CHAPTER FOUR - PROFESSIONAL SOCIALIZATION OF HEALTH CARE PROFESSIONALS

“Thought flows in terms of stories—stories about events, stories about people, and stories about intentions and achievements. The best teachers are the best storytellers. We learn in the form of stories.” —Frank Smith

Today’s clinical learning environments can seem overwhelming. Students in the health care professions face a complex and stressful transition from learners to competent practitioners. How do students make the transition from struggling beginners to fully functioning professionals? The transition occurs in part during pre-service education. However, educating health care professionals is more than teaching them to successfully deliver a series of skills. Students also need to be guided in developing professional values and identity through socialization.

Socialization for health professionals can have two aspects. Organizational socialization is fitting into the structure of the organization, maintaining relationships with colleagues, learning the organizational culture, and learning the formal and informal rules of the practice environment. Professional socialization is internalization of a set of values and the culture of the profession (Zarshenas et al., 2014). Further, professional socialization is the process by which students develop a sense of self as members of a profession, internalize the values of their profession, and exhibit these values through their behaviour (Gaberson, Oermann & Shellenbarger, 2014; Weidman, Twale & Stein, 2001). The focus of this chapter is professional socialization of learners in health care professions. We present a variety of creative strategies that clinical teachers can incorporate into group or conference activities with students.
Professional socialization involves guiding learners to make personal commitments to their chosen profession. This commitment leads to actions and attitudes that are described by Black (2013) as “thinking like a nurse” or other health professional (p. 118). A professional identity evolves from effective professional socialization (MacLellan, Lordly & Gingras, 2011; Mooney, 2007) and professional socialization is a foundation of effective practice (Perry, 2009a).

Here we assume that professional socialization is a desirable outcome. While many authors discuss socialization exclusively as a positive goal for educators, others focus on the potentially negative effects of socialization such as group-think and undermining of diversity. Benner, Sutphen, Leonard & Day (2010) choose to use the term formation (p. 86) to represent the positive effects of workplace learning and consider socialization as something that can exert positive or negative influence. We consider professional socialization an important learning outcome for students and a task for health care educators. In this chapter we provide a primer on professional socialization and then discuss how storytelling and role modeling contribute to professional socialization.

A Primer on Professional Socialization

Professional Socialization. Through professional socialization processes, educators support learners as they gradually develop a sense of belonging to specific professional groups. Professional socialization occurs through a combination of professional education and clinical experience (Beck, 2014). In a study of Japanese nursing students, Condon & Sharts-Hopko (2010) found that professional socialization is multidimensional and includes influences from classroom experience, clinical practice and extracurricular elements. Zarshenas et al. (2014) explore factors affecting professional socialization of nursing students and discover that a sense of belonging and professional identity underlies successful professional socialization. More specifically, this sense of belonging develops through educational experiences and tacit knowledge; acquiring professional identity evolves in part from internal motivation and role modelling (Zarshenas et al., 2014).

Professional socialization is considered a process that begins on day one of formal education programs and continues as learners graduate and enter the work force. Peers, instructors, preceptors, mentors, and patients and their families can all be socializing agents (Chitty & Black, 2011). Black (2013) emphasizes that socialization occurs through a combination of formal and informal processes (such as unplanned observations). She notes that to be most effective, formal socialization in educational programs should occur through a deliberate, systematic block-building process. Socialization occurs in part in the clinical setting where affective learning outcomes are achieved often through observation of other practitioners who demonstrate a commitment to professional values. The clinical setting is also where learners are held accountable for their actions and the outcomes of their interventions are apparent (Gaberson, Oermann & Shellenbarger, 2014).

Studies with social work students reveal how difficult it can be to accurately measure values and attitudes (Barretti, 2004) and to understand how changes actually occur (Valutis, Rubin & Bell, 2012; Weiss, Gal & Cnaan, 2004). In physical therapy, the professional socialization process is highly influenced by interactions with peers and faculty (Teschendorf & Nemshick, 2001). For student athletic trainers, professional socialization is affected by legitimation from socializing agents such as patients and clinical instructors (Klossner, 2008), and by communication with practitioners (Mensch, Crews & Mitchell, 2005).

