the Interviewees

Variable	Count	Percentage
Country of initial entry-to-practice study		
NZ	30	67
UK	8	18
Other	7	16
Age when qualified		
20-29	36	80
30-39	3	7
40-49	6	13
Entry-to-practice qualification		
Certificate	3	7
Diploma	8	18
Bachelor's Degree	26	58
Post-graduate Diploma	4	9
Master's Degree	4	9
Additional qualifications		
None	15	33
Graduate Diploma	2	4
Bachelor's Degree	5	11
Post-graduate paper	5	11
Post-graduate Certificate	5	11
Post-graduate Diploma	5	11
Master's Degree	9	20
PhD	2	4

After working in their profession for some time, ten practitioners completed additional tertiary qualifications as a change in qualification requirements from their professional body meant they could no longer work without upskilling. Although all the

professional groups now require at least a Bachelors degree, some interviewees entered their profession before that requirement and had at minimum a relevant certificate or diploma. As professions increased their minimum qualifications for entry-to-practice, some implemented mandatory upskilling, for example, social work, and others such as speech-language therapy did not. Therefore, social workers, occupational therapists and psychologists were obligated to acquire additional tertiary qualifications in order to continue working in their profession.

All interviewees reported some professional development courses they had attended, although not all had completed a formal postgraduate qualification. Professional development ranged from on-site, internally run sessions on topics ranging across cultural, professional and health and safety topics to year-long coaching, leadership and management courses. Topics included advanced supervision training, privacy and confidentiality, family-centered practice, and dysphagia study days. Twenty-eight people acquired additional, tertiary qualifications completing a total of 35 postgraduate level qualifications between them, on topics such as ethics, research methods, te reo Māori, special education and also profession-specific topics such as Master of Social Work, audiology, and human communication. Only two of the interviewees had travelled overseas specifically for the purposes of studying a tertiary qualification, although nine who had moved overseas had completed additional qualifications in a different country to their initial entry qualification (Woolley & Turpin, 2009). Three interviewees started but did not complete additional tertiary qualifications at Master's level and three others completed unrelated postgraduate study.

Experience, and Career Paths

Table 8 shows details of work experience. All interviewees had a minimum of seven years experience working in their profession since their entry-to-practice qualification, as per the participation criteria. A majority had worked for more than 11 years, with a mean of 21

years of experience (see Figure 6). Sixteen had worked between 10-19 years and seven for more than 30 years. In total there was more than 965 years of experience amongst the cohort.

Table 8

Diversity of Work Experience

Variable	Count	Percentage	Descriptive statistics
Years of experience			
Range (years)			7 - 50
Mean (SD)			21 (10)
Number of jobs since qualifying			
1	2	4	
2-5	23	51	
6-10	12	27	
11+	8	18	
Mean number of jobs (SD)			7 (4.6)
Time out from work > 5 months			
No substantial time out	22	49	
Parenting	15	33	
Recuperation (burnout)	3	7	
Other [a]	10	22	

[a] includes (but not limited to) pursuing unrelated studies, non-practicing due to qualification recognition or visa issues, travelling

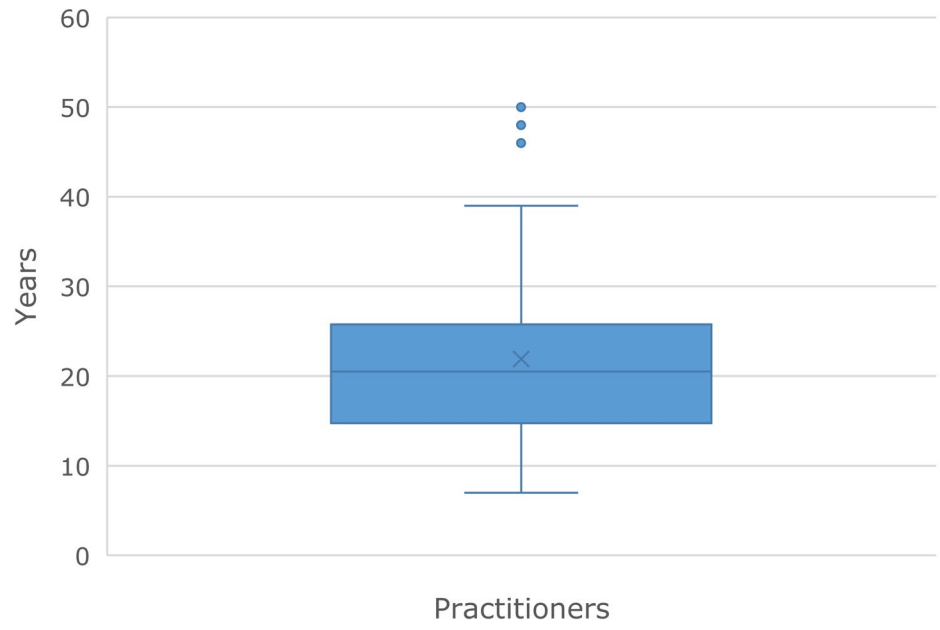
Two interviewees had only had one job since qualifying and had been in those jobs for 26 and 11 years respectively. Nearly half of the interviewees had between 2 and 5 different jobs since they qualified in their profession, however a substantial number had 6 jobs or more. Eight interviewees had more than 10 jobs in their career due to multiple locum positions being held for relatively short periods, such as six months or less. Four people with 16 jobs each, had worked overseas in a number of locum posts, mainly in the UK and USA.

One person had at least 19 different listed jobs, some as short as two weeks long in locum positions.

Whilst half the interviewees had taken no substantial time out from work, the remainder had had various amounts of time away for different reasons. Fifteen had stopped working to take on parenting for between 6 months and 8 years. Others had taken career breaks: some pursued alternative studies such as Fine Art or Theology, a small number travelled overseas without working and the remainder had worked in alternative jobs such as retail, management or childcare. Three interviewees reported in their interviews (not on their CV) that they had taken time out from work because they had, in their own words, burnt out.

Figure 6

Years of Experience in Their Profession



Data from Health Workforce Information Programme (P. Maciver, personal communication, 10 October, 2019) suggests that for the past four years (2015-2019), the mean length of employment within a DHB was 6.5 years across six allied health professions

(Dietitian, Occupational Therapist, Physiotherapist, Psychologists, Social Worker, Speech Language Therapist). SLTs stayed for a slightly shorter time (5.7 years) and social workers slightly longer (7.2 years). The Ministry of Education reported that current employees have an average length of employment of 8 years for SLTs and OTs and 9 years for PTs (Z. Griffiths, personal communication, 13 March, 2020). However, 10% of the SLT workforce left the employment of the Ministry of Education in the year 2018-2019 and their average tenure was 3.5 years. Approximately 3% of all practitioners who left a DHB and 6% who left the Ministry of Education, did so for retirement. Other reasons for leaving or changing job internally cannot be determined from the data.

Geographic Mobility

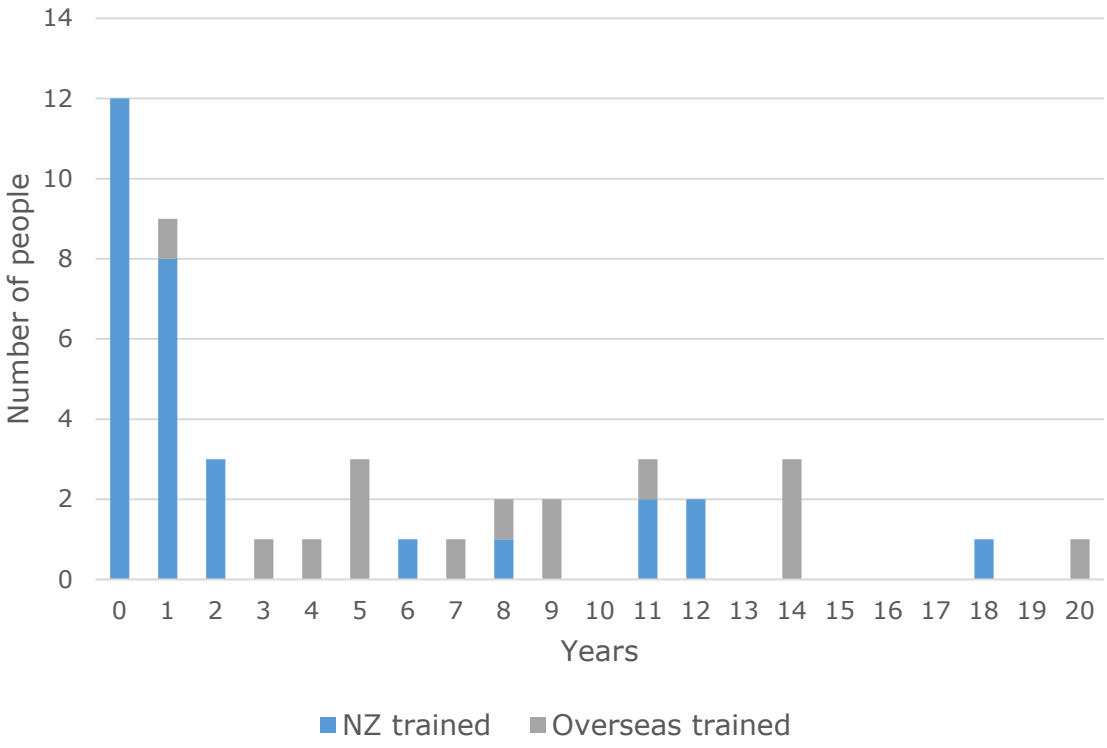
A practitioner's CV contains information that can capture how *mobile* a person has been in the process of accumulating capital and building networks (Woolley & Turpin, 2009). Study 1 found SLTs valued international experience highly and it is useful to explore the international as well as domestic mobility of the interviewees and paint a picture of what that might look like to contextualize the data. Interview and CV data were analysed using a modified list of indicators of mobility used in previous research by Woolley and Turpin (2009). This list included locations of: entry-to-practice/ undergraduate qualification, postgraduate training, employment, professional visits/ volunteer work and conferences/ professional development.

The data from survey respondents, reported in Chapter 2, found that accumulating experiences overseas was highly valued amongst SLTs when they considered the experts in their community (Jackson et al., 2017). Given this importance, it was surprising that not all AHPs included geographical locations of events in their CV, or when discussing them in the interviews. For instance, courses were not always linked to a place, employers were listed only by organizational title and not locality.

Of the 45 interviewees, 12 had not worked in their profession anywhere except in New Zealand; all of these practitioners completed their schooling and entry-to-practice qualifications in New Zealand (Figure 7). Of the remaining interviewees, nine had spent from a few months to a year working as practicing AHPs overseas and 14 spent between one and ten years practicing overseas. Ten had worked as an AHP more than 10 years outside of NZ. The immigrant practitioners had all completed at least one year of work in their place of origin before emigrating to NZ. However, 18 of the New Zealanders had spent time working overseas in their profession, often in the UK or Australia, but also in the USA and Saudi Arabia, with some spending 11 or more years away from New Zealand.

Figure 7

Histogram of Years of Working in Their Profession Outside of NZ



One person had worked in more than five different countries, this included work as a volunteer AHP. A few others had also worked in three or four different countries but for the majority, they had worked in their country of training and in New Zealand.

Domestic mobility was less common, at least across regions. Although there are a small number of training establishments, which limits people's options for places to study, typically, once a practitioner was working in a region, they stayed in that region; even if they changed jobs and went overseas they returned to that region. Table 9 shows the location of their training in NZ and their current region of work. For the handful of practitioners who went overseas and returned a couple of times, they tended to return to the same location, although not necessarily the same job. Only 15 interviewees had worked in more than one region of New Zealand. Seven people were currently working in the same region where they were trained, and four of those had never worked outside of that region. The other three had left for overseas and returned to the previous place.

Table 9

Domestic Mobility of Interviewees

Variable	Count	Percentage
City of entry-to-practice study in NZ (n = 30)		
Auckland	3	7
Christchurch (Canterbury)	15	33
Dunedin (Otago)	10	22
Other	2	4
Region of current work in NZ[a]		
Auckland	8	18
Canterbury	16	36
Manawatū-Whanganui	2	4
Otago	7	16
Waikato	8	18
Wellington	4	9

[a] There are 16 local government regions in NZ.

Only a small number of practitioners reported they had been overseas for a conference or training opportunity. This may have been due to a lack of information provided on CVs, or may be an indication of limited mobility for upskilling through professional development. Countries visited for training purposes included the UK (typically while the people were working there), Australia, Canada (Vancouver) and Sweden (again while the AHPs were working in the UK). A couple of practitioners had been overseas extensively, to present their work to others in Australia, Europe, Singapore, Thailand, USA and UK.

Organisational and Intellectual Mobility

Another source of mobility, and therefore access to intellectual and social capital, is moving between types of employer and fields of practice (Woolley & Turpin, 2009). Table 10 shows the current placement of the practitioners.

Table 10

Current Employer, Workplace and Caseload Mix

Variable	Count	Percentage
Caseload		
Mixed	4	9
Adult	13	29
Child	28	62
Employer		
Public	22	49
NGO	13	29
Private	1	2
Mixed	9	20
Workplace		
Hospital	13	29
School	16	36
Community clinic	2	4
Home visiting	5	11
Mixed	9	20

Broadly, just over half the cohort had changed their area of practice (caseload) from adult to child or vice versa during their career. Previously, some practitioners had maintained working with both children and adults concurrently whilst working for different employers, but this was not the dominant way of working. Only four people currently had a mixed adult and child caseload, and one of those had two different employers. Otherwise, practitioners had switched between being more or less specialised within an adult or child area of practice, particularly if they had worked overseas where there was more opportunity for specialist work. Often in NZ their work was broader in scope. For example, practitioners working at specialist rehabilitation facilities in the UK had come to a general position on a rehabilitation ward in an NZ public hospital. Similarly, those working on specialist children's wards in UK hospitals then worked across all wards in a NZ hospital, or worked with a mixed children's caseload for the Ministry of Education in NZ. However, there was still opportunity for specialist work in NZ. Eleven people described their work as specialist, this included working in areas such as Diabetes, Drug and Alcohol, Oncology, Fluency, Dementia and Autism. These self-declared specialisms were not verified but taken at face value, as practitioners stated that they worked for an organisation or service that provided specifically for that population.

Half the cohort worked for the Ministry of Health or Ministry of Education, as the two largest public providers employing AHPs. NGOs contracted to government Ministries were the second largest employer. Only one person worked solely in self-employed private practice, whilst six others had a mix of some private self-employment along with being employed. The majority had one employer, although eight people had two employers and one person had three. This was not unusual, with more than a handful of practitioners listing multiple concurrent employers on their CVs at points in the past. Twenty-three practitioners

worked part-time (0.9 full time equivalent or less) overall, with two of those working 0.2 full time equivalent.

Another factor to be considered here is the status or level of practice assigned to jobs that AHPs take on. Eleven people described their current role as “senior”. Most organisations have a flat structure with no hierarchy, except perhaps to distinguish between “new graduate” employees and others. Five people stated they were the only employee of their organization working within their profession; everyone else had at least one other permanently employed colleague of the same profession. Five practitioners had held previous roles as managers at team or service level – ranging from leading a discipline-specific clinical team to a large regional multi-disciplinary service. Eight currently had managerial roles, either employing their own staff, leading a clinical team (with or without budgetary responsibility) or running a service.

Supervision

Inclusion of supervision in this chapter is important, because it rarely appeared on CVs or in career histories, but frequently practitioners mentioned it as an essential part of their work. Practitioners can both give and receive supervision and, typically, interviewees included reference to providing supervision on their CV, but no-one wrote about supervision as a source of professional development or otherwise. During interviews, many of the practitioners did talk about supervision, although did not provide specific details such as frequency or location. They indicated that they did receive supervision and that it could be of use, but was not always useful. Some talked about how they could not find suitable supervision within the country and instead looked to overseas for specialist support. Others found supervision from a person in a different profession of huge benefit, particularly if the person was from social work or psychology, which both have substantial in-depth training and ongoing requirements for high quality provision of supervision (Rankine, 2017).

Additionally, practitioners can take on supervision of junior staff and colleagues (through peer supervision). Whilst most practitioners had taken a student on a placement at some time in their career, nine reported they often took students and twelve reported that they had not taken a student in a long time. The later group usually cited an incompatibility between students and the type of workplace, further suggesting they believed the type of work was too difficult or unusual for a student to manage.

In What Ways do Interviewees Look Like their Respective Professions?

In the introduction to this chapter, I suggested that workforce information is sparse and inconsistent. However, some comparisons of the interviewees can be made with data provided by professional bodies. The Physiotherapy Board of New Zealand and Occupational Therapy Board of New Zealand provided the most freely-available detailed information about their workforces, and the New Zealand Speech-language Therapists' Association provided some information on request. Broadly, the interviewees appear quite typical as members of their respective professions in relation to gender, place of qualification and employment.

The largest area of employment for physiotherapists in 2014 was in private practice (58%), where most were self-employed (Stokes et al., 2014). These practitioners worked an average of 33 hours a week and over 70 percent were female; 45% of physiotherapists qualified overseas and 80% of those in the UK and Ireland (McLean et al., 2017). Public health services were the next largest employer with 24% of the registered PT workforce, and in the DHBs, 89% of physiotherapists were female. Average age across physiotherapists employed by DHBs was around 39 years and has slowly increased from 38 years in 2010 (McLean et al., 2017). Whilst interviewees in this study were mostly in employment with a DHB, one was solely in private practice. Two qualified overseas and all had worked overseas. Four were female.

The largest employer of occupational therapists are the DHBs at 49%, then self-employed private practice at 15% (Occupational Therapy Board of New Zealand, 2018). Just under 50% work hands-on in physical health and 15% in mental health. Only 17% work with children and 19% with adolescents. Fewer than 9% of the workforce were male; 80% of OTs qualified in NZ, 11% in UK and the average age across all OTs has remained between 41 and 42 over many years. Four OTs were female in this study, one qualified overseas, two worked outside of a DHB and one in mental health.

In a 2019 survey, 47% of SLTs that provided information worked fulltime and 20% worked part time (New Zealand Speech-language Therapists' Association, personal communication, 20 February 2020). Around 6% of SLTs were not currently working but were registered with their professional body. Just under 3% of registered SLTs were male, and 10% of those registered were qualified overseas. Interviewees in this study were mostly female and worked in a mixture of non-government and government workplaces, with a small number involved in private practice. Nine interviewees qualified overseas and most had spent some time working overseas, but not all of them as an SLT.

Within the different therapy professions, Māori and Pacific staff make up a small proportion of the workforce - psychology (5.6%), physiotherapy (3.7%), occupational therapy (4.2%) - and there are no published figures for speech-language therapy, social work or dietetics (Workforce Information Team, 2019). No interviewees identified as Māori or Pacific. Three interviewees identified as Asian in this study, which is similar to the reported workforce.

Conclusion

Although there are some profession-specific allied health data and some organization-based multidisciplinary allied health profession data, there is no single source of data across

the complete allied health population in NZ. This is despite allied health being grouped together in discussions of the health workforce, having its own peak body and frequently appearing as a group in research articles. The data presented here by no means provide a complete picture of the allied health workforce but instead provide detailed information about a collection of professionals. The data are described as a means to view the landscape (Sturm, 2012). The AHPs in the sample are a diverse group in many ways. The main demographic similarity would be the strong tendency to be female. Some were born and raised in NZ, others not. They trained at different ages, in different locations for different professions with different entry level qualifications. They worked in different locations, in different settings and with different caseloads. Some have been overseas for work and some have not. Typically, they work in small teams where there is some limited opportunity for seniority or for specialist positions. This chapter provides context for the sample of AHPs that participated in Phase 2 of this project. The analysis and interpretation of their interview data will be discussed next.

Chapter 6

This chapter has been submitted for publication and is under review: Jackson, B. N., Cooper-Thomas, H. D., & Purdy, S. C. (2019). *Becoming an expert: Highly-experienced allied health professionals' relationships with their work* [Manuscript submitted for publication]. School of Psychology, University of Auckland.

Becoming an Expert: Highly-Experienced Allied Health Professionals' Relationships With Their Work

> I do get frustrated though because I do, across everywhere I've worked, um, see people who, just don't seem to care about staying up to date. And, I don't know if they've lost the passion or never had the passion, or, are there just because they have to have a job, but you watch it happen to lots of people [Speech-language therapist (SLT) 09].

Allied health professionals (AHPs), such as dietitians (DT), social workers (SW) and physiotherapists (PT) have a relevant tertiary qualification, a professional association, standards of practice and a recognised system for monitoring ongoing competence. To be known as an expert, research has reported that AHPs need to be seen as experienced, knowledgeable practitioners who achieve good outcomes for their clients and who also provide strong personal leadership, teaching and practice contributions to their professional communities (Jackson et al., 2017). In this definition, expertise exists in a relationship between the holder and the consumer, an AHP and their peers (Selinger & Crease, 2006). These expectations of experts, from their practitioner peers, are consistent with a view of expertise as being embodied in performance (Chow et al., 2015; Ericsson, 2015).

There is existing evidence that experienced health professionals can provide substantially different levels of care compared with new graduates and are valuable to their professions and organisations (Brody et al., 2012; Forbes et al., 2017; Hanlon et al., 2018). Studies report significant differences in critical thinking and clinical reasoning between novice and experienced AHPs across psychotherapy (Eells et al., 2011), physical therapy (Sakurai et al., 2016) and occupational therapy (OT) (DuBroc & Pickens, 2015). However, research also finds that after approximately five years of work, performance is no longer related to experience; not all highly-experienced practitioners are performing at expert-level, and experience alone is insufficient to attain expertise (Brody et al., 2012; Ericsson, 2004; Rassafiani et al., 2009). Clearly, developing expert-level performance requires the practitioner to put in effort beyond merely gathering experiences at work. The current study focuses on AHPs' relationship with their work concerning the development and maintenance of expert-level performance. The study explores the current motivators, aspirations and the role of work in the life of highly-experienced practitioners, revealing factors that hinder or support them to further develop their own expertise and be inspiring role-models and mentors for less experienced staff.

In this report, we review the extant literature on work orientation and specifically relate it to expert-level performance. Then, drawing on in-depth semi-structured interview data with 45 practitioners, we propose a typology of four different orientations that highly-experienced AHPs have towards their work. This typology offers new insights on the work orientation of highly-experienced AHPs with a view to them being known as experts in their community.

Work Orientation in the Health Professions

Work orientation captures how individuals differ in their experience of the work they do. It categorises the interplay between a person and their work. The seminal research from

Wrzesniewski et al. (1997) and Wrzesniewski (2003) on work orientation proposes three distinct ways people relate to their work: as *jobs*, *careers*, and *callings*. Their research has formed the basis of numerous studies, particularly in relation to callings. People who view work as a job earn a material benefit and do not seek or receive any other type of reward from their work. Work allows them to acquire the resources needed to enjoy time away from the job pursuing things of more interest to them. People with careers are more deeply invested in their work and achieve not only monetary gain but also advancement within an occupation over time. A person who views their work as a career might gain higher self-esteem, higher social standing and increased power from their work. When people report that work is deeply meaningful and inseparable from their life, this is a calling. Career advancement and financial gain are downplayed in comparison to the fulfilment that doing the work brings to the individual (Wrzesniewski et al., 1997).

Since the initial work of Wrzesniewski et al. (1997), subsequent research has particularly focused on extending and refining the concept of calling. In the literature, the definition of calling is varied and this reflects the complexity of the construct, with individuals perceiving calling differently (Lysova et al., 2019). Living your calling is portrayed as something to aspire to, a way to a happy life (Sturges et al., 2019). This is despite a recognised dark side that impacts negatively on personal and close relationships (Bunderson & Thompson, 2009; Oelberger, 2018) The positive benefits of not just perceiving but living a calling include higher job satisfaction, increased happiness and greater life meaning (Duffy et al., 2017). Around a third of people view their work as a calling (Berg et al., 2010; Wrzesniewski et al., 1997), similarly, approximately on third have callings they have not yet pursued and a number of people, albeit unspecified, do not view any work as a calling (Berg et al., 2010).

The relationship between a calling orientation and meaningful work has been widely researched. Deeply meaningful work is both self-actualising (fulfils one's talents and potential) and transcendent (beyond one's self) and is often referred to as a calling by people who experience it (Bunderson & Thompson, 2009; Oelberger, 2018). Meaningful work has become idealised, situating work as the site for fulfilling one's potential and following one's passion (Berkelaar & Buzzanell, 2014). An increasing number of people are seeking meaningful work (Schabram & Maitlis, 2017; Ward & King, 2017).

