‘Even now it makes me angry’: health care students’ professionalism dilemma narratives

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CONTEXT Medical students encounter situations during workplace learning in which they witness or participate in something unprofessional (so-called professionalism dilemmas), sometimes having a negative emotional impact on them. Less is known about other health care students’ experiences of professionalism dilemmas and the resulting emotional impact.

OBJECTIVES To examine dental, nursing, pharmacy and physiotherapy students’ narratives of professionalism dilemmas: the types of events they encounter (‘whats’) and the ways in which they narrate those events (‘hows’).

METHODS A qualitative cross-sectional study. Sixty-nine health care students (29 dentistry, 13 nursing, 12 pharmacy, 15 physiotherapy) participated in group/individual narrative interviews. Data were analysed using framework analysis (examining the ‘whats’), linguistic inquiry and word count software (examining the ‘hows’ by dilemma type and student group) and narrative analysis (bringing together ‘whats’ and ‘hows’).

RESULTS In total, 226 personal incident narratives (104 dental, 34 nursing, 39 pharmacy and 49 physiotherapy) were coded. Framework analysis identified nine themes, including ‘Theme 2: professionalism dilemmas’, comprising five subthemes: ‘student abuse’, ‘patient safety and dignity breaches by health care professionals’, ‘patient safety and dignity breaches by students’, ‘whistleblowing and challenging’ and ‘consent’. Using Linguistic Inquiry and Word Count (LIWC) software, significant differences in negative emotion talk were found across student groups and dilemma types (e.g. more anger talk when narrating patient safety and dignity breaches by health care professionals than similar breaches by students). The narrative analysis illustrates how events are constructed and the emotional implications of assigning blame (an ethical dimension) resulting in emotional residue.

CONCLUSION Professionalism dilemmas experienced by health care students, including issues concerning whistleblowing and challenging, have implications for interprofessional learning. By focusing on common professionalism issues at a conceptual level, health care students can share experiences through narratives. The role-playing of idealised actions (how students wish they had acted) can facilitate synergy between personal moral values and moral action enabling students to commit and re-commit to professionalism values together.

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INTRODUCTION

The professionalism development of dental, nursing, pharmacy and physiotherapy students is paramount.[1–7] Although students are taught the principles of professional practice throughout their education, workplace learning commonly exposes them to professionalism dilemmas: 'ethically problematic day-to-day events for learners in which they witness or participate in something that they think is improper, wrong or unethical'.[8] Such dilemmas reflect those highlighted in government reports[1–3] and include witnessing and participating in the physical and emotional maltreatment of patients, witnessing substandard care, inadequate infection control and the abuse of self and others in the workplace.[9–16] Importantly, professionalism dilemmas can cause students distress and impact negatively on their developing professional attitudes and behaviours.[17] Although there is an ever-growing body of research examining professionalism dilemmas encountered by medical students – including the range of dilemmas students experience, their reasoning around these dilemmas, explanations for their behaviours during dilemmas and emotional expressions with narratives – less is known about these aspects within the broader health care student population.

Within medical education, Monrouxe *et al.*[18–21] conducted a large-scale international qualitative study listening to 200 medical students' narratives of professionalism dilemmas encountered across all years of their undergraduate education (833 narratives). Using narrative interviewing techniques, they gave medical students a forum to narrate events that they felt comprised a professionalism dilemma.[18–20] By listening to students' accounts of actual experiences, rather than presenting students with researcher-defined events, they found a broader range of dilemmas than reported in previous literature.[19] Furthermore, unlike previous research examining written narratives,[22] students' oral narratives were replete with emotional talk, the meanings of which were explored using both linguistic word count and narrative analyses.[23] For example, clinical students' narratives contained significantly more negative emotional talk than pre-clinical students, student abuse narratives contained significantly more sadness talk than other narratives and narratives of witnessing patient dignity and safety breaches by clinical teachers contained significantly more anger talk than similar breaches instigated by students.[19] Finally, traumatic professionalism dilemmas continued to affect some students emotionally, despite events occurring over a year previously (e.g. some students openly wept while recounting them, others used laughter for coping).[19,24]

Although fewer studies have specifically examined nursing, pharmacy, physiotherapy and dentistry students' professionalism dilemmas, researchers have considered factors underlying student stress. For example, inconsistent feedback, receiving unjustified criticism on work and perceived lack of self-efficacy in ability to treat patients were ranked highest among dental student stressors, all of which relate to potential dilemmas as identified by medical students.[25–31] Furthermore, witnessing abuse and being victims of abuse can cause students distress.[32,33] Although studies are beginning to explore professionalism dilemmas encountered by health care students, they all employ samples from single sites, some use questionnaire surveys, so lack the 'richness' of narratives[10,34] and those capturing narrative use written essays rather like 'crafted confessions'.[9,35–37] Two studies employed focus groups, but analysed the data in a fragmentary rather than holistic manner.[38,39]

In this study we aim to address the limitations of previous research through our exploration of personal incident narratives (PINs) about professionalism dilemmas by dental, nursing, pharmacy and physiotherapy students across three sites in different countries (Wales, England and Scotland). Our conceptual framework is multilayered and complementary as we wish to understand narratives by considering what is said (i.e. content) and how stories are narrated (e.g. linguistic, para-linguistic and structural aspects).