Educators actively guiding learners towards professional socialization is generally agreed to be important. While
educators may set out to assist learners in graduating fully socialized for their professions, many report feeling unprepared to fulfill this role (Clark & Holmes 2007; O’Shea & Kelly, 2007). Further, although new graduates have the competencies for licensure, concern remains about their socialization to professional practice (Gaberson, Oermann & Shellenebarger, 2014). Feng & Tsai (2012) conclude that new graduates are often stressed when organizational and professional values clash. More specifically, Feng & Tsai (2012) find that the organizational value of task-oriented nursing clashes with the professional value of patient-oriented nursing, resulting in distress for neophyte nurses. Clinical educators must therefore deliberately include strategies to help learners become socialized to their professions. Understanding professional identity and values provides a foundation that can help develop these deliberate strategies.

**Professional identity** is a form of social identity by which members of a profession categorize and differentiate themselves from other professions (Schein, 1978). Professional identity is categorized by Wackerhausen (2009) as macro (status, privileges, duties and self-image of the profession) and micro (tacit behavioural norms of the profession enacted by individuals). According to Enns (2014) nursing professional identity is born out of values and encompasses both the individual’s sense of self as a nurse and the image of nurse they project to others. Professional socialisation, in part through formal education, means that individuals are likely to strongly identify with their own professional group (Coyle, Higgs, McAllister & Whiteford, 2011).

**Professional values**, one essential element of professional socialization, are key to success as a practitioner, as they provide a foundation for behaviour (Chitty & Black, 2011). Professional values are the *blueprint for action* for exemplary care providers (Perry, 2009a).

Values are defined by Schwartz (1994) as “guiding principles in the life of a person that motivate action, function as standards for judging and justifying action, and that are acquired both through socialization and through the unique learning experiences” (p. 21). Some research indicates that existing values may influence career choice. For example, Adams, Hean, Sturgis & Macleod-Clark (2006) propose that nursing students are guided in their career choice in part because their personal values align with values of the profession. In other words, students may begin their training programs with certain values in place that are desired by the profession. While the values favoured by dissimilar professions may vary, Thorpe & Loo (2003) discovered that the values of altruism (a desire to help others) and personal development (desire to develop as a person) influence the choice of nursing as a career. Fagermoen (1997, p. 439), one of the early researchers who linked values to certain professions, concludes that common core nursing values include dignity, personhood, being a fellow human, reciprocal trust, and personalization of care. Because of the likely link between values and professional identity, Adams, Hean, Sturgis & Macleod-Clark (2006) conclude that new nursing students have some professional identity prior to professional socialization.

**Creative Strategies**

**Minute at the Movies**

To encourage learners to reflect on their values and beliefs, you can use examples of human interaction from movies or other media as triggers for new learner insights. For this group or conference activity, try providing students with brief clips from inspiring movies related to their real-time clinical situations. For example, to trigger reflection and discussion related to palliative care and the meaning of life and death, you could show the trailer from *A Fault in Our Stars* or *Wit* at a post-practicum conference.

Students watch the clip and share their observations in response to a specific reflection question that you provide. In this...
example, the reflection question could be as simple as “What did this movie teach you about dying?” Often students bring in their own examples from other movies or television shows that they find relevant, furthering the breadth and depth of the discussion.

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**Linking Professional Identity and Values to Career Fulfillment**

Association between professional socialization, values clarification, professional identity and career fulfillment.

One foundation of providing competent health care may be professional socialization that develops professional identity and values. Bernard, Maio & Olson (2003) state that values are the foundation of our attitudes and beliefs that “encapsulate the aspirations of individuals and societies and encompass deeply engrained standards that determine future directions and justify past actions” (p. 64) Thus, professionals determine priorities, weigh options and choose actions based on values (Bardi, Hofmann-Towfigh, Lee & Soutar, 2009).

