In essence, humans do not exist in isolation; rather they live and work in a social world made up of groups, often defined as communities of practice (Wenger, 1998). Each society has its own culture, of norms and values, which is understood and lived through its own language, knowledge, values and beliefs. The culture is learned through the process of socialization, whereby individuals entering the society learn how to live and survive within the culture. Berger and Luckmann (1966) suggested that there are two aspects of socialization: primary socialization, whereby individuals become members of a society, and secondary socialization, as any subsequent processes through which individuals enter new areas of the objective world of their society. Thus, the socialization process becomes a long-term process.

The functional aspect of being a part of a society entails having a role. Some roles are biological or genetic, such as being female, being a daughter, and others are socially constructed, such as being a nurse or being a friend. The role dimension refers to the type of actor rather than the actual person. Hence, occupational socialization is a process through which individuals learn how to behave in newly established roles. In a work environment, this often commences during a period of training and education and continues once the individual enters the workforce.

Entering a profession is seen from a sociological perspective as a secondary socialization process. Indeed, nursing practice and the transition between student and worker has been predominantly studied from a sociological perspective, as is evident by the wealth of nursing literature (for example, Mooney, 2007; Fox, et al. 2005; Ross and Clifford, 2002; Whitehead, 2001; Gerrish, 2000; Maben and Clark, 1998; Duncan, 1997). Much of the early literature in the 1980s was directed towards understanding and capturing the experiences of nurses in this role transition and evaluating the ability to function effectively in the role (Wierda, 1989; Hathaway, 1981). This research was mainly organizational in nature, as it emerged as a result of service providers finding that the new graduates were not living up to expectations as well as not being able to integrate quickly with the team and undertake responsibility. This was attributed to the larger theoretical component of a university-based pre-registration programme that was failing to equip the students with the necessary knowledge and skills to assume the role of a qualified safe and competent nurse in practice. However, upon further analysis, this seems to have had more to do with the process of assuming new roles rather than the differences in educational systems.

In the case of European pre-registration nursing programmes, the practical component, that is the experience in the real clinical setting, is approximately 40 to 50 per cent of university programmes. Thus, time is a significant element as these roles do not develop instantaneously. Various theorists have discussed
role theory, often in terms of role development, role conflict and role overload (such as Biddle and Thomas, 1966; Turner, 1962). In an early study by Melia (1987) which explored the occupational socialization of student nurses, role conflict was particularly evident, as essentially the education institution had socialized them into the role of a student nurse, rather than the role of a nurse. Furthermore, this justifies the emphasis on the practical component at the training stage of professional development and suggests that practice with others in the role is an essential part of the formation of nurses. When actors portray a character in a play, a script as well as other external influences, such as the director’s instructions, performances of other actors and, at times, reactions of the audience, determine their performance. Similarly, role theory proposed that individuals occupy a position in society and that their performance within these positions is determined by social norms, demands and regulations. It is also affected by the roles of others and in a sense by the ‘social script’ (Biddle and Thomas, 1966: 4). The director and the audience will vary according to the circumstance, but in essence the director is often someone in authority, while the audience is anyone who is observing the individual’s behaviour. Within the nursing profession, the authority would be the education and service institutions, including nursing officers, managers, other hospital professionals or senior nurses; fellow actors would be other nurses; the audience would be patients and relatives, as well as fellow nurses and health care professionals working in the team. The script would be the expectations of all involved.

Although conformity is necessary for the functional aspect of role development, the ability of individuals to alter the roles through a role-making process as they relate to other members of the society highlights the flexibility of the role (Turner, 1962). Moreover, role-making consists of two fundamental elements: time and a process of learning. Hence the process of socialization from student to worker is unavoidably a simultaneous process of growth through which learning takes place over a period of time. Therefore, it is unrealistic to expect individuals to perform at optimum levels immediately they take on a new role.

Through experiencing events in daily life, behaviour becomes internalized. Behaviour is copied from other established members, thus ensuring conformity and acceptance within the society. Here, a timeline is a vital element. Various sociologists have argued that the functionalism and structure of society is of utmost importance to enable a stable society (Giddens, 1979; Parsons, 1951; Durkheim, 1933). As long as new members behave in the expected way, then they are readily accepted into the group. Deviant behaviour is frowned upon and various mechanisms are instilled to reduce this behaviour. Although one could argue that in this manner individualism is lost, it is a mechanism of maintaining a stable and constant society. It could be argued that one of the reasons why newly qualified nurses entering the workforce are seemingly not competent is a result of the different types of pre-registration learning that has taken place. Certainly, the more recent university-based courses have a higher theoretical input with a particular emphasis on research-based and evidence-based practice, whereas the traditional courses were carried out in a practical, hands-on apprenticeship style. Perhaps the difference in learning led to variations in nursing care and, subsequently, in acceptance by the other more established members of the group.