One way that people can create more meaning in their work is through job crafting. People can be proactive, shaping their work and leisure time to provide meaning through increased personal identity and significance (Berg et al., 2010; Wrzesniewski & Dutton, 2001). A three-level hierarchy of job crafting has been proposed, whereby people proactively change behavioural, relational and cognitive boundaries of their job to alter their experiences at work (Zhang & Parker, 2019). For example, AHPs might seek more meaning through crafting their job; setting new challenges for themselves such as seeking feedback on their performance from a colleague (increasing relationships), or aiming to complete their paperwork within a shorter time period (reducing demands). Not all job crafting options suit all individuals, particularly if they are already disengaged from their work (Bakker, 2018). There is evidence of AHPs job crafting to create meaning. Specifically, where job crafting opportunities are limited, AHPs that stay in their profession often turn to private practice for increased autonomy and financial resources that can lead to increased meaning (Pather, 2016; Valentine & Rahiman, 2018).

No publications have specifically addressed work orientation in relation to AHPs. This is in spite of popular assumptions that AHPs and healthcare workers in general, do it out of passion and commitment to helping others, that is as a calling, rather than other motives such intellectual or financial interest (Graham & Shier, 2013; Katz et al., 2013). There have

been a number of special issue journals on the topic of calling, but these have not investigated the tripartite work orientation typology in AHPs or other workers (Duffy & Dik, 2012; Lysova et al., 2019). There is an idealised public view of AHPs as having deeply meaningful work, both highly satisfying and contributing significantly to others. There is an expectation of prosocial motivation and others outside of the health workforce may expect an AHP to be highly intrinsically-rewarded by their work (Nesje, 2015). Many students entering into allied health entry-to-practice training also hold this expectation (Craik & Napthine, 2001; Whitehouse et al., 2007).

The context of work is important in enabling or restricting opportunities for different orientations to work. Thus, for AHPs in NZ, they are limited by the capacity of their organisational systems to offer advancement in their work whilst remaining in their profession; these limits on career opportunities hinder the opportunity to pursue a career orientation. Some AHPs may be the only practitioner in their profession, within their organisation, with no opportunity for advancement (Burgess et al., 2016). The nature of NZ's geography and the relatively small population contributes to a low number of AHPs being employed in specialist roles, and instead the majority of AHPs are generalists, again limiting career opportunities. AHPs are paid moderately but there is little opportunity for substantial financial gains due to restricted salary structures. Finding specialist AHPs with experience is an ongoing problem across several professions, including audiology (Valentine & Rahiman, 2018), occupational therapy (Valentine et al., 2017), and physiotherapy (McLean et al., 2017). In these circumstances, it is not surprising that the public might think that AHPs would not have a career orientation, and that they are working in these conditions for intrinsic reward, that they are living their calling.

When the context allows, there is opportunity for highly-experienced AHPs to develop expert-level performance, and to take on supervisory roles to support junior staff

both in setting professional goals and providing them with feedback on goal attainment – essential features in the development of expertise (Ericsson, 2015). However, experienced AHPs, similar to nurses, are not staying in their profession long-term (Tillard, 2011). Retirement, reduced resources, and lack of advancement options all contribute to AHPs' attrition from their jobs as well as from their professions (Hofler & Thomas, 2016; Valentine et al., 2017). Organisations, particularly public health services, struggle to find highly-experienced AHPs that can mentor new graduates to provide high quality care (Pather, 2016; Valentine et al., 2017). Given the importance of a structured transition to work for the newer generation of workers, this is problematic (Hofler & Thomas, 2016).

Some, but not all, highly-experienced AHPs are seen as experts by their professional communities. Given the limited opportunities for career growth, and attrition factors, why are some willing to share their knowledge, skills and actively engage with their professional community, and others are not? We used semi-structured interviews to explore AHPs' relationships to their both their work and their profession.

Method

Interviewees

The university ethics committee granted ethical approval (reference UAHPEC 019482). Adverts were distributed via professional networks, including two national email groups, an AHP professional body and two health boards. Anyone qualified in a client-facing allied health profession, for example: occupational therapist, psychologist, dietitian, social worker, working in that profession for more than seven years (or using those skills and still eligible for registration with their professional body, for example, visiting neurodevelopmental therapist or communication aid specialist) was invited to participate. Potential interviewees contacted the primary researcher to express interest.

A lower limit of seven years of work experience was an inclusion criteria to ensure that interviewees did have a substantial amount of experience, beyond entry level as a new graduate. Seven years was chosen as the lower limit to include the workforce who were more likely to have a breadth and depth of experience across different jobs, based on the mean length of employment for an AHP within a health board in NZ being 6.5 years (McLean et al., 2017; Valentine et al., 2017).

In total, 45 practitioners were interviewed, with a mean of 21 years of experience (range 7 – 50 years, SD 10 years). Four potential interviewees were excluded, as they were no longer in employment as an AHP at the time of interview. Most interviewees had English as their first language (n = 41) even though only 27 were born and went to school in NZ. The proportion of women matches the high proportion of women in this workforce. Interviewees were employed across organisational sectors, including public, private and not-for-profit. The majority had had between two and five different jobs in their profession (range 1 – 16, mean 7, SD 4.6). Twelve had only worked in NZ. Six interviewees ran their own private practice; all the others were solely employees. Additional demographic information is in Table 11.

Table 11

Demographics of the Interviewees

Characteristic	Count	Percentage
Female	41	91
Age		
20 – 29 years	1	2
30 – 39 years	8	18
40 – 49 years	17	38
50 – 59 years	7	16
60 – 69 years	9	20
70 years +	3	7
Population of current clinical caseload		
Paediatrics (0-17 years)	28	62
Adults (18 years+)	14	31
Mixed (paediatrics & adults)	3	7
Primary employment sector		
Public provider	22	49
Non-profit organisation	13	29
Private provider	1	2
Mixed	9	20
Age at entry-to-practice		
20-29 years	36	80
30-39 years	3	7
40-49 years	6	13
Profession		
Occupational therapist	5	11
Physiotherapist	5	11
Speech-language therapist	25	55
Social worker	5	11
Other (psychologist, dietitian, music therapist, play therapist)	5	11

Process

Consistent with the method described by Kluge (2000), empirical analyses were combined with theoretical knowledge, in order to construct "empirically grounded types". Prior to the interview the researcher provided the interview topic guide (see Figure 4 in Chapter 4). Interviewees were interviewed face-to-face by the primary researcher at the

participant's location of choice (Mann, 2016). Conversations were audio-recorded and transcribed.

The extant literature was reviewed pragmatically. Empirical findings and theoretical ideas were identified and accessed, as and when necessary to progress the study, a recommended method for an empirically grounded approach (Dunne, 2011). Literature drawn from the psychology of expertise (Ericsson et al., 2007; Gobet, 2015; Jackson et al., 2017) and the development of professional confidence (Holland et al., 2012a; Jackson et al., 2019) informed the interview questions. The semi-structured interview was iterative in that questions were explored until no new information was forthcoming. Some questions were modified in later interviews to clarify or expand upon responses from earlier interviews (Mann, 2016).

Initially the researcher gave a brief description of the research purpose. Interviews began with gathering information about the participant's current job and discussing their career history. Further questions focused on present work roles (sources of challenge, satisfaction, and worry; professional identity; perceived changes as a practitioner over time) and aspects of professional confidence such as negotiating roles, the significance of their profession, and what they valued about their job (Holland et al., 2012a; Jackson et al., 2019). Open-ended questions enabled interviewees to discuss their past and future career (Mann, 2016).

Additionally, critical incidents were sought (occasions of success, disappointment, difficulty, change, conflict, and personal growth). Critical incident technique has been used extensively in healthcare research (Ferguson et al., 2010; Kvarnstrom, 2008). Interviewees provided detailed descriptions of actual events they considered critical in the sense of significant, rather than crisis or emergency (McAllister et al., 2006).

Member checking was used to increase credibility of the findings, as recommended by Morse (2015). Some analysis was completed during and between every interview, and later interviews included questions that arose from earlier data. For example, confidence was reported by many people to have changed over the years, so the questions were adapted to seek examples of how confidence had changed, or situations that showed how it might have grown.

A professional third party transcribed the audio recordings, and the primary researcher checked each transcript against the audio recording. Where interviewees had requested, transcripts were sent back for comments or changes. Only one interviewee made a change of content, to clarify their self-funding for professional development courses.

The primary researcher used reflexive journaling, immediately after each interview, after transcript-reading and throughout analysis, to capture decisions made about the data and as the basis of regular discussions with co-authors to increase the rigor of data analysis (Braun & Clarke, 2019a).

Analysis

To develop a typology from a grounded theoretical research design, dimensions and their properties were created during the iterative process of analysis of reflexive journal entries, each participant's transcript, comparisons across transcripts, and making connections to the literature, following the process described by Kluge (2000). Transcripts were kept whole, and are referred to as *cases*.

Throughout data collection, interviewees commonly used expressions of feelings, particularly passion, in the discussion of work, and in response, an overarching concept was created, termed *Work Orientation*. On the first read of all the data, work orientation appeared to be related to two dimensions; one related to past successes and the other to continuing

growth as a practitioner. On a second pass of the data, the emotions of excitement, contentment, frustration and despair came through strongly for different interviewees and these were integrated into the emerging types.

On a third pass of the data, further terms and themes that described AHP types were identified and then related to literature. For example, AHPs who were satisfied with their past successes and sought professional growth tended to talk about their work as being highly meaningful. Literature on meaningful work was reviewed and comments that suggested self-actualization and self-transcendence through work were highlighted in the transcripts (Lepisto & Pratt, 2017; Lips-Wiersma & Wright, 2012). For some this was consistent with the description of deeply meaningful work (Oelberger, 2018). As the cases were grouped and combined into types, these types were more clearly delineated, and the descriptions were reapplied to the already coded data, which identified further descriptors that could define the types. The resulting four types were given provisional names. Dimension-names, type-names and descriptors were discussed amongst the research team and each member of the team applied the types to the cases separately and then collectively to evaluate whether the typology was a good fit for the data (Levitt et al., 2018). The dimension-names, names of the types and the descriptors were iterated until the team reached a consensus. The literature on critical perspectives on meaningful work and calling orientation was reviewed in order to provide a richer picture of the types. A fourth review of the data highlighted the role of job and career crafting, as a skill and an opportunity, that successful AHPs had employed. The next section details the findings and the resulting typology.

Findings

The overarching concept developed here is termed work orientation. In total, four empirically grounded types of work orientation were developed – Achiever (n = 11; 24%),

Contented (n = 22; 49%), Striver (n = 9; 20%), and Over It (n = 3; 7%). These types were spread across demographic factors such as age, profession, workplace, and years of experience. For example, all four types featured across the age span from 29 to over 70 years old with each type having AHPs in their thirties as well as their sixties. All four types had a range of years of experience and professions. Distributions are shown in Appendix C.

The types are discussed using interview data to exemplify the types along two dimensions: *Satisfied with Successes* – a past-oriented perspective whereby the person felt they had achieved successes and those had been acknowledged sufficiently; *Future Growth Oriented* – a future looking perspective that was embracing of, and to some extent actively seeking, development and progress. The dimensions and types are shown in Figure 8. Table 12 details the descriptors for each type.

Figure 8

A Typology of Work Orientation of Highly-Experienced Allied Health Professionals

		Satisfied with successes	
		Yes	*No*
Future Growth Oriented	*Yes*	Achiever	Striver
	No	Contented	Over it

Table 12

Descriptors of Empirically Grounded Types of Work Orientation

Achiever (n=11)
Enthusiastic and excited about current and future events, readily share their successes
May be in positions of leadership or leading from the ground up
Have plans, set goals and work for big gains
Actively seek out new information, make and take opportunities
Do not play strictly by the rules: do not always follow things to their expected logical conclusion, for example, not finishing qualifications
Self-actualised and may also be self-transcendent
Contented (n=22)
Satisfied and content where they are in their work
Other things maybe a focus of life, such as non-work activities, family
Work performance is not problematic - At least minimum acceptable (maintaining CPD)
Maybe reluctantly encouraged into leadership, especially mentoring junior staff
Work is somewhat meaningful - maybe self-transcendent but not totally self-actualising
Not future-growth oriented, but not averse to it, not fixed-mindset and have generativity
Striver (n=9)
Expressing that they want to be successful, and may be successful in other's view, but not their own
Feel stuck, powerless, constrained by practical issues such as family, organisational priorities, finances
Try new things but do not get the success they are seeking, may see success is somewhere else or not possible
May be resentful of training others, particularly "outsiders" – those in different professional groups
Play by the rules and do not want to or feel unable to look outside-the-box
Expressing that they want to be leaders, to be acknowledged but may not take on the expected/ authorised routes to achievement recognition as they see them as negative – not worth it
Are not getting intrinsic reward - may be transcendent when working directly with clients
Report that they do not fit with the organisation
Have past successes that they feel are not currently valued by others
Over It (n=3)
Exhausted, disappointed and ready to leave but trapped or biding their time
Lack of opportunity, large caseload, and administrative work override the enjoyment they get from working with clients
May take on training roles, but lack energy and enthusiasm
May still occasionally be self-transcendent when working directly with clients
Report that they have loved aspects of their work in the past – particularly direct client contact
Feel constrained by the organisation, but lack energy to take action

Dimension 1: Satisfied with Successes

This dimension describes the degree to which the practitioner is pleased with their work so far. All the AHPs told a story of something they had accomplished – qualifications, new areas of practice, success for clients, positions of significance on a working group or professional body. For the Contented and Achiever types, these highly-experienced AHPs were satisfied with their work. They felt capable and successful: "I know what to do now! I have transferable skills. I can wing it and walk into a complex situation and work through it" [SLT40]. "It's when you can see those things [progress] months down the track, that's when, I feel like that's when it means the most, you know you've made a huge difference in that person's life" [OT21].

Satisfaction came from holding knowledge and skills, but also intrinsically from the nature of the work with people: "I love connecting with my patients, with my people. And… with the wider team I work with as well, so connecting with all sorts of people. I love when we make an impact on patients in their lives" [SLT45].

This was not the case for the Strivers and Over It types. These AHPs were frustrated and disappointed and felt their work was not adequately recognised. DT1 had taken on extra roles in teaching but had not been acknowledged in a way she found satisfying: "but my frustration is that I end up teaching nurses and midwives to enhance their practice so that they can go on a higher salary grade than me" [DT1].

Similarly, even when an innovative idea was implemented, the manner of implementation often meant that the initiating AHP could not view it as a personal success. For example, SLT6 had campaigned for service change that had only occurred after she had left the organisation:

I remember my old team leader told me "you know you remember that time when you

> gave that speech…and that presentation about how we should be working differently and now we are!' But it was like 5 years later. You know, but that's too long for me and I'm really frustrated with myself that I'm like that [SLT6].

For those who were not satisfied, the difficulties seemed pervasive, as expressed by SLT31:

> So like for years, we don't know if we're even going to have a videofluoroscopy machine, and that's a very difficult way to live as a speech therapist, isn't it? So it's just difficult, coz… now, well I feel, with the work load that I'm just a work horse, and that nobody wants to use what I have.

She was confident that she had knowledge that could be useful to others, but no-one else recognised it and that negated previous successes that she had had in her career. She reported that others in her professional community seemed to think that because she was in a small rural organisation, she had nothing specialised to offer. This lack of fulfilment was shared with other Strivers who, despite a belief in the profession, led ultimately to leaving their organisation:

> I just have real problems with the [public] health system. And that's why I left it. That's the thing I left it! I left it!...It was driving me nuts. I believe in it, I love it but I couldn't stay. And that was really hard, I was traumatised when I left. I never thought I'd leave. I thought I'd work [there] for the rest of my life [SLT6].

Dimension 2: Future Growth Oriented

This dimension relates to the degree of personal and professional growth the practitioner is actively seeking, or is willing to take on through work. Achiever and Striver types were all keen to move forward, but characteristics of the two types were quite different. Achievers actively sought out information, ideas and opportunities. Achievers could be flexible and adaptable to keep growing their knowledge and skills, as well as to achieve what

was needed for their clients, which included spending their own time and money: “Getting PD is hard, looking for advanced things. I'm not a new grad any more. I’m committed to upskilling so I do it in my own time with my own money” [SLT38]. For some Achievers, it involved seeking alternative sources of support other than the designated leaders:

> That changed my career in the sense that I learned that you don’t just keep pushing and keep pushing and keep pushing. Um, when you have no support…You can’t wish that the leader will support you if it’s not going to happen. And you find a gap in the brick wall…um… and you find someone, whoever that is, who will be an ally with you, and you find other ways of doing it [SLT5].

They were not stopped for long by barriers that would challenge others and found alternative ways to achieve their goals. In this way they acted autonomously from their organisation.

Strivers also had a strong forward momentum but felt constrained, even stuck, by what they perceived as very limited advancement opportunities. Particularly in NZ, given the small population and lack of speciality positions, advancement is typically limited to a non-clinical managerial route rather than offering the possibility of senior or specialist clinical roles.

> Not sure what's next...I love my job, but I also can’t imagine, ‘cause I’m kind of at the top of my grade, or whatever. There’s nowhere to go and that also doesn’t feel very good. So there’s kind of this… I love my job, I do not want to do management. I do not want to do management [PT36].

This lack of opportunity was strongly evident in the Striver type, where practitioners felt powerless to advance, with many also reporting their aversion to taking a management position.

> You work for 10 years as a speech therapist, you start as a generalist speech therapist,

> you finish as a generalist speech therapist. After 10 years you don't even increase in pay, they just kind of expect you to do what you're doing and continue doing it, until you decide "oh I'll be a service manager or a practice adviser". Or maybe they expect us all to go away and have babies and come back part-time [SLT33].

Contented and Over It types were not forward oriented. The Contented group were concerned about holding on to existing successes and keeping up with change: "I had more optimism before, now more in for the long haul" [SLT23]. These practitioners felt they were performing competently and enjoyed their work but did not actively seek out further growth or development. For example:

> Oh maybe I could still fit in some more study and one of my colleagues will say, "yeah but do you really wanna do anything else?" And I'm like, "probably not" (laughter). Kind of, maybe I've peaked too early. No, I really… I really love my job at [workplace] so yeah, maybe if I did something else it would only be part-time [OT17].

Although not interested in substantial growth for themselves, they were willing to mentor more junior staff and share their knowledge:

> If you wanted to, you could take on a portfolio or something else like that or, yeah, you could stretch into different areas if you wanted to but you know I prefer not to (pause) I'll carry on here and keep doing what I'm doing at the moment and mentoring and that [SW2].

For Over It types, they were ready to leave their job but trapped or biding their time. DT3 talked about wanting to specialise but roles being very hard to get:

> And, it does sort of lead to (sigh) feeling like you need a career change, and you're sort of like, hmmmm, I think I'm going to be stuck in this role forever (pause). Like

> this is the, kind of like, the end, the end [DT3].

The effort required to keep moving forwards either in terms of change, new innovations or advancement seemed unreasonable and the outcome not valuable enough:

> I haven't found anything that I'm passionate about that would meet that, that amount of time needed [to complete the promotion process] [DT3].

> I kind of stay here, I mean I've been here a long time, so you have annual leave and sick leave and salary and stuff like that, I couldn't work anywhere else [SW42].

Limitations within the organisation were highlighted but, similarly with the Strivers, there was a strong sense of not wanting to leave the profession overall: "I'm not sure if I'll still be working [here], but I did think…it would be nice to do some, not pro bono, but very cheap speech therapy work for people who can't afford it" [SLT31].

Discussion

There were some commonalities across the 45 interviews across the various areas of allied health practice. All interviewees saw their profession as making a significant and valuable contribution. All interviewees identified prior successes they were pleased or proud of, and all communicated their love of working with people, although for some (Striver and Over It) this was not a source of deep satisfaction. A number of AHPs described working for the fulfilment it brought. Meaningful work involves a set of conditions that seem highly likely to be present for AHPs: the opportunity to use technical skills and knowledge, considerable autonomy, observable patient outcomes and task significance; but in spite of this, meaningfulness was elusive (Lepisto & Pratt, 2017). Although some practitioners reported work was meaningful and fulfilling, for others it was a source of frustration or

despair. For some the meaningfulness was insufficient to maintain a positive perspective in the face of other negative factors.

The four work orientations described here – Achiever, Contented, Striver, and Over It – capture relationships between practitioners and their current work that are strongly influenced by their prior experiences. The four types proposed have different perspectives on past experiences and future directions.

Achiever Type

Achiever types found work deeply meaningful – both self-actualising and transcendent – a calling (Oelberger, 2018). Prior research suggests that a person's calling may emerge after working in an occupation for some time (Hagmaier & Abele, 2012), and that a sense of calling can emerge through ongoing sensemaking, characterized by seeing positive connections between actions, context and identity (Sturges et al., 2019). This suggests that satisfaction with prior successes is an important aspect of fulfilling your calling. Achievers talked about their passion for their work, and about how well their profession fitted with their values. There was nothing else they would rather be doing.

Aside from crafting their job to increase a sense of meaning, individuals commonly also have four characteristics related to crafting their careers over time (Savickas & Porfeli, 2012). These characteristics are willingness to explore career alternatives, resources to pursue alternatives effectively, proactively addressing changing circumstances and judging the resulting outcome. Achievers were highly competent career crafters, not afraid to make changes to pursue their goals consistent with their values, even if that resulted in changing jobs and profession.

Achievers created their reputation by actively talking about their innovations and successes. These actions within their professional community would make them likely to be

known as the experts, given that experts willingly share their knowledge and skills (Jackson et al., 2017). A manager of Achievers could support them to flourish by giving them space to try things, which requires trust. Achievers are intrinsically rewarded by their work and can be intensely focused on what they have accomplished and want to accomplish. If the organisation and manager cannot accommodate their approach, Achievers might not stay in their job, seeking out more fulfilling opportunities. Work situations open to high levels of job crafting, such as university lecturing could be a good fit allowing Achievers be flexible, niche and autonomous (Berg et al., 2010; Wrzesniewski & Dutton, 2001).

Contented Type

For Contented types, self-transcendence was evident without self-actualisation, in the sense of being healthy, whole and generally satisfied (Reed, 2009). Contented types were sufficiently fulfilled with their present position, suggesting that any career crafting already done was successful (Savickas & Porfeli, 2012). Contented types are good job crafters who are also crafting their leisure time to enact a meaningful life (Berg et al., 2010). For them the work is sufficient, offering enough meaning and enjoyment without being deeply meaningful.

Prior research suggests two future-facing orientations of mid- to late-career people – forward momentum and maintenance (Arnold & Clark, 2016). Workers with forward momentum seek to expand their personal attributes and try out new things. Achievers and Strivers both oriented to future growth but previous successes were a source of celebration and motivation, or disappointment and frustration. Maintenance-focused Contented types, do not actively seek forward momentum, but they do have generativity: wanting to leave a legacy through investment in the next generation of professional (Arnold & Clark, 2016; Chen et al., 2019). A potential risk of not seeking growth is that generativity could be stifled (Arnold & Clark, 2016). However, a greater sense of generativity is likely with intrinsically rewarding work, particularly when work involves training less experienced workers to

complete complex work tasks, which Contented types attained through mentoring (Chen et al., 2019).

Contented types could be known as experts, they are prosocially oriented and generativity may cause them to share knowledge and skills. Their steady approach may suit more junior staff very well. Managers can actively inspire Contented types and offer opportunities by noticing things they are good at and encouraging them to mentor others. Contented types likely prefer small steps forwards rather than taking the lead in major new projects.

Striver Type

Strivers acknowledged a sense of meaningfulness from the self-transcendent aims of their profession, but emphasized the constraints imposed by the structure of work that failed to draw upon their personal strengths, thus thwarting self-actualization. People who experience self-actualization are not just content with their employment, but view work as providing an opportunity to be personally fulfilled (Lepisto & Pratt, 2017). Not being fulfilled was a concern for Strivers: callings involve work that matters a great deal to people and is rooted in their values, and strong emotions occur when events interfere with the realisation of those values (Schabram & Maitlis, 2017).

The positivity inherent in the idea of living your calling fails to acknowledge the effort in identifying and pursuing your calling (Berg et al., 2010). For Strivers, the inability to pursue what they were meant to do resulted in regret and stress. Literature reports how individuals respond differently to workplace challenges, ranging from passive acceptance, withdrawal, and sabotage, to active and creative job crafting (Schabram & Maitlis, 2017). Strivers may pursue alternative work if organisations are not able to support them effectively.

Strivers had hope. They were trying to grow and develop, but constantly getting stuck,

even when they were doing “next level’ things it was not satisfying. Strivers sought external recognition, to be acknowledged by others, particularly at managerial level. Although Strivers can be highly knowledgeable, skilled and willing to share, their somewhat negative attitude may prevent more junior staff from approaching them as experts. Managers who can help them think around their constraints and work with them to identify alternative ways forward would support the development of a positive, more fulfilling, approach.

Over It Type

Over It AHPs were exhausted, felt the pressure of organisation and social factors and, instead of these instilling devotion to work, they resulted in anger and disappointment. Work devotion, a sense of the meaningfulness of the organisation’s work, has been found to decrease a sense of overload for professional women, but was not present for Over It types (Blair-Loy & Cech, 2017). Hands-on work with clients could still be rewarding, but frustrations of the system were too much for them – one felt trapped at a low level, and the others struggled with the volume of work and bureaucracy that impeded them from practicing with the depth they would like. They did not fit within the model of practice they were being asked to provide and they had been unable to craft the job to increase meaning.