In linking professional identity and values Fagermoen (1997) concludes that “values are inherent in developing and sustaining professional identity and are expressed in…actions in relation to others” (p. 436). Further, applying core values in professional practice increases work satisfaction, which continues the cycle of value enactment (Perry, 2009a). More specifically, nurses who perceive they provide high quality care and make strong connections with their patients are usually very satisfied with their career choice (Perry, 2005).

**Creative Strategies**

**The Health Professional I Would Like to Be**

Invite students to describe the characteristics or qualities of a health professional they know or to imagine a perfect health professional in their field. Discuss the common qualities and characteristics of the health professionals they aspire to be like. Ask them to reflect on their current image of themselves as a health professional and to compare this image to their ideal. Have them identify two areas they would like to focus on for improvement.

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**Storytelling**

To effective professional socialization of health care learners. The clinical setting is rich in opportunities for educators to use learning activities and teaching strategies that achieve what are often learning outcomes from the affective domain. Methods of teaching psychomotor skills and cognitive knowledge are often more straightforward. Effective clinical educators take the challenge to reach learners on an emotional and attitudinal level. Storytelling is an affective strategy that invites students to make links between the professional they hope to be, the values they hold, and the career.
fulfillment they desire.

Using **arts-based teaching strategies** helps students make an emotional connection to their learning, caters to a variety of learning styles, and increases student achievement (Perry & Edwards, 2015). Arts-based approaches may stimulate creative, critical and analytical teaching about clinical situations. Telling stories is a teaching approach rooted in the arts. It can have positive effects on teacher–learner and learner–learner rapport, interaction and community building. Art moves individuals to look at the broader view of concepts and ideas, encouraging them to look at multiple facets and dimensions. Learners are encouraged to move away from breaking knowledge into discrete elements for analytical assessment and from looking at learning as a checklist or assembly line of tasks. Since professional socialization is more non-concrete, it requires multi-layered and complex strategies that inspire thinking broadly, deeply and holistically.

Clinical instructors can use relevant patient stories to trigger transformative learning. Stories can come from many sources, including the instructor’s personal repertoire of clinical experiences, published clinical stories, or from the students themselves. To be most effective, storytelling should be a deliberate and guided learning activity. Stories need to be carefully selected for their relevance to the clinical situation, learner level and desired value or attitude lessons. After sharing the story (either verbally or in written form) the instructor should be prepared to lead a discussion guiding learners to express their reflections and evaluate their conclusions. A summation of the learning experience will help learners clarify and reinforce take-away concepts and ideas.

**Emotional Connections**

The following is an example of a story that can create emotional connections with learning. This story might be used by nursing instructors in a post-clinical face-to-face conference or an online discussion forum after a shift on a medical unit.

A year or so ago, I was working nights. My patient became increasingly restless and agitated. He had a progressive dementia and he was more disturbed than any patient I had cared for in my 25 years or more of nursing. That night, he required two-to-one nursing care.

Around 0300 hours the other nurse I was working with observed that, in spite of his verbal lashing out, he had never once cursed. She remarked that he must not have “bad” words in his normal vocabulary because usually what is in a mind comes out in confusion. The night wore on with our patient experiencing agitation, yelling and extreme restlessness. He would bite his own hands and arms and grab on to anything near him. We began to wonder if we could ever help him rest. I remember feeling helpless and hopeless.

Then I heard him repeat a series of words in a garbled fashion and recognized the words of an old hymn. I began to sing the hymn and immediately he became quiet. The change was instantaneous and profound. The other nurse was able to leave for a break while I sat beside him singing every hymn I could remember.

As long as the hymns were sung, the patient rested. (The nurse added a side note saying that it was a good thing she was a pk—a preacher’s kid—and because of this, she knew a lot of hymns). We later found out that the man had been a lay pastor, and perhaps this explained his reaction to my music.