THEORETICAL AND METHODOLOGICAL FRAMEWORK

We draw on 'Labov's[40] structural perspective, in particular his understanding of personal narrative: 'a report of a sequence of events that have *entered into the biography of the speaker* by a sequence of clauses that correspond to the order of the original events' (our emphasis), which is evaluated emotionally and socially as we make sense of experiences. In terms of narrative construction, Labov[41] outlines a number of structural features typically found: beginning with the story's gist (abstract), moving on to information about who, where and when events occur (orientation) and what happened (the complicating action). Finally, evaluating the event and

its consequences is a core function of narrating and an essential aspect for the individual's needs. Typically, narrators flow backwards and forwards through their story, providing further orientation, complicating actions and evaluations as they make sense of events for themselves and the listener.[19,42,43] Furthermore, the concept of reportability is a key feature of narratives; as a social act, at least one reportable event must be narrated (a key action), with the 'most reportable event' being evaluated most. Finally, narratives have a strong moral dimension. Narrators are motivated to understand why things happened the way they did (the development of a personal theory of causation), assigning praise and blame when doing so. This assignment is key to our understanding of the emotional impact of events for the narrator.[44]

Although some researchers examining professionalism dilemma narratives report a lack of emotional content,[22] by using specialist software to analyse emotional talk, rather than manual coding, we found a plethora of emotions narrated in our previous research of oral and written narratives.[19–21] The Linguistic Inquiry and Word Count (LIWC) software is one such program containing a processing component and a dictionary.[45,46] LIWC identifies the total amount of negative emotion talk (from the dictionary comprising 500 words and stems), which is expressed as a percentage of the data. LIWC further breaks this down into anger, anxiety and sadness talk.

Such numerical data appear to sit uneasily within our interpretivist philosophy that views realities as dynamic and socially constructed and language as contextual: numbers suggest a measured objectiveness that can be generalised. However, some qualitative researchers examine patterns of words and phrases in their data using frequencies, numbers and statistics[47] and many allude to quantities through terms such as 'sometimes', 'often' and 'frequently'.[48] Indeed, numbers facilitate pattern recognition and verify interpretations of data.[49] And philosophically, the simplistic qualitative–quantitative divide is illusionary: measurement is always understood according to the qualities of phenomena we measure.[50] The qualities of the word count that LIWC employs have been rigorously developed and refined, comprising over 80 categories, accurately identifying negative emotion words.[23,46] Our use of LIWC therefore enables us to identify patterns of negative emotion words within our data in a standardised manner, to present sufficient evidence of our interpretations of the data (rather than 'cherry picking' supporting examples) and to compare the emotional content of these data with those from previous studies.[19,20,47]

RESEARCH QUESTIONS

We adopt an inter-subjective perspective, focusing on the personal, experiential and cognitive aspects of individuals' narratives. We aimed to develop the framework analysis of medical students' PINs from our previous work,[19] alongside both LIWC and narrative analysis to answer the following original research questions addressing aspects of what is told (the events) and how those events are narrated:

> RQ1: What is the range of professionalism dilemmas narrated by health care students?
> RQ2: What differences exist (if any) in the amount and type of negative emotional words used by different health care students when narrating professionalism dilemmas?
> RQ3: What can narratives reveal about the role of emotion in the construction of blame in students' lived experiences of participating in professionalism lapses?

Thus, RQ1 examines the types of dilemma and RQ2 explores differences in negative emotional talk between health care student type and across dilemma types. For RQ3, we analyse a single PIN to understand the interrelatedness and complexity of professionalism dilemmas. In doing this we bring together the essence of RQs1 and 2, to understand how the assignment of blame impacts one student's lived experience of events within her sense-making processes of narrating.[40,41]

METHODS

Design

A qualitative narrative interviewing design was used. Participants were interviewed in pre-existing uniprofessional groups or individually.

Participants

A convenience sample of students from three different UK countries in their penultimate or final year of their undergraduate courses were invited to participate through lectures, e-mails and snowballing. Dentistry, nursing and physiotherapy students came from two different locations; pharmacy students came from one.

Data collection

Eleven group and three individual interviews (n = 69; 49 females, 20 males) were held across universities A, B and C (Table 1). The total number of participants in each participant group was: dentistry (n = 29), nursing (n = 13), pharmacy (n = 12) and physiotherapy (n = 15).

We used a narrative approach to interviewing elicited PINs. Participants were asked to describe what professionalism meant to them. They were then asked: 'Have you ever been in a situation that you felt to be a professionalism dilemma?' Participants were asked to focus on a specific situation and to tell their story of events including what they did and why. Data collection ended when participants had covered the breadth of dilemmas experienced or when time elapsed. Interviews were audio-recorded, transcribed (including pauses, laughter, overlapping talk, hesitations, etc.) and anonymised.

Data analysis

The transcripts were linked to the audio-files in ATLAS.TI. Researchers simultaneously listened to audio-recordings and read while analysing transcripts. The data were initially classified according to the predefined framework developed with medical students[19] using thematic framework analysis.[51] This began with three researchers independently reading and analysing one transcript from each participant group. They separately identified students' constructs of professionalism along with PINs of professionalism dilemmas, mapping these on to the existing framework, but also developing the framework to account for new data. The researchers discussed and negotiated their impressions of the data and developed a generic framework to encompass health care student data. The data were then coded by one researcher. Using Labov and Waletsky's[40,41] structure, whole narratives were identified and holistically coded to main (often multiple) content themes.