On the other hand, according to Heller (1984): the process of externalization consisted of three interconnected components: physical artefacts, tools and products; systems of custom and habit; and the use of language. Through repeated exposure to similar events, individuals begin a process of habitualization whereby practice or behaviour that has been successful will be repeated. This is often negotiated between individuals through mutual understanding. Language transcends spaces and provides individuals with a way of knowing things. Through language individuals become familiar with the society’s norms and values as well as allowing individuality to emerge. Thus individuals through interactions construct the norms and values of a society.

The concept of externalization of the role centres the person within society. Yet, human beings do not merely receive knowledge, but process and give meaning to this knowledge. There would seemingly be little change due to the cultural norms and values through the internalization process, as change becomes a constant. Thus individuals become a part of a changing culture. The process of change subsequently
becomes a process of learning, as new knowledge will constantly surface. The process of learning is understood through the interaction of the person’s biography and daily social interactions. Subsequently, although the sociological approach explains various issues relating to the changing nature of roles, it fails to address how the individuals are able to learn and consequently take on new roles.

**Playing versus being the role**

The scope of the pre-registration training programme is to socialize individuals into the role as well as teach them the knowledge, skills, attitudes and values required to be able to function effectively and safely within the role. Recently, I investigated in depth the process of becoming a nurse in Malta, by interviewing a group of individuals over a 22-month period from the time they were in the final stages of their pre-registration programme up until they had completed 18 months of practice as qualified nurses (Camilleri, 2009). It appeared that, upon entry into the profession, these newly qualified Maltese nurses were unable to perform to the expectations of the employer, they felt apart from the system and, most significantly, the majority did not identify themselves as nurses. This resulted in most of the participants initially ‘playing’ the role, rather than ‘being’ the role.

These findings are particularly surprising as the general expectation is that individuals are able to function in the role. Furthermore, this raises serious questions as to whether the educational institution is providing the required level of training, or whether this inability to perform is the result of other factors. No literature, especially within the nursing field, explores this concept of ‘playing the role’ as a first process to ‘being the role’, therefore it is difficult to make comparisons with other similar or different educational programmes and health care support systems for newly qualified staff. The deficit in literature on this subject is possibly due to the fact that retrieved studies on the transition from student to worker were designed in a way to investigate outcomes rather than processes. However, another possible reason for this deficit in the literature could be the expectation that the formal training period is the time in which students are able to experiment with the role and, therefore, are not expected to carry the role or the associated responsibilities of being a nurse.

**Sense of belonging**

The sense of belongingness to the community of nursing professionals was the first noticeable factor in the study I conducted. Although as students they had been socialized into the role of the nurse through many hours of hands-on practice, it was evident that these participants felt external to the ward team to which they were allocated. Wenger (1998) espoused that a community of practice should consist of three dimensions: mutual engagement, a joint enterprise and a shared repertoire. Therefore, to be part of this community, one needed to be able to function, to have trust and a shared vision so as to be integrated into the team. However, for these participants this was not an automatic process that happens naturally on the first day of work.

Primarily, it was difficult for the participants to mutually engage with the community, as they very clearly lacked knowledge and skills and therefore became dependent on other colleagues for support and assistance. One could argue that, following a four-year course, these individuals had become expert students and therefore their ideals, visions and purpose until that point in time had been that of students. Since the responsibilities between being a student and being a nurse vary, it was unrealistic to expect them to immediately adopt a shared vision through which they could engage with the team members. Furthermore, individuals enter the workplace with their own biographies (Jarvis, 2005; Dominice, 2000), which includes a past history of accumulated experiences through which values, attitudes and beliefs have been formed. Differences between one individual and another are very likely to occur; differences between a newly qualified nurse and members of a pre-established team are also likely to transpire. Wenger (1998)
unfortunately failed to explain how new members learn to become a part of the team. Perhaps one of the notable changes that took place in each participant was how they started out with their own individual beliefs and system and, as time progressed, they developed a shared belief and system according to the clinical setting in which they worked. This was evident in the early phases of the data-collection period, where several participants stated clearly that they carried out tasks in a different manner to others. There was a clear ‘me’ and ‘them’ attitude in the discussions.