Importantly, Over It types were not enthusiastic to leave their profession; they were not cynical about the value of their profession or what it could offer. They held an idealised view, believing their profession was important but their work was not currently seen positively as a job, career or calling; instead possibly their work reflected a failed calling, or a calling that was not successfully enacted (Berkelaar & Buzzanell, 2014; Kolodinsky et al., 2017). Literature has reported psychological distress and lower meaning if people are unable to pursue their calling or make too many sacrifices in pursuit of it (Ward & King, 2017). Similarly, as generativity increases, a search for meaningfulness is also more likely with

thwarted goals leading to moments of lower meaning and satisfaction. Over time, this may spiral downwards and result in workers who are disengaged (Ward & King, 2017).

In turbulent employment environments, calling discourses might compound loss. To leave a calling rather than a job requires individuals to recreate themselves and tell their story in different ways to maintain credibility with their professional communities. While Strivers had energy to keep trying to move forward, Over It types were prevented by their lack of energy. Low energy and fear of identity change can cause people to stay in their work despite the negatives (Berkelaar & Buzzanell, 2014).

Over It types may be in an emotional state akin to grieving. Compassion and recognition that there is nothing wrong with them because they feel low about their work may be of benefit. It might help to recognise that at some point the work became unfulfilling. Acknowledging and supporting the person to take action might involve recognition of an identity change (Berkelaar & Buzzanell, 2014). One of the major complaints of Over It types was “useless managers”, those who did not seem to acknowledge their presence or skills. One person reported a total clash with her manager: if the immediate manager is perceived as part of the problem, the organisational leadership needs to recognise this. Similar to Strivers, the attitude of Over It types is unlikely to be inspiring, possibly causing junior staff to avoid those who seem over-burdened and unhappy, and therefore preventing any opportunity for Over It types to share their knowledge and skills. Over It types therefore need additional support for their own benefit and also for that of the organisation.

Implications

A successful, sustainable workforce needs ongoing support. In NZ, the Ministry of Health (Te Pou o te Whakaaro Nui, 2017) workforce development framework supports practices that ensure the workforce has the right capacity (number) and capability (knowledge

and skills) to deliver services. This recognises that retention can be promoted through development activities such as clinical supervision and working alongside experienced staff. Our findings suggest that the current workforce development framework is not fully enabling AHPs to be recognised for successes and supported to thrive. The typology presented here provides an alternative lens through which to assess the development and sustainability of the highly-experienced AHP workforce.

The typology could support AHPs to work to "top of scope" of practice (Te Pou o Te Whakaaro Nui, 2015). By developing new roles and ways of practicing for AHPs, workforce capacity and effectiveness can be optimised at a systems-level, which could suit Achievers and Strivers. Practitioners with extended and advanced scope roles require further theoretical and practical training (Thompson et al., 2019). Policy, provider, and service environments need to support these new roles and practices for success, particularly given the known challenges around role clarity and professional boundaries (Baker et al., 2011; Kim et al., 2017). Supporting top of scope requires validating and maintaining best practice. Working to top of scope offers enhanced opportunities and capacity for practitioners to use specialised knowledge and expertise in a way that benefits clients and their families, and makes efficient and adaptive use of existing resources in a collaborative and ethical manner.

Limitations and Future Directions

Semi-structured interviews including critical incidents provided valuable data for analysing the work orientation of AHPs in the current study. The resulting typology synthesises existing research and new data to create a new categorisation of work orientation amongst skilled health practitioners (Cornelissen, 2017). The multidimensional typology presented here contains cases that have systematic regularities which allow them to be grouped and contrasted with other cases (Collier et al., 2012). These contrasts and comparisons are abstractions rather than specific details of individuals, enabling patterns to

be highlighted, but not showing individual differences or causal effects (Stier et al., 2001). The typology is a conceptual starting point for future quantitative study of how work orientation relates to expert-level performance, for example by comparing types with personality factors and measures of performance.

The typology and its overarching construct, work orientation, is subject to change as further theory and analysis offers new insights (Collier et al., 2012). It presents types created from data taken at a moment in time and therefore does not claim to represent a trait, or enduring work orientation. Further research, is needed to explore further how work orientation changes over time. Measures of meaningful work and job crafting along with wellbeing and satisfaction measures, could establish whether AHPs can change across types over time, and how this relates to role and setting. Evaluation using latent profile analysis could provide empirical data supporting this typology of work orientation and strategies to support the development of expert-level performance.

The skewed population of interviewees, with a high proportion of SLTs and a high proportion of AHPs working with children could result in a typology that is not a good fit for other professional groups, and further research is recommended before the typology is generalised. Similarly, although the NZ context is unique in its geography and demography, and its publically funded health and education systems, the typology is constructed from stories of interviewees that have lived and worked across the world in English and non-English speaking countries. Diverse work orientations seem likely across different professional groups, countries and settings.

Conclusion

The views of highly-experienced AHPs have been integrated with literature on expert-level performance and meaningful work to create a new typology of work orientation. Four

types are characterised capturing the diversity of the workforce, particularly in relation to past-focused personal fulfilment and future-focused ambition. Whilst AHPs have technical skills, autonomy and task significance as underlying components of their work, not all AHPs found their work meaningful and fulfilling. A majority had a Contented orientation, characterised by transcendence, satisfaction with prior successes and a view to continuing to work in their profession in the future. Achievers are self-actualised and transcendent, and are likely to be already known as experts by their peers. This is consistent with the view of expertise as being embodied in performance. Given the value of expertise for patient outcomes, this typology is useful in providing an alternative lens for understanding expert-level performance amongst the highly-experienced workforce. By revealing the contrasting experiences of the four types, through the contrasting past versus future orientation combinations, the typology sheds light on possible barriers and enablers that support highly-experienced practitioners towards expert-level performance, with positive consequences for both clients and the entire AHP workforce. Once recognised, practitioners of each type would benefit from different supports from colleagues, managers and their communities.

This chapter has focused on understanding highly-experienced AHPs' approach to work through a grounded theoretical approach. The next two chapters take a different analytic approach. Critical incident narratives extracted from the interviews are the data for an expanded critical incident analysis, which provides a landscape of the conditions in which highly-experienced AHPs carry out their work. A performative narrative analysis then looks in detail at the identities highly-experienced AHPs pursue within those conditions.

Chapter 7

Understanding the Identities of AHPs through Narrative Analyses

In Chapter 1, the existing literature regarding experts was found lacking in its ability to explain the roles of expert AHPs in the current context of NZ. In response to this, Chapter 2 presented the survey data of SLTs where we created a modern construction of an expert practitioner. Importantly, the survey showed that experts were in demand but not always visible. To be considered an expert, the highly-experienced and knowledgeable practitioner needs to have a positive reputation within their community developed through sharing their knowledge and skills with that community (Emelo, 2012; Jackson et al., 2017). Expert AHPs additionally are active learners, reflecting on mistakes, noticing gaps in their knowledge and actively seeking new knowledge (Alderson, 2010; Ericsson, 2008).

Creating an Identity as an Expert Allied Health Professional

Simplistically, by belonging to a community, and successfully sharing knowledge, skills and experience with that community, highly-experienced practitioners can co-construct an *identity* for themselves as an expert. Identity is a meaning that individuals attach to themselves, often represented in a narrative (Dutton et al., 2010). Identities are an ongoing process, they are multiple, relational and dynamic, "always in a state of becoming" (Kourti, 2016, p. 170). Narratives about professional life become embodied in professional identity (Loftus & Greenhalgh, 2010). Professional identity emerges from interaction between personal identity and collective professional identities through social relations (Payne, 2016). Considerable literature has been written about the development of professional identity in becoming a health practitioner (Best & Williams, 2019; Clandinin & Cave, 2008; Dutton et al., 2010). Much less is written about developing an identity as an expert health practitioner.

In Chapter 3, the review of the literature revealed how professional confidence can influence the knowledge-sharing behaviours of practitioners, even those with proven competence and substantial experience (Jackson et al., 2019). Confident practitioners, who readily share knowledge and skills, could develop an identity as an expert AHP. Within a community, confidence can be nurtured or threatened, and consequently a practitioner's identity as expert can be fulfilled or quashed. Successful interprofessional working can build confidence in an individual's own professional identity (Clark, 2014). On the other hand, a limited capacity to fulfil their expected role either through a clash of boundaries with a practitioner from another profession, or through a lack of resources (equipment, time or evidence-base) can lead to low professional confidence (Hsu et al., 2006). Of particular concern is that ambiguities of role and scope of practice are the most frequently cited sources of conflict in health organisations, yet also work to diminish confidence (Kim et al., 2017). Interprofessional practice requires a practitioner to know their own scope of practice and be comfortable exploring the overlap with other professionals (Williams & Lawlis, 2014). When the status and significance of a whole profession is questioned, by other professions or by an organisation, practitioners may question their own role in the organisation and their ability to contribute (Canrinus et al., 2012; Weitz, 2017). Where threats to scope, role and significance are present, practitioners may lose confidence and question their professional identity (Alves & Gazzola, 2013; Duchscher, 2008; Holland et al., 2012a). In turn, where professional confidence is threatened, this seems likely to reduce knowledge sharing behaviours, resulting in poor visibility amongst the professional community and further restraining a practitioner's identity as an expert.

Confidence develops through reflection on all kinds of experiences, not just positive ones (Clark, 2014). For example, actively reflecting upon negative experiences promoted resilience amongst nurses given time and encouragement from their seniors; the combination

of negative and positive affirming experiences enabled the cohort of nurses to move towards greater confidence (McMullen et al., 2014). Similarly, occupational therapists with more years of experience in the workplace reported that reflecting on negative experiences was useful in building confidence (Wilding et al., 2012). The reframing of these negative experiences added positively to the identities of these practitioners.

Critical Incident narratives of challenging and affirming experiences form the basis of the analyses reported in this chapter and Chapter 8. The aim in this chapter is to describe some of the social contexts in which highly-experienced AHPs work, using the expanded critical incident approach of (Hughes, 2012). Developing an identity as an expert AHP occurs in a social context, and practitioners need to present an identity that best responds to the needs of the current social context (Kourti, 2016). Chapter 5 showed that the AHPs interviewed for this research worked in a diverse range of organisations. They were client-facing, and often worked in more than one team, thus having frequently changing social contexts at work. An AHP may work in numerous different teams, many often assembled for a specific task or for a client's specific needs (Morley & Cashell, 2017). The expanded critical incident approach, reported here, focuses on human experiences and the interactions of people (Hughes, 2012). It provides a way to describe broadly the social contexts in which AHPs might construct an identity as an expert. Expanded critical incident analysis is used here to give a breadth of understanding, providing a window into the social contexts of AHPs at work in NZ. The broad picture is the background that contributes to a greater understanding of the detailed case studies using performative narrative analysis that follow in Chapter 8.

Using Narratives to Explore Identities in the Workplace

Narrative and identity are closely connected, with narratives or stories seen as a primary form of self-expression, revealing our multiple identities (Frank, 2012). The

constructionist view of identity means that different and contradictory identities can co-occur within the same individual (Barreto & Ellemers, 2011; Søreide, 2006). Analysis of narratives shows how storytellers create and represent their selves, both their actions and their knowing. Narrative analysts consider that our stories make us into who we are reflecting our identities through a process of creation, re-creation, negotiation and reward (Bruner, 1994; Schiffrin, 1996). Narratives provide the opportunity for the speaker to *hold one's own*. "By holding one's own, I mean seeking to sustain the value of one's self or identity in response to whatever threatens to diminish that self or identity" (Frank, 2012, p. 22).

Social work and nursing researchers have used narrative analysis to identify meanings and identities their clients hold (Rebman et al., 2017; Sheilds et al., 2015; Swift & Dieppe, 2005). Researchers in organisational and management studies have used narrative analysis to investigate the identities held by health service leaders and managers (Gabriel, 2015; McKenna & Richardson, 2003). There has been very little narrative work focused on the identities of client-facing health professionals themselves, a group of substantial size and significance within the workforce. A narrative study of both physicians and nurses highlighted the identity management strategies that health professionals used to maintain a positive professional identity in the face of conflict, but did not include AHPs (van Os et al., 2015). Kourti (2016) provided a methodological approach for using personal narratives to explore the multiple identities that health organisation workers held (organisational, professional, collaborative, personal) but presented support for narratives as a methodological tool rather than offering specific insights into identities held by workers. The theoretical and specific applications of narrative analysis are of benefit across the diverse workforce that constitutes allied health. Narrative analysis can show how AHPs construct identities in their workplaces amongst their colleagues and clients, and how they display their identities as experts (Barreto & Ellemers, 2011; Greenaway et al., 2016; Schiffrin, 1996).

Method

Chapter 4 outlined the methodological background to this interpretivist critical pragmatist study and specific detail is included here to extend on the methods used. Details of the interviewees are reported in Chapter 5.

Critical Incident Narratives

Critical incident narratives are stories of events. Each incident is critical in the sense of being significant rather than specifically a crisis or emergency. The event might change the way a person is: it is transformative (Fook et al., 2000; Fridlund et al., 2017). Incidents may be mundane, a highlight or a low point. For example, the realisation of ordinariness maybe a turning point and therefore transformative (Ferguson et al., 2010; McAllister et al., 2006). Given the theoretical connections between professional confidence and expertise and the ability of narrative to situate experiences, I collected critical incident narratives of affirming and challenging experiences reported by highly-experienced AHPs. Incidents were explored according to elements of professional confidence to provide context using expanded critical incident approach (Hughes, 2012). Then, I used performative narrative analysis to examine ways in which experiences were narrated (Riessman, 2008). In situations of change, conflict and affirmation, how do AHPs construct their identities, particularly in relation to the identity of expert?

Data Collection Process

Critical incident narratives occurred during the interviews with 45 interviewees. Existing research suggests interviewees need time to identify the incidents and hence the key questions were sent out a week in advance of the interview (Flanagan, 1954). I used reflexive journaling throughout data collection and analysis, as the basis of regular discussions with supervisors to increase the rigor of the data analysis (Levitt et al., 2018). A criticism of

narrative inquiry is that researchers pay little attention to the local context of the narratives, despite considerable attention to societal context (Riessman, 2008). This criticism includes a lack of attention to institutional constraints, power relations and cultural discourses. As a response to these criticisms, I conducted all the interviews myself, accuracy checked all the transcripts against the recorded interviews and made considerable notes on the context of the interview itself, such as the time of day, as well as gathering historical information about the interviewees in regards to their education, work, travel and family. This adds richness to the data collected.

Identifying the Critical Incident Narratives

Between them, the 45 interviewees provided 104 critical incident narrative cases. Each critical incident is a *case* for the purpose of analysis. Critical incident narratives arose within the semi-structured interviews that covered several career-related topics. Utterances from both the interviewees and myself as the interviewer, were transcribed and included in the narratives for analysis, consistent with an understanding of the interview as co-constructed.

I read and re-read the transcripts to identify narratives and the process of identification is described here, as suggested by Riessman (2008). Where I directly invited the interviewee to tell a story that was considered the start of the narrative, for example, “tell me about a case or client that was challenging.” The end of the narrative was typically identified by the interviewee making a summarising statement or a broad statement about possible future directions. Where a story was not directly solicited but arose spontaneously in conversation, then I searched the transcript for language that indicated the beginning of the story, and likewise for the end. If I had signalled the end of the story with a “right, moving on to the next thing” type utterance, then that was taken as the end. However, I read the remainder of the transcript, as some stories were continued or picked up again later on and

this content was included in the story. Where stories were harder to pick out, I looked for linguistic markers such as use of first person: “I did…”, “I thought…”, “I saw…” My talk was included in the story and the story was not “tidied up” beyond the initial transcription.

Some interviewees gave stories that were clearly about a single incident whereas others were more generic, not relaying a single incident but grouping together feelings and situations with no or minimal specific details. These cases have been included in the narrative collection, as they still convey a message. In these narratives the interviewee may have been protecting themselves or the clients by excluding specific information.

The analysis of critical incidents described here provides insights into the conditions in which AHPs tell their narratives. Chapter 8 will explore particular narratives more deeply and draw together the findings from both approaches.

Expanded Critical Incident Approach to Analysis

I entered the critical incidents into QSR NVivo software (version 11) for storage and to aid analysis. Multiple analyses of the critical incident narratives were carried out and are reported – quantitative and thematic analyses of all the incidents are reported in this chapter, and performative narrative analysis of a selection of the incidents in the next chapter. Multiple analyses offer different insights that can be complementary. The quantitative and thematic critical incident analyses provide a contextual framing for the subsequent case-based analysis.

Critical Incident Technique involves an iterative analytic process that is concurrent with data collection (Hughes, 2012). The analysis was informed using the expanded critical incident approach of Hughes (2012). Two different categorisation strategies were used, one being quantitative and one thematic. The quantitative (often known as binary) categorisation identified more concrete or factual details, for example: whether the work was in or outside

of the practitioner's scope of practice. The thematic analysis describes more nuanced categories or themes across the collected incidents.

Quantitative Analysis

The quantitative analysis might appear odd in a largely qualitative study, but it provides a backdrop, a description of the critical incident narratives as a whole. I developed categories for the quantitative analysis prior to coding, influenced by prior theory, and I coded cases as a whole, rather than line-by-line. Coding was first at a semantic level, identifying surface meanings from the cases in order to organise the data (Kim, 2016). I coded all cases as either Affirming, Challenging or a Change of Practice: categories of experiences derived from the earlier Chapter 3 literature review on professional confidence. Change of Practice coded the cases that were ambiguous in their affect, but resulted in new or different practices according to the interviewees. I read and re-read the cases to code them rigorously. The cases were then all coded in relation to elements of professional confidence using five predetermined categories - Scope of Practice, Role Clarity, Significance of the Profession, Sufficient Resources, Competency and Knowledge - drawn from the earlier literature review in Chapter 3 (Jackson et al., 2019).

Thematic Analysis

Thematic analysis of narratives, primarily focuses on what is said rather than how or why (Kim, 2016; Riessman, 2008). An analysis of narratives describes more nuanced patterns of meaning across the collected incidents (Hughes, 2012). Thematic narrative analysis shows commonalities and differences of themes across cases (Kim, 2016). It differs from the reflexive thematic analysis of Braun and Clarke (2019a) in that it aims to organise the data, as whole narrative cases, and maintains a more distant position from the interviewee which is useful in describing the contexts across cases (incidents) (Kim, 2016). Thematic narrative

analysis provides a community or societal level context rather than a narrative analysis which aims to help the reader understand how and why things happened the way they did for a particular protagonist (Kim, 2016). During the coding process, rather than changing the a priori categories of experiences as described above, new codes were created inductively to expand understanding of the nature of the experiences. New codes were generated and considered for all incidents. Codes were refined or collapsed where they overlapped, and were then grouped together under themes of affirming, challenging or change of practice experiences. The expanded critical incident approach combined quantitative and thematic analyses to provide a framework of inter-related categories in the data (Hughes, 2012). This framework is the context for the detailed case-based performative narrative approach that follows (Riessman, 2008).

After several re-readings, each narrative was also condensed into a very short summary, in order to capture the essence of the plot. These summaries are used to exemplify the categories derived in the analysis. This broad context described by the critical incident analysis supports the further interpretations of particular cases through performative narrative analysis (Shukla et al., 2014).

Findings

Two overarching themes are explored here: Categories of Experience and Elements of Professional Confidence. There are three Categories of Experience – Challenging, Affirming, and Change of Practice. There are five Elements of Professional Confidence – Scope of Practice, Role Clarity, Significance of the Profession, Sufficient Resources, and Competency and Knowledge. Table 13 shows where elements of professional confidence were positively present in different categories of experience. All three types of experience were narrated by the interviewees. Of note, a majority of Challenging incidents included resource limitations

and Change of Practice incidents were most likely to include a limitation of competency and knowledge.

Table 13

The Nature of Interviewees Experiences in Relation to Elements of Professional Confidence Positively Present in Critical Incident Narratives

	In Scope of Practice	Role Clarity	Significance of the Profession	Sufficient Resources	Competency and Knowledge
Challenging (n=43)	40	34	31	19	33
Affirming (n=45)	44	43	42	44	43
Change of Practice (n=16)	16	14	15	14	8
Total (n=104)	100	91	88	77	84

Theme: Categories of Experiences

The process of sorting of the incidents into categories of Affirming, Challenging and Change of Practice was complex. Stories told in response to a specific critical incident question were categorised accordingly. For example, responses to a question that asked about something that changed practice were categorised as Change of Practice. Whilst some unsolicited stories were clearly affirming or challenging, some were both affirming and challenging while some were neutrally conveyed, or had a complexity of emotion that resulted in a change of practice but could not easily be categorised. For the purposes of characterising the data, 40% of the stories were clearly affirming to the interviewee, determined by their own categorisation or comment, sometimes following a clarification prompt from me. A further 40% were clearly challenging, with interviewee comments such as “it was really tough”, and “I hope it never happens again”. The remainder were

ambiguous, with both reward and challenge present or no strong overall feeling in either direction. These were included in Change of Practice to recognise the transformative nature of the narrative.

Challenging Incidents

Whilst reading and re-reading the Challenging incidents for the thematic analysis, a differentiated view of the challenges was constructed from the data that offered alternative understanding of the nature of challenges. Five broad areas of challenge were developed from the thematic analysis:

- Resource limitations – due to lack of evidence-base/ literature, money, time, or obstructive service delivery models, what needed to happen could not happen.
- Knowledge limitations – Insufficient or inaccurate technical skill or knowledge to say "I knew what to do" in that situation. Poor clinical decision making. Often textbook knowledge was known but could not be successfully applied given the uncertainty or complexity of the situation.
- Communication breakdown – a breakdown in understanding/ negotiation led to a breakdown in trust/ relationships.
- Different family/ client priorities– the whanau/ client had different priorities to the practitioner, not primarily a communication breakdown.
- Team conflict – one or more people in the wider multi-disciplinary team - not the family or client - were at odds with the practitioner in regards to roles, responsibilities, boundaries ultimately seeming like a lack of trust between colleagues.

To exemplify the challenges, a selection of narrative summaries are shown in Table 14. These challenges are similar to the threats discussed in Chapter 3 in relation to

professional confidence (out of scope of practice, role ambiguity, low status of the profession, insufficient resources, low competency and knowledge). Importantly, the interviewees differentiated the sources of threat as being from both the multi-disciplinary team and the family and client. Analysis also resulted in communication breakdowns being separated from knowledge and skills limitations.

Table 14

Exemplar Narratives that Highlight the Nature of Challenging Critical Incidents

Challenge	Exemplar
Resource limitations	Eventually, I got an interpreter because there was one in the corridor and so I grabbed them out of chance [P47]
	The parent made a complaint as there was no input whilst I was sick. As if I wasn't allowed to be sick, I was meant to be everything and superhuman [P41]
Knowledge limitations	I followed the evidence down a particular track but it didn't work, and I didn't like what I had done [P39]
	I got my hypothesis wrong but at least I could talk to people about it and work it out. It felt awful [P20]
Communication breakdown	There was a clash between what I thought and what the parent wanted. We needed mediation. I didn't have the communication skills to work through it [P23]
	I made an assumption the client would communicate with their family and they didn't. I was shocked when the family were angry with me [P38]
Different family and client priorities	We were eventually able to get the family to take the child to pre-school, but they didn't turn up for any therapy appointments, it wasn't a priority for them [P10]
	The legal situation meant that the foster mother couldn't make decisions about the child's care and my team made a decision that she didn't agree with [P04]
Team conflict	Something I said that just wasn't taken on board by my colleagues and things went wrong for the family [P37]
	I was so unsupported. My managers thought I should be working like a teacher, not a therapist [P32]
	The manager decided that nurses could make changes to client's diets, without consulting me with my specialist knowledge [P01]

Affirming Incidents

Thematic analysis provided two types of affirmations – positive feedback and positive impact: impact being something they could see for themselves, feedback being something other people provided to them. Feedback came from the interviewee's team including colleagues or managers, or from clients and their family. The impact was similarly on colleagues or managers but most commonly was on the clients themselves. Positive impact was typically described without the overt feedback of others and highlights the practitioners' attention to outcomes and their use of reflective practice. Where there was a positive impact, stories could typically be summarised as "I knew what to do for the client and it worked". Exemplars of narratives are shown in Table 15.