A secondary analysis of the data using LIWC (LIWC.net, Austin, TX, USA) was then undertaken. Focusing on the three main dilemma categories (providing sufficient data for comparisons across both dilemma and participant types), one researcher prepared the data according to the LIWC guidelines.[52] All interviewer talk was removed and double negatives were altered to preserve meaning (e.g. 'not uncomfortable' was changed to 'comfortable') as LIWC classifies individual words not word strings. Using LIWC, two researchers entered the percentage of negative emotion talk, anxiety, anger and sadness talk for each PIN into SPSS alongside two variables: student and dilemma types. Kruskal–Wallis and Mann–Whitney statistics (the data were typically non-normally distributed) established statistically significant differences. To compare our findings with

Table 1 Group composition and location

	Student	Year of study	Location	Gender (female/male)
Group 1 (n = *4)*	Physiotherapy	3	A	4 female
Group 2 (n = *8)*	Dentistry	4	A	7 female, 1 male
Group 3 (n = *8)*	Dentistry	5	A	4 female, 4 male
Group 4 (n = *3)*	Dentistry	5	B	2 female, 1 male
Group 5 (n = *10)*	Dentistry	5	A	4 female, 6 male
Group 6 (n = *7)*	Pharmacy	4	A	6 female, 1 male
Group 7 (n = *5)*	Pharmacy	Mixed 2, 3 and 4	A	3 female, 2 male
Group 8 (n = *5)*	Physiotherapy	3	C	4 female, 1 male
Group 9 (n = *6)*	Physiotherapy	3	C	4 female, 2 male
Group 10 (n = *2)*	Nursing	3	C	2 female
Group 11 (n = *8)*	Nursing	2	B	7 female, 1 male
Interview 1	Nursing	2	B	1 male
Interview 2	Nursing	3	B	1 female
Interview 3	Nursing	3	C	1 female

previous research we report a standardised measure – the effect size – using $r = Z/\sqrt{N}$.[53] The magnitude of effect sizes for Cohen's r is: 0.1 is small; 0.3 is medium; 0.5 is large.

Finally, to examine the complexity of dilemma events and how story-telling triggers in-the-moment emotions through the moral evaluation of events, one researcher undertook a detailed narrative analysis (addressing RQ3). This in-depth analysis draws on evidence from sociolinguistics, cognitive linguistics and narrative theory. As narrative analysis is detailed and lengthy, we present just one PIN and focus primarily on the moral dimension of assigning blame,[40,41] including how narrators position themselves and others through narratives in terms of their identities, which brings forth emotional talk.

RESULTS

Our results are structured according to the research questions, with each section building on the previous.

Thematic analysis

The thematic framework analysis resulted in nine main themes (and sub-themes) for content and linguistic aspects of students' talk: (i) Explicit definitions of professionalism; (ii) Professionalism dilemmas; (iii) Acts of resistance and compliance to authority and dominant health care cultures; (iv) How students talk about patients and other health care providers; (v) Reported thoughts and speech; (vi) Humour and laughter; (vii) Metaphoric talk; (viii) Emotional talk, and (ix) Narrative plotlines.

Theme 2: Professionalism dilemmas

We identified 226 distinct PINs (104 dental, 34 nursing, 39 pharmacy and 49 physiotherapy) that were coded within theme 2 to one or more of 19 sub-themes. One researcher identified the primary theme for each narrative for the purpose of the LIWC analysis (negotiated with two other researchers). The five most commonly reported sub-themes were 'student abuse dilemmas', 'patient safety and dignity breaches by health care professionals (HCPs)', 'patient safety and dignity breaches by students', 'challenging and whistleblowing dilemmas' and 'consent dilemmas' (see Box 1 for examples). Less commonly reported sub-themes included dilemmas around learning facts or procedures, patients' health and illness behaviour and death and dying dilemmas. Furthermore, although participants narrated similar dilemmas to those identified in previous medical student research, there were two notable additions to our coding framework: pharmacy students experiencing patient safety and dignity breaches by non-HCPs; and dentistry students inadvertently knowing information about patients' health unknown to others (see Box 2).

Box 1 Main five sub-themes with brief excerpts

Student abuse (total n = 55)

Excerpt 1

One of my colleagues was doing a treatment and I was assisting… it was quite a **difficult** treatment… probably beyond his knowledge… he was kind of forced into doing it, even though the supervisor did say 'I'll give you all the support that you need', it didn't go to plan… the supervisor already had a **bad** day and he came over, in front of the patient he says to my colleague 'you're never going to make a competent dentist'… it's a **tough** situation. Y5DENM10

Excerpt 2

I had a **horrible** placement in the summer… I had a **really horrible** 4 weeks and the staff… they spoke down to me quite a lot… in front of the patients. Y4PHAF25

Patient safety and dignity breaches by health care professionals (total n = 48)

Excerpt 3

I had a patient who I examined and then the member of staff came over and examined without gloves on… and **I wasn't very happy** but because the person was a consultant I felt I couldn't say anything, but they were really quite so high up… first it wasn't in the patient's best interest because you know, you're meant to be protecting a patient not exposing them to heavy pathogens… **disgusting.** Y4DENM1

Box 1 (Continued)

Excerpt 4
There was one patient on the ward who had dementia… we were trying to get them to stand up out of the chair and go for a few steps with a walking frame… and as he kept looking, looking more and more awkward and, like, she [the physiotherapist teacher] just flipped her lid and she literally grabbed the walking frame and chucked it across the ward, and I was standing next to her, I didn't say anything it. Y3PHYF3

Patient safety and dignity breaches by students (n = 37)

Excerpt 5
I was actually told last year by a member of staff if a patient comes in with a big amalgam filling, like a metal filling, just replace it, put some sort of white filling in there, it's all good practise… but really that's unethical because you're using the patient's time. Y4DENF7

And risk, there's a risk of damage. Y4DENM1

Excerpt 6
It was one placement and they wanted me to give like an injection, and we're definitely not allowed to do them at that stage, and I says 'oh no, we're not allowed to do them', she went 'oh no, you are if I watch you, you're allowed to do them' and I was a bit like 'no I don't think we are' and she said 'oh no- no- no- just do it- just do it', just sort of felt 'oh gosh, she's going to make me do it', well eventually I did… but I just sort of said to her 'I don't really want to do that again because if anything does go wrong it will be, sort of, my fault'. Y3NURF31

Students' challenging and whistleblowing dilemmas (n = 18)