I loved being his nurse because none of the usual textbook interventions worked. He required flexible, creative nurses who were not afraid to try the unconventional and who were willing to keep trying until we could find a way to connect
with him and his needs. Large doses of artificial sedation made no difference. Somewhere in the deepest levels of this man’s mind, our presence through music and just being near touched him. It was a profound night because all my years of training and education came down to the simple singing of a song. (Perry, 2009a, p. 210)

A storytelling strategy in clinical teaching may stimulate learners to interact with their colleagues in sharing their insights and comparing their analyses. Connectedness, interrelatedness and integration may be an outcome when arts are the foundation of teaching strategies (Eccles & Elster, 2005). As Clarke & Widdicombe (2002) conclude, the arts as a component of teaching strategies engage students totally, “not just with pen and pencil, but also with imagination” (p. 45).

**Creative Strategies**

**Sharing an Inspirational Story**

Share an inspirational story with your students. Include how the story reflects your own journey towards professional identity, your own values, and how this contributed to career fulfillment.

**The Patient I Will Always Remember**

This learning activity is also rooted in the arts and in storytelling but takes a slightly different approach. The exercise requires instructors to be reflective and willing to be emotionally vulnerable to learners. You can recall and share with learners the story of a person you cared for in clinical practice. Your story can be shared orally or in writing and should be accompanied by guided reflection and discussion questions. The clinical post-conference (either face to face or in an online discussion forum) is an appropriate setting for this learning activity. Success of this learning activity depends heavily on careful selection of the patient example to make it appropriate to the learners and to the clinical setting. The following is an example of a story told by an instructor to a group of nursing students during a public health clinical rotation.

This patient I remember often was a street person. She had lived a hard life. It was beyond anything I had ever experienced. Her hard life was paralleled by her equally hard death. When she did come in to clinic she was dirty, dishevelled, often carrying insects in her backpack and on her frail body. Other staff freaked out when she came in, afraid of bed bugs and lice and afraid of her because her life script was so different from theirs. She actually didn’t have a home so home care was not an option. She didn’t have a home but she did have a cell phone and when I would call to check on her pain level or some other issue and I would ask “where are you” she would answer matter-of-factly “on my bench.” She had taken ownership of a park bench and this was her “home.”

Although her life was far different from mine there was something that drew me to her. I came to know her well over her years of treatment and I always tried to make time to hear at least one of her street stories. I listened to her – to her words but also to the embedded messages and cries for help. I would like to be able to say I was able to whisk her into a clean hospice room and fix all her social and emotional issues but this wasn’t to be. In the end she died in her own world but I hope she knew at least one other person cared about her.

**Transformations**

Storytelling can create transformation in the way learners think about and view the world. Jack Mezirow (1981) defines
transformational learning as critically reflecting on our assumptions and beliefs, then intentionally creating a new view of
the world. He labels this “perspective transformation.” O’Sullivan (1999) emphasizes that transformative learning
involves a deep shift in consciousness that changes a person’s view of their place in the world. Introducing educational
approaches that challenge learners to consciously examine their unrecognized underlying views and assumptions may
transform their view of the world. Learning approaches that challenge students to question what they believe to be true,
and ultimately to interpret information more critically, can be transformative (Melrose, Park & Perry, 2013).

Research supports the potential influence of transformational learning strategies on value development. Williams et al.
(2012) describe transformational learning approaches as one approach that enhances value development among
nursing students. Such approaches must be based on active, realistic experiences that engage students in self-directed
inquiry and critical thinking. More specifically, Williams et al. report that an effective strategy for professional
socialization is to have students working in small peer groups to discuss real practice scenarios. Students exposed to
this learning strategy are self-directed learners and advocates for patients and their profession upon graduation.

In the clinical situation, the practice scenario strategy used by Williams et al. could become real scenarios within a
storytelling teaching approach, rather than fictitious cases. Opportunity for students to share their clinical experiences
with one another, and facilitated deconstruction and discussion of these scenarios in small groups or conferences, offers
the potential for transformational learning. How can clinical instructors skilfully guide these discussions to optimize this
potential? Before attitudinal shifts can occur, learners need to critically reflect on assumptions they believe are true.
Challenging these assumptions, at both a cognitive and an emotional level, can be difficult and the reflection process is
unlikely to be spontaneous. Instead, instructors must provide learners with opportunities to question their views on
specific ideas or issues. Activities with no right or wrong interpretations can stimulate critical reflection.