Table 15

Exemplar Narratives that Highlight the Nature of Affirming Critical Incidents

Nature of affirmation	Exemplar
Positive feedback	
Team	A manager saw that my supervision practice was beneficial and acknowledged me for it [P42]
Client and family	I received wonderful feedback from a client when I felt I hadn't done enough or got where I had wanted to get [P37]
Positive impact	
Knowledge	I followed the evidence-base and other people asked if it was working and I saw that it was [P38]
Team	The paediatrician heard my view and I was able to put forward a possible diagnosis even though it wasn't really my job [SLT41]
Client and family	I was able to advocate for the mother, even though it was a difficult situation, and she did a really good job with her little one [P04]

Change of Practice Incidents

Incidents that were categorised as Change of Practice, were nuanced and complex, but not entirely different in nature from those described above as affirming or challenging, They involved the same characters of the team and the client and family. They also involved issues relating to resources, knowledge, skills and communication. However, they involved a mix of challenging and affirming situations, or were interpreted differently. Some situations were vicarious. For example, P08 described a client and professionals meeting where she was an observer but saw the family "railroaded" into a decision and this motivated her to develop her communication skills and take on a more family-centred approach. In this incident, she witnessed a communication breakdown between others, but the desire to improve her own practice was the dominant expression rather than reporting a direct challenge to her own skills. Other incidents described by interviewees as changing their practice, but not being obviously affirming or challenging included situations where they learnt something new unexpectedly, directly from a client, or from a personal situation outside of work. P33 recounted how having her own children changed how she related to parents that brought their children to therapy, and changed how much capacity for homework she expected the family to have; a story told by several interviewees.

Theme: Elements of Professional Confidence

Professional confidence is a dynamic personal belief in different elements that make up a practitioner's professional identity: belief in the role, scope of practice and significance of the profession a person is practicing in (Holland et al., 2012a). Incidents where belief in one or more of these elements is threatened could create circumstances for low confidence. Challenging incidents presented greater threats than affirming incidents, as might be expected. Thirteen incidents involved multiple threats to professional confidence. Challenging incidents often involved a shortage of resources but in nearly half of the

narratives, this was not of concern. Four narratives classed by the interviewees as Challenging did not include any of the anticipated threats and instead reflected a personal clash with either the team or the family they were working with. Unsurprisingly, most affirming incidents had all professional confidence elements positively present, although seven had some potential threats present. These seven potentially negative situations are valuable to keep in mind as they reflect the ability of the seven different narrators to gain affirmation in spite of these shortcomings. The elements within professional confidence are discussed here for all cases, and the potential threats are highlighted.

Scope of Practice

Most of the narrated incidents were situated clearly within the practitioner's scope of practice, suggesting most interviewees clearly understood and believed in their scope of practice. For example, P37 said:

> And [I] was able to challenge that [clinical decision], and not just once but several times, but at the end of the day, the doctor made the final call, and you know, at the end of the day, he's the responsible medical officer. And I think I did, I feel I did everything in my scope to do that.

A potential threat to confidence was present in four narratives. In two incidents the practitioners temporarily took on extra roles outside of their professional scope – one person purchased prescribed medication for a client who did not buy their own, another pursued acquiring a piece of technical equipment that was not for her own profession's use. The other two incidents arose from situations where the practitioners had acquired new skills and knowledge, such as sensory integration skills or behavioural approaches, and were using them in their practice but others in their workplace and their professional community questioned whether this new work was within scope. The interviewees framed these incidents

differently with one being an affirming situation and the other three were challenging. The purchase of medication for a client was an agreed action, decided upon by the work team, whereas the other three stories suggested that the interviewee had a different view of their scope of practice to the others around them. There was little agreement from the wider team about the extent of their scope, and they had overstepped the perceived boundaries, as P06 told me:

> I've been hammered so much for being accused of stepping out of my scope cause [of what] I took on, but I was supporting my colleague who wanted to be doing this way of working. We thought this was good, and I thought I did have that management approval from her direct person but the high powers thought we hadn't, um, consulted with every single profession that was involved.

Role Clarity

Thirteen narratives involved a conflict or ambiguity of role, typically involving others from one or more different health professions, but not all these were reported as challenging incidents. Broadly, colleagues from other professions did not include them, they were left to do the work alone, or they themselves were not clear of their role in a situation. Examples of exclusion include practitioners who were not included in a client's multi-disciplinary team, despite their relevant skill base and availability; incidents where managers gave work to other less-qualified team members from a different profession and people employed into new roles that were not accepted by the wider multi-disciplinary team. An example of exclusion came from P17:

> And there was a new position and there were a lot of people in the team, a lot of different professions, so that made it tricky. And I looked at some research that had been done in Australia and saw what OTs had done and felt really excited to begin

> with. But it was very hard to keep that energy going because I felt like every idea I presented either another discipline was like "That's our job, you can't do that"…. And were really nasty about it. Or they were like, "What", you know, "why are you thinking about that?"

In contrast to the last example, one interviewee a told story of starting a new job where they were the only person of their profession, and were seen as being able to take on all the needed roles, and thus were left to work alone by the multi-disciplinary team. The third group was characterised by practitioners with expectations that mismatched what the client needed. They expected they could do nothing and took a passive role when they could have been active, as well as the opposite where some felt they could resolve a situation and were active, when a resolution was not possible and their efforts were counter-productive. P19 told me how she had learnt about her role in providing hope, in a recent training:

> I would have said, "Oh, you know, it's not, you know, it's too hard sort of thing, and they're never going to get anywhere." But the team persisted with the [device] and even if the children didn't look at it all, and they just persisted and persisted, and like five years later, they would be using it…and you just have to really try to get the team and the parents and everybody on board to do it, and to use it and not to give up that hope, that it might happen.

This example shows how professional knowledge and the possible roles a practitioner might take on, are closely related.

Four narratives framed role ambiguity as a positive that provided opportunity for development. For example, one affirming incident was the setting up of a service where previously there had been none. Practitioners' roles were not clear in advance of setting up the service but became clearer through negotiation over time. The lack of pre-existing

boundaries allowed everyone to work together to do whatever needed to be done. P25 told me:

> They hadn't had a [therapist] before…And people would feel like… nobody feels like "Bloody hell, the [therapist]'s coming in here telling us what to do" sort of thing. So I feel, you know, it's given me some confidence and having had somewhat negative experiences in that sort of a way in the past, feeling oh well, actually you can affect some change in a way that everybody feels positive about and is happy with.

This interviewee told how she was not clear on her specific role when she was new to a particular job, but she got positive feedback from her colleagues, which helped her gain role clarity.

Significance of the Profession

In about one sixth of incidents, the significance of the profession was questioned, resulting in the practitioner feeling their profession was undervalued. This was often reported as a collective "we" were not included. A typical example of this is a professional group who were regularly not asked for their opinion about clients' diagnosis or prognosis even though they were on the hospital ward team. For example, P17 told me about the contrast between two multi-disciplinary workplaces she had been in:

> I mean they just value everybody. They value the fact that you need everybody to do their part to get somewhere. So I don't feel like there's anyone who is more important than another… And other places I've worked that really has not been the case. And yeah, at the hospital I definitely felt like OT was really the bottom of the heap, especially in the role that I was in.

These interviewees felt excluded, some were sad, others angry. Other narratives included threats from individuals, where a particular doctor, typically, had a reputation for

not valuing a particular professional group and this caused intimidation when the interviewee had cause to communicate with them. Most of the incidents where professional significance was threatened were described as challenging, although three had affirming outcomes. In these three cases, the interviewees overcame their concern and took action despite feeling threatened, with positive consequences for their self-belief.

Sufficient Resources

Consistent with prior literature, a number of critical incidents involved a lack of resources (Foster et al., 2014; Pring et al., 2012). Twenty-seven incidents were impacted or caused by, a shortage of resources and most were categorised as challenging experiences. These included shortages of hands-on staff, of money to purchase equipment, a lack of supervision and managerial support, and also included a shortage of time to do high-quality clinical decision-making, exemplified by P29:

> I've got a pile of readings to get to, but my role here is actually, is too full…In terms of some of the components of my role…really, I should have two days free of caseload, so that I could actually do justice to some other parts of my role or drop all the other parts of my role...

In addition, interviewees noted service delivery models did not match the evidence-based practice that the research literature recommended:

> So if I get someone with acute aphasia, I worry a bit, coz I think, "Oh no, I'm not going to be able to give them the time they need"… I haven't got that, I haven't got enough time for what the literature says [P31].

However, in one affirming incident a client complaint led to a substantial increase in resourcing which left a long-lasting positive impact on the confidence of the interviewee. Resource limitations were not mentioned in all other affirming incident narratives.

Competency and knowledge

In about one fifth of incidents, practitioners described issues relating to competency or knowledge. This ranged from a lack of knowledge that led to a problem, to how they had learnt valuable knowledge in a surprising situation. Ten narratives, categorised as challenging, were included in this category and highlight the stress and distress that insufficient knowledge and skills can cause, particularly when it results in poor decision-making that affects the client and family. One interviewee described how "you can slow down the rate of change by pushing too hard, by not pushing hard enough, and you've just gotta find the right pace" [P43]. Another commented that she "wasn't incompetent, but there's so many things we don't know". Learning new knowledge was often from an unexpected source. Some practitioners noted how having their own children had provided valuable insights into parenting that had transformed their practice. P33 said that becoming a parent had a big impact: "Nothing has had the same-sized impact as that. And sort of realising the emotional attachment as well as everything else. But how much capacity a parent has to do anything at any given time". Half the Change of Practice narratives included an element of knowledge acquisition. Change of Practice incidents including having to retrain in order to meet registration requirements, which was seen by some interviewees as a "blessing" [P29]. Attending courses on the edges of their scope of practice, for example counselling, also resulted in positive changes of practice:

> So it made me really reflect on, as a physio, what we feel comfortable with, like pushing children [to move], other people were like, "God, that mum, you know, she's not even available for love, coz she's so busy pushing that skill". Yeah, so it was really interesting…So that actually was a real aha moment for me [P18].

Discussion

The findings of the quantitative and thematic analyses are complementary. Working through both analytic methods, I could capture aspects of the diversity of interviewees narratives about their work. The nature of experiences and elements of professional confidence are brought together in this discussion.

Using the quantitative analysis, I found that mostly, affirming incidents would be clearly within the practitioners' scope of practice, have role clarity, support their profession as being significant and that the practitioner would report they were competent and adequately resourced, although not all affirming narratives were this positively geared. Similarly, some narratives that told of challenging incidents included clarity about scope of practice, roles and professional significance, and sufficient resources, but many had some elements of professional confidence missing, particularly stories told of insufficient resources and professional significance being undermined. Change of Practice narratives were noticeable for featuring challenges of competency and knowledge.

Using the thematic analysis, I explored the two themes of Categories of Experience and Professional Confidence in more detail. I identified that challenge came through resource and knowledge limitations – both threats that are expected to present challenges to professional confidence (Holland et al., 2012a). Additionally, communication breakdowns and differences between practitioner and client, and practitioner and team are important to consider.

The thematic analysis identified communication breakdown as a source of challenge, separate from Competency and Knowledge. Challenges came from all directions: organisation, professions, team, client and family, but in these narratives, communication breakdowns were often with the client and family. Communication might be considered a

core skill of an AHP, and is included as a required skill for entry-to-practice SLTs as well as other AHPs (McAllister et al., 2013). Effective communication skills between professionals can encourage parents to access childhood behaviour services (Koerting et al., 2013). However, my analysis suggests that in a challenging incident, the interviewee's communication skills were at times insufficient to resolve a situation. Communication breakdowns within professional teams are a known source of medical errors (Sutcliffe et al., 2004), as well as low success for the inclusion of children with cerebral palsy in mainstream schools (Bourke-Taylor et al., 2018). The data presented in this chapter suggest that with families, another challenge occurred when the practitioner and family had different priorities from each other, with or without a breakdown in communication. Communication between the professional and the client and family is essential for an effective therapeutic relationship (Lawton et al., 2018; Reeder & Morris, 2018). Reeder and Morris (2018) report on the importance of the therapeutic relationship in facilitating effective communication, highlighting a circular process.

The stories of challenge were consistent, emotionally, with those told previously by a cohort of social workers (Savaya et al., 2011). In that study, the cohort wrote narratives about their experiences working with families, expressing pain, frustration, and self-doubt that undermined their professional confidence. Challenging narratives told in the current study are also consistent with the challenges written about in the interprofessional practice literature, such as poorly negotiated professional boundaries (Baker et al., 2011; Pinder et al., 2005; Williams & Lawlis, 2014). Specifically, these can threaten the professional identities of practitioners within interprofessional teams (Best & Williams, 2019). Other specific challenges reported in the literature were also narrated here: a struggle with meeting the expectations of the evidence-base (Foster et al., 2015), and denial from government for professional regulation (Weitz, 2017; Williams & Koumenta, 2019).

Affirming narratives told of positive feedback that was either self-reflective or from others. In the current study, where threats to professional confidence were present, some practitioners were able to reframe their experiences as affirming, adding positively to their identity. Some AHPs found affirmation in the most complex and challenging of situations where roles were ambiguous and disputed, resources were lacking and they were personally vulnerable. Self-reflection and feedback from others were valuable resources that AHPs could draw on for affirmation, consistent with recommendations in the literature (Clark, 2014; Loftus & Greenhalgh, 2010; Payne, 2016). Reflection on both challenging and affirming experiences can build resilience to setbacks (McMullen et al., 2014).

Change of Practice narratives were clearly about learning, with the source of that learning being diverse. Sometimes, the learning was intentional, such as attending a course, but other narratives of learning involved outside-of-work events, such as interviewees having children of their own. These events were transformative in that they changed the perspective of the interviewee. Narratives of outside-of-work experiences offer information about interviewees as whole people, not compartmentalising their professional self, but acknowledging the broader context that they situate themselves in (Kourti, 2016).

The expanded critical incident approach is exploratory (Hughes, 2012). Therefore, the findings are descriptive of the interviewees and indicative, rather than predictive or generalizable. The findings might not represent the social work contexts of AHPs in general, but they do contribute to understanding about the strengths, challenges and needs an AHP might experience.

Conclusion

AHPs experienced a huge range of negative and positive emotional experiences. The AHPs interviewed here witnessed human suffering, abuse, ill health and injustice. The stories

told were examples of the numerous distressing, sad, disappointing situations the AHPs encountered. AHPs had challenging and supportive relationships with colleagues and managers. However, the AHPs also experienced partnership and collaboration, families that were attentive, responsive and committed to their own wellbeing; that followed recommendations to achieve a good outcome. These working conditions are contexts in which AHPs create and maintain their sense of self, their identity. Frank (2012) refers to these as *conditions of living*, the circumstances that lead people to tell certain stories in particular ways in order to maintain or create a desired identity: to hold their own. This broadly described context is the backdrop to the detailed narrative analysis in the next chapter.

Chapter 8

Performative Narrative Analysis

The categories of experience described in Chapter 7 showed the varied and complex working conditions in which AHPs construct their professional identities. In this chapter I look in more detail at performative aspects of the interview data, to gain insight into the ways in which expert identities might be constructed through communication and language, by AHPs. The analysis sought to discern how, in their narratives, the interviewees positioned themselves in their work relationships and work tasks, key aspects of identity (Best & Williams, 2019; Holland et al., 2012a; van Os et al., 2015).

I chose four cases out of the total 104 cases, for a detailed case-based analysis, to highlight different identities of AHPs in different scenarios, both challenging and affirming. The four narrative cases chosen here are from AHPs of different ages, in different professions, in different workplaces, facing different situations. The four cases were not intended to represent other narratives or other AHPs but were chosen because of their potential to inform our understanding of behaviours and attitudes as they relate to professional confidence and expertise. They are not exceptional cases, but the narratives were chosen after completing the expanded critical incident analysis, because they particularly exemplify ways in which identities can be constructed by AHPs. Stories can be seen as a life created through dialogue, and the researcher has power in selecting, rejecting or neglecting specific stories (Clandinin & Rosiek, 2007; Frank, 2012). In choosing the four specific narratives to analyse in depth, I actively sought situations that might be unresolved or in fact negative, to counter the concern that my choice of narratives might seem to support my

theoretical interests as the investigator, for example by only reporting positive instances (Frank, 2012; Riessman, 2008).

Narrative research considers how people talk about what they do, which can tell us about their identities, values and possible future actions. There is no one specific way to conduct narrative analysis; rather, the aim in this study was to explore how interviewees constructed identities of themselves as professionals (Nasheeda et al., 2019). Performative narrative analysis focuses on why stories are used (Riessman, 2008). Particularly we can ask why a particular incident is storied (Frank, 2012; Riessman, 2008). Performative narrative analysis considers that identities are dynamically constructed within relationships between people. Within this dataset, there are conversational turns between myself and interviewees that enable analysis of the co-constructed and performative nature of narratives (Shukla et al., 2014). During interviews, I speculated openly about the meaning of an interviewee's utterance and this reflexivity became part of the research data which was analysed (Riessman, 2008).

A case-based analysis focuses on the types of story interviewees told rather than a privileged insight or mindreading of an individual (Frank, 2012; Søreide, 2006). As a starting point, based on a study of work relationships and work tasks by van Os et al. (2015), I asked the following questions of the data: what individual or group characteristic is emphasized in the context of an incident? Is it possible to identify a comparison object, such as another person or group, a standard, or a point in time? What levels of identity are apparent in the narrative for example, personal, professional, and team identities.

Consistent with the view of narrative as a performance, I paid attention to particular word choices; thus words were not taken at face value but were interrogated for meaning (Kim, 2016; Riessman, 2008). Direct speech was highlighted as it shows agency and can be used to build credibility with the audience as well as communicate messages that are

otherwise difficult to describe (Schiffrin, 1996). Direct speech dramatizes the recount and suggests a commonality between speakers, in this case the interviewee and me. Conversational asides are used by storytellers to engage directly with the audience and I noted these. Additionally, I noted repetition of words and expressive sounds as they signal key moments or points of emphasis. The positioning of actors, or characters within the narratives was considered (Riessman, 2008). Riessman emphasises the work of Iser (1972) in talking about how meaning is not concealed within the text, but the text is increasingly brought to life with recurrent readings. To surface meaning, I read each narrative at least six times. As a change in the reader's circumstances can change the interpretation of the story, with each reading I made further notes. I have linked my interpretation to features in the text as well as information from the interview context, to increase plausibility.

To enhance rigour, a second member of the research team checked the four narratives and their corresponding interpretations. In response to her comments, my interpretations were modified and returned for further checking until we reached agreement.

Findings

Across all 104 incidents, interviewees mostly provided specific details, and only 13 narratives were generic. They tended to refer to incidents that occurred only once for example: "So a critical moment for me, it all happened at the same time" [P06], but interviewees also suggested there were multiple incidents, for example: "Do you want a tricky one or an easy one?" [P04], "It's probably a couple of patients" [P03], "There's a few" [P01]. However, a few interviewees struggled to initially think of specific incidents and then typically reported on events from very early on in their working life, for example, "Um, there was one when, does it matter if it was from a long time ago?" [P10]. The early career stage of these narratives suggests their significance in the formation of professional identity. All these

stories have been included in the narrative collection as the interviewees considered them important (van Os et al., 2015).

I present four narratives to retell here, chosen from the narrative collection of 104, to give voice to the interviewees' stories. I selected them to highlight different relationships and positioning of AHPs in different scenarios, one clearly affirming (Erica), the others presented as challenging by the interviewees (Leanne, Kirsten, Chloe). In the four retellings that follow, where possible, quotation of the interviewees' words are presented. Square brackets indicate words inserted for clarity. Ellipses indicate words omitted for confidentiality or brevity. Dash indicates overlapping speech

Erica's Story: "That's One Person That's Not Going to Pick on Someone Else"

Erica was a social worker who qualified after having her own children. She worked with the elderly at a large hospital, when I interviewed her. She was a dynamic and detailed narrator. She explained in detail how an elderly person was being abused in their own home, became very sick and was finally admitted to hospital. An important theme in her account of this affirming incident was teamwork. As part of the team, she was highly valued:

> Erica: Part of the team, part of the team. What I'm doing on the floor is very important and I know they miss me when I'm gone because I know I've got a lot of the knowledge and the skills and I can just go, go, go all the time.

In the incident, she knew what to do and was well connected to make things happen. Erica was instrumental in getting the person into a safe environment at discharge. She positioned herself as central to connecting the team of people that needed to be involved:

> Erica: Then the brother said… This is what the situation is, this is what's going on. And so I rang the agency to find out more. And they didn't realise that the person had actually moved in and taken over. I rang another family member to find out more.

Despite this central position, she included the team in her narrative, referring to “we” and using both “we” and “I” through the narrative. Although the team was involved, she took on responsibility herself.

> Erica: So, we ended up having a family meeting with the brother, [and his family] who gave me the bigger picture of things as well.
>
> Bianca: Right.
>
> Erica: And, um, we ended up activating the enduring power of attorney and getting her put into a rest home where she was getting cared for. So I knew I was getting one person safe.
>
> Bianca: Yeah, yeah.
>
> Erica: Safe, and cared for, and supporting the brother and he said at least someone’s listened. No one on the previous ward, no one anywhere has listened to us.
>
> Bianca: Has done anything.
>
> Erica: No one has done anything. No one has helped.

The repetition of “no one” emphasises the significance of her actions, contrasting them with others. For herself, the priority was keeping the person safe and she made a unique difference by listening and taking action to connect relevant family and services. Erica’s narrative of ensuring the safety of the elderly person and their family positions her as a strong and confident professional, with high standards and ethics. Once the elderly person was safe, Erica continued to address the abuse, acting on her strong sense of justice and caring:

> Erica: So, even the Police had done nothing about it!
>
> Bianca: Done nothing about it?

> Erica: So, so I thought well, you know, this is just not okay and ethically where does this sit? So okay, we've got the patient safe, the brother's a happy person and everything and he's doing everything, he's got a huge job on his hands. How do we get this person out, and is she going to do this to somebody else because living [there], she's going to pick on the next person and get another victim. So I thought, "No this is just not okay."

Once the client leaves the hospital ward, Erica is usually no longer involved, but in this case she was able to use her close connection with a local agency to make further difference. Erica has a social network as a resource. She used the manager's first name in her recount, to emphasise the relationship power she was bringing to the situation, even though the person was unknown to me:

> Erica: And so I got [agency] involved and I said, "[first name] do you want to know about this situation? This is my emails, my evidence on this. Do you want to know what's going on? Because I think this person needs to be struck off..."

The incident narrated was one of several similar situations for Erica. The incidents were complex legally, ethically and logistically. They were also emotionally tiring. She acknowledged the training she has had that has been invaluable and ultimately, she needs time to think things through for herself:

> Erica: Um, I've had similar ones like that too, where I've just had to be really clear, really think through, what's the outcome I want to achieve?

Leanne's Story: "The Sense of Failure"

Leanne was a dietitian working in the community. She had qualified after high school and this was her third job. Central to her recount of a challenging incident was her ongoing

struggle to have a positive impact. As a confident and knowledgeable practitioner she wanted to make a difference:

> Leanne: Um, I think it's also feeling more confident because when I was younger I felt like I was too young to be telling people what to do, or advising people or counselling people on life issues, complicated life issues.

Leanne told a generic story about "a couple of patients" who were obese. A technical solution was available to help them – bariatric surgery, but it was often not funded. Her story was one of being competent but constrained. Her use of repetition and direct speech from the client emphasised her shared sense of unfairness and frustration. Initially, she reported how the situation was for the clients, but on questioning she revealed her own feelings, part of a larger picture of sadness.

> Leanne: Um, so you're basically starving them to get them to lose weight. Um, but yeah, because of not being able to do exercise because of bilateral knee arthritis or, um, or back pain from spinal damage or something, um, so, yeah it is really challenging. Especially cause, I might see someone for two or three times, and give them healthy eating advice and if they don't lose any weight and they will say, "this is very disappointing" because they've been trying really hard, they haven't let themselves have takeaways, they haven't, well sometimes they do, but they haven't let themselves have snacks and things like that, and they say "I've tried really hard this is so unfair. I haven't lost any weight" and [I] just have to say, "well actually it is the case for a lot of people who are in the same situation um, it is just the weight that, when you get to that weight it is very hard to do any exercise and metabolism is very slow. Um, and the healthy eating just isn't going to work for weight loss." So it is very disheartening for them.

Bianca: And how is it for you?

Leanne: It's the, the sense of failure or you take on their disappointment. Yeah.

Bianca: Because you can't, there isn't really an alternative-

Leanne: You can't help them, no.

Bianca: -that's actually going to make a difference

Leanne: Yeah

She framed the situation in two contrasting ways. Individually, the work seemed clearly within her scope of practice, and her role was clear but ineffective at times. The evidence-base and service delivery models were insufficient to make a difference and this led to a shared sense of failure with the client. Leanne used direct speech to convey her competence and to give credibility to what she knew, but the conversational aside suggested resignation as even that option was not ideal:

> Leanne: I will say to them "if you are willing to use the meal replacement drinks I'll support you with that", and they also have to be able to afford the meal replacement drinks

However, as a professional abiding by a code of ethics and an employee of a large public health organisation, she took on some responsibility for the problem, placing herself with the organisation rather than with the client:

Leanne: Not [here], we don't do many surgeries, they often get refused

Bianca: Right, because they're not well enough or-

Leanne: We just don't fund it-

Bianca: -just haven't got the

Leanne: -we put our funding in different areas

Leanne's unhappiness with the options available and lack of effective solutions for her clients were the focus of this story. By placing herself in the organisation, and not against it, her lack of power to make a difference could be absorbed by the substantial power of the organisation, but her disappointment was palpable.