Excerpt 7
There is one guy, one supervisor who will wear the same gloves between each patient, and stick his hands in their mouth and then goes to the next one, but I would not say anything because at the end of the day he's so much more superior than me and you just wouldn't want to upset anyone, because I don't know, it's that **fear of people hating you** um ([laughs]) because the thing is with the dental world is-… it's a very small world for dentists. Y5DENF19

Excerpt 8
I was on neurosurgery… we were doing tracheal care on him and chest physio and he opened his bowel and I said 'Oh, I'll get some wipes and clean him' and she [clinical educator] said 'No, that's not what the physio job is, the nurse will take care of that' and I said 'yes but the nurse might be 10, 15 minutes, I can just do it quickly' and she said 'but we've got other patients to do as well' and I was thinking that 'OK so the guy had brain injury so he might not be fully aware of his environment but still, it's just basic nursing care, you don't have to be a nurse to give nursing care do you?'… I think as a student it's even more easy to almost **put up a fight** and go on a crusade because you're not going to work there in 5 weeks time. Y3PHYF5

Consent dilemmas (n = 17)

Excerpt 9
Had a patient who wanted to be seen by a member of staff but the member of staff said [to the patient] 'look, this is a teaching hospital here, this is a simple case, she will do it' and I did it. Y4DENF5

Excerpt 10
I remember one patient ((laughingly))…she wasn't able to give verbal consent so my Clin Ed said that she gave implied consent and I'm not sure that she did or not, but I was the one giving the suction, I was like standing ready with the catheter to stick it down and as soon as she coughed and like as soon as I stuck it down she started shaking her head, um like whether it was out of discomfort or whether she was saying 'I don't want this take it out' I don't know, but my Clin- Clin Ed was there like standing over me saying 'just keep shoving it down- just keep shoving it down' so I did ((laughs nervously)) she shook her head around which meant like- inside of her nose got cut and so she was bleeding which came into her mouth and she started shaking her head and spitting everywhere so I got covered in blood. Y3PHYF1

Each PIN had a sub-theme to which it was primary coded (i.e. the dominant theme in the PIN), although it might also have contained aspects of other sub-themes to a lesser degree). Participants' unique identifiers include year of study, health care student type (DEN, NUR, PHA, PHY), gender (F/M) and participant number. Students' emotion words are in bold.

Box 2 Developments to the coding framework based on medical students

Pharmacy: patient dignity breaches by non-health care professionals (HCPs)

Pharmacy students' work placements differ from others health care student groups in that they commonly work with non-HCPs (e.g. sales counter staff). Their narratives contained many dilemmas, including breaches of patient dignity instigated by non-HCPs, such as confidentiality breaches, and communications violations to and about patients, such as patients undergoing gender reassignment, with mental health problems and methadone users:

I'd only just worked in the shop a couple days and all I heard was someone shout across the dispensary 'addict on the floor, addict on the floor' and that meant an addict was in the shop, and they weren't allowed in the shop… they were told just to go straight out of the shop and to use their separate entrance in front of a whole customer- a whole room full of- you know. Y4PHAF26

Dentistry: inadvertently knowing information about patients' health unknown to others

Dental students recounted experiences of noticing oral cancer to which their patients were unaware:

We had a patient coming in the consulting clinic and she was saying 'yeah I wear a full upper denture, but I had a bit of a problem and with my gums but I think it's fine now it's wearing off, I went to my GP he thought it was thrush and he gave me a mouthwash, it's fine now- it's fine now' so she opens her mouth ((laughs)) and half of her palate was cancer. Y5DENF13

Student abuse

The most common sub-theme focuses around direct and indirect experiences of verbal abuse (including humiliation and intimidation) and emotional mistreatment (e.g. senior staff ignoring or shunning students), with 55/226 PINs (24%) primarily coded to this theme. Similar forms of abuse were narrated across: dentistry (n = 21; 20%), nursing (n = 3; 9%), pharmacy (n = 17; 44%), and physiotherapy (n = 14; 29%). We report these data in detail elsewhere so provide only a brief explanation here.[54]

The protagonist in these narratives is sometimes a senior HCP, patient or (for pharmacy students only) non-HCPs. The victim is often the participant themselves, but sometimes participants witness mistreatment of others (Box 1, Excerpt 1). Included in this sub-theme are incidents of sexual harassment and gender discrimination, typically experienced by female students from male colleagues or patients, and racial abuse. Often, student abuse occurs in front of patients, causing further distress. Underlying this sub-theme are aspects of power relationships within health care professions and also (in the case of pharmacy students) non-health care professions, where new people are treated as subordinates and forced to undertake menial tasks (Box 1, Excerpt 2).

Common negative emotion words used in this theme include wrong, bad, difficult, upset, inappropriate and uncomfortable. Using LIWC we found significant differences in anger talk between types of dilemma (χ^2 =8.374, d.f. = 2, p = 0.015) and by student type across dilemma type (χ^2 = 9.922, d.f. = 2, p = 0.007). See Table 2 for details of *post-hoc* tests.

Patient safety and dignity breaches by HCPs

Although safety and dignity can be classified separately, these issues can equally be seen as being interlinked – rather like treating the whole person – 'The failure to provide care that respects patients' dignity and autonomy is a harm as critical as a clinical harm... When patients and families are significantly engaged, they will help to achieve important medical outcomes that are more meaningful, efficient and durable'.[55] Using a concrete example from our dataset, even when issues seemed to fall more squarely on the safety than dignity side of the continuum (e.g. poor hygiene), it can be argued equally that unhygienic care can also be classified as undignified care. To avoid unnecessary overlap between themes and for clarity, we decided to combine the two issues thematically. This sub-theme therefore categorises patient safety and dignity breaches by HCPs as witnessed by students. This was the second most common sub-theme, comprising 48/226 PINs (21%). More of these dilemmas were narrated by nursing participants (n = 16; 47%), followed by dentistry (n = 12; 11%), pharmacy (n = 11; 28%) and physiotherapy (n = 9; 18%).