Very interestingly, the participants were acutely aware that other people viewed them as a nurse, even though they themselves did not perceive themselves to be nurses. This was evident through colleagues introducing them as a team member to other health care professionals, as well as relatives and patients referring to them as ‘a nurse’. Although they were aware that, for the lay person, it was difficult to differentiate between a nurse with years of experience and a nurse who has just graduated, the participants placed themselves metaphorically in a separate category. There was a clear distinction between themselves and the experienced nurses, which included anyone who was working in the ward before their arrival.

Those participants who appeared to be particularly confident quickly integrated into the team and developed a strong sense of belongingness, to the extent that they were actively involved in professional activities such as practice development and informal training during the period of data collection. They also felt that, in situations where the team was debating an issue (such as a procedure relating to patient care or an aspect of professional development), they were able to contribute to the discussion and felt comfortable forwarding their ideas and opinions. In stark contrast, those participants who appeared to be more cautious, had only just started to contribute or give an opinion by the end of the 22-month period of data collection. In some wards, especially those with large numbers of nurses in each shift, the hierarchical system was particularly strong and, subsequently, it could be argued that this is what might have hindered the development of the role. Yet, there were ‘self-confident’ and ‘cautious’ participants in wards with small numbers of nurses as well as wards with large numbers of nurses. Therefore, it was not the numbers of nurses present in each shift or the presence of a hierarchical system that made the difference, but rather the individual participants’ degree of confidence to voice their opinion or to abstain. This signifies that a sense of belonging is not merely the result of external influences such as other people, but a true sense of belonging is an internal feeling that develops over time, once the individuals acquire shared beliefs, values, attitudes, vision and purpose of the community they joined.

**Ability to perform to the required level of competence**

There is clearly an unspoken expectation that newly qualified nurses are able to function competently and independently upon entry into the profession. This expectation was held by the participants themselves as well as others around them, including patients and team members. The participants introduced this discussion while they were still students, as it was evidently a cause for concern. Even at this stage, they felt that they would have difficulty in being capable of caring. This feeling was substantiated in the second phase of data collection, at three months of practice, when they vividly explained their experiences with new or previously unfamiliar procedures as well as what they had been learning during those first three months.

Although almost half the pre-registration programme had been situated in practice, once they entered the workforce the participants stated that they were learning new knowledge, procedures and skills as well as engaging in new experiences. All of this compounded together led them to a state of not being capable of caring. More significantly, each time they encountered a new situation they were acutely aware of not knowing what to do, and thus relied heavily on other colleagues. On the other hand, at three months of practice, when asked what kinds of activities they were engaging in, all were able to give detailed descriptions of a range of clinical activities and skills. Furthermore, it was also evident that they compared their performance in practice to the more senior and experienced nurses. Possibly these were the same
professionals who provided them with support and assistance. In comparison, they did not feel that they were competent and this was certainly another external influence.

Practising to a competent level is seen as the benchmark of good and safe practice. Indeed, across Europe, some institutions are implementing competency-based curricula for nurse pre-registration training. Benner (1984): a renowned American nursing scholar, advocated the theory of the acquisition of skills, in which all practitioners commence as novices and progress over a specific number of years through five stages of ability until they become experts. Similarly, Gladwell (2008) argued that individuals need approximately 10,000 hours of practice in the field in order to master a craft. This extensive time in practice supports the argument made by Sennet (2008) that true craftsmanship is a result of individuals being engaged in the craft and emerges once a skill is developed to a high degree. On commencement of mastering a skill, an individual will demonstrate very basic levels of ability with the emphasis revolving around the successful completion of that skill. However, at the level of mastery, ‘at its higher reaches, technique is no longer a mechanical activity; people can feel fully and think deeply what they are doing once they do it well’ (Sennet, 2008: 20).