Kirsten's Story: "The Class that Broke my Heart"

Kirsten, a speech-language therapist, thoroughly engaged with the research process and prepared a document especially for our conversation. She was clearly proud of the special school where she worked and enjoyed her work with children with complex disabilities. She was an active learner and told me she needed to be at least one step ahead of the other staff she consults to. She actively used social media and sought out information in order to keep herself abreast of new developments. She stated a clear view of herself as being an experienced and knowledgeable therapist now, having been in a state of anxiety and feeling helpless for a while when first in the job more than 20 years ago.

As a person who pushed herself outside of her comfort zone, Kirsten was very aware of her own substantial skills and knowledge but was also not afraid to ask for help. She readily included her team in her story. Kirsten had a story in mind that she wanted to tell me about "the class that broke my heart". Kirsten was passionate about her work and the children, and compared herself with a particular class teacher who "refused to relate to any of her [children]". In the incident recounted, in keeping with Kirsten's openness to seeking help to resolve issues, she sought supervision with a colleague who suggested an approach that was effective.

Kirsten: Um, and we sat down and we talked about this class and the lack of interest from the class teacher, the lack of support from the syndicate leader who also pretty

> much told me, “Um, just don’t pressurise the teacher, these kids are [in the] too hard basket anyway”. So can you imagine the emotional impact. And I sat down with my [therapy] colleague um, and what she said to me was, “Pick one student who you think is most likely to make progress, and find somebody”, I don’t know if she said this or if that’s kind of what came out of the conversation but basically “find somebody to help you to achieve that success.” Um, and so I picked one student [with behaviour that was challenging]. Um, and [another therapist], who believed in her. And long story short, was able to produce video evidence to the mother that if you pushed through the [behaviours] your daughter does have the ability to communicate and you’ll grin from ear to ear with pride when she successfully does so.

Not only was Kirsten passionate about success for children, she also positioned herself as emotional and relational. Whilst telling me the story, she mentioned “I can feel myself about to cry now”. The sense of emotion in the room where we met was palpable as she continued with this very moving story. After only a short time working with this child, the child’s mother gave Kirsten feedback that she is still proud of and again she identified herself here as a life-long learner:

> Kirsten: That was one thing that her mum had mentioned in terms of you know, what were my daughter’s favourite things in her life? Um, and one of the things she said was one-on-one time with [Kirsten] and interacting with [Kirsten] is what she saw as (pause). So that [incident], that changed my career in the sense that I learned that you don’t just keep pushing and keep pushing and keep pushing, um, when you have no support.

Previously Kirsten would have kept pushing the class teacher to change her approach, but by making use of input from the wider team, and by changing her own focus as to what she could achieve, Kirsten had achieved success via another route. Despite the story of

success with the child and family, there was no conclusion or resolution of the initial conflict with the class teacher, nor success for the class overall.

The idea of pushing forward and working with the most challenging situations was recurring for Kirsten. She regularly took SLT students and pushed them as much as she pushed herself. She was on a journey and invited the SLT students to join her. Kirsten used "we" to include students and other staff in her team. In her narrative, she emphasised her caring and protective nature by having the particular student walk alongside her. She allowed the student into her world, whilst still actively maintaining her leadership. Her use of direct speech emphasises vividly how she framed this positively for the student:

> Kirsten: Yeah. And there are still some classes like that, that we are dealing with. But when my last student came for her placement I said to her at the beginning, "I'm going to give you a project that I would never, ever, normally give a student. It is not a student-type project, but what I want you to do is to walk alongside me in the most difficult class that I work in and what we are going to do is work together and develop some more strategies. We're not just going to whinge and moan. By the end of your placement you will have learned a whole range of strategies for dealing with that type of situation." And actually we had a really good outcome, and moved forwards, so yeah. So when you say, "I can see that you love your job" it's like "Yes, I do, mostly".

In the closing dialogue here, Kirsten re-emphasises her passion for the work, yet also acknowledges that this is not wholehearted. Thus, Kirsten loved her work yet concomitantly the experiences she had at work broke her heart. The theme of passion recurred throughout the entire interview, and she used present tense verbs to emphasise the passion is still present:

Kirsten: I'm very passionate about my job which, which can have positive and negative effects in that sometimes it's flippin' hard um but yeah, I'm very passionate about what I do.

Bianca: Yep. What, what is it that you love about it? Or that you're passionate about?

Kirsten: I think it is the sheer joy of seeing somebody who has no voice, um, discover and be able to express who they are.

As an AHP who was learning and reflecting, she concluded the interview with further indication of herself on a journey that had not ended yet. Her use of past and future verb tenses indicates the call to action she sees for herself:

Kirsten: I mean I think for me the most useful thing that's come out of this [interview] is the question that you asked me which I have never asked myself which is kind of like "where am I going?" Yeah, that's really made me think a little in terms of, because I said my mind always tends to think, to focus on one thing and training myself in one thing. And if that is where I'm going then I need to make sure that I'm taking opportunities, um, when they arrive. Yeah, to move myself in that direction.

Chloe's Story: "To Give the Patient the Best Chance"

Chloe was a speech-language therapist working in a regional hospital. She had collected diverse experience in locum positions outside of NZ. She now worked full-time with clients and had some leadership responsibilities. She was a specialist in an area of practice, swallowing difficulties (dysphagia), that she had come to love. She was a keen reader of the research literature. She did not always think of herself as the most knowledgeable SLT, but recognised that people come to her for advice. When she attended conferences, the information she gained mostly consolidated existing knowledge rather than being new to her.

During the interview, our discussion about learning and what she did when things got difficult, led to her telling a spontaneous story about a recent case. Initially the story was short: There was a difficult case, the client had severe swallowing problems and was eager to try different options. Chloe referred him to a national specialist centre where the SLT ended coming to the same conclusion as Chloe had done. Chloe made the referral because "I just felt I needed to exhaust all my options". The national specialist centre had been helpful in the past and Chloe often suggested to more junior colleagues to also make use of their help. In this brief narrative, Chloe was very committed to her client getting the best treatment and the relationship between Chloe and the national specialist centre seemed easy-going and open.

When prompted, Chloe expanded on her short story, and the desperation of her client became clear and Chloe in turn took on that desperation. She needed to provide hope in the face of a very limited prognosis, which she was able to do for a time by suggesting a treatment to practice, but over time this was insufficient:

> Chloe: So I just encouraged him to do that [treatment], coz it wasn't too distressing for him. It became more and more distressing, but… So I had, when the time was right, I can't remember exactly where, I had talked to him about the [regional specialist centre], knowing that he would have to fund that himself. But I talked to him about that and he was at the point, "Well I just want to try whatever I can –
>
> Bianca: Try every option.
>
> Chloe: -to be able to reach that goal" and I wanted to for his sake as well. So I, and I was very prepared if I'd missed something. I had that sort of "What if I have missed something that's really major here?" So I put the referral through and everything, and he went up there and yeah (pause), they, they, I can't remember exactly what they did,

but I think they did some [tests] and tried a few different things. But pretty much came back with (pause)

Bianca: The same conclusion.

At this point in the interview it became apparent that making the referral to the regional specialist centre was more difficult than was previously conveyed. Chloe had to prepare herself psychologically for having missed something in case she needed to protect herself later. Chloe highlighted her vulnerability and her willingness to make a referral for her client even though her reputation was at stake.

Chloe: So in a way it was good from the perspective that it confirmed what I, my management and my assessment and that I hadn't missed anything. But it was really awful. I was kind of hoping that they, that I had (pause)

Bianca: That they discovered something?

Chloe: Yeah, you know, you've put yourself on the line by putting your, going to the [regional specialist centre] as a therapist.

Bianca: Yeah you do.

Chloe: But then you, I wanted to for his sake. I just wanted to know that, coz yeah, just knowing what his future was going to look like.

Her reputation remained intact, but the news for the client was not positive. Comparing herself over time, what was different about her actions now was not a lack of fear, but she immediately positioned the client centrally and transcended herself.

Bianca: Do you think if that case had happened when you were newly qualified, you'd have dealt with it in the same way?

Chloe: Nope. I don't think I would have... But say I was a new graduate now, I think I would have been too scared to, thinking that "Well, what if I have got it wrong?"

Bianca: Yeah, right.

Chloe: I think if I go back to, I don't know (pause) I would have probably talked at length with my supervisor at the time and if everyone else was telling me to [make the referral] I would have done that. But it was my first reaction now just to think "Well, it's not about me it's about the patient" and yeah, "I'll do whatever that works for him even if" (pause) yeah.

At the end, she told me that she did not have a lack of skill or knowledge, but a shortage of the right resources. She recounted some great successes that her team were proud of, comparing these favourably as being on par with outcomes achieved by the regional specialist centre. She was able to reflect on these successes to be positive about her own ability. Here, she positioned herself, not only as skilled and knowledgeable but also as a champion for people's health, with ambitions and a big vision:

Chloe: Yeah. But when you've been around for (pause) And I think it's also knowing that we don't have the right equipment. Or not the right equipment, but we don't have as much as what the [regional specialist centre] has. So to give the patient the best chance that's what they need. And that probably comes back to ideally I'd love building a new hospital to be able to have everything at our fingertips. Wouldn't that be amazing–

Bianca: Yes, yeah!

Chloe: -if every place could just do that.

Discussion

Interviewees narrated themselves as knowledge bearers and agents of change: people who laboured and both triumphed and failed in difficult circumstances. They were committed to their clients and to the purpose of making a positive difference to the health and wellbeing of others. Narratives provided important insights into psychological coping and thriving in these environments. In these circumstances or *conditions of living* (Frank, 2012) AHPs told narratives of the need to belong, to make a difference and to be valued. Frank describes conditions of living as the circumstances that lead people to tell particular stories in particular ways in order to maintain or create a desired identity: to hold their own. Erica, Leanne, Kirsten and Chloe all used direct speech to convey their own agency in their narratives; they were not passive in the incidents. Their stories became vivid by using repetition and alternating verb tenses that again showed agency and underlined their cause. Use of present and future tenses emphasised a future perspective and call to action, rather than a focus on what happened in the past (Riessman, 2008; Schiffrin, 1996).

Whilst there are several motives for choosing a specific story and telling it in a certain way, the performative narrative interpretation presented here focuses on the way that AHPs stories are shaped by a need to find meaning in work relationships and work tasks (Baumeister & Newman, 1994). The search for meaning is seen as a basic condition of human existence; through narrative, AHPs are able to construct identities that are meaningful. Social identities are positively associated with need satisfaction (Greenaway et al., 2016; Søreide, 2006). Narratives can contain different needs for meaning: purpose, values, efficacy and self-worth (MacKenzie & Baumeister, 2014). These four different needs for meaning, described by MacKenzie and Baumeister after a substantial literature review, are different motivations that help people make sense of and find meaning in life. Purpose involves a perception that current life activity is connected to future events. Values are feelings that

thoughts and behaviour are good and right. Efficacy is a sense of control over events, often a belief that one is making a difference. Finally, self-worth can be accomplished through comparison with others. The need for meaning is a strong motivator for human beings to interpret experiences in ways that satisfy these four needs.

The narrative from Erica referred to the purposiveness of what she did. She took on a role that no one else had done. Erica made her client safe, and it became her clear purpose to do the same for others. The AHPs represent the morally good which, from a narrative perspective, frames them as the heroines in their stories (Gabriel, 2015), boosting their self-worth. Kirsten's narrative highlights her strong values of fairness and justice, and how she overcame the morally wrong actions of the teacher, for the good of the family. Similarly, Chloe justified exposing her vulnerabilities for the good of the client, transcending herself (Reed, 2009).

The narratives told how some AHPs made a difference with limited resources. Efficacy and a sense of control was communicated in this way. Chloe did what she could without the extensive resources of the specialist centre and was able to come to the same conclusions and recommendations for her client. She carried out work tasks for the benefit of the client, rather than her own identity protection. Although ultimately her therapeutic interventions did little to improve the outcome for the client, in her narrative her retelling of her actions could provide a sense of control over the uncontrollable. Chloe talked about what knowledge she shared with juniors, her courage in making a referral and that, while she knew what to do, she had to refer because she was limited by equipment, not knowledge. In this way she is able to hold her own and open up opportunities for vulnerability by prioritising the patient's needs (Frank, 2012).

Leanne had limited resources and little control over the options to support her clients. Leanne's story is one that reflects tensions between her view of ideal practice, her clients'

needs and limitations, and a resource-constrained organisation. Differing from the other narratives, Leanne has no other characters in her story: no support team, no senior colleague as a guiding light or manager as a protector. Leanne sided with her clients, and with her employing organisation. By taking on the burden of her clients, sharing their sense of failure, she sought to belong but there is recognition she is in the organisation, and this positioned herself differently to the client; her position was awkward and she did not really belong on either side. She wanted to position herself as someone doing a worthwhile job, but this role was not available due to situational constraints from both the client and the organisation. Instead of self-worth and a sense of efficacy, Leanne's narrative revealed her as being isolated, demoralised and low in motivation.

In contrast, Erica, Kirsten and Chloe could identify colleagues and a community where they belonged, and referred to those groups as "we". This was not without its tensions. Kirsten had some colleagues who were not part of her therapeutic community even though they were part of her workplace community. Chloe only had access to the regional specialist centre through a formal referral process, but could closely identify with her workplace community. Identifying colleagues and community required skilful communication and courage on the part of these interviewees and they found sufficient community to sustain a sense of belonging. There is considerable recognition that identification with social groups whether academic, community or political, has positive consequences for feeling capable and in control (Greenaway et al., 2015; Steffens et al., 2017). Kirsten had both a supportive supervisor and peers she could turn to for collaboration. Erica used her network to make a difference for both the client and other elderly people. These strong work relationships were put to positive use. Moreover, Erica, Kirsten and Chloe included junior staff and students in their narratives. Their willingness to share knowledge with colleagues and less-experienced staff was evident. The lesser experience of colleagues was not a burden but an opportunity for

involving more people in the community, creating a further sense of belonging by inviting and supporting others to join in.

The narratives presented here show the complexities and tensions of AHPs' work, resulting in successes and failures: navigating complex routes involving patients, families, different healthcare colleagues and systems to try and achieve successes, but sometimes failing in spite of valiant efforts. Beyond this, my aim is to explore how, in their narratives, the interviewees positioned themselves in their work relationships and work tasks. Initially I asked, "how do AHPs construct their identities, particularly in relation to the identity of expert?" Here I combine the findings of the expanded critical incident analysis (Chapter 7) and the performative narrative analysis (Chapter 8).

The broad context provided by the expanded critical incident analysis, included enjoyable, positive partnership and collaborative working as well as human suffering, abuse, ill health and injustice. Amongst the 45 interviewees, challenging incidents included narratives of resource and knowledge limitations, communication breakdown and conflict between practitioners and their teams, and with families. Leanne had limited resources available for her clients and no network or team to draw on. Chloe was limited by resources but worked hard to make a connection to other professionals who could provide what she could not. Kirsten's story began in conflict with both a family and another professional in her school. Amongst the 45 interviewees, affirming incident narratives told of AHPs making a difference and being recognised for it. As an example, Erica was able to make a difference for a family where no one else had, and she was able to acknowledge that for herself.

The practitioners talked about their work, and to varying degrees, non-work lives. For some, their personal lives were very much part of their work and resulted in changes in their practice. Additionally, they noted how the actions of others – their team, colleagues and clients - also led to them changing their own practice, either by seeing good or bad practices

in others. When practitioners are clear about, and believe in their role, scope of practice and the significance of their profession, they can readily find affirming experiences to reflect upon and recount to others. This positively contributes to their self-belief, promoting their confidence to be vulnerable and to share knowledge.

Where threats to scope, role and significance are present, practitioners may not respond to challenges so positively and might instead lose confidence. Leanne was restricted both by organisation financial decisions, and by patients who were unable to participate in exercise, which would otherwise form part of the recommended treatment. Leanne's narrative was one of isolation and a search for belonging, first aligning with the patients and then with the organisation but not identifying completely with either. A struggle to find a social identity through belonging can reduce a person's sense of meaning with negative consequences for well-being (Greenaway et al., 2015).

A sense of team, achieving successful outcomes for the clients, knowing what to do and acting in ways consistent with their values are important sources of meaning which can maintain the confidence of AHPs even in challenging circumstances. The social identities created by Erica, Kirsten and Chloe, in their narratives, satisfied multiple needs for meaning, consistent with previous findings (Greenaway et al., 2016). It was clear that they did not work in isolation. Erica, Kirsten and Chloe all drew on their networks to help them find solutions. They framed themselves as resourceful and connected. Erica and Kirsten connected with known colleagues and Chloe was willing to connect with other professionals she minimally knew. When practitioners are confident and find meaning through belonging, self-efficacy, purpose and living their values, their ability to share knowledge and skills with others is evident.

Practical Implications

Narratives are useful not only for research but also in clinical practice. The use of narrative during professional supervision, including curiosity and neutrality from the supervisor, could be of considerable use in assisting AHPs in reframing incidents to support their need for meaning, their professional confidence and consequently develop their identity, as an expert if they wish, amongst their community (Barreto & Ellemers, 2011; Launer, 2018).

Telling stories in a professional community of practice has been shown to develop individual professional identities, and to construct the identity of the community ongoingly (Gray, 2004). Narrative-based approaches have been taught to clinicians in Europe, for use in everyday encounters with clients (Launer, 2018). In psychotherapy, narrative supervision is an evidenced and encouraged modality for developing as a therapist (Simmonds, 2010; Whiting, 2007). Taking on the opportunities of narrative reframing, could provide considerable benefit for AHPs across different workplaces and professions, as it takes supervision beyond immediate problem-solving and addresses identity and the search for a meaningful life (Gray, 2004; Launer, 2018; McKenna & Richardson, 2003).

Although narratives are retrospective, I asked interviewees to talk about recent cases: pertinent ones are remembered. The information foregrounded in the interviewees' narratives represents a present perspective on what was important, rather than an accurate description of events or what they were thinking at the time (Launer, 2018). This reflexive account shapes present clinical practice and portrays an identity the interviewee wants to put forward (Ferguson et al., 2010; Savaya et al., 2011). Narrative approaches consider descriptions of human beings as tentative and narratives researchers argue that storytellers can influence their own social identity with different stories (Clandinin & Rosiek, 2007; Frank, 2012; Greenaway et al., 2016; Riessman, 2008). By satisfying the need for meaning - to fulfil

purpose, to feel capable, to create belonging and to live in line with your values - storytellers can have a positive effect on their own psychological health. In other words, positive work stories can promote wellbeing.

Despite how others may see them, interviewees may protect themselves by avoiding a story that makes them seem vulnerable, or may tell a particular story in a particular way to protect themselves from vulnerability (Barreto & Ellemers, 2011; Frank, 2012). In this way, the storyteller can experiment to create the social identity they want for themselves. In a discussion of the purpose of narrative analysis, Frank (2012) asks researchers to consider how well people are served by their stories. The suggestion is that access to different stories could provide different opportunities. Organisational and managerial listening could be enhanced if managers were provided with a simple structure of stories to listen for (Hill & Burrows, 2017). For practitioners, reflection on their own stories can highlight what stories they have been using and not using, and could lead them to ask what alternative stories they could use (Launer, 2018; Lengelle & Meijers, 2014; McKenna & Richardson, 2003).

Conclusion

The combined analyses of expanded critical incident approach, provided in Chapter 7, and performative narrative approach, presented here in Chapter 8, provide a backdrop and foreground detail of highly-experienced AHPs. As backdrop, the interviewees told stories of their work in stressful, unpredictable, complex situations in which they witnessed human suffering, abuse, ill health and injustice. Through close listening of how AHPs made sense of critical incidents, it is clear that the narratives they told showed that their work can provide meaning through purpose, self-worth, self-efficacy and fit with their values. The case-based analysis foregrounds ways in which AHPs can construct their identities through belonging to different communities and drawing on those networks. The expertise of AHPs can be heard in

their narratives: they can represent themselves as skilled, knowledgeable practitioners who strive for and often achieve success with their clients, can be vulnerable with colleagues and are willing to share knowledge with junior staff and students. AHPs can develop and maintain their professional confidence using affirming and challenging narratives, but not all AHPs do this. Whilst contextual constraints appear to limit some AHP's successes, not all AHPs tell these types of stories. Stories that positively re-frame situations of role ambiguity, insignificance, lack of resources and low competence, can promote coping, develop professional confidence and beyond that, a positive sense of self.

Chapter 9

Concluding Discussion

> I think there's, there's a stigma about being an expert….Yeah. It's really not a thing that people want to be known as. Yeah. Particularly in the health, public health services…In a, in a different culture, in a different country I'm sure that everybody wants to be an expert. [OT43]

In everyday terms, experts are variously described as skilful, adept, accomplished and talented. In spite of this, there is substantial public distrust of experts, particularly those who might be considered powerful, such as doctors who promote the use of vaccines for public health. The opening quote to this chapter exemplifies the ongoing conversation about the role of experts in society and ways in which they can be successful in those roles. This chapter brings together the findings from four studies that explored the questions "what is an expert AHP?" and "what might it take to be known as an expert AHP?" The findings are brought together in a multi-layered model of expertise, relating to allied health (therapy) professionals in NZ, who are predominantly female and do not identify as Māori or Pacific. Existing theories of expertise do not adequately explain what it takes to be known as an expert AHP as they have largely focused on measurable performance and results. My model shows that expertise is in communication between people and groups, and that there are "internal" components that help or hinder knowledge sharing. My model shows relationships between individual, professional and community level skills, knowledge and beliefs. As well as presenting this model, I will discuss the academic and practical contributions that this thesis makes.

My overall purpose for this mixed-methods exploratory research (Creswell et al., 2006; Stebbins, 2001) was to investigate the value and nature of experts amongst the allied health professions in NZ. AHPs come from multiple disciplines, and thus comprise a highly diverse group of professionals with a collective value of making a positive difference to people's health and wellbeing. My findings show that allied health practitioners do value experts who can help them develop their own skills and knowledge, in order to provide the best service for their clients (Study 1, Chapter 2).

For expert AHPs, knowledge collecting and contributing is enhanced through professional confidence, which in turn builds their expert identity (Study 2, Chapter 3). Moreover, for expert AHPs, being skilful, making a difference and belonging to a community that aligns with their own values (Study 4, Chapter 8) provides deeply meaningful work, which promotes further development of expertise as well as job satisfaction (Study 3, Chapter 6). The use of mixed methods in this research was valuable for exploring deeper understanding of the ways in which AHPs position themselves both as experts, and in relation to others who might be experts. The quantitative methods provided a broad context for situating the research, complemented by qualitative methods which allowed me to dive deep and discover context-dependent nuanced data (Stebbins, 2001).

I have used an interpretive critical pragmatic methodology to explore expertise amongst a diverse group of highly-experienced practitioners. This is consistent with my view that expertise is relational (Selinger & Crease, 2006). I have evaluated existing models of professional expertise currently published in the literature and related them to the specific context of allied health in NZ (Chapters 1 and 2). I have illustrated and advanced the significance of professional confidence in the development and maintenance of professional expertise for AHPs (Chapter 3). I have highlighted the significance of meaningful work and drawn attention to how AHPs find meaning through their work (Chapters 6 and 8). This

chapter summarises the studies and draws together the results of this research, in order to illustrate the constructions and complexity of expertise in practice. As the project has implications for professional development, and workforce policy, I will explore these as part of the conclusions. Finally, I suggest future directions that could further inform practitioners, managers and policymakers.

Original Academic Contributions

This thesis makes several original contributions to the academic literature. They are:

- providing an alternative definition of expert,
- applying a multidimensional and multidiscipline approach (termed "bricolage" by Pratt et al. (2019)) to the study of expertise amongst AHPs,
- highlighting limitations in our understanding of professional confidence for highly-experienced AHPs,
- creating an alternative typology of work orientation of highly-experienced AHPs,
- identifying the conditions in which AHPs seek out meaning through their work.

An Alternative Definition of Expert

In the healthcare literature, definitions of experts often include highly-tuned interpersonal skills with clients. The definition proposed in this thesis captures the views of SLTs, reported in Chapter 2, in relation to their desire to know who the experts are, and what experts provide for themselves. This definition was developed in Study 1 and was supported and deepened in later studies. Despite the various ways experts have been described and explored in the literature, for example as intuitive (Benner, 1982), having 10,000 hours of deliberate practice (Ericsson, 2008), or having mastery of a skill (Pusic et al., 2011), I have ultimately come to describe expert AHPs as:

Highly knowledgeable and skilled practitioners, with substantial depth and breadth of experience working with clients, who get results and – through ongoing teaching and learning – are confident to share knowledge with their professional community/ies.

This new definition brings together aspects of expertise that are individual and personal to the practitioner, such as their own experience and knowledge, with what they provide for others through teaching and learning within their communities. This multi-layered definition will be expanded upon later in this chapter.