Patient safety involves a range of systems failures and errors connected with patient care and different student groups narrated different types of breach.[56] Dental students narrated more dilemmas around patient safety than dignity. Examples included dental nurses performing procedures outside their competencies or actions such as removing a drill from a student's hands without asking/warning, a senior consultant perforating a patient's tooth (causing serious infection) and covering up his mistake by passing it off as a student error and senior dentists not adhering to hygiene regulations even where methicillin-resistant *Staphylococcus aureus* (MRSA) is present (Box 1, Excerpt 3). Other breaches included nurse students witnessing nurses cheating the audit system and ignoring emergency buzzers, HCPs' poor clinical care putting patients at risk (see our in-depth narrative analysis below) and pharmacy students witnessing (and challenging) prescription errors.

Although other participant groups also narrated dilemmas around poor hygiene (nursing and physiotherapy), these groups mainly narrated patient dignity dilemmas. Dignity is a complex issue that involves how people behave in terms of the worth of others and in terms of people's own perceptions of how others view them.[57,58] Dignity breaches include HCPs' inappropriate talk to or about patients, including addressing the patient by their illness rather than their name, patients' bodies being exposed publically and HCPs being unduly harsh to patients (Box 1, Excerpt 4).

Common negative emotion words used in this sub-theme include wrong, awful, inappropriate, uncomfortable, angry and shock/shocking. See Table 2 for details of our LIWC analysis of emotional terms within this sub-theme.

Patient safety and dignity breaches by health care students

This sub-theme categorises narratives of safety and dignity breaches by students, of their own volition and at the request of a tutor, comprising 36/226 PINs (16%), mainly dental student narratives (n = 26, 70%) but also from nursing (n = 3; 9%) pharmacy (n = 2; 5%) and physiotherapy students (n = 5; 10%).

The majority of narratives focused on patient safety issues. Dilemmas included dental participants being told to undertake dental work on patients who do not need it in order to gain practice (Box 1, Excerpt 5), allowing personal attitudes to negatively impact on students' behaviour with patients (e.g. with HIV or hepatitis B), witnessing peers' inaccurate history taking and recording, witnessing peers treating patients while under the influence of alcohol, working beyond their level of competence without supervision, making and covering up mistakes (e.g. going through the roof of a patient's mouth and trying to hide it). Nursing and physiotherapy participants talked about undertaking work they felt was inappropriate for their level (Box 1, Excerpt 6)

Table 2 Details of the post-hoc tests for emotional talk by dilemma sub-theme and student group

Variable of interest	Sub-theme/student groups compared	n	Median (M), *interquartile range (IQ), average rank (AR)*	Test statistics (Z), *p value and effect size (r)*
Anger talk	Abuse narratives	55	0.3000, 0.0000–0.5100, 52.43	−2.789, 0.005, 0.29
	PSD by students narratives	37	0.0000, 0.0000–0.2400, 37.69	
Negative emotion talk in abuse narratives	Physiotherapy	14	1.1350, 0.0000–1.8575, 12.71	−2.494, 0.01, 0.42
	Dental	21	1.8400, 1.1750–2.3400, 21.52	
Negative emotion talk in abuse narratives	Physiotherapy	14	1.1350, 0.0000–1.8575, 12.71	−3.418, 0.001, 0.61
	Pharmacy	17	2.2200, 1.5300–3.0450, 21.06	
Anger talk	PSD by HSPs narratives	48	0.2450, 0.0000–0.5675, 48.18	−2.416, 0.016, 0.26
	PSD by students narratives	37	0.0000, 0.0000–0.2400, 36.28	
Anger talk in PSD by HSPs narratives	Nursing	16	0.3000, 0.0550–0.6425, 15.31	−2.189, 0.029, 0.44
	Physiotherapy	9	0.0000, 0.0000–0.1500, 8.89	

PSD = patient safety and dignity dilemma; HSP = health service professional.

and one pharmacy student talked about making prescription errors. In terms of dignity, the most common experience was talking about patients inappropriately. The most common emotion words used were wrong, difficult and bad.

Challenging and whistleblowing dilemmas

This sub-theme categorises situations primarily about challenging others' behaviours and whistleblowing. Although many narratives included these issues, 18/226 (8%) narratives were primarily coded to it, including 10% of dentistry and physiotherapy narratives, with nursing (n = 2; 6%) and pharmacy students (n = 1; 3%) narrating fewer events.

The types of event included students being asked to report their peers, situations in which students wished to challenge seniors but did not (Box 1, Excerpt 7) and students successfully challenging peers and seniors (Box 1, Excerpt 8). Reasons for not challenging focus on participants' concerns for themselves including: fear of being marked down, feeling it is not their place, concerns they might be wrong, fearing their seniors and beliefs that nothing will change if they do challenge. Reasons for challenging primarily centred on participants' concerns for patient care and their desire to relieve suffering. The most common negative words included wrong, bad, difficult and dangerous.

Consent dilemmas

Valid consent has been defined as on-going, voluntarily and freely given by an appropriately informed patient who has the capacity to consent and without influence exerted by others.[58] When students undertake physical examinations or procedures, patients must understand students' exact position or abilities, and that it is for the benefit of students' learning, and they must consent to that.[59] Sometimes students performed examinations and procedures (including intimate ones) without valid consent, usually because they were asked to by their seniors, but sometimes through their own volition. Seventeen of 226 (7%) narratives were primarily coded to this sub-theme comprising an equal percentage of narratives (9–10%) from dentistry, nursing and physiotherapy participants, and none from pharmacy students as they are not required to examine patients.