The attainment of the mastery of skills was reflected in the participants’ ability to perform to the required level independently. They were able to describe themselves as competent after gaining experience as well as when they were able to function with minimal interventions from colleagues. Interestingly, when they described themselves as competent, they were also describing several instances in which they were teaching other health care professionals and students. Therefore, being competent is not merely a result of reaching certain milestones, but rather it is a sign that individuals have developed sufficient practical knowledge to be able to function effectively as well as teach others. In order to teach others, it is necessary to be comfortable and confident with the skill or procedure. This was evident as the confident participants stated that they were teaching others by six months of practice, while those who were more cautious only began teaching others after twelve months of practice. An interesting finding that emerged was that the participants seemed to wholly identify as nurses only once they were able to describe themselves as competent, that is, at the third stage of Benner’s continuum. This means that the Maltese participants did not appear to perceive themselves as nurses while describing themselves at the first two stages, that is as novices and advanced beginners. The findings of this study showed that there were substantial differences when compared to Benner’s (1984) study. Furthermore, it appears that the progression from stage to stage is not uni-directional, but rather, throughout one’s career it is possible to be moving back and forth between the different stages according to external changes taking place. By identifying the specific stages they felt they had attained during the study, they showed how their practice had changed and improved, but also compared the change that they were witnessing that guided them in their choice of stage. They also justified their decision by stating that they ‘felt’ more capable than before. This feeling is an internal process of change that is taking place at an individual level as a result of an accumulation of experiences and learning.

**Acquiring an identity**

In order to acquire an identity, individuals need to perceive themselves as capable of caring independently and competently, as well as being a valued member of the team. Initially, the identity of the nurse was imposed upon the participants by others, through the wearing of a uniform that strongly symbolized the role of the nurse, by other colleagues and patients who referred to them as ‘a nurse’, as well as by the expectations of others to carry out certain skills and procedures accurately. Furthermore, they were literally forced into the role of a nurse by the system. As a result, initially they were ‘playing the role’ of the nurse to match the expectations of others. It is therefore evident that the social identity clearly precedes individual identity.

The findings of this study showed that, while the participants were ‘playing the role’ they were not able to describe themselves as nurses. Also, as time progressed, the dependency on their colleagues diminished.
and they began working in their shifts with minimal interventions from others. Hence, by being independent in their practice they felt that they were being nurses. This suggests that the identity evolves over time and is pre-consciously learned – it is a tacit process. They were able to state that they were nurses once the role had been internalized.

**Learning the role**

In discussing the sense of belongingness, the ability to perform and the acquisition of an identity, it is apparent that there is a mismatch between the expectations of the profession in comparison with the individual abilities. In other words, the participants were aware of the level of competence expected of them, yet simultaneously did not feel capable of meeting those expectations, resulting in the difference between ‘playing the role’ and ‘being the role’ as discussed previously. Considering that, to be a nurse, one must complete a specified training programme, this indicates that it is possible to teach someone to perform a role; however, they, in turn, must learn the role.

Indeed, the participants had used a multitude of strategies to assist them in learning the role. In accordance with previous nursing literature, they learnt using a combination of behaviourist, cognitive and social learning theory approaches, such as observing the practice of more senior colleagues; using active experimentation of trial and error; and reflection, as well as critical thinking. By the very nature of the socialization process upon entry into the profession that situated them within a team of experienced professionals, using secondary experience they learnt about their practice. They also learnt using primary experiences as they themselves were directly involved in the hands-on care delivered to patients. It appears that the way in which most newly qualified nurses learn is by discussing with others as well as by referring to published material such as books or through the internet. However, by having access to a knowledgeable group of people such as senior colleagues and hands-on practice does not mean that learning automatically takes place. It is only through a process of internalization that is centred within an individual, that the cycle of learning occurs (Jarvis, 2005, 2004, 1992).

It is clear that the learning processes vary from individual to individual. The awareness of learning and one’s own self-development also differs from one individual to another. Furthermore, those individuals who have a heightened self-awareness are able to learn even once harmony and routine have settled into their daily working lives. Hence, the findings of this study showed that learning is centred in the individual. Therefore individuals should be allowed to learn in their own unique way, at their own pace.

**The time–confidence–learning trajectory model**

Time, confidence and learning are all essential elements of the process of becoming a nurse. Figure 3.1 represents a self-designed model that visually maps the findings of this study through which the journey of becoming a nurse can be understood. This model builds on Jarvis’ (2005) theory of Human Learning, in which he describes the processes of learning taking place as part of human living.

The model starts with the same reference point, that is, the individual. The individual in this model represents individuals who enter the work place as newly qualified nurses. At this point, they are ‘playing’ the role of the nurse, as they have not as yet acquired the identity of a nurse, they are dependent on others and do not feel that they are a significant member of the team. Towards the middle of the diagram are factors that contribute towards ‘being’ a nurse, including the acquisition of an identity, the ability to perform and feeling like they are a significant member of the team. ‘Playing’ and ‘being’ are linked diagrammatically by a series of lines that are interrupted. These interrupted lines symbolize the passing of time. They also symbolize the liminal period between playing the role and being the nurse. These arrows are interrupted, as each individual will journey between ‘playing’ and ‘being’ at different speeds. The long solid arrow at the top of the diagram symbolizes the ongoing learning processes, whilst the long solid
Figure 3.1 The time–confidence–learning trajectory of becoming a nurse

arrow at the bottom of the diagram symbolizes the development of confidence. Both these arrows have been interrupted, representing the passing of time to which both confidence and learning are attached. These solid lines represent each individual’s ongoing career path.