In this thesis, I used a diversity of approaches to investigate the nature of highly-experienced AHPs, with the aim of understanding AHPs' expertise, and how AHPs form expert identities. My initial focus was on SLTs but I extended this subsequently to include other professions, in light of the multidisciplinary and interprofessional context of allied health in NZ. That is, I saw the potential for more comprehensive and thus impactful understanding of expertise by broadening my approach. Study 1 (Chapter 2) involved an online survey of SLTs exploring their perceptions and opinions of the experts in their local, national and international communities. Online surveys can quickly capture opinions from a large group of people, which was a useful starting point for this project. The thematic analysis of open-ended questions identified that experts were both great practitioners and gurus. Rather than experts being solely those practitioners that got great outcomes with their clients, instead SLTs reported that experts were others in their community who made a visible contribution and directly helped them.

SLTs identified experts as those practitioners who were willing to share their wealth of experience and highly developed knowledge. Rather than an anti-expert sentiment, Study 1 found that experts were valued and sought after by respondents. The findings increase our understanding of the role experts play amongst the SLT community and highlight the need to develop experts for professional communities. Previous models of expert practice have

included the ability to work with uncertainty and complexity (Jennings et al., 2008; Jensen et al., 2000; Kamhi, 1995). In contrast, I propose that in the current context many AHPs work with uncertainty and complexity, which can drive them to seek out the knowledge of others, but it does not characterise them as experts per se. That is, working with uncertainty and complexity is a common feature of work for all AHPs, and not all of them are experts.

In my definition, AHP expertise is clearly relational, it occurs between people. It is about the practitioner, their clients and their communities. In this way, it is possible that there is more than one expert in a relationship or system, and a practitioner can have many relationships. A relationship can be positive and collaborative, but also, within a relationship the community or the client can pose threats to a practitioner's identity as an expert (Wilson et al., 2006). My research shows that the expert practitioner can still maintain their identity as an expert in the most complex of relationships through actions such as knowledge sharing, reflexivity and narrative reframing.

Knowledge sharing, particularly, is a relational act. The confidence for AHPs to share with their professional community is in contrast to previous theories of expertise that include the role of reputation (Ericsson, 2014; Plomin et al., 2014). In my definition, sharing behaviours that a confident practitioner uses, highlighted in Chapter 2, can result in a positive reputation, but the action of sharing rather than the reputation is foregrounded. There is growing academic interest in ideas of personal reputation, both within an organisation and across virtual communities (Emelo, 2012; Treem & Leonardi, 2015). Reputation may be based on a person's task capability, integrity or charisma (Zinko et al., 2016). Zinko reported these reputations can be built in different ways, and one facet of reputation can overshadow another, which can be misleading for those trying to identify experts. Additionally, a person may have different reputations in different communities (Zinko et al., 2016). To navigate

through these reputations and seek out the experts that are most useful, it is valuable for the AHP to have a personal connection with the potential expert, through knowledge sharing.

For an AHP to build their reputation, it is frustrating to search the internet for professional advice, there is minimal information or specific advice. Similarly, there are barely any published academic papers about reputation or personal branding for AHPs or other practitioners. One study from Romania, a country with a pay-per-use health system, identified that for above average income families, a doctor's reputation was the main factor in choosing them (Luca et al., 2015). The authors highlighted how personal branding was a way to escape the anonymity of a profession, which is particularly relevant in a pay-per-use system, but also suggested that actions to create a positive reputation also construct a particular identity. More generically, Gorbatov et al. (2019) identified the growing interest in personal branding as a productive career behaviour across professional groups, leading to greater career satisfaction. I would add that even in a publicly-funded health system, personal branding could be a productive career behaviour, providing that the individual is also able to develop personal sharing relationships with other practitioners.

My definition of expertise highlights the characteristics of the practitioner, rather than the characteristics of the community, but the interpretivist framework of this thesis does not ignore the role of the community. Sharing is a two-way process between the expert and the AHP seeking assistance. In my definition, inclusion of *teaching and learning*, emphasises the two-way process of developing an identity as an expert, as well as the role of reflection on practice as a form of learning, consistent with the deliberate practice theory of Ericsson (2008). The view of expertise as created within relationships requires the potential expert to develop their relational skills, ideally through reflective practice learning, which they share with their community through supervision, mentoring, teaching and writing.

A Bricolage

Within an interpretive, critical, pragmatic methodological framework, qualitative methods that focus on narratives come to the fore. They provide a valuable way to explore AHPs' experiences of work and their profession, and to co-construct new understandings of what it might take to be known as an expert.

The application of a multidimensional and multidiscipline approach to studying expertise is a response to prior research. Kamhi (1994) initially suggested a multidimensional research strategy for the profession of SLT. The place of techniques, procedures and knowledge had been established as leading to high-quality service provision in theory and Kamhi called for empirical studies that showed how expert clinicians solved clinical problems. However, the question of defining the expert clinician remained problematic. His suggestion was that no single study could answer this question and that multiple approaches should be used. This thesis is a contribution to that research strategy. Additionally, Gobet (2015) called for a multidiscipline, cross-domain approach to studying expertise. My thesis in response to this challenge has a unique emphasis on highly-experienced AHPs, across professional groups and incorporating a broad academic literature from psychology, sociology, education and business studies.

The combination of methods presented are consistent with the exploratory nature of the project (Stebbins, 2001). Upfront planning was important, resulting in the use of an online survey to start with, but further analyses and data collection were dependent upon the results of earlier stages. This agile bricolage is useful in work that addresses identities, which is where this project has ended up (Giddens, 1991). Although bricolage has been criticised for creating a soup of theorising that can lack coherence and integration (Gehman et al., 2017), it has also been celebrated for its flexibility and non-linearity (Brown, 2017; Pratt et al., 2019). Grant and Giddings (2002) clarify that good bricolage involves a thoughtful consideration

and choice of approach that suits the needs of the questions being explored, rather than an ambiguous methodology that would result in a theory soup. The agile structure of a bricolage allows for creativity (Pratt et al., 2019). As mentioned previously, this thesis establishes its trustworthiness through its construction from a considered range of approaches taken from existing research methods and its use of reporting standards to present the information both in published chapters and as a whole (Levitt et al., 2018). Although bricolage does not require a structured approach to trustworthiness, three elements will be addressed here (Pratt et al., 2019). Authenticity is established through considerable and ongoing reference to the voice of the interviewees in each study. Where possible, their own words have been used to exemplify the interpretations made. Member checking practices, with the interviewees and with my supervisors, add to the credibility. And finally, the extensive discussion of findings and interpretation between myself and my supervisors leads us to believe the findings are plausible given our collective experience and knowledge of the allied health workforce in NZ.

Limitations in our Understanding of Professional Confidence for Highly-Experienced AHPs

The limitations of the literature in relation to the development and maintenance of professional confidence should not be overlooked. Whilst there is research regarding the initial development of confidence in becoming a therapist (Carpenter et al., 2013; Hecimovich & Volet, 2011; Holland et al., 2012b), there is no literature discussing the ongoing maintenance of confidence throughout a potentially lengthy career. This is despite the well-documented problem of low confidence leading to social withdrawal, work avoidance and people leaving their work (Hecimovich & Volet, 2011; Holland et al., 2012a). Yet at the other extreme, overconfidence can result in dangerous practice, working out-of-scope and not keeping up-to-date with professional development (O'Donoghue & Dean-

Claytor, 2008). There is an assumption that experienced AHPs are confident, or that confidence is not of concern, yet the findings of Studies 2, 3 and 4 all show how professional confidence does affect the wellbeing and performance of highly-experienced AHPs.

Threats to confidence commonly arise from interactions with other practitioners, managers and organisations, which can undermine a practitioner's identity. Additional threats to professional confidence arise over the course of time. In the Phase 2 interviews, AHPs identified artificial intelligence, robotics and technological innovations as potential but distant threats. These threats have not been studied in detail to date and warrant further consideration. Current threats came from different sources and some were profession specific. For example, several SLTs commented on a lack of professional registration processes, which has since been resolved for SLTs (New Zealand Speech-language Therapists' Association, 2018). More commonly, interprofessional and managerial practices, such as excluding a professional group from diagnostic discussions, were sources of threat reported by the interviewees. When an AHP does great work with a client, it is confidential to the practitioner-client relationship and maybe minimally visible to the communities that practitioners access (Greenhalgh et al., 2014). Doing great work with clients is not a sufficient counterargument to these threats: AHPs could consider how publications, news articles and presentations are a way for them to be visible across different communities and reduce the threat of exclusion.

One SLT discussed her anxiety about not being able to provide evidence-based practice to people with aphasia, another reported a lack of managerial support in carrying out a feeding intervention in the way the evidence suggested. Evidence-based practice has been mentioned both theoretically (Greenhalgh et al., 2014) and empirically (Foster et al., 2015) as a threat to professional practice, and would be valuable to include as a topic of inquiry in future research in this area. If the AHP has a commitment to evidence-based practice, but the

workplace cannot resource the level of service required, the AHP may question how much the workplace values them (Greenhalgh et al., 2014; Holland et al., 2012a). The studies presented here are starting points for more quantitative research that assesses the confidence of experienced AHPs, threats to their confidence and establishes conditions for interventions. The recommendations in Chapter 3 are for practitioners to work through, and a next step would be to evaluate the effectiveness of these recommendations for developing professional confidence.

An Alternative Typology of Work Orientation of Highly-Experienced AHPs

In Study 3, a typology of work orientation was developed in response to the interview data. This theoretical categorisation was grounded in the data developed in conversation with 45 AHPs from across NZ. Switching iteratively between collected data and the literature on work orientation and meaningful work (for example, Berkelaar & Buzzanell, 2014; Oelberger, 2018; Wrzesniewski et al., 1997) suggested that a practitioner's orientation to their work may influence their willingness to share and their interest in future growth, both features of the expert AHP. Four orientations were developed – Achiever, Striver, Contented and Over It. Identifying four empirically grounded types of highly-experienced AHP helps to understand the diversity of views that AHPs have toward their past success and their future growth.

All practitioners had the desire to make a difference for people; that was a prime motivator for entering their profession consistent with findings from authors across health professions (Stevens et al., 2010; Stone & Pellowski, 2016). Practitioners who were satisfied with their past successes were contented or excited about the future, whilst those who reflected on their successes without any sense of satisfaction were instead frustrated or exhausted. Achievers found their work deeply meaningful, and Contented types found

sufficient meaning (Oelberger, 2018). Meaningful work is associated with a sense of belonging and both Achiever and Contented types felt a sense of belonging to their profession. Achiever and Contented types talked of transcending themselves and being with others, both clients and colleagues. Good working relationships with colleagues create a bond and common sense of purpose that increase a sense of meaningfulness (Lips-Wiersma & Morris, 2009). Achievers were positive about the future, looking forward to further achievement with plans for sharing knowledge and skills and developing innovations; characteristics that defined an expert AHP in Study 1. Strivers were not fulfilled, nor were Over It types, although Strivers still had hope that they could find fulfilment in the profession. Strivers and Over It types did not tell stories of belonging, instead suggesting that they did not belong. Over It types struggled to find positive recognition of the past and were not positive about the future either. The four types revealed AHPs having, at their heart, a desire to make a difference, yet this was not always enough: this desire to make a difference helped to explain the significance of their successes but also that meaningful work was not always attained, or even if attained was not necessarily sufficient (Berkelaar & Buzzanell, 2014). In circumstances where procedural and resource constraints are overwhelming, the meaningfulness inherent in allied health practice was diminished: this is discussed next.

Identification of Conditions in Which AHPs Maintain their Identities

The analysis of narratives offers the opportunity to wonder "in what conditions of living do people hold their own by telling stories like these?" (Frank, 2012, p. 12). In Study 3, a typology of work orientation was created that amongst other factors included the concepts of deeply meaningful work, self-actualisation and self-transcendence. Achievers found their work deeply meaningful, being both actualising and transcendent. The conditions of their work and the challenges their clients presented to them were opportunities to find meaning for themselves. Strivers and Contented types were somewhat self-transcendent,

although self-actualisation was less present in both types. For Contented types they found satisfaction elsewhere, whereas Strivers still had hope that work would provide self-actualisation. Those with an Over It work orientation were possibly in a state of grieving for a loss of identity. They struggled to find meaning in what they did yet were also not ready to give up their profession. Grieving for a loss of identity because of a struggle to find meaning is minimally discussed in the literature (Berkelaar & Buzzanell, 2014; Schabram & Maitlis, 2017) and would be valuable to investigate further in this context.

Literature suggests that people have a need for meaning and increasingly work tasks and work relationships are seen as able to provide meaning (Baumeister & Newman, 1994). The critical incident narratives analysed in Chapter 8, created by four AHPs from their own work experience, highlighted the need to make a difference for others, to have a purpose and to belong, reinforcing the findings of the typology. Narratives explored in Chapter 8, underlined the important roles that team and belonging play for AHPs and highlighted that AHPs were driven by a strong motivation to find meaning even in adverse circumstances.

Expanded critical incident analysis revealed the nature of practitioners affirming and challenging incidents as diverse and relatively unpredictable. Affirming incidents were typically those where the practitioner was competent and well-resourced; the tasks were within the practitioner's scope of practice, they had role clarity and significant professional status. However, some AHPs were able to find affirmation in the most complex and challenging of work situations.

Identifying as an expert or identifying others as experts is an act of performance (Frank, 2012). People in relationship with others portray an identity as an expert that other people can encourage, maintain or quash. Performative narrative analysis offers in-depth, purposive interpretation of the stories people tell about themselves, stories that convey their desired identities (Riessman, 2008). Through narratives in the interviews, some AHPs

presented themselves as effective, informed practitioners who got results, were vulnerable with colleagues and were willing to share with junior staff and students. Despite witnessing considerable human suffering, abuse, injury and injustice, some AHPs thrived. They developed their skills and knowledge and gained depth and breadth of experience that they were able to reflect on positively, consistent with the definition of expert I proposed earlier. In Chapter 8, Chloe was an example of this. In visibly sharing what she knew, she exposed her vulnerabilities for the benefit of the client and herself (Hsu et al., 2007; van Os et al., 2015). Chloe and a number of other interviewees told narratives where they could hold their own, find meaning and maintain their identity in conditions of adversity and vulnerability. These presented identities are consistent with the definition of expert AHP that I offered.

Drawing the Findings Together

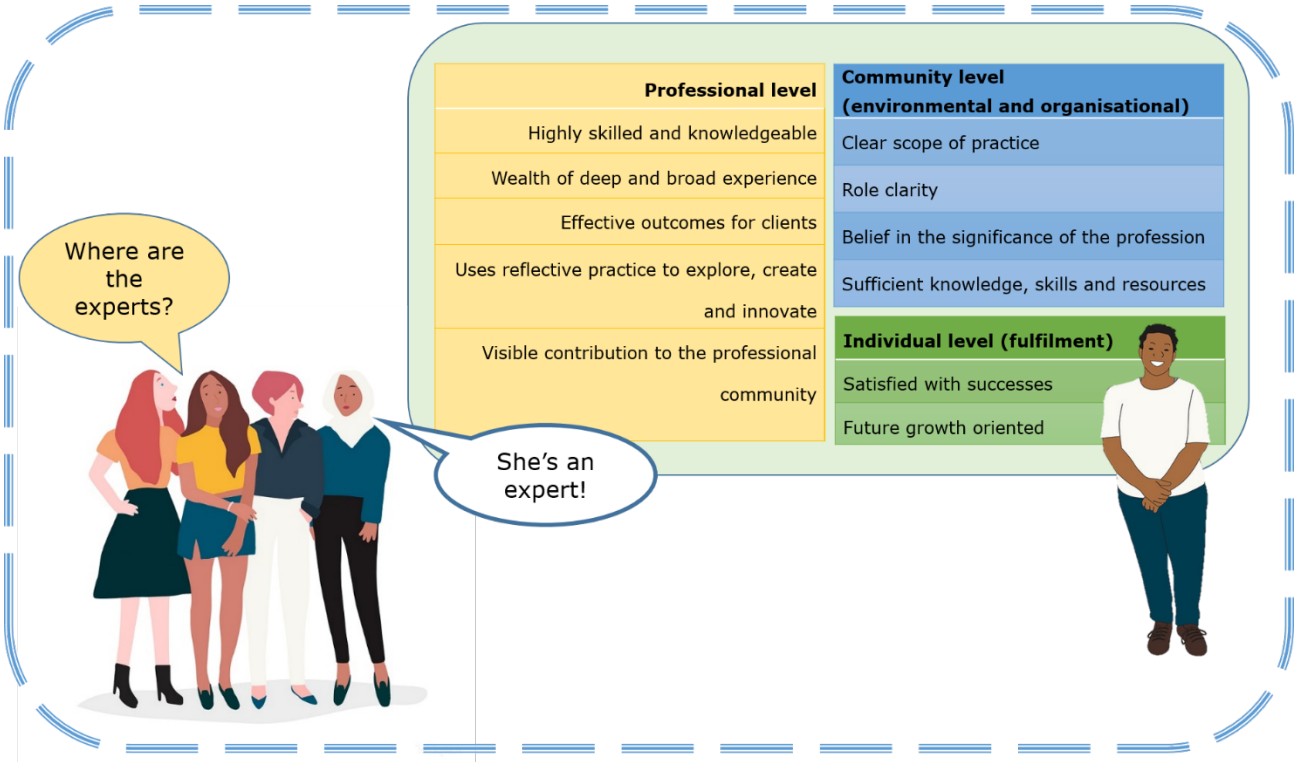
The broad view of expertise discussed in Chapter 2 is drawn from 119 SLTs to suggest ways in which expertise is valued. Managers and employers can make use of this knowledge to create a flourishing workforce. The detailed view provided by 45 highly-experienced AHPs in Chapters 7 and 8, offer opportunities for deep exploration of individual and collective understanding which might then be extended to the workforce at large. The broad and detailed views complement each other and are brought together here.

Expert AHPs are created in a multidimensional space – individual, professional, community and societal. Chapter 6 showed that at the individual level, experts are likely to be those highly-experienced practitioners who are satisfied with prior successes and have a desire for future growth. This is intrinsically related to finding their work at least meaningful if not deeply meaningful; Strivers, Contented types and Achievers all have the opportunity to be known as experts, although I propose that Contented types are less likely to pursue this identity.

Chapter 2 showed that at the professional level, expert AHPs have broad and deep knowledge, skills and experience, but beyond this it is their ongoing reflective and reflexive practice combined with an interest in future growth that leads them into lifelong learning, innovation and – importantly for being known as an expert – teaching of others. Their confidence in their ability to do their job, within their profession and to be valued for that within one or more communities, promotes lifelong learning and a desire to keep getting great results for clients, keeping abreast of changes to technology and the evidence-base. All of these combined could lead to an identity as an expert, a leading light, if the practitioner is willing to share knowledge and skills. The expert is created by and for the community, but not without the agreement and effort of the individual. To bring together the aspects of individual, professional and community, Figure 9 represents the collated findings of the four studies.

Figure 9

A Model of the Highly-Experienced AHP as an Expert

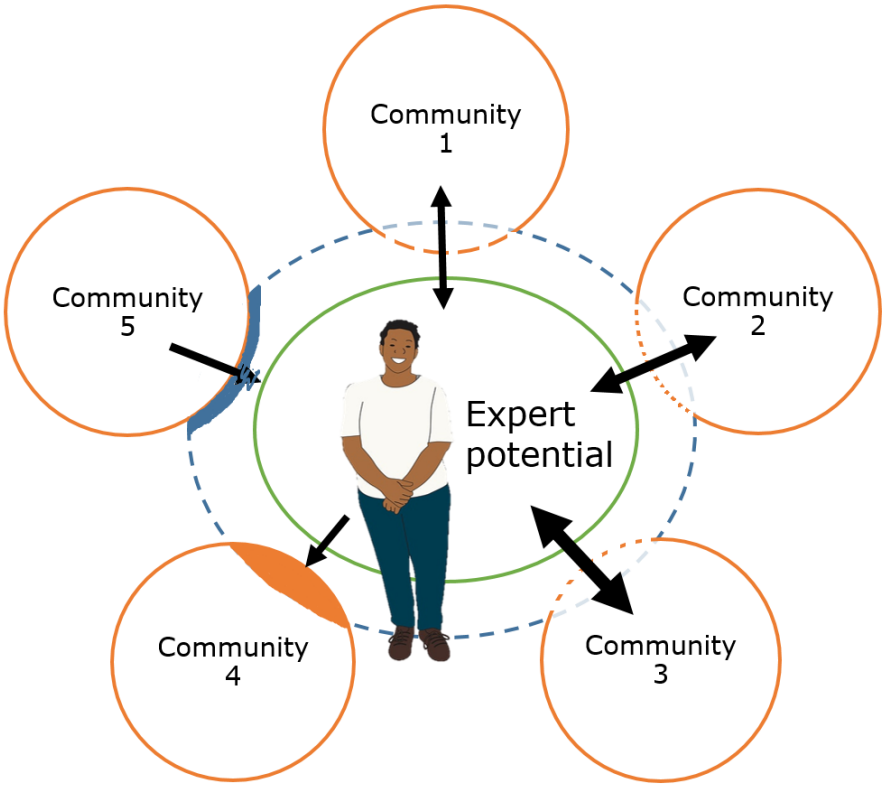


Note. This example community is looking for expertise amongst its members. Community members each have their own set of individual, professional and community level features. The AHP on the right can be known as an expert by making a visible contribution to this professional community that demonstrates her own set of features in a positive manner.

Expertise also occurs at a societal level. AHPs are not only members of one community, but many. The networks amongst communities form across society. The interviewees involved in this research had multiple workplaces, multiple caseloads and their domestic and international mobility provided potential for membership of numerous communities within society. Figure 10 shows varied levels of success in knowledge sharing between an individual and several different communities they interact with. In communities where there is success in knowledge sharing, there is both knowledge contributing and collecting – a two-way flow of learning that can encourage a practitioner with relevant skills, knowledge and experience, to be known as an expert. Where there is not success in knowledge sharing, there may be a lack of willingness to contribute or collect knowledge, on the part of the practitioner, or on the part of the community. With different communities, a practitioner can have varying success with knowledge sharing at the same time.

Figure 10

Conceptual Examples of Varying Success in Knowledge Sharing



Note. Arrows indicate the direction of knowledge sharing. The individual in the centre shares knowledge with varying levels of success. Communities 1, 2 and 3 represent different levels of successful knowledge sharing with Community 1 being at a lesser level than Community 3. Community 4 is obstructing the individual from sharing knowledge. Community 5 is actively seeking knowledge but the individual is not willing to share with them.

An individual who is not willing or able to share, who does not contribute to the community or collect knowledge from it is much less likely to be known as an expert. As an example from my data, a dietitian was reluctant to share her knowledge with a community of nurses because she believed that in giving them knowledge, they no longer called on her to be

involved clinically and they were eligible for promotion to a level that she was unable to attain in her profession. This could result in a vicious circle of not being willing to share knowledge, leading to not being known as an expert and therefore not being sought out to share knowledge. Likewise, a community that does not support individuals to share will also jeopardise opportunities for a member to be known as an expert.

In my data, interviewees often reported a lack of managerial support for sharing knowledge, but also a number practitioners were reluctant to be part of professional communities beyond their workplace, indicated for example by not using social media or attending journal groups. As a critical pragmatic researcher, I do not inherently view this as a problem; no-one is in need of emancipation (Butt, 2000). However, the community did raise in the online survey (Chapter 2), that for some, they did not know who the experts were, and that they had looked in vain. This suggests that experts are valued and sought after, but not always available, within AHP communities. As a critical pragmatic researcher, I have an ethical drive to address this as a problem (Butt, 2000; DeForge & Shaw, 2012). Within a particular community there can be room for more than one expert. Achiever types may already be experts within some of their communities. Additionally, those with a Striver work orientation could make use of strategies and supports to develop themselves and their identity as experts. The work orientation typology developed here does not hold AHPs in a fixed orientation and I propose that with effective support, Strivers could most easily transition to become Achievers, although such a transition is also open to the other types. The exact nature of this support is still to be determined and in the next section, I offer practical recommendations that already have some existing support in the literature, and discuss these recommendations in relation to the development and identification of expertise.

Practical Contributions

Practical contributions of my thesis include recommendations for practitioners, managers, supervisors and training organisations and I will elaborate which practices may be of most value. There are three practices discussed here, that might be beneficial when there is a drive to develop and maintain expert practice: knowledge sharing, reflective practice and reflexivity, and narrative reframing. AHPs practices in their professional community in turn shape the view of themselves by that community. Further research is needed to deepen understanding of how these practices could contribute to the identification of expertise.