Dental participants' narratives primarily concerned patients coming into teaching hospitals demanding to be seen by consultants rather than students, but told that the student would carry out the procedure (Box 1, Excerpt 9). Other situations were students misrepresented their status and experience to patients, patients lacked the capacity to consent (e.g. mental health) or patients' first language not being English and so consent was ambiguous (Box 1, Excerpt 10). Verbal coercion was the main topic of nursing and physiotherapy participants' narratives. The most common negative emotion words in these narratives included difficult, uncomfortable and argue(d).

Bringing it together: identity, emotion and the construction of blame through narrative

We now consider our final research question though narrative analysis of one story to illustrate how events are constructed and the emotional implications of how we assign blame (an ethical dimension). We chose this narrative because it: (i) comprises a number of sub-themes, including patient safety breaches by an HCP, student abuse and challenging/whistleblowing; (ii) has on-going evaluations of events; (iii) includes 'identity work' as the narrator positions herself and the perpetrator in her narrative, and (iv) includes strong emotional talk.

The narrator is Sara (a pseudonym for anonymity), a second-year, White, female nursing student. A significant proportion of the narrative is reproduced in Box 3, transcription notations (e.g. laughter) aid interpretation along with comments on the event structure of the narrative.[40,41] The full narrative is available from the corresponding author.

'Even now it makes me angry'

Sara's narrative concerns an event during her 'very first placement' on an elective neurosurgery ward. In terms of narrative plot (Theme 9, not presented here), although it has strong elements of a regret narrative, it is also a journey narrative she tells her story because it demonstrates how her attitudes change over time. The most reportable event is where Sara, knowing the correct procedure, watches a health care assistant (HCA) incorrectly removing staples from a patient's back and without creating a sterile field, resulting in the patient's wound opening and necessitating further surgery. Sara accepts moral responsibility, blaming herself for not speaking out. Over a year after the event, she still feels morally distressed.

Box 3 Sara's edited narrative: 'Even now it makes me angry'

Orientation #1

… so I'd spent the morning with my mentor a few days before and she'd taught me how to take staples out of a- a wound… she taught me about aseptic technique (.) how to use the clip remover to take them out (.) that it should be alternate staples one day to ensure that the wound is fine (.) that it's not going to open (.) and the following day under doctors' instructions they would then take the rest out (1.0)

Complicated action #1

a few days later one of the HCAs

Evaluation #1

who I'd like to add ([laugh]) hadn't been very pleasant to me since I'd been there (.) don't quite know why

Complicated action #2

but (.) has come up to me and said 'right I'm going to take some staples out of this back wound (.) do you want to come and watch because (.) you know (.) you need to know how to take them out'

Evaluation #2

(.) so I thought 'well I'm not going to say to her 'it's alright thanks I've already seen it' (.) because I thought I want to try and fit in (.) I don't want to be student nurse (.) pain in the butt'… because I've been an HCA (.) I do know how some people treat student nurses and thought 'I don't want to be one of the ones that's not going to get stuck in and be part of the team' (.)

Complicated action #3

so I said 'okay (.) yes I'll come along and watch' (.)

Evaluation #3

won't bother saying to you I've seen it

Complicated action #4

but off I went (.)

Evaluation #4

and even now it makes me so angry (.)

Most reportable event

I sat there and I watched her (.) take these staples out of this patient's back **without** using aseptic technique (.) she **didn't** put any sterile gloves on (.) she **didn't** create a sterile field (.) and she took all of the staples out all in one go (.)

Evaluation #5

now (.) I'd been with the doctor when he did the doctor's round and I remember him saying 'I'd like alternate staples taken out of this wound (.) in the morning' (.) she then came and took them all out (.)

Complicated action #5

and I didn't say anything (.)

Evaluation #6

part of me- I didn't say anything because I was scared to death of her (.) she'd been really rude and really derogatory to me since I'd started the placement (.) she spoke to me like a complete idiot (.) and I knew that she'd worked there for **years** (.) so I thought 'well she obviously knows what I'm doing there' (.) maybe it's one of these places where some nurses do things like that and some nurses do it like that (.) I thought 'well I'll only do it how my mentor's taught me because that's what she's taught me to do' (.) but I don't know if that's (.) I've never worked in neurosurgery before (.) I didn't know if that was what you should do (1.0) so I'm (.) mortified now that I didn't say anything (.) the doctor was furious (.) absolutely furious when he came back to see this patient (.)

Complicated action #6

and the reason he had to come back to see the patient was because the wound completely split open (.) and that patient had to go back to theatre (.) that night to have her wound reclosed (.) erm

Box 3 (Continued)

Evaluation #7

and I felt that that was my fault because I didn't say anything (.) **because** I was scared of her (.) **because** I didn't really know what I was doing (.) **because** I'd only been there a few days and just wanted to fit in and had no experience (.) **now** I would do it completely differently ([laughs]) I wouldn't even let her touch the patient without using aseptic technique (.) I would stand up for what I knew was right (.) I would say 'I'm sorry (.) I've heard the doctor say this is what he wants (.) I'm going to go and check the notes just to confirm' (.) and I would say something **now** (.) but I don't know whether that comes with experience and the fact that the more my course has gone on (.) the more confident and assertive I've become.

Transcription notations: (.) = micro-pause; (1.0) = pause in seconds; - = running on talk; ([says laughingly]) = paralinguistic detail; bold = word said with emphasis.

Identity construction

Sara's narrative reveals how she rhetorically constructs her identity through moral assertions, including her use of direct reported thought and speech within evaluation talk e.g. 'I said', 'I thought'.[60] Thus, Sara's narrative has a moral purpose. She tells it, not for herself, but for 'student nurses' in general, as a moral story of change (these comments are edited from the narrative for expediency). But her change is not in her morals; rather it is in how she acts on those morals. Sara is an eager apprentice. Following her mentor's instruction, she learns the correct procedures on the ward and vows to follow the 'right' way, despite the prevailing culture. Sara continually asserts her strong moral identity as she repeatedly reports her own thoughts about the HCA's actions: 'that's not right'.