Time occupies the central space in the diagram, precisely because it is central to this whole process. The two long bold arrows continue beyond the phrasing of ‘being a nurse’, as each individual is continually developing and changing. These two solid long arrows represent the ongoing nature of professional and personal development. Hence, just as the learning process is ongoing, so too is the state of becoming. From the findings, it appears that, in order to reach the stage of being a nurse, the acquisition of an identity and the ability to perform, as well as being a significant member of the team, all need to develop simultaneously. Indeed, all three components are essential, as they are interlinked and interdependent upon each other. Hence, one cannot progress without the other interlinking components.

The model represents the complexity of the process of becoming a nurse in a two-dimensional view. In reality, the process from ‘playing the role’ to ‘being the role’ is not a simple linear process that merely happens with the passage of time. Rather, it represents a multitude of experiences, interactions and thought processes through which individuals learn the role. Not only did the Maltese participants play the role upon entry into the profession, but, more disconcertingly, some participants spent many months in a state of ‘playing the role’ due to lack of competence, confidence and the ability to function independently. This has been presented quite forcefully through variations in the sense of belonging, the ability to perform and the acquisition of an identity.

Discussion of the implications

Transitions are complex and multidimensional. Clearly, the transition from student to worker is about a process that invokes a need for individuals to learn new experiences, new rules and new responsibilities arising from new circumstances. Through these processes of learning the individuals acquire the identity of the nurse, through which they are able to perform. Indeed, it is an existentialist process. Transitions pose challenges and create stress, but also offer opportunities for growth and development. Although it is beneficial to explore these issues through various disciplines such as psychology or anthropology, the complexity of the process of learning a new role, such as becoming a professional nurse, fails to give an understanding of this concept in its entirety. It is evident that nursing has traditionally drawn on other disciplines to inform and develop its unique body of knowledge. However, in attempting to understand the transition from student to worker, many unanswered questions remain.

The concept of ‘playing’ the role at the initial stages is not a new discovery. Indeed, Turner (1962) documented this phenomenon well when he explained his role theory. He maintained that, upon entering
a new role, individuals necessarily ‘play’ the role, which he likened to the allegory of theatre acting. Over time, individuals learn the values, attitudes, knowledge and skill and, through a process, take on or acquire this role through a process of internalization. At this point the person is actually ‘being’ the role. Furthermore, in moving between playing and being, the catalyst is learning.

The acquisition of the identity is not automatic upon completion of the programme of studies, or upon entering the workforce on the first day of work. Rather, it requires a process of change that takes place at both a professional as well as a subjective level. As time progresses and individuals internalize the role, they begin to be the role, rather than merely play the role. This is a gradual process. Furthermore, the timing of this change varies from individual to individual. Once the role is internalized, an identity is acquired and simultaneously the ability to perform safely, competently and independently with minimal interventions from others. A sense of belonging emerges through the responsibilities held and the contributions that are made within the work socio-cultural milieu. Consequently, this means that we truly acquire an identity and become a role in society through a combination of processes: initially there is an external ascription, which is then followed by an internal realization of the manner in which we perform the role (Jarvis, 2009).

The change from being a student and becoming a nurse enabled a transition that allowed for the social structures of one society to be broken down, thus allowing for the opportunity to learn new things including values, knowledge, language and beliefs. Therefore, change generates newness and forces individuals to learn so as to become part of a new society. Individuals may choose to engage or disengage from this new society. Those who engage are constantly challenged to learn new things. Therefore, in being a role, we are necessarily always learning.

This paper has identified that the acquisition of the identity of a specific role requires change to take place internally at a subjective level in order for the external and professional level to be fully materialized. Moreover, it has demonstrated that the subjective level takes place as a result of a process of learning. Furthermore, since humans change as a result of the learning that is taking place, then the acquisition of an identity will change too, thus resulting in an ongoing process of becoming. So, in being a specific role, an individual is necessarily always in an ongoing state of becoming.

References
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