Knowledge Sharing

Experts are willing to share information, skills and practical wisdom, a process known as knowledge sharing (Hsu et al., 2007). Knowledge sharing has been studied extensively within the management field: it is a process of transmitting information from one person to another which, when effective, eventually enables individual career success (Tangaraja et al., 2016). Knowledge sharing also benefits healthcare organisations (Rohajawati et al., 2016) and schools (Shih & Tsai, 2016). The findings of Study 1 suggest that knowledge sharing also applies to being known as an expert AHP. Study 2 investigated the extant literature regarding professional confidence, a key facilitator in knowledge sharing. A narrative review considered a broad scope of literature from the health professions, in relation to the development of professional confidence from the time of entry-to-practice study. Beyond the first year of practice post-qualifying, there was little discussion of professional confidence in the literature. The literature available suggested that role ambiguity, unclear scope of practice, low professional status and role conflict all threaten the confidence of practitioners (Holland et al., 2012a). However, adopting a reflective practice stance can counter these threats, and specific reflective questions were offered in Study 2 (Table 3) as recommended practices for the development of professional confidence. AHPs could reflect on these

questions by themselves, or in a supported context such as in clinical supervision or with trusted peers. Reflection could lead to actions that AHPs and their managers could collaborate on.

Expertise does not occur in isolation but can be observed when practitioners relate to others, either in sharing information or in seeking information (Selinger & Crease, 2006; Treem & Leonardi, 2015). Whilst Treem and Leonardi identified experts in a manufacturing firm's leadership programme, my study extends the significance of knowledge sharing across organisations and beyond formal programmes. Studies have reported interpersonal communication as a core feature of expertise but this tends to be in relation to communication with clients. For example, interpersonal communication is included as an expert-level competency for medical imaging technicians, which does include mention of teamwork, but is mainly focused on communication with clients and families (Yielder, 2004). Within a detailed study of expert physical therapists, there was mention of experts all having teaching roles, but considerable emphasis was again on developing communication with the clients (Jensen et al., 2000). My findings suggest a different style of interpersonal communication is needed to share knowledge with the community of practitioners, as this arises in different structural conditions.

Knowledge sharing can be successful when there is something to share, skill in being able to share it, and a trusting community to share it with (Chen & Hung, 2010; Hsu et al., 2007; Rutten et al., 2016). Specific communication skills are not explicitly spoken about in the knowledge sharing literature, but a person's belief in their ability to convey information is considered a key factor in successful knowledge sharing. People with greater belief in their ability to communicate effectively are more likely to contribute knowledge and create a positive environment for sharing (Chen & Hung, 2010).

Communication across professional groups requires trust and respect between both individuals and groups (Chen & Hung, 2010; Rutten et al., 2016). Whilst literature has focused on interprofessional communication in acute care and from a patient safety perspective, my research highlights the need for effective interprofessional communication that develops positive relationships for the benefit of professionals. Interprofessional education at tertiary level increasingly focuses on communication between students of different professional groups (Abu-Rish et al., 2012). For AHPs already qualified and in the workplace, the reflective questions from Study 2 can be used similarly to develop positive interprofessional relationships. In the workplace, AHPs are encouraged to have conversations with colleagues across professional boundaries, with a focus on building professional relationships, which in turn create the conditions for expert clinical care.

The knowledge sharing literature reports on both online, virtual communities as well as those that meet physically in person and both types of community are relevant here. Knowledge collecting and contributing both require trust, a degree of belief in good intentions and reliability of others who share knowledge (Chen & Hung, 2010). Given the power plays and struggles for professional recognition discussed in Study 2, exemplified in Studies 3 and 4, and reported in the literature (Baker et al., 2011; Traynor et al., 2015; Williams & Lawlis, 2014; Williams & Koumenta, 2019) it is unsurprising that practitioners may not feel they can trust particular communities. However, practitioners are generally members of several communities and should be encouraged to participate actively in those communities where they do feel safe to be vulnerable by exposing what they know, and therefore what they do not know. It may be beneficial to explore alternative communities to join. Lack of trust is a substantial barrier to knowledge sharing, and is particularly challenging in virtual (online) communities, but can be overcome by managerial support to

participate and encouragement to help others (Chen & Hung, 2010; Razmerita et al., 2016; Rutten et al., 2016).

Developing confidence does not happen in isolation and practitioners are encouraged to connect with colleagues of different professions to forward their understanding of each other's role and scope of practice and to create practices that value the diverse professions that contribute to client well-being. These actions can promote trust that is wider placed than just those people in immediate contact. Each AHP is typically part of several professional communities that might bring practitioners together geographically, by workplace or by special interest. All members of a professional community are important in fostering a safe, supportive environment conducive to knowledge collecting and contributing. This includes the active contributors and collectors as well as the silent witnesses.

One of the interviewees in this project, with eight years of experience, reported that she did not yet have anything to share: "I don't feel experienced enough to say anything" and later reiterated this by saying "I've got nothing to contribute yet". Positively, the interviewee conveyed that she might in the future have something to share, just not yet. Another interviewee said a similar thing, feeling that after 16 years of experience she was not good enough to share anything. Alternatively, an interviewee with 14 years of experience was keen to share their knowledge and skills, "the level of stroke knowledge is not great [here] at the moment. So I'm hatching a plan…to do some education days, but also to go out to the outlying hospitals and sort of up-skill physios there". This qualitative data is consistent with the substantial existing literature that finds expertise is not merely accumulated hours or years of experience (Ericsson, 2008; Rassafiani, 2009). It underlines the complexity of factors at play in being known as an expert.

The knowledge sharing literature shows that asking questions, knowledge collecting, as well as answering questions, knowledge contributing, are both essential ways that people

can transmit knowledge and skills within a community (Chen & Hung, 2010). For the AHP who feels they do not yet have anything to share, asking questions of the community is a way to further themselves. AHPs might feel nervous and vulnerable in asking questions but this could be facilitated by enduring encouragement from their supervisor or manager. Knowledge sharing is not a single event and needs to occur over time and be supported over time, to be beneficial.

Reflective Practice and Reflexivity

The importance of confidence to share is apparent (Chen & Hung, 2010). Table 3 (Chapter 3) provides questions to provoke reflective and reflexive thinking around these issues. The power of reflective practice in the development of confidence should not be underestimated, and should be actively promoted through organisational and professional channels. Interviewees in Phase 2 who fitted an Achiever type work orientation were highly reflective, giving support to the use of reflection and reflexivity in developing professional confidence. Examples of ways to promote reflective practice include ensuring that practitioner-focused training and experiential learning opportunities make time for reflection on events with the aim of changing future practice (McMullen et al., 2014; Wilding et al., 2012). Practitioners should be enabled and encouraged by their organisation to take time to reflect on workplace events, and their reactions to them, because these provide valuable inputs to building confidence. Study 2 highlighted the known significance of reflective practice for promoting confidence and the findings of Study 4 show how confident practitioners can sustain their confidence by reflecting on events. Interviewees were able to identify affirming situations because of the positive impact of their actions. Without the overt feedback of others, the practitioners paid attention to their outcomes through reflection. Where there was a positive impact, I interpreted practitioners as saying that on reflection, “I knew what to do for the client and it worked”. However, researchers also point out that self-

reflection can be both beneficial and risky (Lengelle, Luken, et al., 2016). Glassburn et al. (2019), who are researchers in social work where reflective supervision is common, point to the limitations of reflection, which may simply confirm biases, encourage blaming others and support division between the practitioners and their colleagues and clients. To discourage poor behaviours, Glassburn et al. (2019) and Riessman (2015) both take the view that multiple mirrors to the self should be held up, in the process of reflexivity. The recommended questions in Table 3 are an opportunity to hold up multiple mirrors by seeking views from multiple people. The questions encourage reflexive conversations and also narrative writing. Written narratives offer a proven opportunity for developing identities through a process of finding the right words to tell the story (Lengelle & Ashby, 2017; Lengelle, Meijers, et al., 2016).

Aside from OT and SW, reflexivity is minimally mentioned amongst allied health professions, yet it is an essential component of understanding our own place in our social and environmental context (Edwards, 2010). OT is a profession that has embraced reflexivity: a process of looking critically at our own personal understandings, thinking about the history of our ideas and what alternatives are available (Robertson et al., 2015). In an examination of OT through Foucault's teachings, Mackey (2007) proposed that the identity of an OT is created through work on the self. Through a reflexive process of surveillance via journaling and supervision, OTs could produce a *truth* about themselves as an OT. The OT that experiences themselves as complex and co-constructed is more responsive and open to other people, both clients and colleagues. New possibilities for relationships become available. Training in and encouragement of not just reflection, but reflexivity, could increase practitioners confidence through greater understanding of the history of their own personal values and beliefs (Delany & Watkin, 2009; Robertson et al., 2015; Wilding et al., 2012).

More of the allied health professions should follow the lead of OT and SW, and should consider the value of reflexivity as a skill for their practitioners.

In Study 4, interviewees put forward an identity of themselves, a performance for an audience (Ferguson et al., 2010; Savaya et al., 2011). Mackey (2007) approaches identity as if it can be constructed to form a preferred self. This identity construction requires identity work to form, repair, maintain and revise the sense of self, and is the pragmatic view taken in this thesis. Others suggest that identity is not definable, nor can it be deliberately worked on, which results in an ongoing struggle to know ourselves (Brown, 2017). Either of these approaches suggest that reflexivity, within an interpretive methodology, could be of benefit. Either we can construct our preferred identity through a reflexive process of questioning who we are, coming to an understanding of the self and trialling alternative versions of a preferred self, or we can come to know the self as it is right now, with acceptance (Brown, 2017). In either approach, reflective and reflexive practices seem essential in the development and maintenance of identity as expert. Mackey (2007) reinforces the continuous demand for an AHP to work on their professional identity in light of ever-changing demands and expectations from clients, professional groups and organisations. The AHP community as well as managers and clinical supervisors have a role to play in promoting and supporting reflective and reflexive practice that supports the development and maintenance of a strong professional identity.

Narrative Reframing

> And I think anyone who considers themselves an expert is almost kind of closing their mind to those other possibilities and new knowledge and new learning. [SLT41]

This quote highlights a risk of being an expert and exemplifies an anti-expert sentiment, but the research presented in this thesis finds it is not useful to do away with experts. SLT41 says that it is not wise to call yourself an expert, but I propose that if others relate to you as an expert, as described in this thesis, then you become a valuable asset to the community of practitioners who are looking to learn and needing support and advice.

How can we reframe what it is to be an expert? Narrative reframing requires a process of story creation and dissection. Frank (2012) recommends that reflection on our own stories can highlight benefits and downsides to our narratives and may lead us to question whether certain stories are serving us well: change your story – change your life. Again, the importance of reflection and reflexivity shows up.

Narrative is a good tool for AHPs; natural and powerful (Simmonds, 2010). Natural because most people can tell their own narrative. Powerful because it can serve the individual well. For narrative inquirers, it is necessary to be tentative in representing their own experiences or the experiences of others (Clandinin & Rosiek, 2007; Frank, 2012). In order to be able to change a description, a narrative, it must be unfixed. Narrative analysis and reframing could be utilised for the benefit of practitioners through the supervision process, as research and professional practice elsewhere has demonstrated (Launer, 2013; Simmonds, 2010; Whiting, 2007). In school settings, narrative inquiry is a recommended approach for trainee teachers to develop their professional identity (Hooley, 2007), and for practising teachers to use in self-assessment (Craig, 2011). In Britain and Europe, the use of narrative-based supervision has increased across the health professions (Frank, 2019). The significance of supervision as an opportunity for professional development is important to note.

Receiving supervision was rarely, if ever, mentioned in CVs and work histories of interviewees in this research project, yet in interviewee narratives, the place of receiving supervision from a skilled colleague, and of approaching colleagues for help was apparent.

The performance of selling your personal brand through your CV is well-known (Cohen & Duberley, 2013) but there may be a perception amongst AHPs that receiving supervision is not a positive to celebrate, or is an assumed practice that does not need stating on their CV. However, there is overwhelming support for supervision as an essential component of professional practice and development, as well as a process that builds resilience (Beddoe et al., 2014). There is opportunity for practitioners to promote themselves by referencing the supervision they receive, and for managers and hiring personnel to actively seek out those who engage in supervision in order to grow expertise in their workforce.

Identifying the Experts

The online survey in Study 1 (Chapter 2) created a context of professional communities and asked SLTs "who are the experts?" Whilst LaDonna et al. (2017) argue that open-ended questions from surveys cannot provide robust thematic findings; the voice of respondents was clear on several factors.

Firstly, PhD and research contributions from practitioners were considerably less valued than clinical contributions. Practitioners valued other hands-on practitioners most. Qualifications were not seen as an indicator of expertise. This may emerge as a phenomenon of a small population. Traditionally SLT in NZ has not been a profession replete with PhD level practitioners. There are currently fewer than 30 PhD level SLTs working, and many are not clinically active, so clinicians are unlikely to work with PhD-qualified practitioners, that is, they are not close peers. More generally, the small population of SLTs in NZ and diverse work roles lead to few close peers. For example, the number of SLTs who work in specialist voice clinics is very small – fewer than 10, and if one of those becomes a researcher without a clinical focus, the pool of clinical knowledge resources is diminished. In contrast, amongst nurses in Australia and clinical psychologists in NZ, Australia and UK, a PhD is a huge asset

to job availability, promotion and the opportunity to work in academia (Wilkes & Mohan, 2008). For physical therapists in the USA, a doctorate is now the only available route to working in the profession (American Physical Therapy Association, 2019). Thus the emphasis on clinical rather than research skills and knowledge may be specific to NZ SLTs. The opening quote of this chapter also suggests that practitioners in NZ may have different views to those in other countries. Repeating this research in alternative contexts of Australia, Europe, the UK or North America, may yield different results, and would be a useful follow-up study.

Secondly, some SLT practitioners were frustrated about who to turn to for help: no gurus were to be found locally. The challenge of identifying specific experts that SLTs could turn to is not resolved in this thesis, becoming known as an expert is not a rapid or passive process. Instead, this thesis offers ways in which practitioners can come to be known as experts, given the motivation, opportunities and time.

There are different ways to categorise AHPs that help stakeholders to understand the practitioners in the workforce. The interviewees described in Chapter 5 are broadly similar to the majority of the highly-experienced AHP workforce in NZ. They are predominantly women with English as a first language, but are diverse in their entry-to-practice training, work history, geographic mobility and current employment. The findings of Study 3 offer an alternative view of the workforce, wherein the emergent typology consisted of four types of work orientations of highly-experienced AHPs, grounded in their interviews and their stories. Interviewees talked about their work life and people they admired and were inspired by. Additionally, some interviewees – Achievers – told stories of being admired and inspiring others through their work. Numerous authors advocate that powerful people are skilful storytellers (Fairburn, 2002; Gabriel, 2015; Kim, 2016; Schiffrin, 1996) and I would argue that Achievers are powerful and skilful storytellers.

Two work orientations particularly lend themselves to knowledge sharing, Achievers and Strivers. Practitioners with an Achiever work orientation are successful and driven, are known, self-aware, and confident, and push boundaries. Achievers are already sharing what they know and think. The future growth orientation of Achievers is consistent with the career achievement aspiration described by Gorbatov et al. (2019). Career achievement aspiration was found to be a strong predictor of engaging in personal branding, as was positive self-efficacy beliefs about one's own ability to be successful in one's career. Their study found that actively taking part in self-promotion behaviours was positively related to career satisfaction. In my research, Achievers have agency in managing their own career both through job and career crafting, and through the strategic activities of branding and self-promotion. These are likely to be contributing to their success and satisfaction.

Practitioners with a Striver work orientation are willing to be experts, keen even, but struggling to know how to be seen. Strivers told stories of struggle and frustration, and this group are searching for some recommendations for achieving success. Support from managers and organisations to work to top of scope is recommended (Te Pou o Te Whakaaro Nui, 2015). Skilful storytelling could be another way forward. Personal branding is an emerging career competence requiring specific technical, metacognitive, creative and critical skills (Gorbatov et al., 2019). Whether training in this skill would be useful for moving Strivers in the direction they want to go remains to be seen and warrants further investigation.

The Contented group are successful, and they are good at what they do. They may be very much contented with what they are doing and not so driven to be achieving more and being known more, and they may or may not be willing to share. Taking action to share their experiences might seem like more work than they want to do, for example time in writing and maintaining a blog, or preparing for and talking at professional meetings. The perceived costs

of being known as an expert, such as time and effort to contribute to the community outside of everyday job requirements, may dissuade Contented practitioners from sharing.

People with an Over It work orientation are exhausted, worn out, seeing only barriers and hurdles in their way and, unlike the Strivers, they are no longer fighting the system; rather, they are getting on with things but struggling. Positively, and perhaps most importantly for Over It types, the existing literature suggests that these work orientations are temporary, not fixed or progressive – a person may identify with one of those orientations over short or long periods of time. A particular work orientation might lead to a change of role, job or profession (Schabram & Maitlis, 2017). For example, Achiever types may be volitionally, actively seeking additional or alternative roles, jobs or professions. Over It types may need encouragement and support to change to something that might suit them better, whereas Contented types are likely to not seek or need a change of role, job or profession. Alternatively, skilful story-telling provides an opportunity to shift identity and potentially to change work orientation (Frank, 2012). Supported reflection and reflexive thinking could enable practitioners to develop their narratives, take on a new identity, shed an identity that no longer works for them and to newly find meaning in their work.

Practitioners across all four work orientations were geographically distributed within NZ, across work sectors and organisations. The small (but growing) population of NZ in dispersed communities suggests that virtual and online communities are of value, but Study 1 emphasised the importance of face-to-face connection, such that the significance of having local experts should not be ignored. Whilst international experts can be revered and their work accessed online or at conferences, they are not often readily available in person to provide knowledge and skills. However, some practitioners, mostly Achievers, had direct access to international experts through supervision arrangements they had established. Not all interviewees were interested in using social media or computer technology to connect with

others, and those that were interested were already participating in Facebook groups, Twitter followings and other options. Opportunities for informal learning in the workplace, such as breakfast journal clubs, team meetings, peer observation, text messaging or chat interfaces are possible but not embraced by everyone (Gray, 2004; Joynes et al., 2017; Li et al., 2017). Managers and organisations need to adopt technology that supports informal learning (Joynes et al., 2017) in ways that suit the practitioners they oversee. A diversity of opportunities is the way forward, rather than only one channel of communication.

Reflection on the Findings

The exploratory work described in this thesis requires that I avoid making exclusive claims about reality. Instead, I recognise that all explanations are partial and open to revision. The emphasis of my research has been to describe and interpret the behaviours of AHPs through data gathered in communication with them. The interpretivist critical pragmatic approach leaves room for alternative explanations. As a researcher native to allied health, I do not have the benefit of the outsider's view (Kanuha, 2000). I cannot un-know my own experiences and knowledge as an AHP, and through ongoingly reflecting throughout this research project, I have come to know the positive value I place on being an AHP. I asked the community about experts, they told me they valued experts, I then sought out experts and identified a number of them. Other researchers may have come to a different conclusion. Particularly, quantitative measures captured by non-AHP researchers might yield different results, but this is speculation. Considerable literature has been consulted in the course of my research and I have worked with my supervisors throughout, to hear alternative views in response to the data, both of which have challenged my thinking. These practices bring rigour to the findings (Morse, 2015).

The New Zealand context has been a feature of this thesis. Interviewees were diverse and somewhat representative of the NZ population they were part of. Unfortunately, no Māori or Pasifika AHPs took part in the interviews, and I do not claim that the findings are generalizable to those populations. I have recently become aware of the Māori concept of *ako,* which describes a teaching and learning relationship where the educator is also learning from the student. Ako is grounded in the principle of reciprocity (Mika, 2013), a strong feature of the relational expert described in this thesis. In this approach, educators' practices are both deliberate and reflective (Ministry of Education, n.d.), again both essential features of the expert AHPs I describe here. Ako is a concept that could provide AHPs in NZ with direction if they want to be known as experts.

Strengths and Limitations

Whilst the four studies have their own strengths and limitations detailed in each chapter, there are also strengths and limitations of the collection of studies in the whole project. Strengths of the project include the planned use of various methods of data collection and analysis, as well as the multiple professions that were involved in providing data. Also, findings are supported by extensive literature in an iterative process of data analysis and literature analysis. The sources of data across the whole project were varied – survey responses, published literature, interview data, CVs and reflexive journal entries, allowing for multiple perspectives in response to the research question of "what makes an expert AHP?"

The philosophical and theoretical underpinnings of this project provide strength to the findings. In mixed methods research, as in all research, the sources, quality and types of data and analytic processes might support or weaken methodological integrity. In this exploratory research, I have created a bricolage, which has its supporters and detractors. In support of this approach, multiple data sources and analyses come together to create a rich understanding of what makes an expert AHP. This was the result of iterative planning throughout the four-year

course of the research, a strength of this project. The data represent snapshots in the lives of the interviewees and, as mentioned in previous chapters, can be seen as performances that are not taken as absolute truth but rather a presentation by AHPs at a moment in time. The limitations of this approach mean that any generalisation should be made with caution. However, as an exploratory project, I do not claim to have found causality, nor do I make any recommendations for action with certainty.

Turning to the limitations, broadly viewed, this research provides only a sample of a few of the numerous different therapeutic allied health professions in NZ. Only six professions were represented by more than one interviewee, leaving many professions without a voice in the project. Additionally, there was a dominance of SLTs in Phase 2 and exclusively SLTs in Study 1 (Chapter 2). The population of SLTs is small in relation to SW or PT, although similar in size to other professions, and different professions work in somewhat different contexts which does make generalisation of Study 1 across AHPs more tentative. Understanding the perspectives of other AHP groups towards their own experts would be valuable in establishing professional and workforce development programmes. Given the nature of AHP employment described in Chapter 5, it is important to consider that whilst the findings here could be generalised to other professional groups, as they are often grouped together, this should be done with caution as cultural, philosophical and educational backgrounds may differ, resulting in different perspectives that are not captured here. The employment situation in NZ is unique and findings may not be directly relevant in different contexts where there is a pay-per-use health system, or in a fully funded context, again suggesting caution when considering how results might apply to other contexts.

The interviewees were predominantly female and did not identify as Māori or Pacific. Purposive sampling is required to hear the voices of male AHPs and those who identify as

Māori or Pacific whose views cannot be assumed to be the same as the interviewees presented here.

The survey used in Study 1 (Chapter 2) could have asked respondents to describe their ideal expert, but instead, by asking for examples of experts, the researcher was able to interpret the responses to form an ideal type. It is not the intention of this thesis to deny the capacity of non-AHPs to also be known as experts (Simmonds, 2010). In his discussion of narrative supervision practices, Simmonds (2010) suggested that practitioners do not ignore their status or power but put it to good use in the interests of the client in a transparent manner. A new question would be to ask not just about AHPs, but about all the possible experts in relationships, which could include managers (Fulop & Campbell, 2011), and the clients and families themselves (Edgar, 2005).

Survey respondents may provide answers that have social desirability bias (Krumpal, 2013), a limitation which could similarly be applied to interview data. Respondents may try to portray themselves in a more favourable light, or to create a particular identity for themselves in front of the researcher. The survey questions were not seemingly about sensitive or about taboo subjects, although this can never be guaranteed, and so social desirability bias is less likely to lead to inaccurate responses. Given the interpretive methodology of this project, social desirability behaviours are not seen as detrimental to the research findings, but are a part of them.

Limitations of CVs as sources of data were discussed in Chapter 4. CVs can be written to highlight strengths and downplay weaknesses; they may contain gaps and information may be inflated or minimised. Given the methodological approach used here, the performative nature of a CV was taken into consideration in the analysis and collated data were presented to describe the interviewees in Chapter 5. In addition to CVs, work history information was also collected verbally during the semi-structured interviews, as

recommended by Dietz et al. (2000), which allowed me to ask for more information and the interviewee could expand on the detail given in the CV.

Member checking was limited to returning interview transcripts for feedback and following up prior analysis of interviews in future interviews. Whilst the findings were discussed between my supervisors, and myself they were not discussed with the interviewees. Morse (2015) and Birt et al. (2016) both recommend returning the findings to interviewees for their feedback, to check on resonance with their experiences. Future plans for this research include presenting the findings to AHPs at a conference. A workshop would be a valuable way to discuss the findings and gather feedback for future research. This approach addresses the co-constructed nature of knowledge by giving interviewees the opportunity to engage with the data after interpretation by the researcher, which adds to the richness of the findings and gives more credibility to the research.

Prior research has documented that health professionals with extensive experience and a highly positive reputation do not necessarily perform exceptionally in the domains of medicine (Ericsson, 2007) and nursing (Ericsson et al., 2007). As a result, in this research, I made no attempt to seek out participants on the basis of experience or reputation, but also I did not measure expert or exceptional performance. Rather, I asked participants to identify characteristics of experts, and I aimed to identify expertise myself. This exploratory study aimed to identify characteristics that might discriminate a highly-experienced AHP from an expert AHP. I have considered that expertise is socially-constructed and made no attempt to measure performance. When we can identify what makes an expert, then we know what to measure. However, with the definition of expert AHP I have proposed, performance parameters could be established and measured. Some examples of parameters that could be measured include the number of communities a practitioner interacts with, numbers of publications, training sessions delivered, measures of specific professional knowledge, and

accuracy of skills. Using multi-source feedback is another option for measuring performance of staff in healthcare settings. It includes performance feedback from supervisors, coworkers, self-assessment, and also clients and their families. The process requires a high number of responses per practitioner to provide a useful evaluation but has shown some validity amongst doctors and nurses (Al-Jabr et al., 2018; Corbett et al., 2019; Meghdad et al., 2020) and psychologists (Morrison et al., 2020).