Sara constructs the identity of the perpetrator as a bully, tolerated by other staff, who acts beyond her level of competence. She feels to be a victim of abuse by the HCA; feeling 'scared to death of her', resulting in Sara not acting on her moral stance. The patient's doctor receives little attention, except that he is 'absolutely furious' with the actions of the HCA. Interestingly, the patient is invisible; a body devoid of gender and any form of reaction to their predicament.

Personal theory of causality, evaluation, emotions and identity change

Rather than attributing blame to the HCA for the patient's wound opening, Sara blames herself for 'not saying anything'. In blaming herself, her narrative focuses on how she felt at the time, 'scared of her', and how she feels now (over a year after the events), 'angry' and 'mortified'. As she evaluates her (in)action during the most reportable event, Sara narrates a change. This change indicates her shifting identity as a nurse. A few days after the event, she challenges the HCA by refusing to go beyond her own limits as a student nurse (signing off a drug chart). And in her narrative she uses future hypothetical statements, laughter and reported talk to re-write history: 'now I would do it completely differently… '. Furthermore, this re-writing of history seems to mitigate the emotional impact her inaction caused.

DISCUSSION

We asked 69 dentistry, nursing, pharmacy and physiotherapy students to tell us stories about the different types of professionalism dilemma they had experienced during their work placements. They narrated 226 PINs, which we classified by developing our existing framework of medical students' narratives of similar events.[19] All participant groups narrated dilemmas around student abuse, patient safety and dignity breaches (by HCPs and students) and dilemmas around challenging others and whistleblowing. All except pharmacy students narrated dilemmas around gaining patient consent for their learning. Pharmacy students alone narrated patient safety and dignity breaches by non-HCPs (e.g. counter staff). Dental students also narrated dilemmas around inadvertently knowing information about patients' health unknown to others: specifically oral cancer. Our findings therefore extend our previous research with medical students by identifying a wider range of professionalism dilemmas than previously found, highlighting similarities and differences across health care student groups.[19–21]

When we consider emotional words, unlike the hand-coded written narratives examined by Karnieli-Miller

et al.,[22] our participants' oral narratives were filled with such talk. This finding replicates our earlier findings with medical students' oral[19] and written[20] narratives in which we used the LIWC software. We believe that the use of this software enabled us to identify and measure emotional talk more effectively and efficiently than hand-coding methods. In terms of our findings, when examining emotional talk by dilemma type, we found that participants used more negative emotion and anger talk when narrating abuse dilemmas, especially dental and pharmacy participants. Again, a finding similar to that with medical students' written narratives.[20] However, this runs counter to our previous findings with medical students' oral narratives, who used more sadness talk (e.g. talk of crying and other *inward-focused* acts)[61,62] when narrating abuse dilemmas.[19] Indeed, the findings here resonate more with previous research about workplace abuse, which commonly report *outward-focused* reactions (e.g. verbal aggression) to an injustice whereby victims become angry with 'another'.[62]

Replicating a similar finding in our previous studies with medical students' oral and written narratives, participants used significantly more anger talk when narrating patient safety and dignity breaches by HCPs than when narrating similar breaches by students.[19,20] We believe this disparity in anger talk between similar actions of HCPs and those of students can be understood as participants' attempts to reconcile personal negative acts that run counter to their own moral beliefs; a kind of cognitive dissonance where a person's behaviours and beliefs contradict each other, thus creating the need to resolve this tension.[63] Although we make no claim for actual belief or attitudinal change, narratives are constructions through which we are able to fashion events for personal resolution and face-saving purposes.[64] Therefore, through evaluation phases of narratives, participants work to save their own and others' positive face when recounting professionalism lapses by students. Such events were narrated as 'difficult' and 'bad' experiences, revealing the internal tension between ethical beliefs and actual behaviours. However, when such lapses are by HCPs, who were not present in the room, face-saving and dissonance resolution are not required. Participants are thus able to join together to exert their strong moral stance, expressing the injustice they feel about the 'awful' and 'shocking' events.

We also found that physiotherapy students expressed significantly less negative emotion talk for abuse dilemmas compared with dental and pharmacy students and less anger talk for patient safety and dignity breaches by HCPs compared with nursing students (with moderate to large effects sizes). When looking at the content of these narratives, the events narrated by physiotherapy students appeared less serious, traumatic and life-threatening compared with, for example, the patient safety and dignity dilemmas experienced by nursing students. Furthermore, the physiotherapy focus groups seemed to contain more laughter than that found in the other groups and interviews, and so perhaps they expressed their emotions through laughter for coping rather than through negative emotion talk.[24]

Through our in-depth analysis of a single narrative we see a complex relationship between moral values, (in)action, identities and emotions. Sara's dilemma sheds light on to the issue of challenging/whistle-blowing as health care students develop their identities within a health care culture and the long-term negative effect that witnessing breaches of patient safety can have in the face of inaction. Sara knew the correct procedure for removing staples yet did not speak up. Her relative inexperience, her assuredness about the specific cultural 'rules' of the ward, her desire to 'fit in' and her fear of the HCA prevented her from acting on her personal moral code. Because she did not act she felt responsible for the patient's predicament, leaving her feeling angry with herself and vowing to change. Sara's narrative reminds us of the frustrations reported in an earlier study by Maben and colleagues[65] as newly qualified nurses reported their ideals and values being thwarted by structural and organisational constraints of the culture within which they worked. Through their detailed analysis, Maben et al. identified three categories of participants: 'sustained idealists', 'compromised idealists' or 'crushed idealists'. Of the 26 participants they interviewed, only four were classified as sustained idealists (working within a supportive culture). The majority compromised their ideals, leading them to experience frustration (as Sara reported). Eight were classified as crushed idealists who believed there was no way they could implement past ideals, working in a culture that undervalued them and feeling their care for patients was 'awful', 'terrible' and 'horrible'.[65] What differs here is that Sara managed to regain her compromised ideals. Although we presented only one in-depth narrative here, this is by no means an outlier. We have a range of different narratives but the general thrust of these stories remains the same: health care students are learning within a culture of care that goes against messages found within their formal learning environments.[66] This narrative is

thus presented as a representative case with implications for our understanding of the development of students' moral identities, both theoretically and practically.