Creative Strategies

Which Patient Would I Choose?

The Which Patient Would I Choose? strategy is one way you can guide students in uncovering their assumptions about
patient race, gender, sexual orientation, social economic status, etc. In this learning activity, hold a group debriefing
session after a clinical practice shift. Ensure a private setting where students can speak openly about their experiences.
Have each student report briefly about a person he or she cared for during the shift, ensuring the student includes
patient biographical details as well as health status updates. Next, ask learners to select the two patients, from those
described by their peers, that they would choose to care for if they had the option to select. Students also identify two
patients they would choose not to care for. Ask learners to then consider why they made their choices and record any
common themes they observe in their own choices. After working on their choices individually, students share their
choices of patients and their reasons. The goal of this activity is to help students examine their deeply held values,
bases and attitudes. Value awareness may be an initial step in value transformation and professional identity
development.

Giving Voice with a Photo

Mezirow (1981) emphasizes the importance of providing challenges within educational process. Teachers who
challenge learners provide them with opportunities to question commonly accepted values and to reflect critically on
points of view that are different from their own. Using selected photographs as an approach to storytelling can challenge
learners. Again, the photo selected must be relevant to the clinical setting and should be chosen to deliberately challenge specific values, assumptions and attitudes students may hold. The image can be circulated during a group learning activity, such as a post-clinical conference, to focus student attention and initiate discussion of reflection questions provided by the instructor. As an alternative, students can be asked to provide images they locate that challenge their attitudes and values and make then consider alternative views. These student-generated images can also be shared and discussed as a group.

Many open educational sources offer images that can be used for educational purposes. For example, Flickr is Creative Commons licensed and images can be downloaded and printed for educational purposes. The following is an example of an image used to provoke discussion and to challenge embedded attitudes related to aging.

![Image](https://med.libretexts.org/Bookshelves/Nursing/Book%3A_Creative_Clinical_Teaching_in_the_Health_Professions_(Melrose_…)

Sermoneta / CC-BY-NC-SA 2.0

**Role Modeling**

Merton (1949, 1957, 1968) introduces the concept of role modeling as the process by which medical students in his study compared themselves to a reference group. Bandura’s (1963) social learning theory furthers our understanding of how imitation and observation of others contributes to human learning. Modeling and Role-Modeling (MRM) theory, developed by Erickson, Tomlin & Swain (1983, 2010), proposes that when learners observe models, they perceive another person’s point of view, values and framework. The results are learner growth and improvement.

Role models influence student values and professional identity development; experiences with role models can facilitate transformational learning. In a study of effective role modeling in nursing education, Mokhtari Nouri, Ebadi, Alhani & Rejeh (2014) conclude that educators need to pay attention to personal and environmental factors. Further, these investigators conclude that observational learning through role modeling is especially important in clinical settings. In such settings, instructors both teach skills and demonstrate values and attitudes as learners come to reflect what they see, hear and observe.

Helping learners attain learning outcomes from the affective domain is challenging but role modelling is one strategy to support attitudinal and emotional growth (Perry, 2009b). Cultivating attitudes such as compassion and caring is complex, so reaching these learning outcomes can create emotional challenges for students and instructors (Curtis, 2014). Modeling of compassionate practice by a skilled clinical instructor or preceptor is one strategy for furthering adoption of professional attitude and identity by health care learners. The following is an example of observation of an exemplary
nurse as role model, recorded in field notes by Perry (2009a). The role model taught the nursing intervention of touch to establish connection with a patient, a skill that is challenging to teach in any way but through modeling.

*She often sits on the bed next to her patients, or she stands very close to their chairs. This physical closeness seems to create an air of familiarity. It makes their relationship close very quickly. It was by touching, by holding her patient’s hand, laying a cold cloth on her forehead, and rubbing her sore back, that the nurse communicated that she cared. All that she did with touch said how much she wanted to help* (Perry, 2009a, p. 81).