Finally, I have not attempted to explain what causes some AHPs to behave in particular ways, which could be seen as a limitation. A combination of personality traits and vocational interests offers a plausible causal explanation. Personality traits are stable over time, motivate behaviour and are psychological in nature. They determine a person's affective, behavioural and cognitive style (Mount et al., 2005). Vocational interests are long-term dispositions that influence behaviour through a person's preference for particular environments, activities and types of people. Personality, particularly conscientiousness and emotional stability, is a valid predictor of job performance (Leutner et al., 2014). Extraversion predicts job performance for professions that involve social interaction, and as my research shows, allied health professions involve social interaction, often a considerable amount of social interaction. However, my intention in this research was not to explain causality, or predict why some AHPs are experts, and others not. Instead, I have provided a definition of an expert AHP that can be used as the basis for quantitative studies that respond to questions of causality.

Areas for Future Research

This thesis opens many avenues for future research as have been mentioned throughout this final chapter.

1. Further qualitative analysis of the interview data already collected would be valuable in exploring the perceived threats to the professions discussed by interviewees. Additional data from a wider range of AHPs would also strengthen the findings or highlight differences between professional groups.
2. A similar critical incident study of less experienced AHPs would provide understanding of the development of professional identity, the search for meaning and the development of professional confidence in the first seven years of work after graduating. These AHPs will be the future workforce and therefore understanding their development is key for the future.
3. Professional confidence was not measured directly in any study presented here; this would be a useful addition to future work, particularly for highly-experienced AHPs to map the path of confidence over the careerspan.
4. The recommendations in Table 3 for developing professional confidence through reflection and reflexivity could be trialled and tested in order to develop a useful training package for AHPs in the workplace.
5. Measures of meaningful work would provide a detailed description of the AHP workforce that could further inform the work orientation typology. Self-actualisation, transcendence and other factors could be measured using established tools such as the Comprehensive Meaningful Work Scale (Lips-Wiersma & Wright, 2012).
6. The work orientation typology could be tested on a large group of AHPs leading to refinement of a tool for managers and organisations to support all their AHP staff in an individualised manner. Given the ethical challenges in people being labelled as a particular type, the design of this study would need to be carefully considered to create a tool that is respectful of all AHPs. With a refined work orientation typology and effective

training approaches, potential experts could show up in the community and be supported to develop and maintain their skills and practices.

7. Knowledge sharing activities, including personal branding and developing a reputation, may come naturally to some but the competencies could be taught to others. There are cultural considerations to accommodate in devising effective training for NZ AHPs who might be reluctant to promote themselves (Kirkwood, 2007). The Māori concept of ako could prove valuable in bringing sensitivity to practitioners' cultures (Ministry of Education, n.d.). Measuring the effectiveness of this training on career crafting and satisfaction could provide a valuable tool for the workforce, that could be incorporated into entry-to-practice education programmes.

Conclusion

In this thesis, I have problematised the concept of expertise for the allied health (therapy) workforce and discussed the knowledges that inform and shape the concept of expertise. The thesis offers a multidiscipline and multidimensional study of expertise and develops new understandings of highly-experienced allied health professionals and their relationships with work. Overall, the studies show that the AHP workforce values expert practitioners as go-to people who help to develop practice and push at the boundaries of innovation. Experts do exist within the current AHP therapy workforce, in different professional communities. At their heart, expert AHPs have a strong drive to make a difference, and can maintain a positive outlook, as is evident through their ability to find affirmation in the most challenging of circumstances.

The model of expertise proposed shows that individual factors such as experience and knowledge, when shared with the community through supportive processes can develop identity and confidence around professional values and interprofessional boundaries and

status. The thesis brings together these previously unconnected factors and highlights the roles of reflexivity and narrative framing in developing an identity as an expert amongst professional colleagues. Particularly, it proposes that professional development for highly-experienced practitioners could be advanced through inclusion of deliberate reflective and reflexive practices. The development of expert practice is complex, and involves social-relational processes between individuals, organisations, and communities. For all AHPs to flourish, these three entities need to create a common vision of a future where multiple identities, including that of expert, are valued for what they provide.

Appendices

Appendix A - Study 1 Online Survey Questions

Thanks for your help. We'll ask you questions about expert speech-language therapists who work with people with dysphagia. Even if you don't feel familiar with dysphagia, we would like to hear from you. You need to think about experts in three different locations: local to your region, across New Zealand and those who are based overseas. There are only a couple of questions and we invite you to write as much as you like.

1. Think of speech-language therapists/ pathologists who are based overseas, that work with people with dysphagia, who you would consider to be an expert. For those people overseas, what makes them an expert in your opinion?

   _____

2. Think of speech-language therapists/ pathologists in New Zealand, that work with people with dysphagia, who you would consider to be an expert. Thinking about those people in New Zealand, what makes them an expert in your opinion?

   _____

3. Think of speech-language therapists/ pathologists locally, that work with people with dysphagia, who you would consider to be an expert. Thinking about those people local to you, what makes them an expert in your opinion?

   _____

4. Tick 7 elements that you consider describe an expert Speech-language Therapist that works with people with dysphagia.
   - Highly experienced (1)
   - Has a PhD (2)
   - Has a clear set of values (3)
   - Has a strongly client-centred approach, focusing on the person and their family, the environment and other people (4)
   - Teaches professional development courses (5)
   - Provides supervision to other therapists (6)
   - Holds a specialist role (7)
   - Solves problems with great ease (8)
   - Has a superior memory for information and patterns of features (9)
   - Performs complex tasks accurately (10)
   - Is involved in research (11)
   - Is highly reflective and learns from their practice (12)
   - Creates new ways of working (13)
   - Readily shares innovations and/ or new practices (14)
   - Takes on SLT/P students regularly (15)
   - Has an in-depth understanding of the mechanics, biology and science of swallowing and swallowing difficulties (16)
   - Is a highly skilled communicator (17)
   - Has strong links with other dysphagia experts (18)

5. Drag and drop the items below to rank your choices from question 3, with the most important features of experts at the top.
   Carry Forward Selected Choices from "Tick 7 elements that you consider describe an expert Speech-language Therapist that works with people with dysphagia."

Please tell us a little about yourself. This helps us describe the research participants when we come to publish our findings.

6. Where do you currently work? (Tick all that apply in the last 4 weeks)
   - Ministry of Education (1)
   - Ministry of Health/ DHB - paediatrics (2)

- Ministry of Health/ DHB - adults (3)
- Trusts, charities, non-profit organisations, etc... e.g. Laura Ferguson Rehabilitation, Ohomairangi Trust, (4)
- Special School (5)
- Private practice/ ACC provider (6)
- University/ tertiary education provider (7)
- Other (8) _____

7. How old are you?
   - 20-25 (1)
   - 26-30 (2)
   - 31-35 (3)
   - 36-40 (4)
   - 41-45 (5)
   - 46-50 (6)
   - 51-55 (7)
   - 56-60 (8)
   - 61-65 (9)
   - 66+ (10)

8. When did you qualify/ graduate as a Speech-language Therapist? (In what year did you complete your SLT training?)

   _____

9. How many years have you been working with people with dysphagia, since you graduated? (Please count all years where you considered that dysphagia practice was part of your active caseload once you were a qualified SLT.)

   _____

10. Where did you gain your foundational dysphagia knowledge?
    - During my pre-qualifying course e.g. as a diploma, bachelors or masters SLT student (1)
    - Professional development courses after I had started working (2)
    - On-the-job training and/ or mentorship in the workplace (3)
    - Reading textbooks, journal articles, online information (4)
    - Other (5) _____

11. Please indicate the balance of your caseload according to your current Full-Time Equivalent hours (FTE) (average over the past 4 weeks). For example, one 8 hour day per week = 0.2, 12 hours per week = 0.3.

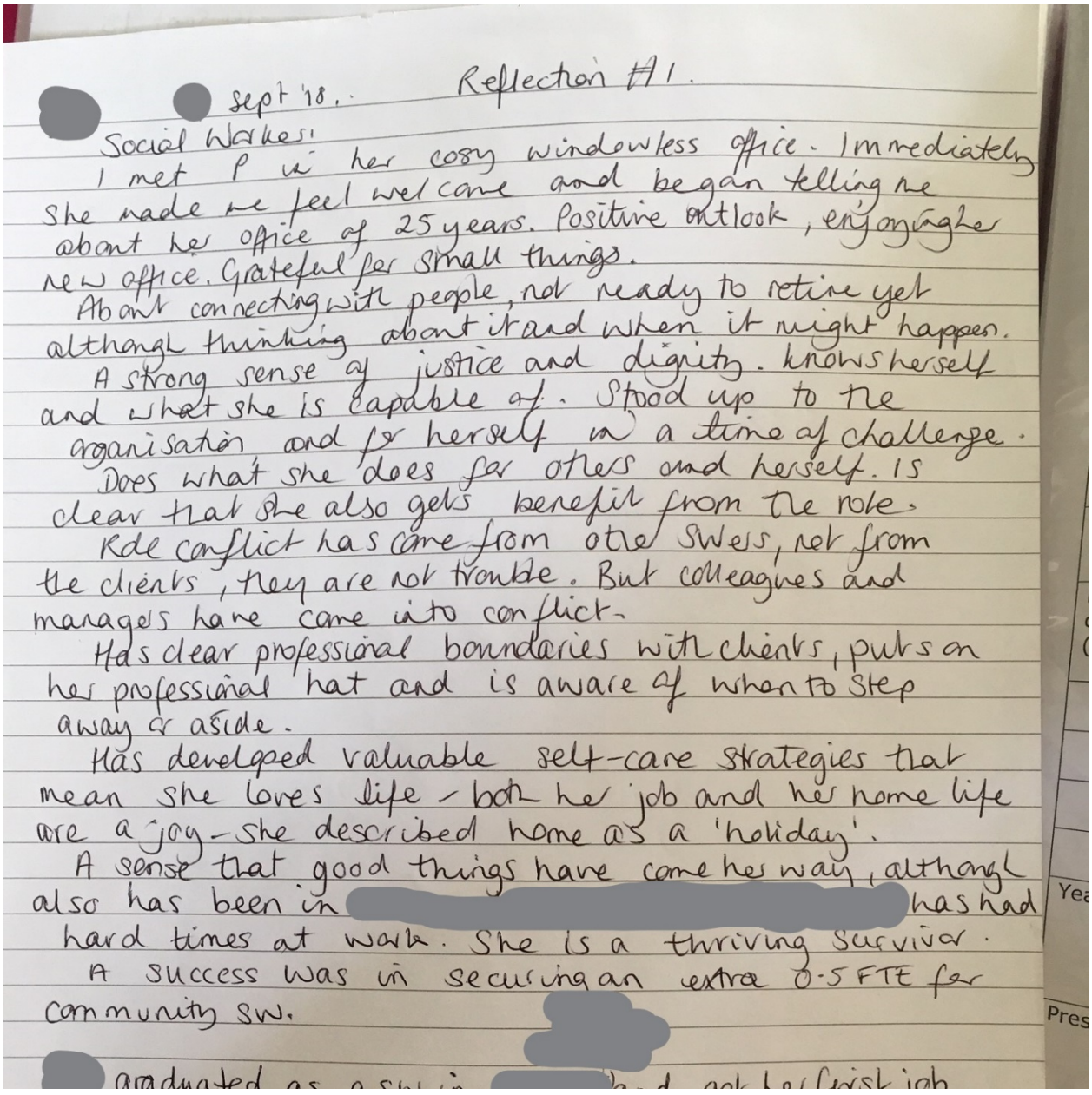
    Adults 65 years and older: _____ (1)
    Adults under 65 years: _____ (2)
    Children aged 5 - 21 years old: _____ (3)
    Children from birth to 5 years old: _____ (4)

    Total: _____

That is all for now. Thank you for taking time to participate in this research project.

Appendix B - Examples of Reflection and Reflexivity

Summary Note Immediately After an Interview



[redacted] [redacted] sept '18.. Reflection #1.

Social Worker:

I met P in her cosy windowless office. Immediately she made me feel welcome and began telling me about her office of 25 years. Positive outlook, enjoying her new office. Grateful for small things.

About connecting with people, not ready to retire yet although thinking about it and when it might happen.

A strong sense of justice and dignity. knows herself and what she is capable of. Stood up to the organisation and for herself in a time of challenge.

Does what she does for others and herself. Is clear that she also gets benefit from the role.

Role conflict has come from other SWers, not from the clients, they are not trouble. But colleagues and managers have come into conflict.

Has clear professional boundaries with clients, puts on her professional hat and is aware of when to step away & aside.

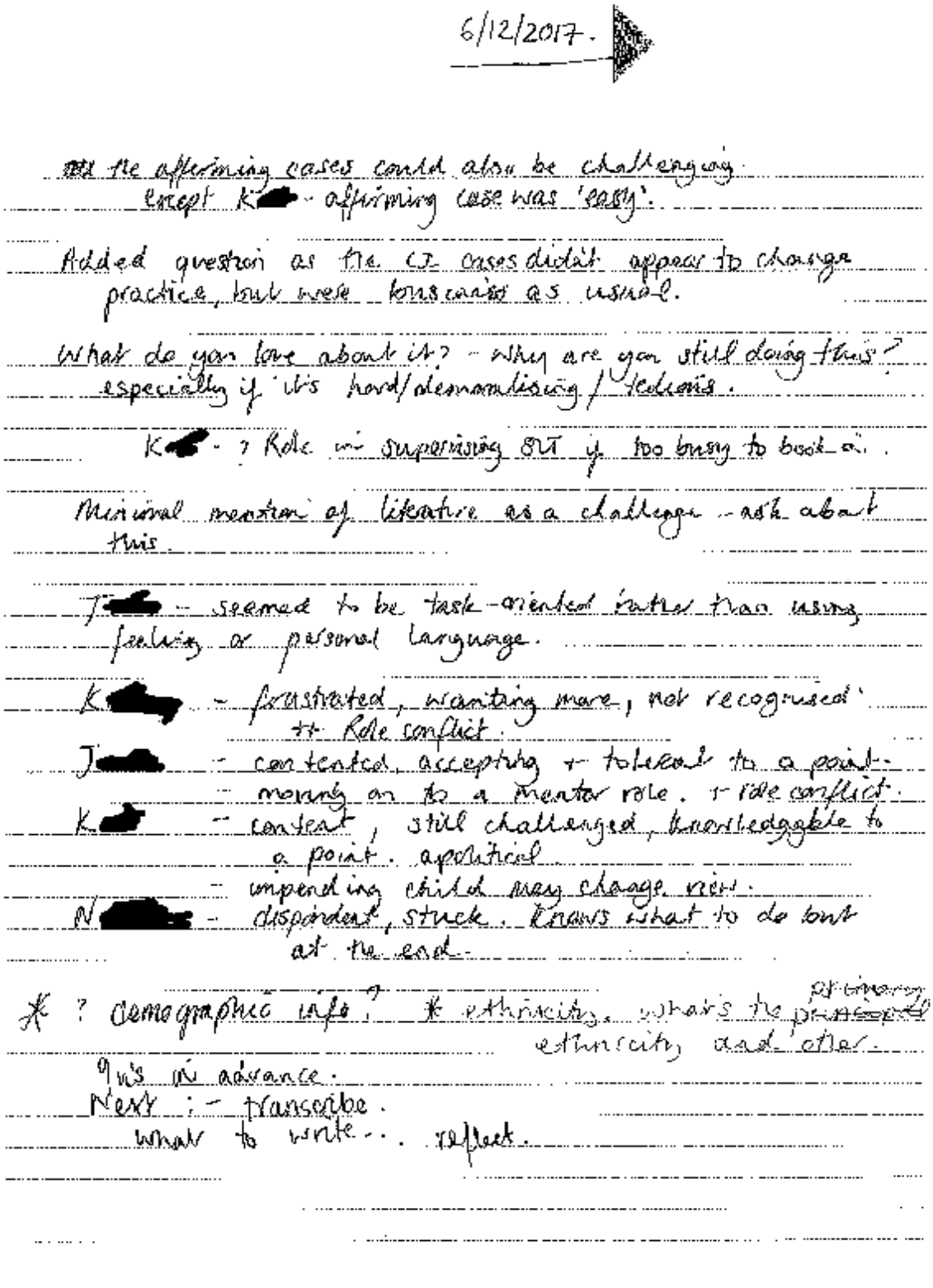
Has developed valuable self-care strategies that mean she loves life - both her job and her home life are a joy - she described home as a 'holiday'.

A sense that good things have come her way, although also has been in [redacted] has had hard times at work. She is a thriving survivor.

A success was in securing an extra 0.5 FTE for community SW.

[redacted] graduated as a SW in [redacted] had ask her first job

Reflection After Initial Set of Interviews



6/12/2017.

All the affirming cases could also be challenging except K[redacted] - affirming case was 'easy'.

Added question as the CI cases didn't appear to change practice, but were long cases as usual.

What do you love about it? - why are you still doing this? especially if it's hard/demoralising / tedious.

K[redacted] - ? Role in supervising OT if too busy to book in.

Minimal mention of literature as a challenge - ask about this.

J[redacted] - seemed to be task-oriented rather than using feeling or personal language.

K[redacted] - frustrated, wanting more, not recognised + Role conflict.

J[redacted] - contented accepting + tolerant to a point - moving on to a mentor role. + role conflict.

K[redacted] - content, still challenged, knowledgable to a point. apolitical
- impending child may change view.

N[redacted] - disjointed, stuck. knows what to do but at the end.

* ? demographic info. * ethnicity, what's the primary ethnicity and other.

q's in advance.

Next :- transcribe.

what to write... reflect.

Reflection on Reading the Literature

Comments on Cohen, L., & Duberley, J. (2013). Constructing careers through narrative and music: An analysis of Desert Island Discs

23 February 2019

What a fascinating paper, and from an unusual perspective. It has certainly given me some things to think about. Firstly the idea of career – a career as a public performance! Ron Barnett 2009 Reading International Careers Conference. "At a recent Careers conference (2009) Professor of Education Ron Barnett defined career as the 'public working out of one's possibility in an uncertain world'. This performative aspect of career is a dimension that has thus far received relatively little coverage in the career field, despite its ubiquity."

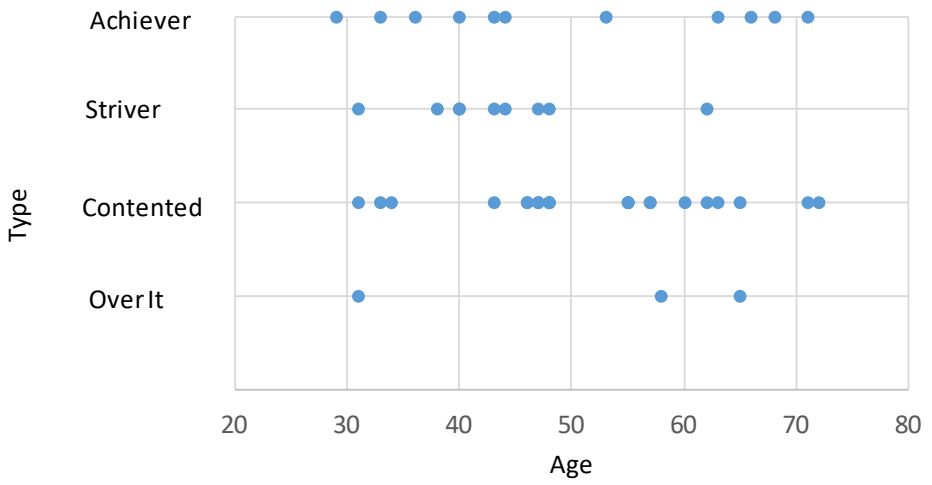
I can see how this relates to my data - most obviously the couple of people who 'told me their story' [redacted] particularly wanted to tell me the story of their careers and it seemed more of a performance than a created conversation. The paper talks about how we construct our stories of our careers to highlight and obscure aspects. "In our daily lives we perform careers in a myriad of contexts. In recruitment and selection, training and development programs, promotion processes, marketing activities and in documents like curriculum vitae, application forms, covering letters, performance review records and marketing brochures, we frame our experience in particular ways to illuminate salient aspects of our career lives, and to obscure others." And therefore *looking at CVs surely becomes a relevant source of data.*

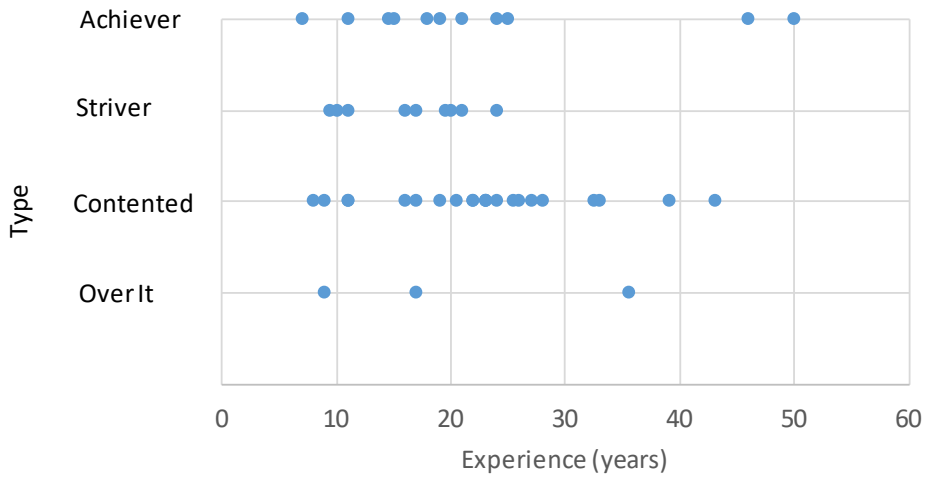
Secondly, themes that have emerged from the Desert Island Discs radio programme that seem pertinent in relation to Science Careers particularly:

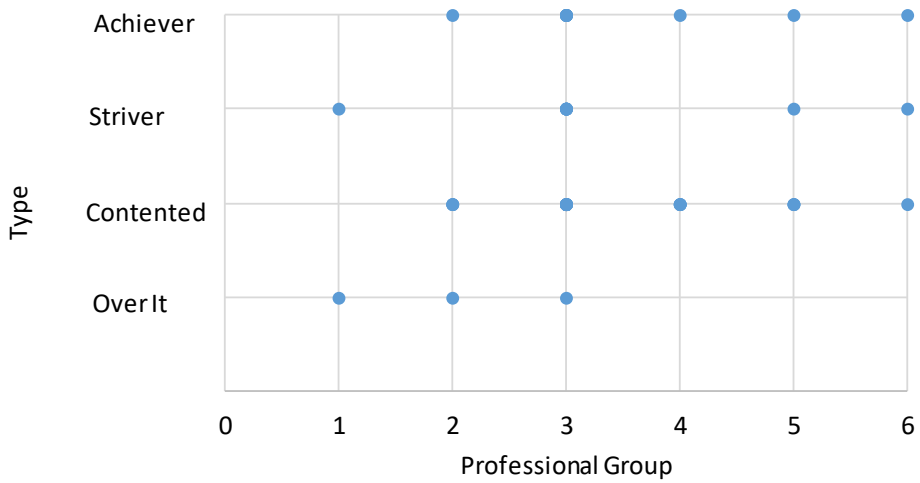
1. The scientific career as part of a collective endeavour – people do science collaboratively and collectively. They get in to science, are inspired by science and achieve science innovation through social works. Alluded to standing on the shoulders of giants. This was less so for the women in this study, but in my study – mainly women, in women's roles, the influences of other people come through strongly either a mentor, a placement supervisor, a manager, or alternatively the role of the family as either supportive or challenging.
2. The scientific career as triumph over adversity – I can not see that this relates in the same way. Women naturally are expected to go in to health roles and although several of the women had a somewhat tricky path, there was a sense of getting on with it, of enduring and resilience, rather than a sort of competition that needed to be won, or a fight. But maybe that needs listening for differently. Maybe I'm not hearing that because these are women's expected paths.
3. The scientific career as a quest for truth and beauty – certainly a parallel here would be the discussion about connection with others that came through strongly from many participants.
4. The scientific career as making the world a better place – and this is pretty much a given for my population. And if it isn't the case then burnout, and leaving the job would result.

I hadn't thought of the career as a performance before and now I will be listening out for it as it's clearly evident somewhat and may be more so.

Appendix C - Distribution of Grounded Empirical Types by Age, Experience and Professional Group







Note. Professional group 1 = dietetics; 2 = social work; 3 = speech-language therapy; 4 = occupational therapy; 5 = physiotherapy; 6 = other.

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