In terms of moral development theory, based on Kolberg's model, Rest et al.[67] proposed a schematic rather than stage approach to moral development: comprising the personal interest schema (focusing on personal gains/losses), the maintaining norms schema (based on one's need to get along with others with rules/norms dictating actions) and the post-conventional schema (where morals take precedence over other needs). In her narrative, Sara shifts from drawing predominately on a maintaining norms schema, to demonstrating her commitment towards a post-conventional schema. She narrates this shift by focusing on how her motivation to 'fit in' to established ways resulted in her experiencing strong negative emotional distress when she saw the outcome of events. This emotional reaction appears to trigger her shift towards a hypothetical future in which morals, rather than cultural norms, take precedence.

Sara's narrative also has practical/informational implications for the moral identities of health care students. That she still feels angry over a year after the events suggests she is experiencing severe distress. As with our study of medical students' dilemmas,[19] this is not the only narrative in our data in which participants narrate strong emotions months after the events. It appears that despite witnessing distressing events during their workplace learning, rather than eroding ideals, many health care students retain a sense of morality and patient-centredness. Although this lack of erosion is reassuring, as educators we must find ways to help reduce students' distress.

As with any study there are numerous caveats. First, using LIWC we have quantified some of our qualitative data. Through this quantification process, paralinguistic elements of talk (e.g. laughter, metaphor) that suggest an emotional tone have been omitted. Therefore, our findings might underestimate actual negative emotional talk within participants' narratives. Essentially, our motive was to facilitate the identification of patterns in participants' emotional talk and to examine these against previous research using similar analyses. Indeed, our findings in this paper are similar to those previously found,[19,20] demonstrating the transferability of our findings to the broader health care context. This is further strengthened by recruitment of participants from across three UK countries. Second, although we interviewed 69 participants, we accept that the absolute numbers of students in some health care groups are relatively low. We therefore make no claims about the prevalence of the dilemma types identified.

Thus, through our thematic, linguistic and narrative exploration of a wide range of health care students' narratives from three different countries, we have developed a deeper understanding of professionalism dilemmas and participants' associated moral and emotional talk. That we have replicated and developed findings obtained with similar analyses of medical student narratives indicates a programmatic robustness in our approach to research ensuring that the study makes an original contribution to the developing literature on professionalism dilemmas across a range of health care students. Further research should consider assessing issues such as the frequency of specific dilemma types and associated moral distress using questionnaire methods in an attempt to unravel some of the complexities that narrative research embodies.

IMPLICATIONS FOR EDUCATION

We focus our discussion regarding educational implications around two issues: (i) interprofessional learning about professionalism dilemmas, including issues around whistleblowing/challenging others, and (ii) ways in which we might facilitate the development and maintenance of students' moral identities.

The similarities of professionalism dilemmas experienced by health care students across this and other studies suggest that the topic of professionalism dilemmas provides an ideal forum in which to bring students together to learn with, from and about each other. Indeed, students report an inability to challenge others' behaviours drawing on both personal and situational aspects. In their narratives, participants displayed a common consciousness of being less powerful: being 'just a student', lacking confidence and knowledge. Furthermore, perpetrators of lapses were typically more powerful: being responsible for assessing them and having greater knowledge. Students also expressed a desire to 'get along' with people who they will later work alongside. Finally, cultural factors (including taking cues from others) are commonly cited. However, some students do challenge, despite these factors being present for them, commonly citing issues such as the injustice of the situation.

This varying behaviour brings us to ask why some students challenge yet others do not. Social-cognitive

research suggests that much moral behaviour takes place without explicit awareness, so has both procedural (implicit) and declarative components.[68] Procedural knowledge is developed through 'frequent and consistent experience with a specific domain of social behaviour'. Therefore, it becomes 'more likely than other constructs to be evoked for the interpretation of interpersonal experience'.[68] According to such perspectives, moral categories (e.g. schemas) are essential to our self-identity. Schemas that are chronically accessible (constantly online or readily primed) comprise procedural knowledge that is used to interpret the social landscape. Such knowledge is produced so efficiently it approaches automaticity. Thus, if our primary moral schema is to maintain norms, we will act accordingly.

Consider Sara's narrative. Although she knew the behaviour of the HCA was wrong, she was motivated to maintain the perceived norms of the ward culture, thereby feeling unable to challenge.[65] However, with experience (driven by her strong sense of injustice and her refusal to sign the drug chart), alternative schemas were primed (e.g. post-conventional schema focusing on morals and justice). Rather than leaving the development of moral schemas to chance, educators should facilitate this process through, for example, role-play activities. Given that many professionalism dilemmas are interprofessional in nature,[66] we think that role-play activities should be undertaken in an interprofessional context. By focusing on common professionalism issues at a conceptual level, encouraging health care students to share their experiences through narratives and then role-playing idealised action should help them commit and re-commit to professionalism values, behaviours and practices. After all, facilitating synergy between our personal moral values and moral action is key to facilitating the embodiment of those principles, strengthening our integration of identity and morality.[69]

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