**Do slowly, think aloud.** Model teachers facilitate emotional growth in learners by demonstrating effective interactions and interventions. Clinical educators need to embrace the reality that everything learners see their instructors do or hear them say (or not say), may be observed and may influence socialization and eventual success of graduates. This is a heavy responsibility but it is a reality of accepting the role of clinical instructor. Instructors who choose to maximize the potential positive effect of their role modeling my deliberately slow down their actions and interventions to allow learners time to observe fully and absorb what is happening. When appropriate role models speak aloud their rationale for selected actions and interventions, they maximize the teaching potential of a situation. The following example of a role model (exemplary nurse) demonstrates nursing interventions in such a manner.

*Her patient tonight can’t talk. Each breath is a struggle. He is so afraid that the next breath just won’t be there. In his eyes I see an unmistakable look of panic. A laryngeal cancer and tracheostomy have taken his vocal cords and a tonsillar tumour has impaired his hearing. How can she let him know that she is there, that she cares? She works slowly. She doesn’t say a word. As she strokes his hair, her eyes tell him what he so desperately wants to hear: that she is with him, that she will stay, that she will watch over him. Gradually, silently, he drifts off to sleep. When we return to the med room she tells me her beliefs about the importance of the nursing intervention of silence and touch in communicating caring.* (Perry, 2009a, p. 60)

**Admit when you make a mistake.** The reality is that no one is perfect, including clinical educators. The educator may be less than perfectly prepared mentally, physically or intellectually to model exemplary care on some days. Learners may observe errors in judgement, responses that are less than therapeutic, or rushed interventions. Reflective educators will be aware of possible negative modeling and openly discuss their reflections with learners. Together the instructor and students should analyze the situation and develop more optimal approaches to be used in subsequent patient care situations.

**Cultivate opportunities to role model.** Since role modeling is a powerful teaching tool for health care learners, clinical instructors will want to seek out opportunities to model specific values and professional attitudes they want to cultivate in students. Clearly articulating these desired values and attitudes in learning outcomes can highlight points that educators will focus on modelling. For example, if students are to develop strategies for respectful communication then role models should prepare themselves to demonstrate this and watch for opportunities to have students observe them. Follow-up with learners is important to be sure the role modeling is effective and students internalize the desired learning.

**Appropriate use of humour.** Humour is seeing the funny in everyday encounters and maintaining a light-hearted attitude (when appropriate) in potentially difficult situations (Perry, 2009b). Curtis (2014) notes that learners value an appropriate sense of humour in role models and find it facilitates their learning. Role models who use humour effectively and appropriately help students to manage their feelings of vulnerability and maintain their emotional well-being in challenging clinical situations.

**Consider using social media.** Students can receive role modeling from a variety of sources. Clinical teachers are an obvious source of modeling but other health care professionals in the clinical environment often model positively or...
negatively. In negative situations instructors need to provide learners with opportunity to discuss and interpret what they observe. Social media such as Twitter may also provide a type of modeling for learners. In one example students sought to develop leadership skills for the clinical setting. They were invited to follow the Twitter feed of a well-known leader in their profession and to extract leadership lessons from what they read. Students were asked write a paper translating these leadership lessons into effective leadership approaches in the clinical setting. The learning activity encouraged learners to seek role models from a variety of sources and to participate in higher order learning through analysis and evaluation. Learners are motivated to engage in this learning activity in part because of its novelty and in part because it used a medium with which they are familiar and comfortable.

**Conclusion**

Fully educating health professionals includes helping to socialize them to their professions. Clinical educators have an important opportunity and responsibility to guide learners in developing values and professional identity as steps in the process of professional socialization. Health care students may bring deeply seated and well-established beliefs and assumptions to their learning. Cultivating selected values and attitudes can be a challenge for educators. Formation and transformation are possible in part through approaches such as storytelling and role modeling. Clinical educators can utilize creative teaching approaches akin to transformational learning pedagogy to facilitate professional socialization in learners.

**References**


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